



# **Indiana University Health West Hospital**

## **RULES AND REGULATIONS**



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Members of Medical Staff at Indiana University Health West Hospital are involved in activities to measure, assess and improve performance throughout the organization. Medical Staff Quality Review will consist of indicators set by the department of the Medical Staff as well as events that involve potential risk situations or customer service issues that may affect patient care. Other data will be collected and shared with members of the medical staff that are required by outside organizations such as JCAHO, Anthem, and the PRO. Data collected through this process will be addressed on an ongoing basis and will be included as part of the reappointment process.

**Internal Peer Review Process:**

Peer review will be completed on a timely basis, based on the department in which members belong. Ideally, a true peer in the specialty should review each case if possible.

A peer is defined as an individual from the same discipline (for example dentist to dentist, physician to physician) and with essentially equal qualifications.

A member of the department will review cases that do not meet the standards established by the department. When the review has been completed, if there are suggested improvements or if the reviewer feels the care was not managed appropriately, the attending physician will have the opportunity to respond. The reviewer will then be given the opportunity to see the attending physician's comments and all comments will be forwarded to the department for a final conclusion. Conclusions reached at the department level will then be forwarded to the Patient Care Review Committee.

In some cases where multiple specialties are involved, a peer review panel of physicians in these specialties may be established to study the process of care and areas for improvement. These panels will be coordinated by Performance Improvement Services with the direction of the department chair people. Results of this process will be forwarded to the physicians involved for comment prior to final conclusions being shared with all departments involved.

Confidentiality is conferred by the law to protect and, therefore, promote information sharing in certain relationships. Confidentiality encourages professionals to fully review each other without fear that their concerns or critiques will be divulged. All departments and committees sanctioned by the Medical Staff will follow the peer review statute for attendance and the information shared will remain confidential and peer review protected.

**External Peer Review Process:**

An external peer review process will be primarily utilized in three situations:

1. When there are no internal peers available to conduct a thorough, credible, on-going review to assure high standards are maintained.
2. Peer review with those available may cause conflict within the specialty.
3. When there is significant disagreement among the medical staff as to whether care was managed appropriately.

In all cases, the Medical Executive Committee of the Medical Staff will approve the process developed by the Department to determine the organization and the details of the review process. All external reviews agreed to by the Medical Executive Committee will be coordinated through the Performance Improvement Department to assure protection under the peer review statute.

The Fair Hearing Plan continues to be in place.

**101. General Statement**

It shall be the policy of Indiana University Health West Hospital that abortions may be performed in the situation that the fetus has been diagnosed with a lethal anomaly. All other situations (Maternal indications and non-lethal anomalies) will be referred to another appropriate facility or care center.

Prior to the termination, the attending physician must provide documentation of the following:

- Indication for procedure
- Maternal Fetal medicine consultation that includes prenatal diagnosis and counseling regarding options for care.
- Written summary of pre-abortions counseling provided at least 18 hours prior to procedure, including Name of physician performing procedure, Nature of proposed procedure, the risks and alternatives to the procedure, probable gestation of the fetus, Medical risks associated with carrying the fetus to term.
- Written consent form signed by patient or legal guardian, certifying above information has been provided, at least 18 hours prior to the procedure.

The manager of labor and delivery must be notified at least 18 hours before the procedure to consider special staffing issues.

**102. Right to refuse to Perform Abortions**

No practitioner, staff member or employee who objects to abortions on ethical, moral or religious grounds shall be required to perform or assist in the performance of the abortion. No one, including the hospital, may discriminate against such persons because of their beliefs concerning abortion.

**103. Monitoring of the Abortion Policy**

The Peer Review Committee of the OB/GYN Department shall review all cases of abortions with respect to the adherence to this policy and shall report violations to the Medical Executive Committee.

**104. Consent for Abortions**

IU Health West Ethics Committee will be consulted in the case that the health care provider and the family disagree as to the procedure to be performed, or family members or staff disagree.

**105. Reporting to the State Department of Health**

The attending practitioner shall provide all information required by the State Department of Health on the appropriate form and it shall be his/her responsibility to see that the form is submitted to the State Department of Health. The form shall be transmitted no later than July 30 for each abortion performed in the first (6) months of the year and no later than January 30 for each abortion performed the last six (6) months of the preceding year.

**106. Late Term Abortions**

Late Term Abortions to be defined by the OB/GYN Committee. If it is the determination of the attending physician that a Late Term Abortion is indicated the IU Health West Ethics Committee will be consulted.

## 200 ADMINISTRATIVE

### **201. Medico-Administrative Officers**

A physician employed by the hospital in a purely administrative capacity with no clinical duties or privileges is subject to the regular personnel policies of the Hospital and to the terms of his/her contract or other conditions of employment, and need not be a member of the Medical Staff. A medico-administrative officer who has clinical responsibilities, must be a member of the Medical Staff, achieving this status and his/her clinical privileges as provided for within these Bylaws. The Medical Staff membership and clinical privileges of any medico-administrative officer shall not be contingent on his/her employment agreement.

## 300 ORDERS

### **301. Member of Staff Telephone and Verbal Orders**

Orders shall be written in ink or computer entry and utilize only Hospital approved abbreviations.. A verbal or telephone order shall be considered valid if criteria met per CWMC Patient Care Division Policy, defining what disciplines are qualified to take a telephone/verbal order, what type of order that discipline is qualified to take, and the method followed to process the order.

### **302. Physician Order Authentication**

Physician orders within the medical record must be authenticated electronically in the medical record within 48 hours. .All orders for treatment shall be in writing or direct physician electronic entry. A verbal order shall be considered to be in writing if given to a licensed nurse or licensed personnel as approved by the Medical Staff, functioning within their sphere of competence and signed by the responsible practitioner. All verbal and telephone orders shall be “read back” to the physician to assure correctness. These personnel shall include Registered Nurses, Registered Respiratory Care Practitioners, Physical Therapist, Occupational Therapists, Speech Therapists, Registered Dietitians, Pharmacists, and Psychologists shall be restricted to orders specific to their discipline. All orders dictated verbally over the telephone shall be dictated by the practitioner and shall be signed by the appropriately authorized person to who dictated with the name of the practitioner. All verbal orders need to be “repeated back” and “verified” and written as RVVO (repeated verified verbal order). All verbal orders are to be reserved for emergent/urgent circumstances. All telephone orders are to be “read back” and verified and written as RVTO and should only used when not in the department.

### **303. Medication Stop Order Policy**

(Decisions regarding stop order and auto substitution to be developed by Pharmacy and Therapeutics Committee).

### **304. Standing or Routine Orders**

Standing or routine medication orders must be approved by the Pharmacy and Therapeutics Committee for final approval and consistency. The orders must be dated and signed by the practitioner.

