MEDICAL STAFF OF WHITE OAK MEDICAL CENTER
RULES AND REGULATIONS

Revised: 1.3.11 ; 3.1.16; 4.6.16; 5.4.16; 6.1.16; 9.2018; May 16, 2019; June 20, 2019
Approved by the Medical Executive Committee: June 6, 2016; October 1, 2018; July 1, 2019
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Table of Contents

1) **Interview:**
All initial applicants for medical staff membership and clinical privileges may be interviewed (preferably in person) by their respective section and/or department chairperson at their discretion. In the event the appropriate section or department chair is unavailable, a member of the Credentials Committee may interview the applicant. A record of this interview will be kept in the applicant's credentials file.

2) **Orientation:**
All new members of the medical staff will participate in an orientation process in which they will be informed of the hospital and medical staff policies and procedures regarding:

Code Alerts	Patient Admission/Registration
HIPAA	Procedure Scheduling
Infection Control	Patient Rights/Responsibilities
Fire Safety	Informed Consents
Sexual Harassment	Advance Directives
Clinical Practice Expectations	Electronic Access to Patient Clinical Data
Medical Records Compliance	EMTALA & Patient Transfers
Use of Restraints	Autopsy Criteria
Pre-Op Requirements	Badges/Parking & Access
Pain and Pain Management	Patient Safety
Prescribing/Medication Orders	Contacting the Joint Commission

3) **Applicability of Bylaws and Rules & Regulations**: All provisions of the Medical Staff Bylaws apply to all units within the Hospital. Accordingly, the granting of clinical privileges for specific procedures will apply to all units within the Hospital unless otherwise specified in particular cases, and the termination of clinical privileges shall automatically apply to all units within the Hospital.

4) **Applicability of Hospital Policies and Procedures:** Medical staff is required to adhere to all hospital policies and procedures.

5) **Autopsies/Transplant Organs**: Every member of the Active Medical Staff is expected to be actively interested in securing autopsies in accordance with the criteria and procedures described in Hospital Policy. No autopsy shall be performed without prior written consent or as permitted by law. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty, when the autopsy meets the autopsy criteria. The pathologist shall notify the attending physician when an autopsy on his/her patient is being performed. The judgment of the attending physician shall determine notification of additional interested members of the medical staff.

Transplant organ procurement shall be performed by accredited qualified members of a recognized transplant team, who will be granted privileges for the specific purpose of harvesting organs.

6) **Policies on Diagnostic and Therapeutic Orders**: (For purposes of this rule, "attending physician" shall mean the physician with primary responsibility for the care and management of the patient, together with any physician consulting for or authorized to cover such physician upon his/her unavailability and "authorized provider" shall mean an appropriately privileged nurse practitioner, certified registered nurse anesthetist, nurse

mid-wife, or physician's assistant.)

a. **Who Can Order**: Diagnostic and therapeutic orders will be issued only by practitioners with appropriate clinical privileges.

b. **Requirements of a Written Order**: All orders for treatment shall be signed, dated, timed, include the hospital-issued medical staff member number, and issued in accordance with this rule. An order shall be considered to be in writing when (a) dictated to licensed registered nurses for medication and treatment and signed by the attending physician or authorized provider, or (b) dictated to registered or certified respiratory therapists for respiratory medications and treatments and signed by the attending physician or authorized provider, or (c) dictated to registered pharmacists for medication orders and signed by the attending physician or authorized provider; or (d) dictated to physical, occupational, and speech therapists for treatment within their various disciplines and signed by the attending physician or authorized provider; (e) dictated to registered dieticians regarding dietary orders and signed by the attending physician or authorized provider. (f) dictated over the telephone, as described below; or (g) given verbally, as described below. Every page of a multi-page order must be signed, dated and timed.

c. **Orders for Medication**: Attending physicians or authorized providers ordering or reordering medications including those that require the use of medication-related devices (e.g., nebulizers, catheters) must specify the following: name of the drug (generic name preferred), dose (including volume, concentration, type of fluid, and rate for IV administration), route/mode of administration, frequency of administration. Concentrations and formulations are to be included when multiple selections are available. All medication orders are to have a related diagnosis, condition or indication for use documented in the patient's medical chart. Orders for multiple medications with similar indication (e.g. pain) must include a basis for selection. Attending physicians or authorized providers ordering or reordering treatments must specify the treatment modality by name and frequency.

d. **Reinstatement of Previous Orders**: Blanket orders (a summary order to resume all previous orders) for medications will not be allowed. Blanket orders that affect unspecified medications (such as orders written as "Continue Previous Medications" or "Resume Preoperative Medications) will not be accepted as legitimate orders.

