METHODODIST HEALTHCARE - MEMPHIS HOSPITALS AND
METHODIST HEALTHCARE – OLIVE
BRANCH HOSPITAL

UNIFIED MEDICAL STAFF POLICIES
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1.0 AMENDMENT AND ADOPTION OF GOVERNANCE DOCUMENTS BY THE ORGANIZED MEDICAL STAFF

1.1 If the Medical Executive Committee (MEC) proposes to adopt or amend a rule or regulation it first communicates this to the medical staff. The MEC will ratify this proposal not earlier than its next meeting.

1.2 In cases of a documented need for urgent amendment to rules and regulations, (to comply with law or regulations), the MEC may provisionally adopt and the governing body may provisionally approve. In such cases, the medical staff will be notified by the MEC and has the opportunity for review of the comment on provisional amendment. If there is no significant conflict between the organized medical staff and MEC, this provisional amendment stands and is so noted at the next appropriate MEC and governing body meetings. If there is conflict, the process for resolving conflict between the organized medical staff and MEC is implemented. If necessary, a revised amendment is submitted to the governing body for action.

1.3 The organized medical staff has the ability to amend and adopt its governance documents by proposing them directly to the governing body. The procedure for this includes first submitting the proposal to an MEC member. After review by the MEC, the MEC Board Representative will submit the proposal in an unaltered format to the governing body.

2.0 CONFLICT MANAGEMENT BETWEEN ORGANIZED MEDICAL STAFF AND MEDICAL EXECUTIVE COMMITTEE

The Conflict Management process applies to, but is not limited to, proposals to amend or adopt a rule, regulation, or policy.

1. The Department Chair or another elected Medical Staff leader will consider issues of conflict between the MEC and the organized Medical Staff (OMS). At least 1% of the OMS should support the issue to initiate the conflict management process.

2. Resolution begins with the Medical Staff executive leadership and can escalate to the MEC if resolution is not imminent. If these steps are not productive, the MEC will forward their response to the Board.

3. If the Board finds the MEC response satisfactory, the Board will forward to Medical Staff Services Department (MSSD) for dissemination to the OMS. If the Board finds the MEC response unsatisfactory, the matter will be sent to a special committee comprised of three OMS representatives, three MEC representatives, and one Board representative. The committee will review, discuss, and resolve.
3.0 MODERATE SEDATION POLICY FOR NON-ANESTHESIA STAFF

3.1 Purpose
The purpose of this policy is to set forth procedures for the management of all patients receiving moderate sedation while undergoing therapeutic, diagnostic or surgical procedures at Methodist Le Bonheur Healthcare System Hospitals and in Provider-based clinics. These guidelines apply to all locations where moderate sedation is administered. These include, but are not limited to:

- Endoscopy Suites
- Critical Care areas
- Emergency Department
- Diagnostic Imaging
- Interventional Radiology
- Operating Room
- Cardiac Cath Lab
- Starlight Room

3.2 Focus
This policy is not intended to apply to the following settings:

- General anesthesia
- Administration of medication intended solely to counteract anxiety
- Administration of medication intended for deep sedation as defined by department(s) of anesthesia.
- Management of pain before, after, or unrelated to a therapeutic or diagnostic procedure
- The use of parental or oral medications in the setting of alcohol withdrawal management
- Sedation used during the placement or maintenance of an artificial airway (e.g. mechanical ventilation)
- A single oral sedative or analgesic medication administered in doses appropriate for the unsupervised treatment of insomnia, anxiety or pain

3.3 Definition
A patient under sedation can convert into deep sedation and/or loss of consciousness because of the unique characteristics of the drugs as well as the physical status and sensitivities of the individual patient. The level of sedation planned will determine the level of qualified personnel and monitoring requirements.

Levels of Sedation and Anesthesia are defined as:

1. Minimal Sedation (anxiolysis)
   A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. The lowest dose expected to produce this degree of sedation should be administered.

2. Moderate sedation/analgesia (“conscious sedation”)
   A medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient’s ability to maintain a patent airway independently and continuously, and (3) permits age-appropriate response by the patient to physical stimulation or verbal command, e.g., “open your eyes.”

3. Deep sedation/analgesia
Deep sedation: A medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes, and by the inability to maintain a patient airway independently and respond purposefully to physical stimulation or verbal command.

4. Anesthesia
General anesthesia: A medically controlled state of unconsciousness accompanied by a loss of protective reflexes, including the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command. (American Academy of Pediatrics)

3.4 Responsibilities
The P&T Committee, through its Sedation Subcommittee (with Anesthesiology representations), as delegated by the MEC is responsible for the development of standards of practice for moderate sedation and deep in collaboration with other departments that provide the service, and with the Drug Information Center at Methodist University Hospital (MUH).

The Department(s) of Anesthesia will define appropriate agents for moderate and deep sedation. This information will be maintained in the Drug Information Center and on MOLLI.

The Medical Director of each department administering sedation will be responsible for ensuring that the standard is followed.

The Pharmacy & Therapeutics Committee will be responsible for overseeing the continuous quality improvement process for assessing outcomes in patients receiving moderate sedation.

3.5 Patient Selection Criteria
This policy is applicable to all ages served. The American Society of Anesthesiologists (ASA) classification system will be used as a guideline in the selection criteria. Patients appropriate for sedation will have an ASA classification of I - III. Patients with an ASA classification of IV or greater may require evaluation by Anesthesiology, depending on the setting.

The physician is responsible for assigning the patient an ASA classification, and for airway assessment.

ASA Classification

<table>
<thead>
<tr>
<th>STATUS</th>
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<td>A normal healthy patient</td>
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<td>II</td>
<td>A normal patient with mild systemic disease</td>
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<td>III</td>
<td>A patient with a severe systemic disease that limits activity but is not incapacitating</td>
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<td>A patient with an incapacitating systemic disease that is a constant threat to life.</td>
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<td>A moribund patient not expected to survive 24 hours with or without the procedure</td>
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</table>

3.6 Airway Assessment
The following findings may increase the likelihood of airway obstruction during spontaneous ventilation and should be recognized:
Habitus: significant obesity (especially involving the neck and facial features)
Head & Neck: short neck, limited neck extension, decreased hyoid-mental distance (<3cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation
Mouth: small mouth opening, edentulous, protruding incisors, loose or capped teeth, high arched palate, macroglossia, tonsillar hypertrophy, nonvisible uvula
Jaw: micrognathia, retrognathia, trismus, significant malocclusion

If any of the following findings is present by history or exam, the physician should strongly consider consultation:

- Previous problems with anesthesia or sedation
- CPAP-dependent sleep apnea
- Dysmorphic facial features (e.g. Pierre-Robin syndrome, Trisomy 21)
- Advanced Rheumatoid Arthritis

### 3.7 Criteria for Administration

Medication to provide moderate sedation will be given on the direct order of a physician who has been trained to perform sedation during procedures and who is physically present during the initial and continued administration of sedation. (see credentialing policies).

Medication administered during the procedure may be administered by the physician or by qualified personnel under the direct supervision of the physician. Qualified personnel include staff with appropriate preparation, education, and competency performing consistent with state and regulatory guidelines.

Maintenance of IV access is required for patients receiving IV sedation. For patients receiving sedation by other routes of administration (e.g. PO, IM, PR, intranasal), personnel must be proximally available to secure IV access in case of emergency.

An airway assessment and ASA classification must be present prior to the administration of sedation.

### 3.8 Pre-Procedure Assessment Responsibilities

**Physician**

Obtain baseline history. Assess the airway, including mouth and neck, and note ASA status.
Document plan for sedation (i.e. sedation with monitoring).
Obtain and document appropriate informed consent
Address NPO status per guidelines (see Appendix II).

The patient will be reassessed by the physician immediately prior to the procedure, and the reassessment will be documented in the record.