### **305. Dismissal Orders**

Patients shall be discharged only on a written order (or upon a verbal order as stated in Rule 301).

### **306. PRN And On-Call Medication Orders**

All PRN and/or on-call medications ordered by a physician must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24 hour period.

### **307. Diagnostic Test Interpretation**

Authenticated reports of all radiographic (except dental x-rays), fluoroscopic, pathologic, pulmonary function and electrodiagnostic examinations shall be placed in the patient's medical record as soon as possible. A member of the Medical Staff who has been granted specific privileges through the normal Medical Staff credentialing mechanism shall provide an authenticated report for all such examinations to enhance consistency and correctness in interpretations and reports of test findings.

### **308. Alternate Brand Drugs**

The pharmacy may substitute an alternate equivalent product for a prescribed brand name when the alternate is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner. All drugs and medications administered shall be those listed in the latest edition of: United State Pharmacopoeia, National Formulary, and American Hospital Formulary Service. Drugs for bona fide clinical investigations may be involved in Use of Investigational Drugs in Indiana University Health West Hospital and all regulations of the Federal Drug Administration.

### **309. Administration of Medication to Patients**

Physicians may personally administer medications deemed appropriate per his/her clinical judgment and recorded in the order sheet or MAR. Medications will also be administered by CWMC personnel per CWMC Patient Care Division policy that defines what disciplines are qualified to administer medications, including route.

## **400 MEDICAL RECORDS**

### **401. Context**

All patient care services delivered at Indiana University Health West Hospital including inpatient and outpatient care shall be documented in a format and manner acceptable to the Medical Records/Utilization Review Committee. The medical record will contain sufficient information to identify the patient, justify the treatment, document the course of treatment, promote continuity of care, and assist with transferability of the patient.

1. ED Records Requirements
  - (a) Identification data
  - (b) Time and means of arrival, time treatment is initiated and time examined by physician, if applicable
  - (c) Pertinent history of illness or injury, description of the illness or injury, and examination, including vital signs
  - (d) Diagnostic or therapeutic orders
  - (e) Description of treatment given or prescribed, clinical observations including the results of treatment and reports
  - (f) Emergency patients-conclusions at termination of treatment, final disposition, condition at discharge, and follow up care instructions.
2. Outpatient Record Requirements
  - (a) Identification data
  - (b) Diagnostic and therapeutic orders
  - (c) Description of treatment given, procedures performed, and documentation of patient response to intervention, if applicable
  - (d) Results of diagnostic tests and examination done, if applicable
  - (e) Discharge instructions, if applicable

(See rule and regulation 809 for specific requirements when anesthetics are administered)

3. Inpatient record requirements
  - (a) Identification data

- (b) Dictated or written medical history and physical exam
- (c) Statement of the diagnosis or impressions drawn from the H&P
- (d) Diagnostic and therapeutic orders and results
- (e) Evidence of appropriate Informed consent, when appropriate and evidence of known advance directive
- (f) Clinical observations, including results of therapy
- (g) Progress notes
- (h) Operative notes
- (i) Results of consultations
- (j) Nursing notes, nursing plan of care, and entries by other health care providers, and all medications
- (k) Pathology and clinical laboratory reports, anesthesia reports, nuclear medicine examinations or treatment, and any other diagnostic or therapeutic procedures
- (l) Documentation of complications and unfavorable reactions to drugs and anesthesia
- (m) A discharge summary authenticated by the physician. A final progress note may be substituted for the discharge summary in the case of a normal newborn infant and uncomplicated obstetric delivery. The progress note or discharge information should include condition at discharge, instructions given to the patient and family, and follow up care required.
- (n) Final diagnosis

#### **402. Legibility**

No part of the medical record may be written in pencil and all handwritten entries shall be legible and in blue or black ink.

#### **403. Operative Report**

Dictated operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. The report shall include name and hospital identification number of the patient; the patient's hospital identification number; date of operation; name of the surgeon and any assistant; pre-operative and post-operative diagnosis; name of the specific surgical procedure(s) performed; type of anesthesia administered; complications, if any; surgery for outpatients as well as inpatients unless an emergency procedure prevents this. All operative reports shall be dictated within 24 hours. The report will be promptly signed by the surgeon and made a permanent part of the patient's current medical record.

A note shall be placed in the progress note immediately post op that includes the date, post-operative diagnosis, procedure, findings and complications. Any specimens removed, blood loss, and assistants, if applicable, shall be included, and it shall be authenticated by the surgeon.

#### **404. Patient Request for Copy of Medical Record**

A patient or his/her duly designated recipient may receive a copy of his/her completed medical record or an individual report upon presentation of an appropriately signed release form. In order to allow an appropriate period of time for the physician(s) of the record to review the medical record, the copy will be provided not later than 96 hours from the time of receipt of the request.

#### **405. Consent to Release**

A written consent of the patient or legal guardian is required for the release of medical information to others, not otherwise authorized to receive this information.

#### **406. Permanently Filed**

A medical record shall not be permanently filed until it is completed by the responsible physician(s), or is ordered filed by the Medical Records/Utilization Review Committee.

When a physician is no longer a member of the Medical Staff and charts are filed as permanently inadequate, this shall be recorded with the physician's credential file and considered by the Credentials Committee at any time in the future when application for reappointment is made.

Any medical record of a Medical Student or Resident found to be incomplete after the member has terminated his/her affiliation shall be completed by the supervising physician.

All incomplete medical records of physicians who have either died, become incapacitated or whose privileges have been revoked shall be annotated by the chairperson of the department or his/her designated representative as follows:

- (a) If it is necessary to give a diagnosis, the diagnosis shall be designated as a "conditional diagnosis" and based only on records and information available;
- (b) The chairperson shall state on the chart that: "The medical record is incomplete due to the failure, illness or death of the attending physician."

#### **407. Admission History and Physical**

A history and physical reflecting the patient's condition at time of admission must be provided by the admitting or attending physician within 24 hours of admission. Inpatient history and physicals must be written or dictated. For elective procedures that require a dictated history and physical, the report shall be written or dictated in advance of admission. If the report is completed more than seven (7) days but before thirty (30) days prior to admission, it must be updated by a note to reflect subsequent changes or a note indicating there has been no change in the patient's status within 24 hours of admission.

In cases where the patient has been readmitted to the hospital within thirty (30) days of discharge, an Interim History and Physical Examination may be used to indicate any changes since the last History & Physical Examination. The original History and Physical Examination shall then be placed on the readmission chart.

#### **408. Symbols and Abbreviations**

Symbols and abbreviations may be used only when they have been approved by the Medical Staff and an official record of these shall be kept on file in the Health Information Department.