e. **Verbal Orders**: For patient safety purposes, verbal orders will only be allowed during emergent situations, when patient safety would be jeopardized by delays in treatment resulting from the initiator writing the order or when it is physically impossible for the initiator to enter the order.

f. **Telephone Orders:** Telephone orders shall be dated, timed and signed by the provider who gives the order. The attending physician or authorized provider providing a verbal or telephone order will participate in the read-back and confirm process.

g. **Faxed Orders:** Faxed orders must contain the practitioner's full name, address

and telephone number, pre-printed or legibly handwritten, and be signed by the practitioner.

h. **Authentication of Orders:** All telephone and verbal orders shall be authenticated by the person who issued them (or another provider involved in the patient's care) within 30 days. Either the attending or the covering physician may authenticate the verbal or telephone orders of the other, but the physician authenticating these orders shall have participated in the care or management of the patient.

7) **Policies on Admission and Discharge of Patients:**

a. **Unassigned Patients**: Patients being admitted without an attending physician shall be assigned to members of the Medical Staff on duty in the department or section to which the illness of the patient indicates assignment.

b. **Diagnosis is Mandatory**: Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

c. **Potentially Dangerous Patients**: Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

d. **Transferring Care:** A physician transferring a patient to another physician shall enter an order for the transfer of care.

e. **Discharge Requirements**: Patients shall be discharged only on order of the attending physician. The physician is responsible for reconciling all medications and providing the patient or his representative with a written list of these medications with instructions for home administration. In addition, written instructions are to be provided addressing diet, activity follow up care, and any condition or disease-specific instructions. The attending physician shall see that the record is complete, state the final diagnosis, and sign the record.

8) **Coverage Requirements**

a. **Alternate Coverage:** Each member of the Medical Staff shall name a member of the Medical Staff who is privileged and qualified to attend a patient in an emergency when they are unavailable. In case of failure to name such a provider, the department chair, medical staff president or Chief Medical Officer shall have the authority to call any member of the staff should it be considered necessary. In the absence from the city of any attending physician by reason of vacation, meetings, etc., a physician shall be named who has comparable qualifications and privileges at White Oak Medical Center to care for his patients. The physician so designated shall be informed as to the patient's condition. T.

b. **Emergency Department "On-Call" Rosters:** All patients presenting at the

Emergency Department without an attending physician shall be assigned to an appropriate physician, when necessary, by the Emergency Department physician pursuant to on-call roster protocols. Physicians on-call for the Emergency Department are obligated to perform, upon request, in-house consultations in their specialty on patients whose admission required assignment of an attending physician from the Emergency Department on-call roster. There shall be no appeal from or due process rights related to the preparation and administration of rosters for Emergency Department coverage. The Executive Committee shall supervise the Emergency Department roster system as necessary to assure conformity with this Rule.

c. **Emergency Preparedness**: The medical staff will participate in the Emergency Preparedness Program and Plan for the hospital.

9) **Consultation Requirements**

a. **Duty to Provide Consultation:** As a condition of membership on the Medical Staff, each member who is on call shall be obligated to provide consultations upon the request of a chairman of a clinical department or specialty section when necessary for a patient of an attending physician. Failure or refusal to provide such consultations shall be a basis for corrective action under the Bylaws.

b. **Responsibility to Request Consultation**: The patient's attending physician is responsible for requesting consultations when indicated. It is the duty of the medical staff through its department chairperson and Executive Committee to make certain that members of the medical staff do not fail in the matter of calling consultations as needed.

c. **Cases Requiring Consultation**: Except in emergency, consultation with another qualified physician is required in:

1. Procedures by which a known or suspected pregnancy may be interrupted.

2. Cases in which according to the judgment of the physician:
   a. The patient is not a good risk for operation or treatment.
   b. The diagnosis is obscure.
   c. There is doubt about the best therapeutic measures to be utilized.

d. **Definition of a Consultant**: Must be a member of the Medical Staff and well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of the individual's training, experience, and competence.

e. **Essentials of a Consultation**: A satisfactory consultation includes examination of the patient and the record. A complete consultative note signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation.

f. **Unresponsive/Unavailable Consultants**: In the event the attending physician is unable to obtain the services of a consultant in a given specialty, he/she shall contact the departmental chairperson of that specialty, Medical Staff President, or Chief Medical Officer for a resolution.