A. Physician
B. Qualified Personnel
C. Verify informed consent
D. Verify presence of H&P
E. Verify presence of ASA classification by MD
F. Verify physician pre-sedation plan
G. Ensure availability and working condition of Age specific Emergency equipment
H. Crash cart with Ambu bag
I. Cardiac monitor including defibrillator
J. Oxygen availability by a system with positive pressure delivery
K. Suction apparatus
L. Pulse oximetry
M. Emergency drugs including flumazenil (Romazicon™) and naloxone (Narcan™)
N. Non-invasive blood pressure monitoring equipment
O. Confirm presence of venous access as indicated
P. Perform and document age-specific, procedure-pertinent assessment to include:
Q. Current medication
R. Drug allergies or adverse reactions
S. Procedure-pertinent history
T. NPO status (see attached NPO guidelines: Appendix II)
U. Baseline Vital signs (blood pressure [may be excluded if it interferes with care of the pediatric patient], heart rate, respiratory rate, heart rhythm, oxygen saturation, temperature)
V. Level of Consciousness (pediatric patients will be evaluated according to developmental and age appropriate responses)
W. Baseline Aldrete score

3.9 Intra-procedure Monitoring
Qualified personnel will be present in the room throughout the conduct of all cases requiring moderate or deep sedation.
The minimum number of available personnel available shall be two: the operator and the monitor. Patients receiving sedation are to have oxygenation, ventilation, and circulation and cardiac rhythm continuously monitored during all procedures.

The qualified personnel responsible for monitoring the effects and patient response to moderate sedation will have responsibilities that allow for the continuous monitoring of the patient; they may assist the practitioner with interruptible ancillary tasks of short duration.

3.10 Standards for Patient Monitoring
A. Assessment of Level of Consciousness
The conscious patient will receive continuous age- and procedure-appropriate reassurance during the procedure. The qualified personnel will continuously assess the patient’s level of comfort and tolerance during the procedure.

B. Oxygenation
During all procedures a quantitative method of assessing oxygenation (e.g. pulse oximetry), shall be employed. Supplemental oxygen shall be administered as needed.

C. Ventilation
During all procedures the adequacy of ventilation shall be evaluated by at least the continual observation of qualitative signs and the use of a stethoscope when needed.

D. Circulation and Rhythm
Every patient shall have their heart rate continuously monitored by pulse oximetry and electrocardiogram. Blood pressure will be monitored every 5 minutes during the procedure. In the patient 13 years old or younger, blood pressure will be monitored if the patient is hemodynamically unstable. All patients: continuous heart rate monitoring by pulse oximetry and electrocardiogram.
Blood pressure (BP) shall be monitored every 5 minutes during the procedure. In the patient 13 years old or younger, BP will be monitored if the patient is hemodynamically unstable.

E. Documentation
At a minimum, level of consciousness, oxygen saturation, respiratory rate, blood pressure and heart rate and rhythm shall be determined and recorded:

Before the beginning of the procedure
After administration of each dose of the sedative/analgesic. During prolonged procedures, monitoring shall be continuous, and documentation shall occur every 5 minutes.
Upon completion of the procedure.
During initial recovery.
At the time of discharge.

Documentation shall include medication(s) given with the dosage, route, time, and person administering.

3.11 Post-Procedure Care
Patient’s post procedure status will be assessed on admission to and before discharge from the post sedation or post anesthesia recovery area. The qualified personnel will assess and document vital signs every 15 minutes or more frequently if the patient’s condition warrants.

The qualified personnel will observe and document any unusual events or post-procedural complications and the patient’s response.

Inpatients will be transferred to their units and outpatients will be discharged home in the company of a responsible adult or parent.

3.12 Discharge Criteria
Patient will be discharged from the post sedation or post anesthesia recovery area upon the documented order from a qualified licensed independent practitioner or attainment of Aldrete score within two (2) points of presedation assessment score (see Appendix I). Patient cannot be discharged with a score of “0” in any category.

Patients receiving reversal agent(s) must be monitored for a minimum of one (1) hour after last dose of reversal agent.

Documentation of time and condition of patient prior to discharge. Documentation that discharge criteria has been met.

Documentation of the name of the individual that will be responsible for transportation of the outpatient.

Provides report to the patient care staff receiving the patient.

Provide outpatients and/or significant other with documented discharge instructions.

3.13 Credentialing and Competency
Physician Privileges for Sedation
Shall be granted by the Credentials Committee. Physicians shall be granted privileges in administering moderate sedation at the same time privileges are granted for performing operative/invasive procedures.
Privileging should be based upon a demonstrated record of successful experience in procedures requiring moderate sedation. Privileging criteria are delineated in the credentials policies/DOPs. Sedation should be administered in accordance with the current relevant clinical policies and procedures.

A. Physician Qualifications – Credentialing and Competency
In addition to a record of experience in successfully administering sedation during procedures (minimum of 10 per year), the physician shall:

1) Be able to demonstrate rescue competencies, either by core privilege, and/or successful completion of advanced certification (i.e. PALS, ACLS)

   a. ACLS/PALS Requirements
      Rescue competencies for moderate sedation must be demonstrated by successful completion of ACLS/PALS except for physician specialty groups with demonstrable intubation rescue medication competencies, including:
      i. Active staff members who are board certified in Emergency Medicine
      ii. Active staff members who have core critical care privileges
      iii. Active staff members with rescue competencies in cardiac resuscitation as evidenced by core privileges in invasive cardiology and completion of a hospital approved airway management course as approved by the Department of Anesthesia and the MEC.

2) Have a working knowledge of the medications to be administered, including pharmacology, adverse effects, and emergency interventions.

B. Qualified (Non-physician) Personnel
   Personnel shall meet the following requirements. These requirements are consistent with regulatory standards.

   1) BLS training and
   2) Successful completion of advanced certification (PALS, ACLS) or resuscitation management review (for Moderate sedation)
   3) Successfully complete (as demonstrated by “passing” grade on an exam) a review of the pharmacology and adverse effects, administration, dosage, and emergency interventions of the sedative drugs used within the area.
   4) Review equipment setup, troubleshooting, and monitoring parameters.

C. Compliance with Guidelines
   Compliance with guidelines will be monitored by the Sedation Subcommittee of the P&T Committee.

3.14 Performance Improvement
Performance improvement will be addressed as outlined in the attached appendix (Appendix III).

3.15 Appendices

Appendix I: ALDRETE SCORE

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<th>Score</th>
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<td>Activity</td>
<td></td>
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<tr>
<td>Able to move 4 extremities voluntarily or on command</td>
<td>2</td>
</tr>
</tbody>
</table>
Able to move 2 extremities voluntarily or on command 1
Not able to move extremities voluntarily or on command 0

Respiration
Able to deep breathe and cough freely 2
Dyspnea, shallow, or limited breathing 1
Apneic 0

Circulation (Note: For baseline, automatically assign a score of 2)
Blood pressure +/- 20% of pre-sedation level 2
Blood pressure +/- 20-50% of pre-sedation level 1
Blood pressure +/- 50% of pre-sedation level 0

Consciousness
Fully awake 2
Arousable on calling 1
Not responding 0

O2 Saturation
Able to maintain SaO2>92% on room air 2
Needs O2 to maintain SaO2>90% 1
SaO2 <90% even with O2 supplement 0

Appendix II: NPO Guidelines

Patients undergoing elective procedures should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying before the procedure. If NPO requirements have been violated the physician will decide to proceed, delay, or cancel the procedure. This decision will be documented in the medical record.

Ingested Material        Minimal Fasting Period Before Procedure
Clear liquids            2 hours
Breast milk              4 hours
Infant formula           6 hours
Solid food               8 hours

Appendix III: Performance Improvement

The P&T Committee will be responsible for monitoring patient outcomes associated with the administration of moderate or deep sedation. Pertinent data will be collected and reported for review through the Pharmacy & Therapeutics Committee.

Patient outcomes will be monitored using the following criteria:

Hypoxia: drop in oxygen saturation to <90% for ≥ 2 minutes
Unplanned admission or transfer to a higher level of care
Administration of reversal agents
Hypotension: drop of ≥ 20mm Hg in systolic and/or diastolic blood pressure, requiring medical intervention(s). For the pediatric population, episodes of bradycardia will be assessed instead of this parameter.
Requirement to place airway support (oral airway or ET tube).
Requirement for assisted ventilation.
All episodes of medical emergency (i.e. “Emery House” or “Harvey Team”) related to the procedure.
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Requirement for assisted ventilation.
All episodes of medical emergency (i.e. “Emery House” or “Harvey Team”) related to the procedure.