#### **409. Authentication of Reports and Use of Rubber Stamps**

All clinical entries in the patient's medical record shall be dated, authenticated and timed.

A rubber stamp is prohibited for use of authentication of patient's medical record.

#### **410. Coding Sheet**

The coding sheet must be completed for all patients and must include; final diagnosis, additional diagnoses, operations performed, complications, condition on discharge, without symbols and abbreviations, and dated and signed by the responsible physician.

#### **411. Ownership of the Medical Record**

All medical records, including x-rays, ECGs, special diagnostic procedures and other like diagnostic aids are the property of Indiana University Health West Hospital and no original record shall be permitted to leave the Hospital, except to be scanned into the electronic record and long term storage.

Unauthorized removal of the record from the Hospital is grounds for suspension of the member of the Medical or Health Professional Affiliate Staff for a period to be determined by the Executive Committee.

Under certain circumstances, certain pertinent select original x-ray films may be sent when necessary to facilitate patient care. Every effort will be made to keep the bulk of original films at Indiana University Health West Hospital.

#### **412. Progress Notes**

Pertinent progress notes shall be recorded at the time of the evaluation, sufficient to permit continuity of care and transferability. Progress notes shall be written at least daily on all patients by a physician or his/her representative and authenticated by the physician.

#### **413. Prenatal Record**

The current obstetrical record shall include a complete prenatal record, and may be a legible copy of the attending physician's office record transferred to the Hospital prior to admission. The prenatal record must be updated at time of admission and may be used in lieu of a dictated history and physical exam for purely pregnancy-related problems. A dictated or written history and physical report shall be required for all medical problems.

#### **414. Medical Staff Access to Medical Records**

Access to all medical records of patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee or its designee.

Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

#### **415. Delinquent Medical Records**

All aspects of the patient's medical record shall be completed at the time of service. Attending physicians will maintain documentation compliant with billing requirements, regulatory and accreditation standards. The medical record will be made available to the physician(s) in a designated place in the Medical Records Department.

The Medical Record will be considered delinquent if reports and signatures are not completed within 15 days following allocation (date when dictation is assigned or report is transcribed).

The physician shall be notified per hospital Completion of Medical Record Policy. Suspensions for lack of chart completion shall be governed by Administrative Policy.

If a physician has not completed his/her delinquent records prior to his/her leaving on vacation, or situations beyond their control such as illness, military duty, etc. he/she shall have his/her privileges suspended when he/she returns, however, any record which becomes delinquent during the time he/she is on vacation will need to be completed within seven days following his/her return from vacation.

The suspended privileges (admitting new patients, performing invasive or high-risk procedures, delivering babies, giving anesthesia, providing consultations, etc.) of the physician shall be restored immediately upon the completion of the delinquent records.

#### **416. Consultations**

##### **A. Requests for consultations**

Consultation requests should be made by physician-to-physician contact and should be reflected in progress note. Consultations may also be specifically ordered.

## 500 ADMISSION AND DISCHARGE OF PATIENTS

### **501. Admission Privilege**

Only a member of the Medical Staff who has an unlimited license to practice medicine or dentistry in the State of Indiana may admit a patient to the Hospital, and shall be governed by the official admitting policies of the Hospital.

It is expected that all patients admitted to Indiana University Health West Hospital shall have been seen and examined by the attending physician or his/her designee, on a timely basis as is dictated by the clinical needs of the patient.

- a) Patients designated as emergency cases and those admitted directly are transferred into the ICU area from the admitting offices, emergency department or general care area must be evaluated within a reasonable amount of time as indicated by patient's condition or within 12 hours.
- b) Patients admitted via the emergency department to a general care area must be evaluated in a timely basis as indicated by the patient's condition or twelve hours, unless the patient has been seen by the physician or designee immediately prior to admission.
- c) Elective admissions must be evaluated within eighteen(18) hours.

### **502. Admission Consent to Treat**

A consent form authorizing the Hospital to treat and care for the patient must be signed by or on behalf of every patient admitted to the Hospital. Unless it is an emergency, the patient shall not be admitted until a consent form is obtained.

### **503. Emergency Admission**

Physicians admitting emergency cases shall be prepared, if requested, to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

### **504. Hospital Deaths and Autopsies**

It is the policy of the medical staff to encourage the seeking of autopsy permission in all hospital deaths that meet the established criteria. No autopsy shall be performed without consent of the next of kin or a legally authorized agent. Details on requesting autopsies, obtaining consent, established criteria, and cases to be reported to the coroner are available in the Administrative, Nursing, and Pathology Department policy manuals.

To facilitate the use of autopsy findings in quality assurance activities, a copy of the autopsy report is available in the Medical Records Department.

### **505. Admission Priorities**

Patients will be admitted by the Admissions Department on the basis of the following order of priority:

- (a) Emergency (Emergency is defined as "an immediate threat to life")

Within 48 hours following an emergency admission, the attending physician shall furnish to the Medical Records/Utilization Review Committee a signed, sufficiently complete documentation of the need for this admission, when requested. Failure to furnish this documentation, or evidence of willful and continued misuse of this category

of admission will be brought to the attention of the Executive Committee for appropriate action.

- (b) Urgent (Urgent is defined as “irreparable harm without immediate threat to life”)

This category includes those so designated by the attending physician and shall be reviewed as necessary by the Medical Records/Utilization Review Committee to determine priority, when all such admissions for a specific day cannot be accommodated.

- (c) Pre-Operative

This category includes all patients already scheduled for surgery. If it is not possible to accommodate all such admissions, the chairperson of the Surgery Department may determine the urgency of such scheduled category of admissions.

- (d) Routine

This category shall include all elective admissions involving all clinical services.

#### **506. Transfer Priorities**

No patient may be transferred without approval by the attending physician, and the priorities of the transfer shall be:

- (a) Emergency Department to the appropriate bed
- (b) From the obstetric patient care area to a general care area when medically indicated
- (c) From the Critical Care Unit to a general care area
- (d) From a temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

#### **507. Provisional diagnosis**

Except in an emergency, no patient shall be admitted until a provisional diagnosis or valid reason has been stated. In such emergency cases, the provisional diagnosis shall be recorded as soon as possible.

#### **508. Continued Hospitalization Documentation**

The attending physician is required to document the need for continued hospitalization after specific periods of stay are identified by the Medical Records/Utilization Review Committee and approved by the Executive Committee. This documentation shall include:

- (a) An adequate written record of the reason for continued hospitalization
- (b) The estimated period of time the patient will need to remain in the hospital
- (c) A plan for post-hospital care, as soon as can be determined.

Upon request of the Quality Assessment Utilization Review Committee (QAUR), the attending physician shall provide within 48 hours of receipt of such request written justification for continued hospitalization of any patient. Failure to comply with such request will be brought to the attention of the Executive Committee. Any patient the QAUR Committee reasonably assumes to be an outlier based on extended length of stay shall have his/her continued stay approved by the Committee.