10) **Policies on Medical Records:**

a. **Responsibility**: The attending physician is responsible for the preparation of a complete medical record for each patient.

b. **Elements of a Complete Record**: The medical record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, pain assessment and reassessment special reports such as consultations, clinical laboratory, x-ray, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, follow-up and autopsy when available. No medical record shall be processed as complete until all deficiencies have been satisfied, except on order of the Medical Records Committee. All entries must be signed, dated, timed, legible and free of unapproved abbreviations.

c. **Authentication**: All portions of the medical record created by privileged Practitioners and Advanced Practice Practitioners should be signed, dated, and timed (either electronically, or by hand if using a paper form), and countersigned as specified in Sections 7, 18, and 31.

d. **Custodian of Records**: All records are the property of the hospital and shall not leave the safe-keeping and jurisdiction of the hospital without a court order, subpoena, or statute.

e. **Privacy of Patient Information:** Practitioners are entitled to only access patient information in the Hospital which is necessary and relevant to the medical care and treatment to be rendered by the practitioner to his/her particular patient or one for whom the practitioner is providing consultation. Accordingly, except as permitted by Hospital policies,Medical Staff Bylaws and/or law, a practitioner shall not review nor make use of any Hospital department, personnel, property or equipment to discover or review patient information which is not germane to his or her care of such patient, or which has not been authorized by the patient or his legal representative.

f. **Delinquent Medical Records**:

It is the policy of White Oak Medical Center that discharge summaries must be dictated within 30 days of discharge. The dictated report must be signed, dated and timed by the 30th day following discharge. Failure to complete a medical record within 30 days of the patient's discharge may result in disciplinary action against the practitioner.

Practitioners may be suspended from the medical staff in the event they have delinquent medical records that fall into one of the following categories:

- Any charts that remain incomplete greater than 90 days post-discharge

Notwithstanding the criteria described above, the decision to suspend may be modified based on the degree to which suspension will disrupt normal hospital operations.

Should the physician choose to resign his/her privileges, the practitioner is still responsible for the completion of the medical records. Therefore: The resignation will be classified as voluntary so long as outstanding medical records are completed by the 30th day. If the medical records are not completed by the 30th day, the failure to complete medical records may be reported to the Maryland Board of Physicians.

Notwithstanding the above, exceptions may be made for practitioners who can document extreme circumstances (such as disability) impeding their ability to complete delinquent medical records and have made good faith efforts to arrange for their completion through some other means.

If the practitioner completes the delinquent medical records before the 60th day of delinquency, the practitioner's membership and clinical privileges will be restored. If the practitioner is recommended for revocation of privileges, the practitioner will be sent a certified letter informing him or her of the recommendation and of the due process rights in accordance with the Medical Staff Bylaws. If the practitioner fails to exercise his or her due process rights in accordance with the Medical Staff Bylaws, the revocation shall become effective as of the 90th day of delinquency.
When a chart remains incomplete and the Medical Record Department cannot deduce the diagnosis, the chart shall be submitted to the appropriate departmental chairperson for determination of probable diagnosis.

Medical Staff and Advanced Practice Practitioners will be notified of impending actions before they occur. If the provider is going on vacation when a patient is discharged, and so notifies the Medical Record Department, then the vacation period would be added to the 30 days before placing a physician on the delinquent list.

11) **Requirements for History and Physicals (H&Ps)**

a. **H&Ps and H&P Updates:** A complete history and physical examination and any required updates shall in all cases be completed, entered into the patient's medical record, and signed, dated and timed (or if completed by an Advance Practice Practitioner, countersigned, dated and timed by the supervising Practitioner) within 24 hours after admission or registration of the patient, but prior to surgery or a procedure requiring anesthesia services. An H&P completed up to 30 days prior to admission is acceptable as long as an H&P update note is added to the medical record within 24 hours after admission or registration. The update note must document an examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of

treatment. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she shall indicate in the patient's medical record that: the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. Any changes in the patient's condition must be documented by the practitioner in the update note and placed in the patient's medical record within 24 hours of admission or registration, but prior to surgery or a procedure requirement anesthesia services. If components are found to be missing (see section d below), they should also be added at that time. The H&P update should be signed, dated and timed by the Practitioner (or, if completed by the Advance Practice Practitioner, countersigned, dated and timed by the supervising Practitioner) within 24 hours after admission or registration of the patient, but prior to surgery or a procedure requiring anesthesia services.

b. **Acceptance of, and Updates to H&Ps from Community Physicians:** H&Ps may be accepted from any community-based licensed independent practitioner (LIP). However an appropriately privileged LIP must update the H&P as described above, within 24 hours after admission or registration of the patient, but prior to surgery or a procedure requiring anesthesia services.

c. **H&P's and H&P Updates Prior to Surgery/ Procedure:** If the surgery or procedure requiring anesthesia services was not included as part of the plan in the most recent H&P, an updated H&P shall be required as described under (11.a) above. When a history and physical examination or any required updates are not recorded before the time stated for surgical procedure or diagnostic procedure, the surgical procedure or diagnostic procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

d. **Standard Components of a Complete H&P**

- Date of admission
- Chief complaint/reason for admission
- History of present illness/condition
- Past medical/surgical history/past treatment
- Current medications
- Allergies
- Psychosocial/social history
- Family history
- Review of Systems
- Physical Examination, which will include an exam of:
    - heart and lungs