4.0 DEEP SEDATION POLICY FOR NON-ANESTHESIA STAFF

4.1 Purpose
The purpose of this policy is to set forth standards and expectations for all patients receiving “deep sedation” conducted by non-anesthesiologists at Methodist Le Bonheur Healthcare hospitals. This policy applies to all areas where deep sedation might be administered by non-anesthesiologists; Emergency Departments, Critical Care Areas, Radiology, Operating Rooms, and Starlight Room.

4.2 Focus
It is recognized that certain drugs, may be used for brief periods of sedation as might be needed for the conduct of a diagnostic or therapeutic procedure. Unfortunately, these drugs are accompanied by a higher risk of production of “deep sedation”, from which the patient is not easily aroused, and accompanied by loss of protective reflexes. Thus, this policy applies to the use of these agents, as defined by the department(s) of anesthesia.

4.3 Definition
A patient under sedation can convert into deep sedation and/or loss of consciousness because of the unique characteristics of the drugs as well as the physical status and sensitivities of the individual patient. The level of sedation planned will determine the level of qualified personnel and monitoring requirements.

Levels of Sedation and Anesthesia are defined as:

**Minimal Sedation (anxiolysis)**
A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected. The lowest dose expected to produce this degree of sedation should be administered.

**Moderate sedation/analgesia (“conscious sedation”)**
A medically controlled state of depressed consciousness that (1) allows protective reflexes to be maintained; (2) retains the patient’s ability to maintain a patent airway independently and continuously, and (3) permits age-appropriate response by the patient to physical stimulation or verbal command, e.g., “open your eyes.”

**Deep sedation/analgesia**
Deep sedation: A medically controlled state of depressed consciousness or unconsciousness from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes, and by the inability to maintain a patient airway independently and respond purposefully to physical stimulation or verbal command.

**Anesthesia**
General anesthesia: A medically controlled state of unconsciousness accompanied by a loss of protective reflexes, including the inability to maintain a patent airway independently and respond purposefully to physical stimulation or verbal command. (American Academy of Pediatrics)
4.4 Responsibilities/Oversight
The P&T Committee, through its Sedation Subcommittee (with Anesthesiology representations), as delegated by the MEC is responsible for the development of standards of practice for moderate and deep sedation in collaboration with other departments that provide the service, and with the Drug Information Center at MUH.

The Department(s) of Anesthesia will define appropriate agents for moderate and deep sedation. This information will be maintained in the Drug Information Center and on MOLLI.

The Medical Director of each department administering sedation will be responsible for ensuring that the standard is followed.

The Pharmacy & Therapeutics Committee will be responsible for overseeing the continuous quality improvement process for assessing outcomes in patients receiving moderate sedation.

4.5 Patient Selection Criteria
This policy is applicable to all ages served. The American Society of Anesthesiologists (ASA) classification system will be used as a guideline in the selection criteria. Patients appropriate for sedation will have an ASA classification of I - III. Patients with an ASA classification of IV or greater may require evaluation by Anesthesiology, depending on the setting.

The physician is responsible for assigning the patient an ASA classification, and for airway assessment.

ASA Classification

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Airway Assessment
The following findings may increase the likelihood of airway obstruction during spontaneous ventilation and should be recognized:
- Habitus: significant obesity (especially involving the neck and facial features)
- Head & Neck: short neck, limited neck extension, decreased hyoid-mental distance (<3cm in an adult), neck mass, cervical spine disease or trauma, tracheal deviation
- Mouth: small mouth opening, edentulous, protruding incisors, loose or capped teeth, high arched palate, macroglossia, tonsillar hypertrophy, nonvisible uvula
- Jaw: micrognathia, retrognathia, trismus, significant malocclusion

If any of the following findings is present by history or exam, the physician should strongly consider anesthesia consultation:
Previous problems with anesthesia or sedation
CPAP-dependent sleep apnea
Dysmorphic facial features (e.g. Pierre-Robin syndrome, Trisomy 21)
Advanced Rheumatoid Arthritis
4.6 Criteria for Administration
Agents likely to produce deep sedation must be administered only by a qualified physician. This physician must be specifically and solely focused on the administration of the medication and monitoring of the patient’s response to the medication.

Maintenance of IV access is required for patients receiving IV sedation.

Appropriate monitoring equipment will be immediately available, including:
- Cardiac monitor, including defibrillator
- Oxygen availability by a system with positive pressure delivery
- Pulse oximetry
- Non-invasive blood pressure monitoring equipment
- Age-specific Emergency equipment
- Crash cart, with appropriate intubation equipment
- Suction apparatus
- Emergency drugs, including flumazenil and naloxone

4.7 Location for Administration
Deep sedation may be administered only in an appropriately equipped diagnostic unit, limited to:
- Emergency Department
- Critical Care
- Radiology
- Operating room
- Starlight room
- MEG Lab

4.8 Pre-Procedural Assessment Responsibilities

Physician
Obtain baseline history. Assess the airway, including mouth and neck, and note ASA status.

An airway assessment and ASA classification must be present prior to the administration of sedation

Document plan for sedation (i.e. sedation with monitoring).

Obtain and document appropriate informed consent

Address NPO status per guidelines (see Appendix II).

The patient will be reassessed by the physician immediately prior to the procedure, and the reassessment will be documented in the record.

Physician
Qualified Personnel
Verify informed consent
Verify presence of H&P
Verify presence of ASA classification by MD
Verify physician pre-sedation plan
Ensure availability and working condition of Age specific Emergency equipment
Crash cart with Ambu bag
Cardiac monitor including defibrillator
Oxygen availability by a system with positive pressure delivery
Suction apparatus
Pulse oximetry
Emergency drugs including flumazenil (Romazicon™) and naloxone (Narcan™)
Non-invasive blood pressure monitoring equipment
Confirm presence of venous access as indicated
Perform and document age-specific, procedure-pertinent assessment to include:
Current medication
Drug allergies or adverse reactions
Procedure-pertinent history
NPO status (see attached NPO guidelines: Appendix II)
Baseline Vital signs (blood pressure [may be excluded if it interferes with care of the pediatric patient], heart rate, respiratory rate, heart rhythm, oxygen saturation, temperature)
Level of Consciousness (pediatric patients will be evaluated according to developmental and age appropriate responses)
Baseline Aldrete score

4.9 Intra-procedure Monitoring
Qualified personnel will be present in the room throughout the conduct of all cases requiring deep sedation.

The minimum number of personnel available for all cases requiring deep sedation shall be two: the operator (physician) and the qualified personnel administering and monitoring sedation. The qualified personnel administering and monitoring sedation is to be independent of the practitioner performing the procedure. Only physicians qualified by privileging and competencies may administer deep sedation.

The qualified personnel monitoring the patient during deep sedation shall have no other responsibilities except for the monitoring.

4.10 Standards for Patient Monitoring

Assessment of Level of Consciousness
The conscious patient will receive continuous age- and procedure-appropriate reassurance during the procedure. The qualified personnel will continuously assess the patient’s level of comfort and tolerance during the procedure.

Oxygenation
During all procedures a quantitative method of assessing oxygenation (e.g. pulse oximetry), shall be employed. Supplemental oxygen shall be administered as needed.

Ventilation
During all procedures the adequacy of ventilation shall be evaluated by at least the continual observation of qualitative signs and the use of a stethoscope when needed.

Circulation and Rhythm
Every patient shall have their heart rate continuously monitored by pulse oximetry and electrocardiogram
Blood pressure will be monitored every 5 minutes during the procedure. In the patient 13 years old or younger, blood pressure will be monitored if the patient is hemodynamically unstable.

All patients: continuous heart rate monitoring by pulse oximetry and electrocardiogram
Blood pressure (BP) shall be monitored every 5 minutes during the procedure. In the patient 13 years old or younger, BP will be monitored if the patient is hemodynamically unstable.