#### **509. Appropriateness of Admission to Critical Care Unit or the Hospital**

Any unresolved questions regarding the appropriateness of admissions to or discharges from the Critical Care Unit or the hospital will be referred to the Chairperson or physician advisor of the MR/RU Committee, who will consult as necessary with chairpersons of Clinical Departments or the involved physician to resolve the unresolved questions.

#### **510. Protective Measures**

For the protection of the patient, medical staff, nursing staff and the hospital, certain principles shall be adhered to:

- (a) The admitting physician shall be responsible for providing such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patient might be a source of danger.
- (b) Any patient known or suspected to be a suicidal intent shall be transferred to another facility where suitable accommodations are available. When an appropriate transfer cannot be arranged, the patient may be admitted to a unit of the hospital and temporary protective measures should be taken and special nursing care provided.

#### **511. Assigned Emergency Admission**

When a patient to be admitted on an emergency basis does not have a private physician, a member of the staff or his or her designee from the rotation list will be assigned.

In any emergency case in which it appears the patient will need to be admitted to the hospital, the admitting physician or his/her authorized representative shall, when possible, contact the admitting department to ascertain that there is an available bed.

#### **512. Attending Physician**

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital for the prompt completeness and accuracy of the medical record for the necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to the relatives of the patient. Whenever these responsibilities are transferred to another appropriate staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

Each member of the staff, who is unavailable to attend his/her patients shall name a member of the Medical Staff who may be called to attend his/her patients in a emergency or until he arrives. If no back-up is named or cannot be reached, the President of the Hospital, the CEO of the Medical Staff or the Chairperson of the Department concerned shall have authority to call on the appropriate staff member.

#### **513. Call Coverage**

- (a) When covering on-call services for Indiana University Health West Hospital, the physician on call or their designee should respond promptly to all pages within fifteen (15) minutes.
- (b) The physician on call should be within a reasonable distance of Indiana University Health West Hospital with a suggested response time of less than forty-five (45) minutes or per professional standards such as 30 minutes per American College of Gynecologists (ACOG).
- (c) Following a response by the Emergency Department physician or other physician to a "Code Blue" anywhere in the hospital except the in the Emergency Department with a successful outcome, the attending physician or his/her designee should come to the hospital within a reasonable amount of time to reassess the patient. If the attending physician or his/her designee does not comply with this standard, then an incident report will automatically be completed for the Emergency Department to review.
- (d) Unless specifically exempted by the Medical Executive Committee, an appointee to the Active Medical Staff exercising privileges agrees to participate equally in the on-call schedule and accept responsibility during the time specified by the published schedule for providing care to any patient referred to the service for which he is providing on call coverage. On Call responsibility shall be in compliance with EMTLA and any other

Federal and State law or regulations. The On Call physician will be responsible for, or arrange for, the patient's continued care.

**514. Patient Leaving Against Medical Advice**

If a patient desires to leave the hospital against medical advice of the attending physician/dentist or designee without proper discharge, the attending physician/dentist or designee will be notified and the patient will be requested to sign the appropriate release from, attested by the patient or legal representative of the patient and a competent third party. Such departure from the hospital is to be noted in the medical record by the attending physician/dentist or designee. Child Protective Services shall be contacted if parents or guardians of minors remove or threaten to remove a pediatric patient against medical advice.

**600 EMERGENCY DEPARTMENT**

**601. Emergency Department Coverage**

The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department in accordance with the Hospital's basic plan for the delivery of such services. Physicians who staff the Emergency Department shall be members of the Medical Staff with the appropriate delineated clinical privileges.

**602. Other Emergency Department Personnel**

The duties and responsibilities of all personnel serving patients within the Emergency Department shall be defined in the policy and procedure manual of the Emergency Department.

**603. Medical Records**

An appropriate medical record shall be kept for every patient receiving emergency service and is to be incorporated into the patient's hospital record, if such exists. Each record shall be signed by the physician in attendance that is responsible for its clinical accuracy.

**604. Periodic Review of Clinical Records**

There shall be periodic review of the Emergency Department medical records by the Emergency Department and other appropriate clinical departments to evaluate the quality of medical care.

**605. Mass Casualty Plan**

There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be approved by the Medical Staff and the Board of Directors.

**606. All patients To Be Seen by Physicians**

All patients who "Come to the dedicated emergency department" (as defined within 42 CFR489.24) will receive a medical screening examination appropriate to their presentation signs and symptoms and consistent with the capability and capacity of the hospital to determine whether or not an emergency medical condition exists. This screening shall occur regardless of the patient's ability to pay and shall be conducted in whole or in part by the following individuals designated as "Qualified Medical Personnel" (QMPs) within the statutory definition:

- Credentialed Physicians or Dentists
- Credentialed Allied Health Practitioners
- Emergency Department Triage Nurses
- Psychiatric Professional/Assessment Team Members
- Labor and Delivery Nurses.

When non-Credentialed staff members assist with or perform the medial screening examination, their assessments are consistent with established policies and protocols in collaboration and consultation with appropriate Credentialed practitioners as necessary.

The patient's primary physician/dentist, if applicable, will be notified of the patient's condition. If, based on the patient's condition, the Emergency Department physician/dentist determines that consultation of a specialist is required; the Emergency Department physician/dentist will contact a specialist in accordance with the primary care physician/dentist's normal referring patter.

Patients received in the Emergency Department without a referral by or not under the care of a private physician/dentist will be assigned to a physician/dentist on-call as deemed appropriate by the Emergency Medicine/dentist. The Emergency Department physician/dentist will contact an appropriate primary/specialty care physician/dentist guided by the on-call schedule established by each Service.

## 700 INFECTIONS & ISOLATIONS

### **701. Infection Control Committee Authority**

The Infection Control Committee, through the chairperson, shall have the authority and responsibility to establish an effective infection control program and to initiate or recommend appropriate corrective action or studies in all cases in which there is an identifiable infection control hazard or problem. The committee shall work in cooperation with the attending physician.

In situations involving the medical management of a patient and/or cases in which a patient's health may be endangered, the Hospital Administration and department chairperson of the clinical department involved should be notified of the corrective action taken or recommended.

## 800 SURGERY

### **801. Surgery Department**

The Surgery Department membership shall be comprised of the various surgical specialties, anesthesia, pathology and other members of the Medical Staff as appointed by the President of the Medical Staff. The department shall meet at least quarterly to review the functions of the surgical services and to recommend additions or changes in policy and/or rules when indicated.