  And any system correlated to:
    - the patient's chief complaint
    - the reason for admission
    - the reason for operative procedure
    - the reason for diagnostic procedure requiring anesthesia services

• Diagnostic and therapeutic results
• Assessment/Impression/working diagnosis
• Plan

e. **Minimal Requirements for H&Ps Based on Setting, Level of Care, Treatment and Services**

1. *Obstetrical Patients*: The entire prenatal record should be included in the record, together with an updated H&P as defined under (11.a) and (11.d). These shall be completed prior to delivery, but prior to surgery or a procedure requiring anesthesia services (except under emergency conditions).
2. *Same-Day or Outpatient Pre-op (Procedure) Patients*: If a patient is a same day admit or outpatient surgery patient, they must have an updated H&P as described under (11.a) and (11.e), once the patient is physically present in the facility, but prior to surgery or a procedure requiring anesthesia services. This is required even if the H&P is performed the day of surgery but outside the facility.
3. *Outpatients*: Patients in the Catheter and Electrophysiology Labs, Endoscopy, and those receiving sedation for special radiologic procedures must have an updated H&P as described under (11.a) and (11.e) prior to moderate or deep sedation. For outpatients not receiving moderate or deep sedation, an H&P is not required.
4. *Outpatient Behavioral Health Patients*: An updated H&P is only required when indicated by the initial health assessment triggers per departmental policy. Otherwise, COMAR regulations should be followed.

12) **Requirements for Operative Reports**: Operative Reports shall be dictated or documented and authenticated in the medical record within 24 hours after surgery or a high-risk procedure. The required elements of this note are: the name of the procedure/s performed, a description of the procedure, the indications for surgery, a description of the findings, the specimen removed, the pre and postoperative diagnosis, estimated blood loss, and the name of the primary surgeon and any assistants. A brief operative progress note shall be documented in the medical record immediately after the procedure if the full operative report cannot be entered into the record upon completion of the procedure but before the patient is transferred to the next level of care.

13) **Requirements for Discharge Summaries**:

All patients (inpatients and outpatients) will have a discharge summary covering the following components:

- Reason for hospitalization/procedure
- Procedure/s performed, care, treatment, services provided
- Significant findings
- Final diagnosis
- Condition at discharge/outcome
- Disposition
- Provisions for follow up care, including
    - Follow up appointment
    - Medications
    - Diet
    - Activity

A final progress note in lieu of a dictated summary covering all of the above components is acceptable for outpatients, for inpatients with hospital stays under 24 hours, and normal vaginal deliveries with a hospital stay less than 48 hours.

14) **Professional Practice Evaluation**:

a. **Cases Subject to Review:** All outpatient and short stay surgical cases performed in the hospital are subject to the same review processes as all in-patient care activities.

b. **Duty to Respond**: Every member of the Medical Staff is required to respond to inquiries from case management or Quality and professional peer review activites in accordance with Hospital policy. Failure to do so within 14 days shall require notifying the physician by certified mail, return receipt requested, that he/she may be suspended within 30 days of the initial inquiry and the facilities of the hospital will not be available to him/her for admission of new patients, consultations, special procedures or surgical procedures. The department chairman will be notified that the physician has failed to respond within 14 days. If the physician has not responded within 30 days, the Medical Staff Office is to be notified and the physician automatically suspended. Failure to respond in a timely manner may lead to further disciplinary actions.

15) **Restraints and Seclusion:**

LIPs ordering restraints or seclusion must be familiar with and adhere to the hospital policy.

16) **Medication and Narcotics Policies**:

a. **Duty to Use Formulary**: Each member of the Medical Staff, in agreeing to abide by the Bylaws, Rules and Regulations, gives his assent to the use of the hospital Formulary,.

b. **Drug Standards**: Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs with the exception of drugs for bona fide clinical investigations. Exceptions to the rule shall be well justified.

c. **Medication Errors**: All medications errors of commission and/or omission and all adverse drug reactions will be reported to the Hospital incident reporting system or the Pharmacy & Therapeutics Committee in accordance with the written policy of that committee.

d. **Medications will Auto-Stop**: In accordance with hospital policy.