4.11 Documentation
At a minimum, level of consciousness, oxygen saturation, respiratory rate, blood pressure and heart rate and rhythm shall be determined and recorded:

Before the beginning of the procedure
After administration of each dose of the sedative/analgesic. During prolonged procedures, monitoring shall be continuous, and documentation shall occur every 5 minutes.
Upon completion of the procedure.
During initial recovery.
At the time of discharge.

Documentation shall include medication(s) given with the dosage, route, time, and person administering.

4.12 Post-Procedure Care
Patient’s post-procedure status will be assessed on admission to and before discharge from the post sedation or post anesthesia recovery area. Qualified Personnel will assess and document vital signs every 15 minutes or more frequently if the patient’s condition warrants. Discharge from recovery will occur upon the direct order of a physician, following documentation of a level of consciousness that is consistent with that prior to the procedure, or based upon specific assessment criteria.

Qualified Personnel will observe and document any unusual events or post-procedural complications and the patient’s response.

Inpatients will be transferred to their units and outpatients will be discharged home in the company of a responsible adult or parent.

4.13 Discharge Criteria
Patient will be discharged from the post sedation or post anesthesia recovery area upon the documented order from a qualified licensed independent practitioner or attainment of Aldrete score within two (2) points of pre-sedation assessment score (see Appendix I). Patient cannot be discharged with a score of “0” in any category.

Patients receiving reversal agent(s) must be monitored for a minimum of one (1) hour after last dose of reversal agent.

Documentation of time and condition of patient prior to discharge. Documentation that discharge criteria has been met.

Documentation of the name of the individual that will be responsible for transportation of the outpatient.

Provides report to the patient care staff receiving the patient.

Provide outpatients and/or significant other with documented discharge instructions.

4.14 Credentialing and Competency
Qualified Physicians
Physician Privileges for Deep Sedation shall be granted by the Credentials Committee and are limited to Anesthesiology, Emergency Medicine, Pulmonary (Critical Care), or Critical Care physicians. Qualified physicians will also have privileges for Moderate Sedation as defined in the Moderate Sedation policy.

In addition, physicians qualified for administration of deep sedation will have intubation as part of core privileges and will successfully complete (as demonstrated by “passing” grade on an exam) a review of the pharmacology and adverse effects, administration, dosage, and emergency interventions of the sedative drugs used within the area.

Qualified (Non-physician ) Personnel
These individuals are qualified for monitoring deep sedation (not for administration). Personnel shall meet the following requirements. These requirements are consistent with regulatory standards.

BLS training and
Successful completion of advanced certification (PALS or ACLS) or resuscitation management review (for Moderate sedation)
Successfully complete (as demonstrated by “passing” grade on an exam) a review of the pharmacology and adverse effects, administration, dosage, and emergency interventions of the sedative drugs used within the area.
Review equipment setup, troubleshooting, and monitoring parameters.

4.15 Compliance with Guidelines
Compliance with guidelines will be monitored by the Sedation Subcommittee of the P&T Committee. Performance improvement will be addressed as outlined in the attached appendix (Appendix III).

4.16 Appendices
Appendix I: ALDRETE SCORE

<table>
<thead>
<tr>
<th>Assessment</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity</td>
<td></td>
</tr>
<tr>
<td>Able to move 4 extremities voluntarily or on command</td>
<td>2</td>
</tr>
<tr>
<td>Able to move 2 extremities voluntarily or on command</td>
<td>1</td>
</tr>
<tr>
<td>Not able to move extremities voluntarily or on command</td>
<td>0</td>
</tr>
<tr>
<td>Respiration</td>
<td></td>
</tr>
<tr>
<td>Able to deep breathe and cough freely</td>
<td>2</td>
</tr>
<tr>
<td>Dyspnea, shallow, or limited breathing</td>
<td>1</td>
</tr>
<tr>
<td>Apneic</td>
<td>0</td>
</tr>
<tr>
<td>Circulation (Note: For baseline, automatically assign a score of 2)</td>
<td></td>
</tr>
<tr>
<td>Blood pressure +/- 20% of pre-sedation level</td>
<td>2</td>
</tr>
<tr>
<td>Blood pressure +/- 20-50% of pre-sedation level</td>
<td>1</td>
</tr>
<tr>
<td>Blood pressure +/- 50% of pre-sedation level</td>
<td>0</td>
</tr>
<tr>
<td>Consciousness</td>
<td></td>
</tr>
<tr>
<td>Fully awake</td>
<td>2</td>
</tr>
<tr>
<td>Arousable on calling</td>
<td>1</td>
</tr>
<tr>
<td>Not responding</td>
<td>0</td>
</tr>
</tbody>
</table>
O2 Saturation
Able to maintain SaO2>92% on room air  
Needs O2 to maintain SaO2>90%  
SaO2 <90% even with O2 supplement

Appendix II: NPO Guidelines

Patients undergoing elective procedures should not drink fluids or eat solid foods for a sufficient period of time to allow for gastric emptying before the procedure. If NPO requirements have been violated the physician will decide to proceed, delay, or cancel the procedure. This decision will be documented in the medical record.

Ingested Material | Minimal Fasting Period Before Procedure
--- | ---
Clear liquids | 2 hours
Breast milk | 4 hours
Infant formula | 6 hours
Solid food | 8 hours

Appendix III: Performance Improvement

The P&T Committee will be responsible for monitoring patient outcomes associated with the administration of moderate or deep sedation. Pertinent data will be collected and reported for review through the Pharmacy & Therapeutics Committee.

Patient outcomes will be monitored using the following criteria:
- Hypoxia: drop in oxygen saturation to <90% for ≥ 2 minutes
- Unplanned admission or transfer to a higher level of care
- Administration of reversal agents
- Hypotension: drop of ≥ 20mm Hg in systolic and/or diastolic blood pressure, requiring medical intervention(s). For the pediatric population, episodes of bradycardia will be assessed instead of this parameter.

5.0 Patient Care

5.1 Guidelines for Withholding or Withdrawing of Life Sustaining Treatment

PURPOSE
To establish procedures for determining when and how to properly implement “terminal care orders”, i.e. medical orders under which life support measures may be either withheld or withdrawn.

A. Patients with decision-making capacity: A patient with decision-making capability has the right to make decisions about his/her medical care. This encompasses the right to decline any medical procedure, including procedures relating to resuscitation and/or life sustaining treatment. This includes artificially administered nutrition and hydration.

B. Patients without decision-making capability: If a patient has executed an advance directive which addresses resuscitative services and/or life sustaining treatment methods, the treating physician or his
designated consultative attending physician (DCAP) (each, as defined by hospital policy) shall attempt to comply as fully as possible with the patient’s directive. For further explanation of hospital policy on advance directives, see Methodist Healthcare Policy S-05-018.

C. Minors: A minor patient is anyone lacking decision-making capability under State law due to age.

**General principles**

The following principles are to be followed in decisions concerning care for critically ill patients:

A. Every patient treated at Methodist Le Bonheur Healthcare will have maximum efforts used to maintain life and health except in those circumstances in which such efforts are not medically indicated or ethically justified. These cases include the terminally ill and/or inappropriate medical situations at the end of life. In cases where surrogate decision makers are not available, the decisions of the providers will always be made on the basis of the best interest of the patient. Surrogate decision-makers will be identified in accordance with applicable state law(s).

B. The attending physician or his DCAP has the ultimate responsibility for medical diagnosis, prognosis and identification of medically acceptable treatment options. Consultation with the appropriate medical consultants is encouraged, but left to the judgment of the attending physician. (The attending physician is defined as the physician primarily responsible for the patient’s hospital care).

C. The attending physician or his DCAP, patient, when he/she has decision making capability, or otherwise the parent/guardian or surrogate decision maker, has the primary responsibility for making decisions concerning the medical care of the patient. It is the responsibility of the attending physician or his DCAP to see that the patient, parent/guardian, or other acceptable surrogate decision maker, has been supplied with all information necessary in the sensitive decision making process. Family members should be kept informed and their wishes taken into consideration (unless the patient chooses not to include them), but the decisionally capable patient or appropriate surrogate always has the right to make his/her own healthcare decisions.