### **802. Surgery Schedule**

Operations are to be scheduled by the surgeon according to the following guidelines:

- (1) (Block time method to be determined)
- (2) Non-emergent cases are to be scheduled in advance. Schedulers are to be available from 8:00 a.m. to 4:30 p.m., Monday through Friday. Administrative Patient Care Supervisors will assist with scheduling on evenings, weekends, and at other times if necessary.
- (3) The schedule may be interrupted for emergency cases where delay would increase morbidity and/or mortality, and will be placed on the schedule after consultation with the OR Team Leader and the "charge" Anesthesiologist. If schedule is interrupted, cases will be rearranged to follow in the most timely and efficient manner. There shall be a reason noted in the medical record of the emergency case whenever it is necessary to preempt the normal schedule. The "bumping" surgeon or designee, should call the "bumped" surgeon personally. Surgeons should "bump" their own

- elective cases when possible. In the case of an unresolved dispute, the on-call anesthesiologist will act as arbitrator.
- (4) When a case is cancelled, the surgeons on the schedule will be contacted in chronological order to determine a preference for the vacated period time.
  - (5) No elective surgery will be scheduled during the Surgery Department's monthly meeting.
  - (6) Surgeries will start at the scheduled time and the surgeon must be in the surgery area at the time scheduled. The operating room will not be held longer than 15 minutes from the scheduled time without expressed approval by the Surgery Medical Director or designee.
  - (7) The surgeon or designee is required to be information requested on the department scheduling worksheet. In the event there are requests for "add-on" cases on the day of surgery, they will be accommodated to the extent time is available. Scheduled cases will be offered to be "moved up" first and then "add-ons" will be scheduled in the order received. Scheduled elective cases before 3:00 p.m. will take priority.

### **803. Notification of Overly Long Delay in the Schedule**

In the event of an overly long delay by unexpected complications of cases, those directly affected in the cases to follow shall be notified. Those notified shall include the surgeons, anesthesiologists, first assistants; floor nurses prepping scheduled patients and others who might be affected.

### **804. Tissues Removed**

All tissues removed during an operation shall be sent to the hospital pathologist who shall make such examination, as he/she may consider necessary to arrive at a tissue diagnosis. The Authenticated report of the pathologist shall be made a permanent part of the patient's medical record.

The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include, but are not limited to, the following:

Specimens that, by their nature or condition, do not permit beneficial examination or productive results such as:

- (a) Cataract
- (b) Orthopedic appliance
- (c) Foreign body
- (d) Portion of rib removed only to enhance operative exposure.
- (e) Teeth
- (f) Toenails
- (g) Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.
- (h) Specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant
- (i) Placentas from Cesarean sections shall be sent to the pathologist for examination upon the request of the surgeon.
- (j) Products of conception may or may not be sent for examination by the pathologist, depending on the request of the physician and/or patient and is supported by the hospital policy on bereavement in the OB Department.

### **805. Tissue and Examination Reports**

Tissue removal procedures as directed through Medical Staff Policy, MS .302 Tissue/Surgical Case Review Policy. All surgery pathology reports prepared by the Pathology Department shall have a code inserted by the pathologist to convey one of the following:

**Code 0:** Insufficient clinical information concerning pre-operative diagnosis for coding purposes.

**Code 1:** Tissue removed for diagnostic purposes.

**Code 2:** Tissue removed for therapeutic purposes with no major discrepancy between the pre-operative (clinical) and post-operative (pathological) diagnosis.

**Code 3:** A major discrepancy exists between the pre-operative (clinical) and the post-operative (pathological) diagnosis.

**Code 4:** Referral or consultation case originating at another institution.

**Code 5:** Failure to review outside diagnostic material prior to treatment (surgery, radiotherapy, bone marrow transplantation or chemotherapy).

Through audit efforts of Pathology and the Tissue Committee, cases of concern will be channeled for peer review.

#### **806. Efficient Utilization**

The Director of Surgical Services and Post Anesthesia Care Unit or his/her designee shall be responsible for the control of the operating rooms to maximize efficient utilization.

#### **807. Podiatrists & Dentistry History & Physicals**

All surgical procedures performed by a podiatrist shall be governed by all rules, policies, etc., of the Department of Surgery. A patient admitted for dental or podiatry surgery involving anesthesia services shall be under the care of a dentist or podiatrist and a qualified physician, credentialed by Indiana University Health West Hospital.

1. Dentist
  - (a) Detail a dental history justifying the hospital admission or outpatient procedure;
  - (b) Detail a description of the physical examination of the oral cavity and make a preoperative diagnosis;
2. Podiatrist
  - (a) Detail a podiatric history justifying the hospital admission or outpatient procedure;
  - (b) Detail a description of the physical examination of the foot involved and make a pre-operative diagnosis;
3. Physician (MD or DO)
  - (a) A qualified physician is responsible for the remaining history and appropriate physical examination for dental or podiatry cases to include confirmation of the findings, conclusions, and assessment of the risks;
  - (b) A history and physical examination to determine the patient's condition prior to anesthesia and surgery;
  - (c) Management of any medical or surgical care other than that specifically delineated to the Podiatrist or Dentist in accordance with his/her approved clinical privileges;

The anesthesiologist shall maintain a complete anesthesia record for the surgical procedure and should include evidence of a pre-anesthetic evaluation and a post-anesthetic follow-up for the patient's condition.

#### **808. Requirements Prior To Anesthesia and Surgical Procedures**

The following requirements shall be adhered to prior to anesthesia being administered on any patient requiring Anesthesia Services.

1. Except for emergency cases, all surgical inpatients and outpatients that require anesthesia services are to be admitted at least two hours prior to scheduled time.
2. Except for emergency cases, all surgical inpatients and outpatients requiring anesthesia services must have a written or dictated history and physical on the chart that meet the following requirements:
  - (a) The history and physical shall be performed within 48 hours of admission for unplanned procedures or emergency cases, and if this is not present, the chart must have a note with the preoperative diagnosis recorded before surgery.
  - (b) Or the history and physical should have been completed within 7 days prior to admission for elective procedures