17) **Practice Parameters for Advance Practice Professionals**

a. **Limits on the Advanced Practice Professional (APP):** The Advanced Practice Professional may not admit patients to the hospital. APP's may only treat a patient under the supervision of, or in collaboration with , the patient's attending physician. In the event of disagreement between a patient's attending physician and anAPP as to treatment of a patient, the attending physician's decision shall prevail.

b. **Physician Assistants:**

The following types of documentation, if created by a Physician Assistant, must be countersigned by a Physician:

- History and Physicals, within 24 hours of admission or registration, but prior to surgery or procedure requiring anesthesia services.
- Operative Notes, prior to transfer to the next level of care
- Consultations within 48 hours of consultation
- Discharge Summaries within 48 hours of discharge

Other types of notes and documentation (such as orders and prescriptions) do not require countersignature by a Physician provided the Physician's Assistant has been granted privileges to make such documentation by the medical staff and by the Board of Physicians in the Delegation Agreement.

c. **Advanced Practice Nurses (APRNs)**

APRNs will require countersignature by a physician for the following:

- History and Physicals within 24 hours of admission or registration, but prior to surgery or procedure requiring anesthesia services
- Discharge Summaries within 48 hours of discharge
- Procedural notes for procedures not performed by the APRN, prior to transfer to the next level of care

Unless precluded by their job description or not in possession of proper credentialing, Advanced Practice Nurses shall not require the countersignature of a physician for the following:

- Consultations and verbal and telephone orders
- Procedures performed wholly by the APRN
- Prescriptions,medication orders, verbal and telephone orders

18) **Delegation of designated medical services to Qualified Medical Personnel**

When an emergency medical condition exists, the medical staff may delegate conducting medical screening examinations to "Qualified Medical Personnel"

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"Emergency medical condition" refers to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy
b. Serious impairment to any bodily functions
c. Serious dysfunction of any bodily organ or part
d. With respect to a pregnant woman who is having contractions: that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Qualified Medical Personnel" are those professionals who have been identified by the Hospital's governing body as qualified to administer a medical screening examination as set forth in the Hospital's Medical Staff Bylaws or Rules and Regulations. In all cases, Qualified Medical Personnel will include medical and osteopathic physicians, and may include non-physicians such as nurse practitioners, registered nurses, and physician assistants operating within their scope of practice and, where required by law, in accordance with standardized procedures. Under these guidelines, for maternity patients, Qualified Medical Personnel may include registered nurses assigned to the Labor and Delivery Department pursuant to an approved standardized procedure.

19) **Intensive Care Units and Intensivists**:

a. Except for patients with a cardiac diagnosis and who are under the care of a cardiologist, any patient admitted to the intensive care units will receive a mandatory consultation with the in-house intensivists group and will be followed by that group on a daily basis.

b. All mechanically ventilated patients managed in the intensive care unit will receive a mandatory consultation with the in-house intensivists group and will be followed by that group on a daily basis.

c. Attending physicians may co-manage patients in the intensive care units; however, in the event of disagreement on clinical management, the opinion of the in-house intensivist shall prevail.

d. In-house Intensivists have the authority to ask the attending physician to obtain consultation with a qualified specialist on patients in the intensive care unit. Should the attending physician refuse to obtain such consultation, the intensivist may call the consultation. The chairman of the attending physician's department will be notified.

e. Post-operative cardiac critical care patients needing the services of an intensivist for continuing management purposes must be under the care of the in-house intensivists group as the sole critical care consultant.

20) **Protocol for Isolation of Infectious Diseases Patients**:

The physician directly responsible for the care of the patient is expected to order proper isolation or precautions as necessary. The nurse or infection control practitioner also has the authority to initiate the proper isolation precautions when a patient is suspected to be

infectious. The infection control practitioner serves as a resource to recommend appropriate culture orders when indicated. If there is disagreement on isolation status, the final authority rests with the chairperson of the Infection Prevention Committee to write culture orders and to institute/maintain the appropriate isolation procedures.

All personnel are responsible for reporting improper techniques in carrying out isolation in the hospital's occurrence reporting system as well as to the Infection Prevention nurse and/or chairperson of the Infection Prevention Committee.

In the absence of the chairperson of the Infection Prevention Committee, authority shall be delegated to the Infectious Disease practitioner on call.

21) **Director of the Medical Staff Services Department**

The director and/or designees in the Medical Staff Services Department shall keep accurate and complete minutes of all staff meetings, call meetings on order of the president, attend to all correspondence and perform such other duties as ordinarily pertain to his/her office.