D. Euthanasia, i.e. intervention with affirmative measures intended to cause death of the patient, is not only illegal, but also violates the mission and core values of Methodist Le Bonheur Healthcare. Such interventions are clinically and ethically unacceptable at Methodist Le Bonheur Healthcare.

**Categories of clinical care**

The following categories of clinical care will apply:

A. Full care – any patient who does not fall into categories B or C below.

B. Full care efforts except specified interventions.

1. This category may be applied to patients who have a poor prognosis or terminal condition and who have had such for a period sufficiently long that the prognosis has been determined with reasonable medical certainty. The attending physician or his DCAP is responsible for communicating this prognosis to the patient/surrogate, along with medically acceptable treatment options, and for assuring their comprehension as much as possible. All attending physicians may also offer their treatment recommendations.

2. The decision to limit therapy by excluding specific interventions is a decision which should ordinarily
be made by the patient/surrogate decision-maker, after appropriate discussions with the patient’s attending physician or his DCAP, and documented by a physician’s order in the patient’s medical record. Annotations must be made in the progress note which detail the discussions with the surrogate decision makers or patient regarding the prognosis and specifics concerning their understanding of the treatment plan, including specific quotes if possible. This note should be signed or countersigned by the attending physician or his DCAP, and ideally by a second party such as a Nurse, Social Worker or Chaplain who is present during the discussions as a witness.

3. In situations where initiation of life sustaining therapy, including cardiopulmonary resuscitation, would be, in the opinion of the attending physician or his DCAP, of no benefit and/or disproportionate (of more harm than good), said therapy need not be offered as an option. In such situations, if conflict arises, it is recommended that the attending physician or his DCAP consult the Ethics Committee or similar body per hospital policy. The Ethics Committee may facilitate communication and offer recommendations. Legal Affairs/Risk Management should also be notified if there is conflict. Until the conflict is resolved, there should be no limitation of therapy. Hospital procedures should be followed in the case of irresolvable disagreements, per the guidelines on the determination of Inappropriate Medical Interventions in End of Life policy.

**Discontinuation of life-sustaining therapy**

1. This category may be applied to patients who have a terminal medical condition or for whom the conditions of existence on prolonged life sustaining therapies are not acceptable, and achieve no useful benefit for the patient.

2. Such condition should have existed for a time sufficiently long that the prognosis has been determined with reasonable medical certainty. The attending physician or his DCAP is responsible for communicating this prognosis to the patient/surrogate, along with medically acceptable treatment options, and for assuring their comprehension as much as possible. All attending physicians may also offer their treatment recommendations. Patients may be placed in this category only after careful discussion with the patient/surrogate and appropriate others who are involved. Medical consultation with another physician or the Ethics Advisory Committee is recommended. The decision and the factual basis for the decision must be thoroughly documented in the medical record, including the extent and general content of discussion with all concerned individuals in the form of a progress note by the attending physician or his DCAP.

3. In situations where initiation of life sustaining therapy including cardiopulmonary resuscitation would be, in the opinion of the attending physician or his DCAP, of no benefit and/or disproportionate (of more harm than good) harm, said therapy need not be offered as an option. In such situations, if conflict arises, it is recommended that the attending physician or his DCAP consult the Ethics Committee.

**Responsibilities**

**Attending physician**

Ethics Committee or similar body, per hospital policy. Such a Committee may facilitate communication and offer ethical recommendations. Legal Affairs/Risk Management should also be notified if conflict is problematic. Until the conflict is resolved, there should be no limitation of therapy. Hospital procedures should be followed in the case of irresolvable disagreements, per the Guidelines on the Determination of Inappropriate Medical Interventions in End of Life Care.

The decision to place a patient in Categories C and to withdraw certain ongoing therapy in the situation described must be communicated by a specific order by the attending physician or his DCAP. In the case of a designee, the attending’s designee in the progress note must document this discussion at the time the order is
written. The attending physician or his covering associate must countersign any such order at his/her earliest convenience.

For patients in Categories B or C presenting for operative procedures, the operative period is considered to begin upon the patient’s arrival to the holding area and to end once the patient meets post-anesthesia/sedation discharge criteria. The specifics of the code status during this period will be addressed in accordance with separate hospital policy by the anesthesiologist and/or surgeon in coordination with the patient/surrogate decision-maker and the attending physician or his DCAP prior to the procedure. Documentation of this discussion will be detailed in the patient’s chart.

ACTION:

1. Has ultimate responsibility for making diagnoses deciding of proper elements of treatment and determining and relating prognosis to the patient/surrogates.
2. Consults with physicians from other specialties and subspecialties as appropriate.
3. Ordinarily defers to the expressed wishes of the patient/surrogate. If the attending physician or his DCAP disagrees with the patient/surrogate on the category of clinical care, the attending physician or his DCAP need not be compelled to initiate or continue therapy. The Ethics Committee may be consulted to assist with resolution of any conflict. Resolution of disagreements should be undertaken in accordance with hospital policies, such as the Guidelines on the Determination of Inappropriate Medical interventions in End of Life Care.
4. Any physician order placing a patient in a specific category of clinical care will be reviewed by the attending physician. In addition, it can be changed at any time via patient/surrogate request, or as the result of conflict resolution procedures described above. The reason for this change should be documented in the progress record.
5. Change of orders must be documented on the physician order sheet and be to the appropriate parties.
6. A healthcare provider or institution may decline to comply with an individual instruction or health care decision that requires medically inappropriate health care or health care contrary to generally accepted health care standards applicable to the health care provider or institution.
7. In the event there is not agreement pertaining to para. 6. above, Section 68-1708, (f), p. 8 in the TNHCDA or Section 41-41-215, (7), p. 19 in the MS Uniform Health-Care Decisions Act shall provide further guidance.

Social Worker, Nurse,

1. When requested, participate as a witness in the Chaplain discussions with the parent/guardian, surrogate decision maker, or patient.
2. Participate, within the limits of their expertise, in the process of enhancing communication between the patient/surrogate and health care provider.

5.2 Guidelines on the Determination of Inappropriate Medical Interventions in the End of Life Care

The traditional goals of medicine have been to heal and relieve suffering and pain. In recent years, it has been recognized that these goals are sometimes best served by limiting rather than by continuing medical interventions. These guidelines affirm both the traditional goals of medicine and the moral values of physician and institutional integrity in discerning the appropriate limits of medical interventions at the end of life. Respect for this integrity provides the basis for the right to refuse to provide ongoing medical interventions in a futile situation. These guidelines understand a medically inappropriate situation to be (1) one in which further treatment or intervention, except for comfort care, cannot be reasonably expected to improve or restore a quality of life that would be satisfactory to the patient as he or she has expressed personally, by means of
advance directive, or through a legal surrogate; or (2) to be a situation in which further treatment or intervention does not serve a legitimate goal of medical practice. This complements the right of patient self-determination that must be given both voice and effect in any forum for medical decision making. This appeal to integrity is generally rooted in a combination of concerns such as avoiding harm to patients and avoiding provision of unsuitable care. These guidelines affirm the value of integrity so long as appropriate institutional review and evaluation support the determination of medical inappropriateness.

Caregivers will strive to understand and address the reasons regarding patient/surrogate decision maker/provider conflicts. After following the procedures set forth in this policy and after providing attention to the emotional needs and questions of the patient and/or surrogate decision maker, a medically inappropriate intervention may be withheld or withdrawn without obtaining the agreement of the patient or legal surrogate.

**Procedures**

1. The existence of this policy and procedure, as well as other policies and procedures regarding limits to treatment should be made known to the patient as determined by each institution to be appropriate.

2. When the attending physician or his/her designated physician (hereinafter the “responsible physician”) determines that a medical intervention is inappropriate, the responsible physician should discuss carefully with the patient or legal surrogate the nature of the ailment, options for treatment including palliative and hospice care, and the prognosis and the reason(s) why the intervention is medically inappropriate. The responsible physician should explain that not providing the intervention in question does not mean abandoning appropriate medical care designed to provide comfort, dignity, pain management, and emotional and spiritual support. If the patient or legal surrogate concurs with the physician’s recommendation to limit treatment, then procedures outlined in the institution’s policies regarding patient treatment refusals shall be followed.