- (c) Or the history and physical should have been completed between 7-30 days prior to date of admission with an update confirming that the necessity for the procedure or care is still present and the H & P is still current.
3. The following pre-operative evaluation and documentation is required for all inpatients and outpatients requiring anesthesia services.
- (a) A history and physical must be performed and documented prior to surgery requiring Anesthesia services. The history and physical should include the following elements.
- (1) Medical history, including the chief complaint; details of the present illness; relevant past, social, and family histories (appropriate to the patient's age); and a review of systems;
  - (2) A report of relevant physical findings;
  - (3) A statement on the conclusions or impressions drawn from the admission history and physical;
  - (4) A statement on the planned course of action;
- (b) Laboratory work shall be completed as follows:
- (1) ASA class I or II-All pre-operative testing is to be completed within 6 weeks prior to surgery
  - (2) ASA classes III, IV, & V-The date of testing is to be left to the discretion of the surgeon in accordance with the patient's medications and disease processes. It is also recommended that these tests are reviewed by the surgeon and repeat testing ordered in accordance with the findings, medications, and disease process.
- (c) The informed consent and any required special consent forms shall be signed prior to any parental sedation. Any surgical procedure planned or anticipated as an incidental procedure to the major procedure to be performed shall be discussed with the patient and so documented on the informed consent form.
- (d) Consent may be implied when an immediate operation is imperative and the patient's condition is such that he/she cannot rationally consent, or where delay in obtaining the consent of the next of kin or guardian involves serious risk to the patient. When a surgeon operates under such circumstances, he/she should be prepared to show:
- (1) That an immediate operation was necessary, and
  - (2) That a lawful expressed consent could not be obtained from the patient or from any person authorized to act for him/her without seriously endangering the health or life of the patient.
4. For unplanned or emergency cases, if there is not evidence of a history and physical examination on the chart, then there shall be a hand-written preoperative note recorded before surgery, which shall state the patient's diagnosis and general condition and indicate significant medical conditions affecting the proposed surgical procedure. If such a written note is present, then hospital personnel shall rely upon the joint determination by the surgeon and anesthesiologist involved that the patient is a proper candidate for surgery.
5. Except for emergency cases, all surgical inpatients or outpatients receiving local anesthesia by physicians shall have a dictated history and physical, Pre-Procedure/Conscious Sedation Record, or co-signed nursing assessment form prior to the procedure.
6. Except for emergency cases, all surgical inpatients or outpatients receiving conscious sedation by non-anesthesiologists (MD or DO) must have a pre-anesthesia assessment documented on the chart prior to the procedure consisting of: ASA classification, airway assessment, and Pre-procedure/Conscious Sedation Record (office notes may be used in conjunction with the Pre-Procedure/Conscious Sedation Record)
7. Except in critical emergencies, the pre-operative diagnosis and required test results must be recorded on the patient's medical record prior to any surgical procedure, or the surgical procedure will be cancelled. For an emergency case, the surgeon shall make at

least a comprehensive note sufficient to justify the emergency regarding the patient's condition prior to the induction of anesthesia and the start of the procedure.

#### **809. Anesthesia Agents**

Only non-flammable anesthesia agents shall be administered for surgical procedures performed at Indiana University Health West Hospital.

#### **810. Post Procedure Notes**

A note will be entered in the progress notes consisting of the following elements if the operative report is not placed in the medical record immediately after surgery:

1. Date
2. Post Op Diagnosis
3. Findings
4. Procedure
5. Specimen (if applicable)
6. Assistants (if applicable)
7. Estimated blood loss (if significant)
8. Signature
9. Complications
10. Parental/replacement fluids (specify quantity and type)

## **900 PSYCHIATRY**

#### **901. Suicidal Patients**

Any patient known or suspected to be actively suicidal or severely depressed should be ordered suicidal precautions (as defined in the Nursing Policy and Procedure Manual).

#### **902. Assault or Disturbed Patients**

All precautions should be taken to prevent patients from harming themselves or others, and physical intervention should be used only after all other measures have failed.

The least amount of physical contact that will subdue, secure and transport the patient should be used when the threat of bodily harm to other staff members or patients exists.

Documentation of visit by the attending physician or his/her designee is to be in accordance with Rule 412, which requires progress notes daily on patients.

#### **903. Seclusion and Restraint**

The charge nurse can initiate seclusion and/or restraint to gain control over a disturbed patient who is judged to be dangerous to self or others, but a physician's order must then be immediately obtained. These measures should be taken only after all other means have been unsuccessful. Seclusion should be tried first, and restraint used only if seclusion is not effective. These measures must be discontinued as soon as behavior dangerous to self or others is no longer present. The specific techniques to be followed are defined in the Nursing Policy and Procedure Manual.

Documentation of visits by the attending physician or his/her designee is to be in accordance with Rule 412, which requires progress notes daily on all patients

#### **904. Restrictions on Admission**

Any psychiatric/suicidal /threatening patient who is a medical emergency, or requiring intense medical care can be admitted to the Hospital for appropriate medical stabilization prior to transfer to an appropriate psychiatric facility.

## 1000 DENTISTRY

### **1001. Medical Staff Rules and Regulations**

The members of the Department of Dentistry shall confirm to the Rules and Regulations of the Medical Staff for admitting and treating patients.

### **1002. Continuing Study**

Members of the Department of Dentistry have the obligation of increasing their technical ability by continuing studies, and should provide to the Medical Staff Secretary such proof for inclusion with their Medical Staff membership file.

### **1003. Teeth Extraction**

In cases of extraction of teeth, the dentist shall clearly state the number of teeth and tooth number removed and record this number in the report of the operation. Teeth are not required to be submitted to hospital pathologist for examination.

### **1004. Dental Cases**

A patient admitted for dental surgery shall be under the care of dentist and a physician member of the Medical Staff. Their individual responsibilities shall be:

(a) Dentist

- (1) Detail a dental history justifying the hospital admission;
- (2) Detail a description of the examination of the oral cavity and make a pre-operative diagnosis;
- (3) Complete an operative report describing the findings and techniques used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments;
- (4) Detail progress notes as are pertinent to the oral condition of the patient;
- (5) Detail a discharge summary or statement.
- (6) Obtain medical consultation to assure proper treatment of post surgical complications and medical problems.

(b) Physician

- (1) A medical history pertinent to the patient's general health;
- (2) A history and physical examination to determine the patient's condition prior to anesthesia and surgery;
- (3) Supervision of the patient's general health status while hospitalized.

## 1100 DRUG REVIEW

The Pharmacy and Therapeutics Committee shall conduct a monthly audit and review of medical records for the purpose of monitoring the use of drugs at Indiana University Health West Hospital.

## 1200 ORGAN REMOVAL

### **1201. Organ Removal**

Any appropriately credentialed physician holding an unlimited license to practice medicine and his/her team may perform, at the request of the attending physician, the removal of viable organs at Indiana University Health West Hospital when prior documented consent of the next of kin has been given. Cornea, skin and bone procurement may also be performed by qualified organ

procurement personnel from the Indiana Organ Procurement Organization when prior documented consent of the next of kin has been given.

## 1300 PODIATRY

### **1301. Medical Staff Rules and Regulations**

The members of the Podiatry section shall conform to the Rules and Regulations of the Medical Staff for admitting and treating patients.

### **1302. Continuing Study**

Members of the Podiatry section have the obligation of increasing their technical ability by continuing studies, and should provide to the Medical Staff such proof for inclusion with their Medical Staff membership file.