22) **Physical and Verbal Abuse/Sexual Harassment Policy**

a. **Positive Work Environment**: The Medical Staff is determined to maintain a working environment for everyone that is free of physical and verbal abuse and sexual harassment. As a result, the Medical Staff expressly prohibits physical and verbal abuse or sexual harassment of any member of the Medical Staff, resident, medical student, technician, Hospital employee, patient, or visitor. It is expected that all levels of staff, patient and visitor, will be treated with respect.

b. **Abusive Behavior, Definition**: includes, but is not limited to: attacks leveled at other medical staff members which are personal, irrelevant, or go beyond the bounds of professional comment; impertinent and inappropriate comments impugning the quality of care in the hospital, or attacking physicians or nurses or other personnel; non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity, or incompetence. All members of the Medical Staff are required to abide by the Policy, and any violation of the Policy may result in disciplinary action, up to and including revocation of membership and clinical privileges.

c. **Sexual Harassment, Definition**: Sexual Harassment includes, but is not limited to: sexual advances; requests for sexual favors; the taking of any action that may affect any facet of an individual's employment or work retention (such as promotion, assignments, or compensation) on the basis of the individual's appearance; the display of sexually suggestive pictures or objects; foul or obscene language, jokes, or gestures; and any other offensive conduct or suggestive statements having a sexual connotation.

d. **Physical and Verbal Abuse** Definition:Unreasonably interfering with an individual's work performance.Creating an intimidating, hostile or offensive working environment.

e. **Reporting of Abuse**: Any individual who believes that he/she has been the victim of physical and/or verbal abuse/sexual harassment or who has knowledge of any such behavior should report such conduct immediately to the President of the Medical Staff or the Hospital CMO for investigation and appropriate action. Hospital employees should report any such conduct to their supervisor, and the Hospital CMO will notify the President of the Medical Staff. Once the President of the Medical Staff has determined the severity of the incident and a recommendation or action has been made, the Hospital President will be informed.

f. **Records of Abuse**: All incident reports and documentation regarding abusive behavior and/or sexual harassment shall be promptly forwarded to the Medical Staff and Risk Management Offices. Protocols as delineated in the Medical Staff Blyaws and Hospital policies shall be followed

23) **Policies on Physical/Mental Fitness to Practice:**

a. **Physical Examination**: At the time of biannual reappointment or sooner (if indicated by peer review activity), the Credentials Committee and/or Medical Executive Committee may require any member of the medical staff to demonstrate their physical capacity to perform the clinical privileges they have requested.
b. **Mental/Behavioral Health Evaluation**: At the time of reappointment or sooner (if indicated by peer review activity), the Credentials Committee and/or Medical Executive Committee may require any member of the medical staff to demonstrate their mental capacity to perform the clinical privileges they have requested.
c. **Tuberculosis:** All members of the medical staff are required to undergo evaluation bi-annually. This in no way negates individual departmental policies that may require more frequent verification of a negative status.

24) **Collegial Intervention Policy:**

The Medical Staff Leadership at White Oak Medical Center is committed to addressing practitioner unprofessional/disruptive behaviors by employing a supportive infrastructure that is a tiered intervention process for fostering professionalism and professional accountability. The model for addressing disruptive behavior is based on the evidenced-based, tier-based “Professional Accountability Pyramid” (see Addendum B) that focuses on four graduated interventions: informal “cup of coffee” conversations for single incidents, “awareness” interventions when data reveal patterns, leader-developed action plans if patterns persist, and imposition of disciplinary processes.

The first tier, the *Cup of Coffee* conversation, provides a way for the department chair or his/her designee to informally discuss with the practitioner how his/her observed behavior seems to undermine the organization’s culture of safety and respect. These conversations

are intended to be private, timely, respectful and collegial. The goal of the *Cup of Coffee* conversation is to convey the salient points of the reported observation to inform the practitioner that the behavior was observed and to promote accountability for a nonegregious episode of unprofessional conduct or behavior. It is also an opportunity to hear both sides of a situation. A brief memo of the conversation should be noted in the hospital's occurrence reporting system.

The second tier, the *Level 1 Awareness Intervention*, is used when an apparent pattern of unprofessional/disruptive behavior occurs. The apparent pattern is typically defined as three or more Cup of Coffee Conversations in a rolling, two-year period (although it may be appropriate to escalate to this level without having had three such conversations.) The aim remains to encourage practitioners to pause, reflect and self-regulate. In the awareness intervention, the reported events are shared with the practitioner, the Leadership Council is made aware of the escalation to the second tier, and a certified letter is sent to the practitioner documenting the intervention. A copy of the letter is placed in the hospital's occurrence reporting system.

Escalation to the third tier, *Level 2: Guided Intervention by Authority,* occurs when the pattern of disruptive behavior continues. At this point, Leadership Council meets with the practitioner privately to alert the physician that the pattern has persisted. A written corrective/improvement and evaluation plan is developed, and a copy is provided to the practitioner as well as placed in the practitioner's Medical Staff file.

The fourth tier, *Disciplinary Action*, is reached when the practitioner fails to comply with the authority intervention and leads to disciplinary action, or when the action is egregious, as appropriate. This might include appropriate referral to outside organizations, restriction of or termination of privileges, and other sanctions authorized by the Medical Staff Bylaws, which will govern the terms of any such action.