3. If, despite this explanation, the patient (or surrogate decision maker) insists that the medical intervention be provided, the responsible physician should address with the patient (or surrogate decision maker) the options of patient transfer to another institution and of obtaining an independent medical opinion concerning the medical inappropriateness of the intervention in question. The responsible physician should also provide the patient (or surrogate decision-maker) with a copy of these guidelines and explain the process, along with a list of institutional resources that might assist either in considering this issue further.

4. The assistance of institutional resources (such as nursing, patient care representatives, chaplaincy, social services or the Committee on Advance Care Planning/Bioethics, hereinafter “the Committee”) shall be made available to the patient (or surrogate decision-maker) and to the responsible physician. In any deliberation, the first concern will always be the welfare of the patient.

5. If, after reasonable effort by the responsible physician using the available institutional resources, agreement is not reached between the responsible physician and the patient (or surrogate decision maker), the responsible physician who still wishes to limit the intervention must obtain a second medical opinion from a physician who has personally examined the patient and who is not currently involved in the care of the patient. The responsible physician must present the case for review by the Committee or other approved institutional body, and must provide to that body, clinical and scientific information pertinent to the determination that the intervention is medically inappropriate, including the results of the second opinion that was sought.

6. The responsible physician must notify the patient (or surrogate decision maker) that this process has been invoked, what it involves and what are its possible outcomes, when and where the review will take place, and that the options of transfer before the meeting exists, but that arranging such a transfer
is the responsibility of the patient or surrogate decision maker. Absent patient or surrogate decision maker consent to an earlier time, the meeting cannot take place for at least 72 hours after the patient (or surrogate decision maker) is notified and must occur within 48 following the expiration of that 72 hour period.

7. During the review by the Committee or other approved institutional body, the responsible physician and the patient (or surrogate decision maker) are encouraged to be present to express their views for consideration, including alternative plans of care.

8. If, however, the Committee or other approved institutional body does not concur with the responsible physician’s determination of medical inappropriateness, then orders to limit the medical intervention will not be recognized as valid without patient (or surrogate decision maker) agreement. In this situation, either the patient or the responsible physician may request a transfer of care to another physician and the institution will endeavor to locate another physician who is comfortable carrying out the medical intervention which the patient or surrogate decision maker requests.

9. If a finding of inappropriate medical intervention is affirmed by the Committee or other approved institutional body, the intervention may be disallowed and a plan of care established that addresses comfort care and the preservation of patient dignity. In this situation, intrainstitutional transfer of the care of the patient to another physician to provide palliative care is allowed. However, intrainstitutional transfers to another physician to provide the intervention that has been judged by the Committee to be medically inappropriate will not be allowed. In this case the patient and family may on their own seek care from providers outside this institution. If such case arrangements can be made, then the institution will attempt to aid in the orderly and safe transfer of the patient.

10. It is agreed by all caregivers that the emotional needs of the patient, family and/or surrogate decision maker will be supported throughout this process.

5.3 Medical Screening Exam

It is the policy of Methodist Healthcare – Memphis Hospitals and MHOBH that all persons presenting to the hospital for unscheduled care, procedures or evaluation shall receive a medical screening examination (MSE) within the capabilities of the facility’s emergency department and the ancillary services routinely available.

Emergency Department

The emergency physician or nurse practitioner/certified physician assistant conducts, and is responsible for, the MSE. It is defined as the initial and ongoing evaluation of the unscheduled presenting patient to determine whether the patient has an emergency medical condition and/or to ensure that the patient does not have an emergency condition. The MSE is specific to age and presenting complaint. It includes the history, physical examination, appropriate testing as indicated, evaluation of the patient, documentation of findings, and use of on-call physicians as appropriate.

In the event a hospital is experiencing extraordinary Emergency Department surges, the hospital may utilize RNs who have been trained to conduct medical screening in such circumstances. These RNs will have been trained in conducting MSEs as outlined by the hospital facility. These extraordinary situations may be declared by the facility CEO in conjunction with the Emergency Department Medical Director and are anticipated to be temporary and not to exceed a time period of 120 days unless reviewed and approved by the Medical Staff President, Chief of Staff, Vice Chief of Staff and Chief Quality Officer.

Patients shall not be denied evaluation, screening, treatment, or stabilization on the basis of means or ability to pay, race, creed, color, national origin, age, sex, or actual or perceived disability.
The triage nurse may collect data required to complete the MSE, such as the initial patient assessment and any reassessment. The Emergency Department Technician (EDT) may initiate collection of vital signs and chief complaint and assign the initial triage acuity. The triage nurse shall verify the data collected by the EDT and assign the final triage acuity. However, the medical screening examination must be performed by a physician and/or nurse practitioner/certified physician assistant and is not complete until the ED physician and/or nurse practitioner/certified physician assistant has reviewed the triage assessment, the results of any necessary testing or treatment, and has examined the patient.

**Obstetrical Patients**

For obstetrical patients 20 weeks or greater gestation, the medical screening examination may be conducted by an appropriately trained and competent obstetrical registered nurse. After examination, the obstetrical nurse must communicate the findings and consult with the patient's physician or on-call physician. The physician will determine if the presenting condition is an emergency medical condition or that the patient may be discharged.

5.4 **On Call Physicians And Emergency Transfers**

A. **On-Call Physicians**

Hospital administration should determine which specialties (if any) are required to be on-call based on the reasonable needs of the Hospital. The determination shall be documented by the MEC and records of this determination should be maintained on file in MSSD. Lists of on call physicians shall be maintained in MSSD and posted on MOLLI.

The Hospital should maintain a list in the Hospital Emergency Department (ED) of individual physicians who are on-call for duty after the initial examination to provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition, in accordance with the procedures below:

- If, after an initial medical screening exam (MSE), a physician (or other QMP) determines that the individual requires the services of an on-call physician, then the on-call physician should be contacted. Alternatively, if the on-call physician has been made aware of a transfer by the transferring physician, the on-call physician should contact the Hospital emergency department to notify the ED of the transfer.

- On-call physicians should respond to Hospital calls/requests for emergency on-site coverage within a reasonable time. If a scheduled on-call physician fails to respond, the emergency department physician or designee should attempt to obtain the services of another appropriate physician from the Hospital’s medical staff.

Unless otherwise contractually agreed, it is the general policy of the Hospital that physicians who are considered to be on-call are allowed to schedule elective surgeries and take call at other facilities. Such physicians are required to be medical staff members in good standing of Hospital, and if taking call at two facilities simultaneously, the physician must make the Hospital aware of the physician’s on-call schedule so that these back up call lists or specific procedures can be developed.

Any changes to call availability shall be communicated to MSSD for corrected call coverage posting. If an unavoidable change occurs after hours or during the course of the call requirement, the physician should notify the facility ED and/or transfer center directly and also notify MSSD the next business day.

See also below for procedures for use in responding to situations in which a particular specialty is not available or the on-call physician does not respond.
B. Procedures for Responding to Situations in Which a Particular Specialty is not available or the On-call Physician Does Not Respond

If a physician on-call is not available or does not respond, Department Chair or designee or the Chief of Staff should be contacted by the ED physician or designee. Patients should not be referred to the on-call physician’s private practice office for emergency screening or treatment.

If available call coverage and capability exists at another MLH hospital, the patient may be transferred to that other facility for further care.

This procedure also applies to situations when the on-call physician is unavailable due to elective surgeries or being on call for another hospital.

C. Obligation to Accept Certain Transfers – Specialized Capabilities

To the extent that the Hospital has specialized capabilities or facilities that are not available at a facility that has requested the Hospital to accept the transfer of an individual needing those capabilities or facilities, the Hospital should accept appropriate transfers of such individual if the Hospital has the capacity to treat the individual. The Hospital may not condition the acceptance of an appropriate transfer on the use by the sending hospital of a particular transport service instead of the transport arrangements made by the attending physician at the sending hospital. A request for transfer should be documented along with the response to the request, and the basis for any denial of such a request.