### **1303. Podiatry Cases**

A patient admitted for podiatric surgery shall be under the care of a podiatrist and, must also be attended by a Medical Doctor or Doctor of Osteopathy with requisite qualifications.

Their respective responsibilities shall be:

- (a) Podiatrist (DPM)
  - (1) Detail a podiatric history justifying the hospital admission or outpatient registration;
  - (2) Detail a description of the foot involved and make a pre-operative diagnosis;
  - (3) Complete an operative report describing the findings and techniques used;
  - (4) Detail progress notes as are pertinent to the clinical course of the patient; and
  - (5) Detail a discharge summary on patient.
- (b) Physician (MD or DO)
  - (1) A medical history pertinent to the patient's general health if the patient will undergo surgery under general anesthesia and/or has medical conditions or complications which might impact the outcome of surgery or which must be medically managed during the hospital stay;
  - (2) A history and physical examination to determine the patient's condition prior to general anesthesia and surgery;
  - (3) Management of any medical or surgical care other than that specifically delineated to the Podiatrist in accordance with his or her approval clinical privileges.

## 1400 PROCTORING

### **1401. Proctoring**

- (a) Department of the Medical Staff will assign new appointees and other members granted new clinical privileges to a proctor within the Department. Proctors may also be assigned by Departments in conjunction with peer review processes.
- (b) The assigned proctor will be a practitioner whose clinical knowledge and expertise qualifies them for evaluating the performance of the proctoree.
- (c) Responsibilities of the new proctor are:
  - (1) Assist the new appointee in becoming acquainted with policies and procedures of the Department, the Medical Staff, and the hospital and to help him/her understand his/her responsibilities as a member of the Medical Staff.
  - (2) Review patient charts of the proctoree and provide regular reports on the clinical performance of the practitioner to the Department for a period of time as established by the Department.

- (3) Directly observe the performance of the practitioner in areas in the event specific problems or concerns are noted.
- (4) Submit a written evaluation to the Clinical Department at the conclusion of the period of evaluation.

## 1500 CHEMICAL IMPAIRMENT

The Medical Staff has developed a plan to help identify members of the Medical Staff who may be chemically-impaired and assist them in obtaining appropriate treatment and rehabilitation.

### **1501. Scope of Coverage and Legal and Reporting Requirements**

The unlawful manufacture, distribution, dispensing, possession or the abuse of an addictive chemical substance (alcohol or drugs) by members of the Medical Staff is prohibited. As a condition of appointment and/or continued membership, all members of the Medical Staff are required to abide by this policy. It is applicable to all contract physicians, locum tenens physicians, medical students, residents assigned to Indiana University Health West Hospital, and members of the Health Professional Affiliate Staff. Such physicians or other professionals must notify the hospital of any criminal drug statute conviction for a violation no later than five days after such conviction occurs.

### **1502. Procedure to be following when Chemical Impairment is suspected**

In the event of a situation arising or occurring at Indiana University Health West Hospital in which evidence (not hearsay or rumor) exists to support the conclusion that there is reasonable cause to believe that chemical impairment is involved, the physician or other professional involved will be confronted immediately by one of the following: his/her Departmental Chairperson, an officer of the Medical Staff regarding his/her behavior and/or professional performance. The physician or other professional involved will be informed that chemical impairment can be grounds for termination of his or her appointment and clinical privileges. The practitioner will be asked to provide blood and/or urine specimens at the time of confrontation by those mentioned above. Refusal to submit to such testing will leave three options open to the physician or other professional:

1. Submitting to an assessment by a group of physicians approved by the Indiana State Medical Association's Physician Assistance Program or, for non-physicians, by a similar service provided by their professional association; and completing a program of treatment recommended by such program or service which is acceptable to the Physician's Assistance Committee with regular progress reports provided to the Committee; or
2. Taking a medical leave until the Medical Staff completes its review of the incident and/or situation; or
3. Terminating his/her current appointment and clinical privileges (resulting in whatever reports to government and/or regulatory agencies required by law).

### **1503. Testing Procedures**

If the physician or other professional involved is confronted and the physician or physicians confronting him or her determine, based on tangible evidence, that testing is necessary to help determine the presence or absence of a chemical impairment problem, arrangements will be made for a supervised collection of the specimens involved in a toilet location where privacy can be protected to the maximum extent practical. Specimen collection will be witnessed male to male or female to female utilizing the "chain of custody" procedure. The specimen will be sealed in the presence of the physician or other professional being tested and the physician or hospital representative witnessing the procedure. The signature of the physician or other professional being tested will be placed on the seal with the witness's initials. The specimens will be sent by the hospital to an outside laboratory as a further effort to maintain confidentiality. Blood testing may

also be required if, in the opinion of the confronting physicians, it is necessary to help determine the nature of the suspected chemical impairment.

In the event positive test results are obtained, the provisions of the Medical Staff Bylaws, Corrective Summary Suspension, will be initiated. If the practitioner involved agrees to undergo treatment as described in Rule 2002 above, upon the written request of the practitioner involved, the Summary Suspension may be rescinded and he or she may be placed on Medical Leave of Absence in accordance with the Provision of Membership, Leave of Absence. If treatment is refused and/or no such request is made, the Summary Suspension would remain in effect.

In the event negative test results are obtained, the physician or other professional will be promptly informed. All test results (positive or negative) will be kept in a confidential file in the possession of the Chief Executive Officer or his designee. If further information is received or if aberrant behavior continues, it will be reinvestigated and may be addressed in accordance with the provisions of, Corrective Action, of the By Laws of the Medical Staff.

#### **1504. Impairment**

For purposes of this regulation, an "impaired physician" shall be defined as a physician who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process, loss of motor skill, or excessive use or abuse of drugs, including alcohol.

#### **1505. Report and Investigation**

If any member of the hospital medical staff receives information or witnesses activities which would indicate a reasonable suspicion that a physician appointed to any category of membership on the medical staff is impaired, the following procedures should be followed;

1. A written or oral report will be given to the CEO and the Medical Staff President, or Vice President of the Medical Staff in his absence, of the alleged impairment. The report must be factual and shall include a description of the incident(s) that led to the belief that the physician might be impaired. The individual submitting the report does not need to have proof of the impairment, but must state the facts that would lead to a reasonable suspicion of impairment.
2. If, after discussing the incident with the individual who filed the report, the CEO and the Medical Staff President, or the Vice President of the Medical Staff in his absence, believes there is enough information to warrant an investigation, the CEO or the Medical Staff President shall request that an investigation be conducted and a report of the findings rendered from such investigation by any of the following:
  - (a) Medical Staff President
  - (b) Standing Committee of the Medical Staff
  - (c) An outside consultant; or
  - (d) Another individual or individuals appropriate under the circumstances
  - (e) A report shall be made to the CEO and the Medical Staff Officers
3. If the investigation produces sufficient evidence that the physician is impaired, the Medical Staff Officers shall meet personally with the physician or designated other appropriate individual. The physician shall be told of the results of the investigation indicating that the physician suffers from an impairment that affects his/her practice. The physician will not be told who filed the report. If the investigation indicated that the physician is suffering from a "chemical impairment", the procedures relating to chemical impairment contained in regulations 1000 through 1003 shall be followed.