As the arrow on the right side of the pyramid indicates, important exceptions exist to the linear progression of the pyramid such as when the disruptive behavior is considered egregious. These might include where the law mandates reporting the event and/or provides sanctions for engaging in prohibited behavior, claims of discriminatory behavior, allegations of sexual boundary violations, substance abuse, or other impairment affecting a health professional's ability to practice safely.

25) **Progressive Policy on the Enforcement of Medical Records Compliance**

Medical Staff and Advanced Practice Professionals who fail to maintain medical records in the manner mandated by the hospital and regulatory agencies are subject to the following progressive steps:

First Occurrence: A letter will be sent by the appropriate hospital department.

Second Occurrence: A letter will be sent by the appropriate hospital department and collegial intervention by the Department Chairperson, President of the Medical Staff, Chief Medical Officer or other appropriate physician leader.

Third Occurrence: Suspension of clnical privleges.

Notwithstanding the above, practitioners remain subject to the consequences for failure to maintain medical records described in other relevant sections throughout these Rules and Regulations, including suspension of clinical privileges.

26) **Policies on Practitioner's Access to Own Files**

I. General Principles

(1) A Medical Staff member may be notified and given an opportunity to review and respond in writing to any written communication concerning the individual that is prepared by a Medical Staff leader or a member of the Hospital's administration and included in the individual's Practitioner File. The Medical Staff member's response shall be maintained in the Practitioner File along with the original communication.

(2) In accordance with this Policy, each Medical Staff member shall also be afforded a reasonable opportunity to inspect his/her credentials file and make notes regarding it, in the presence of the Medical Staff Office Director, the CMO, an appropriate Medical Staff leader (e.g., President of the Medical Staff, department chairperson, Credentials Committee Chairperson), and/or the Hospital President in accordance with the terms of this Policy. In no case shall a Medical Staff member remove the credentials file or any portions thereof from the Medical Staff Office or make copies of it, without the express permission of the Hospital President.

(3) The CMO, the Medical Staff Services Director, or their authorized representatives shall correct or delete materials contained in a credentials file only after the individual has submitted a written request demonstrating good cause for the correction or deletion and that request has been approved by the Executive Committee and the Hospital President.

(4) Practitioners will be allowed to review and copy their full credentialing and quality assurance files if an adverse action is taken against their privileges based on the recommendation of the MEC or action of the Hospital's Board of Directors.

II. Category 1 Access

A Medical Staff member shall routinely be permitted access to the following information, provided appropriate notice is given to the Medical Staff Office Director:

(1) applications for appointment, reappointment, and requested changes in staff status or clinical privileges, with all attachments;

(2) all information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, or changes in

staff status or clinical privileges (except for confidential reference information obtained from third parties);

(3) any performance improvement trend sheets data, and reports concerning the individual's practice at the Hospital;

(4) any routine correspondence between the Hospital and the Medical Staff member; and

(5) information concerning the Medical Staff member's meeting attendance record and compliance with other citizenship requirements.

III. Category 2 Access

A Medical Staff member may review Category 2 documents while in the presence of an appropriate Medical Staff leader (e.g., President of the Medical Staff, department chairperson, Credentials Committee Chairperson, the CMO, and/or the Hospital President. At this meeting, the Medical Staff member shall be shown the document or an appropriate summary of it (but shall not be told the identity of any individual who provided the information unless, in the discretion of those involved in the meeting, revealing the individual's identity would be conducive to quality and performance improvement and would not result in adverse consequences to the individual(s) or willingness of other individuals to document incidents).

Category 2 documents are the following:

(1) any and all incident reports concerning the Medical Staff member which are placed into the file, along with any written explanations submitted by the individual;

(2) any confidential correspondence and/or memos to the file, prepared pursuant to collegial intervention efforts or other progressive disciplinary steps with the individual, along with any responses from the individual;

(3) any periodic review and appraisal forms completed by the appropriate department chairperson, including those completed at the time of appointment or reappointment;

(4) any routine peer review evaluation forms completed;

(5) any evaluations or reports from proctors, monitors, and/or external clinical reviewers, and any written explanations submitted by the individual;

(6) confidential reports and/or minutes (redacted) of peer review committees pertaining to the Medical Staff member;

(7) any correspondence setting forth formal Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements, or final adverse actions

following completion or waiver of a hearing and appeal, accompanied by any written explanation the individual submits; and

(8) any written explanation to any of the above submitted by the Medical Staff member.

IV. Category 3 Access

Because of the expectation of confidentiality on the part of individuals who submit Category 3 documents, a Medical Staff member may not have access to these documents, unless (i) the individual providing such information consents to the disclosure, or (ii) the information is the basis for an adverse professional review action that entitles the individual to a hearing pursuant to the Medical Staff Bylaws.