ED physicians are authorized to accept and manage transfers from requesting hospitals. Only ED physicians or Pediatric ICU (NICU, PICU, CVICU) attendings should deny transfers.

D. Inappropriate Refusal of Transfers

Hospital medical staff and employees, in particular those who work in a dedicated emergency department, who have “reason to believe” that the Hospital may have inappropriately refused to accept the transfer of an individual from another facility should report the incident directly to the Compliance Officer or to the Compliance Hotline promptly for investigation.

If, based on the investigation, it is determined that there is “reason to believe” a transfer was inappropriately refused, the Compliance Officer should consult Hospital’s Risk/Legal Officer regarding the Hospital’s obligations and potential staff or employee sanctions (if appropriate).

E. Reporting the Receipt of Inappropriate Transfers

Hospital medical staff members and employees, in particular those who work in a dedicated emergency department, who have “reason to believe,” that the Hospital received an inappropriate transfer in violation of the law, should report the incident promptly to the Hospital Compliance Officer or through the Compliance Hotline.

Factors that might give rise to “reason to believe” that an apparent receipt of inappropriate transfer may have occurred include, but are not limited to, the following:
• Transfer was made even though (i) the risks of the transfer outweighed the expected medical benefits of the medical treatment; (ii) the individual transferred did not request the transfer; and (iii) neither a physician nor a qualified medical person of the transferring facility certified that the benefit of medical treatment at the receiving Hospital outweighed the increased risks of the transfer;

• Individual was transferred with an unstable EMC from another hospital in violation of 42 C.F.R. § 489.24(e).

• Transfer was made even though the transferring facility was notified that the Hospital did not have available the capacity and/or capability/personnel for the treatment of the individual;

• Transfer was made without the provision of appropriate level of qualified personnel and/or transportation equipment and/or medically appropriate life support measures;

• Representatives of the transferring Hospital stated to the Hospital personnel that the transfer was made for financial reasons (e.g., lack of insurance/funds where the transfer was not requested by the individual);

• Hospital did not receive the appropriate medical records;

• Hospital received no advance notification of the transfer of an individual with an emergency medical condition; or

• The transfer was a lateral transfer.

The Compliance Officer should promptly investigate reports of apparent inappropriate transfers. At the conclusion of the investigation, the Compliance Officer or designee should determine whether there is “reason to believe” that an apparent inappropriate transfer occurred. If, based on the investigation, it is determined that there is “reason to believe” that an inappropriate transfer has occurred, the Chief Executive Officer and Compliance Officer should consult with Hospital’s Risk/Legal Officer regarding Hospital’s obligations. The Hospital’s Risk/Legal Officer should report the incident to the appropriate agencies/parties within 72 hours of its occurrence - if, in his/her judgment, an inappropriate transfer was made to the Hospital from other medical facilities in violation of EMTALA and if reporting is required by 42 C.F.R. § 489.20(m).

5.5 Guidelines for Appropriateness of Adult Transfusion

The following criteria for blood component administration are not meant to be standards of care. Rather, they represent guidelines for transfusion that would be considered reasonable, not mandatory. The criteria are for autologous as well as allogeneic transfusion.

Blood utilization based on these criteria is designed to continuously improve the use of blood and blood components.

RED CELLS:

Managing the decision to transfuse is difficult, and there are very few well-designed trials that assess the effectiveness of interventions. In general, almost everyone with a hemoglobin less than 6 g/dl will require
transfusion, while very few with a hemoglobin greater than 10 g/dl will need it. Given this complexity and the need for clinical judgment, the following guidelines are recommended:

1. In less acutely ill or younger patients, transfusion may be reasonable if the hemoglobin/hematocrit levels are less than 7/21.

2. In elderly patients with active cardiovascular disease/end-organ ischemia, transfusion may be reasonable to achieve a higher hemoglobin/hematocrit.

3. Transfusion is indicated for symptomatic anemia in a normovolemic patient, regardless of hematocrit.

4. Transfusion is indicated in acute blood loss (typically greater than 30% of blood volume) with evidence of inadequate oxygen delivery.

5. Simple transfusion/exchange transfusion is indicated for sickle cell disease for prevention of stroke, prior to surgery, and for a number of other other life- or organ-threatening diseases.

6. Continuing transfusion of red cells in patients who have already had one blood volume replaced (massive transfusion) will often depend primarily on clinical judgment, as the hematocrit may not accurately reflect tissue oxygenation in these situations.

NOTE: Transfusion of a single unit of red cells should be the standard practice in stable, non-bleeding patients, with post-transfusion evaluation of the hemoglobin and hematocrit prior to further therapy.

PLATELETS:

1. Platelet count less than 10,000/uL in a patient with failure of platelet production and no evidence of fever or bleeding.

2. Platelet count less than 20,000/uL in a patient with failure of platelet production and evidence of fever or bleeding.

3. Platelet count less than 50,000/uL and impending surgery or invasive procedure, or if major bleeding is occurring.

4. Diffuse microvascular bleeding in a patient with disseminated intravascular coagulation and platelet count less than 50,000/uL, or laboratory values not available.

5. Diffuse microvascular bleeding following cardiopulmonary bypass or massive transfusion (replacement of greater than or equal to one blood volume) and platelet count less than 100,000/uL, or not yet available.


7. Platelet count less than 100,000/uL and impending neurologic or ophthalmologic procedures.

FRESH FROZEN PLASMA:
1. PT greater than 1.5 times the mean normal value in a non-bleeding patient scheduled for surgery or invasive procedure.

2. PT greater than 1.5 times the mean normal value in a massively transfused patient, or if lab values are not available.

3. Warfarin overdose with major bleeding, impending surgery, or if urgent reversal is required. Other patients can usually be treated with withdrawal of warfarin and vitamin K administration. Note: Patients on warfarin undergoing minor invasive procedures (such as lumbar puncture, liver biopsy, catheter insertion, etc.) typically do not require FFP if the INR is less than 1.6.

4. Thrombotic thrombocytopenic purpura.

5. Treatment of specific plasma deficiencies when no concentrate is available.

CRYOPRECIPITATE:

1. Diffuse microvascular bleeding and fibrinogen less than 100 mg/dl.

2. Bleeding associated with Factor XIII deficiency.

3. Bleeding associated with dysfibrinogenemia or hypofibrinogenemia and fibrinogen less than 100-120 mg/dl.

4. Use in Von Willebrand disease or Hemophilia A should only occur if appropriate concentrates are not available.

5.6 Neonatal Massive Transfusion Guideline (Patients weighing > 10 kilograms)

1. PRINCIPLE:
   1.1. Massive Transfusion is defined as an infusion of Packed Red Blood Cells in amounts approaching or exceeding replacement of the recipient’s total blood volume within less than 24 hours or the acute administration of more than half of the patient’s estimated blood volume per hour.

2. SCOPE:
   2.1. This guideline applies to patients weighing less than 10 kilograms at Le Bonheur Children’s Medical Center.

3. PROCEDURE:
   3.1. The Neonatal Massive Transfusion Guideline may be initiated by either the patient’s physician or by the Medical Director of Transfusions Services (or the designee Pathologist).
   A. It is the responsibility of all technologists in the Transfusion Service to monitor patients receiving large numbers of red cell units without the addition of other blood products (i.e., Fresh Frozen Plasma (FFP), Platelets and Cryoprecipitate).
   B. It is standard procedure for the blood bank technologist to review a patient’s transfusion history before dispensing blood products.
   C. If 6 doses (ml/kg as indicated for the patient) of Red Blood Cells have been ordered and dispensed within a 24 hour time period without FFP, Platelets and Cryoprecipitate being transfused, the Transfusion Service should call the patient’s physician to see if he/she wishes to invoke the Massive Transfusion Guideline, which will include Fresh Frozen Plasma, Platelets and Cryoprecipitate in addition to Packed Red Blood Cells. The Medical Director of Transfusion Services (or the designee Pathologist) must be notified.
3.2. When this guideline is initiated, the blood bank staff will prepare and issue “Massive Transfusion Pack #1” according to the Massive Transfusion Guideline chart (see attached). Once the MTP Pack #1 has been issued, the blood bank technologist will prepare the next MTP Pack (MTP Pack #2). Subsequent MTP Packs (#3, #4, etc) will be prepared when the previous MTP pack is issued until the Massive Transfusion Guideline has been terminated by either the patient’s physician or the Medical Director of Transfusion Services (or designee Pathologist).