If the physician is believed to have suffered from impairment other than a chemical impairment, the hospital may require the physician to do the following:

- (a) Undergo a rehabilitation program to remove the impairment or impose appropriate restrictions on the physician's practice to limit danger to any patients resulting from the impairment of the physician; or

- (b) Immediately suspend the physician's privileges in the hospital until total rehabilitation has been accomplished and the CEO and the President of the Medical Staff, or the vice President of the Medical Staff in his absence, have reasonable belief that the physician's privileges may be reinstated without posing a danger to any patient.
4. If a physician does not agree with any process of rehabilitation, any limitations on the physician's privileges, the physician may apply for a fair hearing under the Fair Hearing Plan of the Medical Staff Bylaws.

**1506. Reinstatement of Impaired Physician or Impairment Other Than Chemical Impairment**

Under sufficient proof that a physician previously found to be suffering from an impairment other than chemical impairment, had successfully completed a rehabilitation program, the hospital may consider reinstating that physician to the appropriate Medical Staff privileges. The Medical Staff must obtain a letter from a Physician Director of the Rehabilitation Program where the physician was treated. The written letter from the Director of the Rehabilitation Program should include the following:

- (a) Verification of the extent of the physician's participation in the program.
- (b) The extent that the physician's behavior and/or conduct is monitored as a part of the program.
- (c) Whether, in the opinion of the Rehabilitation Director, the physician is rehabilitated; and
- (d) The nature of any follow up care, which is recommended in the opinion of the Rehabilitation Program.
- (e) Whether, in the Rehabilitation Program Director's opinion, the physician is capable of resuming medical practice and providing continuous competent care to patients.

If the alleged impaired physician does not provide the information or allow the hospital to receive the information as stated in this regulation, the hospital may suspend or limit the physician's privileges until such information has been obtained.

Assuming the hospital has received the information that the physician is rehabilitated and capable of resuming patient care; the hospital shall take the following precautions when restoring such clinical privileges:

- (a) The Chairperson of which the impaired physician is assigned (Department Chair) or a physician appointed by the Department Chair shall monitor the physician's exercise of clinical privileges in the hospital. The Credentials Committee shall determine the nature of the monitoring after reviewing all the circumstances.
- (b) The CEO and the Medical Staff Officers shall require the physician to provide the hospital with periodic reports from his or her primary care physician for a period of time established by the CEO and the Medical Staff President in consultation with the Department Chair and said statement from the impaired physician's primary care physician shall state that the physician is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the hospital is not impaired.

**1600 SMOKING ON HOSPITAL PROPERTY**

Physicians influence how individuals, organizations and even the nation perceive smoking as a preventable cause of death. In keeping with the principle of a sanctuary of healing at Indiana University Health West Hospital, it behooves us to communicate the dangers of second hand smoke and tobacco use to our patients, staff, and community. Implementation of a smoke-free environment is designed to establish a healthy and safe place for patients, employees, and visitors. Many surgeons currently require patients to quit smoking prior to surgery because of increased complications such as: longer recovery times, longer length of stay, and complications with

anesthesia. Smokers' average healthcare claims per year are \$635 more than non-smoking employees at IU Health. In addition, it is estimated that lost productivity for each smoker is \$1760 per year.

Not allowing patients to smoke on the hospitals grounds will have many positive benefits for our patients, visitors and staff including:

- Eliminating second hand smoke exposure for compromised patients
- Supporting our patients' efforts to be smoke-free for surgery
- Culturally supportive of a healthy environment with a clear message to patients, employees and visitors about the ill effects of second hand smoke and tobacco use

Physicians will not write orders allowing patients to go outside to smoke while in the hospital allowing Indiana University Health West Hospital to have a smoke free facility and grounds.

As an appropriate, Physicians may write orders for nicotine replacement such as the patch or consult with Respiratory Therapy to identify appropriate alternatives.

## 1700 PROFESSIONALISM

These rules and regulations are intended to provide comprehensive information to members of the IU Health Medical Staff in order for them to fulfill their commitment and responsibility to provide quality and safe patient care. In addition, members of the Medical Staff are obliged to carry themselves in a manner, which exemplifies the utmost respect and professionalism toward patients, families, visitors, staff and employees of Indiana University Health.

## 1800 GENERAL RULES

### **1801. Confidentiality**

In keeping with the state and federal laws as well as IU Health policy, all medical records, patient-specific information, peer review materials, risk management materials, credentialing records and files, minutes of relevant Medical Staff and hospital meetings, are the property of Indiana University Health.

Access to confidential materials by Medical staff is permissible only when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, credentialing or other authorized activity. This requirement applies to information in electronically stored or had copy format.

### **1802. Adherence to Indiana University Health's Policy and Procedures**

All members of the Medical Staff are expected to adhere to established policies and procedures for IU Health. This includes adherence to all health care regulatory and accreditation requirements. Breach of policies, standards or regulations by individual physician/dentist will be handled through peer review mechanisms of the IU Health Medical Staff.

### **1803. Root Cause Analysis (RCA) and Risk Management Activities**

Physician/dentist may be requested to participate at intervals in activities to promote patient safety and reduce risk to patients and improve processes throughout IU Health. Root Cause Analysis (RCA) sessions will be conducted on any sentinel event, serious event with systems implication of a sentinel event, or a near miss event. The Risk Management Department, or in some cases, the Quality Management Department, will contact the physician/dentist to determine

a meeting time to conduct a systems review. Physician/dentists are asked to make attendance at such meetings a priority.

Additionally, physicians/dentists are to promptly report patient errors or other patient-related safety issues to the Risk Management Department by completing an occurrence report or by contacting the hospital patient representative.

**1804. Quality Measurement and Improvement**

Participation in quality activities of the clinical service for which the physician/dentist practices is required. Trending of aggregate data on clinical processes and outcomes, professionalism, administrative and utilization data is to occur through each clinical service of the Medical Staff. Physician/dentist is expected to examine their individual performance as compared to peers among their service in order to identify opportunities for improvement in their clinical practice. Physician/dentist will at intervals be asked to participate on performance improvement teams.

**DATES:**

Revised:	2/25/2008
MEC Reviewed/Revised:	12/20/10
Board Approved:	1/10/2011