Notwithstanding this, a Medical Staff member may meet with an appropriate Medical Staff leader, the CMO, and/or the Hospital President to discuss any Category 3 information and may review a written summary of the information (provided the summary does not reveal the identity of any individual who submitted the information).

Category 3 documents are the following:

(1) any and all confidential correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents concerning the Medical Staff member's training, clinical practice, professional competence, or conduct at any other health care facility or medical school; and

(2) notations of telephone conversations with references and other third parties concerning the Medical Staff member's qualifications.

V. Disputes

Should any dispute arise over access to information in a practitioner file, the dispute shall be resolved by the CMO and the President of the Medical Staff, after discussing the matter with the Medical Staff member involved, whose decision shall be final and not subject to appeal.

27) Any member of the medical staff with concerns about the safety or quality of care provided in the organization may report these concerns to the Joint Commission. The hospital will take no disciplinary or punitive action because a member of the medical staff reports safety or quality of care concerns to the Joint Commission.

ADDENDUM A
Medical Staff and Advanced Practice Professional Clinical Practice Expectations

The goal of the Medical Staff of White Oak Medical Center is to provide the highest quality of care to our patients. In an effort to accomplish this, the medical staff and the advanced practice professionals have articulated generally accepted criteria which govern the practice of medicine within this hospital. All members of the medical staff and advanced practice proessionals are exted to adhere to the following principles as a member of a community of health care professionals in the delivery of high quality medical care.

1. Abide by the Bylaws, Rules and Regulations and other policies & procedures of WOMC.

2. Examine and develop a plan of care for patients promptly on their admission to the hospital.

3. Ensure continuous physician coverage (24hrs/day, 7days/week) for providers' in-house patients by the provider or a covering physician with similar privileges at WOMC.

4. Maintain medical records consistent with medical staff bylaws and rules and regulations including:

    a. Completing a dictated or written H&P within 12 hours of patient admission and prior to transfer to the Operating Room or for any invasive procedure requiring sedation.

    b. Completing a brief operative note before transfer to the next level of care.

    c. Completing a fully dictated and signed operative report within 24 hours of procedure.

    d. Provide a daily progress note in the record for all inpatients that updates the patients condition and plan of care and addresses their need for continued stay in an acute care facility.

    e. Complete a dictated discharge summary within 30 days of discharge, and transfer summaries immediately when patient is to be transferred. Attending physicians who transfer care from one service to another must dictate a transfer summary that includes all pertinent details to enable the next provider to manage the patient's care.

    f. All written entries in the medical record are to be legible, signed, dated and timed.

5. Provide regular thoughtful communications with patients and their families regarding the patient's condition and the plan of care.

6. Maintain acceptable standards of quality care, utilizing, when appropriate,

approved clinical pathways.

7. Participate fully in the Peer Review process by responding fully and promptly to Peer Review inquiries regarding quality of care issues.

8. Follow generally accepted medical practice in the ordering of medications and blood products.

9. Communicate effectively with other members of the health care team including nurses, therapists, other physicians and APP's, and anyone involved in the welfare of patients. This includes:

    a. Responding promptly to pages in no more than 30 minutes

    b. Keeping other members of the team informed of the plan of care.

    c. Communicating directly with consulting physicians regarding the specific reason for requesting consultation and the level of urgency of the consultation.

    d. Avoiding disruptive or threatening behavior or communication including the avoidance of impulsive, disrespectful or sexually harassing behavior directed at fellow providers, WOMC staff, patients or their families.

    e. When transferring complete responsibility for a patient (such as during vacation coverage), physicians will conduct a verbal hand-off to the covering physician. This hand-off will contain pertinent information about current treatment and condition as well as about any recent or anticipated changes. The information will be provided within a timeframe sufficient for the receiving physician to review the information and request any additional information needed. A similar verbal exchange will be provided by the covering physician on the return of the physician taking leave.

    f. When transferring on-call responsibility, physicians will verbally inform the oncoming on-call physician of any patient that is anticipated to require monitoring or intervention during the on-call period prior to the on-call coverage period. At the end of the call period, the covering on-call physician will verbally inform the receiving team or on-call physician of patients with urgent clinical issues.

    g. Providers are required to provide their current cell phone number to the medical staff office for the reporting of critical results and urgent information about patients.

    h. Providers are required to maintain an active e-mail account for all non-urgent communications such as policy changes & meeting announcements. Spam filters must be set to permit messages from the hospital.

I agree to abide by these Clinical Practice Expectations.

_____	_____	_____
Printed Name	Signature	Date

ADDENDUM B
PROFESSIONAL ACCOUNTABILITY PYRAMID