A. If a current Type and Screen has been completed, Red Blood Cells will be assigned to patients less than four months of age, and initial-spin crossmatches with type-specific Packed Red Blood Cells will be performed on neonates greater than four months of age (whenever time permits for the crossmatch). ABO-compatible plasma components will be issued for the MTP Packs by the Transfusion Service. If the packed red blood cells are needed emergently and time does not allow a crossmatch to be performed for neonates greater than four months of age, Emergency Uncrossmatched, O Negative packed Red Blood Cells will be dispensed per current policy for these patients. The Physician will need to sign the “Release of Uncrossmatched Blood” form per current policy.

B. If the Type and Screen has not yet been received for testing, the Transfusion Service will dispense the appropriate volume of Emergency, Uncrossmatched, Group O, Rh Negative Packed Red Blood Cells and Group AB plasma components until the Type and Screen is completed. The ordering Physician will need to sign the “Release of Uncrossmatched Blood” form per current policy in this situation.

C. If the Type and Screen has been partially completed (patient’s ABO and Rh has been determined, but the Antibody Screen is not yet completed) Emergency, Uncrossmatched, Type-specific Red Blood Cells can be dispensed until the Antibody Screen is completed. The ordering Physician will need to sign the “Release of Uncrossmatched Blood” form per current policy, in this situation as well.

D. The ordering physician should be encouraged to obtain a sample on the patient as soon as possible, to enable the blood bank to perform the Type and Screen and dispense immediate-spin crossmatch-compatible Type-specific packed Red Blood Cells.

E. Once an Rh-Negative patient has been transfused with ten packed Red Blood Cell units, the blood bank technologist will call the Medical Director of Transfusion Services (or designee Pathologist) for further recommendations on transfusion support for the patient.

F. A new specimen must be obtained for Type and Screen every 24 hours within the setting of the Massive Transfusion Guideline.

5.7 Pediatric Massive Transfusion Guideline (Patients weighing > 10 kilograms)

PRINCIPLE:
Massive Transfusion is defined as an infusion of Packed Red Blood Cells in amounts approaching or exceeding replacement of the recipient’s total blood volume within less than 24 hours or the acute administration of more than half of the patient’s estimated blood volume per hour.

SCOPE:
This guideline applies to patients weighing greater than 10 kilograms; the patient should be treated at Le Bonheur Children’s Hospital.

PROCEDURE:
1 The Pediatric Massive Transfusion Guideline may be initiated by either the patient’s physician or by the Medical Director of Transfusions Services (or the designee Pathologist).
A. It is the responsibility of all technologists in the Transfusion Service to monitor patients receiving large numbers of Red Blood Cell units without the addition of other blood products (i.e., Fresh Frozen Plasma (FFP), Platelets and Cryoprecipitate).

B. It is standard procedure for the technologist to review a patient’s transfusion history before dispensing blood products.

C. If 6 units of Packed Red Blood Cells have been ordered and dispensed within a 24 hour time period without FFP, Platelets and Cryoprecipitate being transfused, the Transfusion Service should call the patient’s physician to see if he/she wishes to invoke the Massive Transfusion Guideline, which will include FFP, Platelets and Cryoprecipitate, in addition to Packed Red Blood Cells. The Medical Director of Transfusion Services (or the designee Pathologist) must be notified.

2. When the guideline is initiated, the blood bank staff will prepare and issue “Massive Transfusion Pack #1” according to the Massive Transfusion Guideline chart (see attached). Once the MTP Pack #1 has been issued, the blood bank technologist will prepare the next MTP Pack (MTP Pack #2). Subsequent MTP Packs (#3, #4, etc) will be prepared when the previous MTP pack is issued until the Massive Transfusion Guideline has been terminated by either the patient’s physician or the Medical Director of Transfusion Services (or designee Pathologist).

   A. If a current Type and Screen has been completed, immediate-spin crossmatch-compatible type-specific Packed Red Blood Cells and ABO-compatible plasma components (Platelets, FFP, Cryoprecipitate) will be issued for the MTP Packs by the Transfusion Service. If packed Red Blood Cells are needed emergently, and time does not allow for crossmatching of the RBCs, Emergency Uncrossmatched O Negative packed RBCs will be dispensed per current policy. The ordering Physician will need to sign the “Release of Uncrossmatched Blood” form per current policy.

   B. If the Type and Screen has not been received, the Transfusion Service will dispense Emergency, Uncrossmatched, Group O, Rh Negative Packed Red Blood Cells and Group AB plasma components until the Type and Screen is completed. The ordering Physician will need to sign the “Release of Uncrossmatched Blood” form per current policy.

   C. If the Type and Screen has been partially completed (patient’s ABO and Rh has been determined, Antibody Screen not complete), Emergency, Uncrossmatched, Type-specific Red Blood Cells will be dispensed until the Antibody Screen is completed. The ordering Physician will need to sign the “Release of Uncrossmatched Blood” form per current policy.

   D. The ordering physician should be encouraged to obtain a sample on the patient as soon as possible so that the blood bank may dispense immediate-spin crossmatch-compatible, Type-specific Packed Red Blood Cells.

   E. Rh Negative Male patients may be switched to ABO-compatible, Rh Positive immediate-spin crossmatched Packed Red Blood Cells after 10 units of ABO-compatible or Group O, Rh Negative Packed Red Blood Cells have been transfused, with approval from the Medical Director of Transfusion Services (or designee Pathologist).

   F. Female Rh Negative patients should continue to receive Rh Negative Packed Red Blood Cells.

   G. In the event ABO-compatible Rh Negative Packed Red Blood Cells are not available for Rh Negative patients, the patient may be switched to ABO-compatible Rh Positive immediate-spin crossmatched Packed Red Blood Cells only with the approval of the Medical Director of Transfusion Services (or the designee Pathologist) in conjunction with the patient’s physician.

3. Subsequent orders for blood are also dispensed as a “Massive Transfusion Pack #2, #3, etc, (which will also include Cryoprecipitate with MTP Pack #2 and forward), until further notice from either the clinical team or the Medical Director of Transfusion Services (or the designee Pathologist). A new specimen must be obtained for Type and Screen every 24 hours within the setting of the Massive Transfusion Guideline.
5.8 Clinical Effectiveness Standards

The purpose of this policy is to delineate all evidence based and best practice clinical guidelines approved for use. Use of these should occur for each patient care episode at MH-MH and MH-OBH, and as appropriate in Provider-based clinics.

Clinical Care & Best Practice Default Standards

Pneumococcal vaccine  The following acute care hospitalized in-patients will receive the Pneumococcal vaccine if no acceptable contraindication:

- Aged 65 and older
- Aged 6 years to 64 years who are considered high risk and have not received the vaccine before. High risk criteria include:
  - Alcoholism
  - Asplenia (congenital or acquired, splenic dysfunction, or splenectomy)Asthma (only includes age 19 years to 64 years )
  - Cerebral spinal fluid leaks
  - Chronic heart disease (including CHF and excluding hypertension)
  - Chronic liver disease (including cirrhosis)
  - Chronic lung disease (including COPD, bronchitis, and emphysema)
  - Cigarette smoker (only includes ages 19 to 64 years)
  - Cochlear implant
  - Diabetes
  - Sickle Cell Disease and other hemoglobinopathies
  - Congenital or acquired immunodeficiencies
  - Chronic renal failure
  - Generalized malignancy
  - HIV/AIDS
  - Hodgkin’s disease
  - Leukemia
  - Long-term systemic corticosteroids
  - Lymphomas
  - Multiple Myeloma
  - Nephrotic syndrome; nephrosis
  - Solid organ transplant
  - Radiation therapy
  - Residents of nursing homes or long-term facilities
Acceptable Exclusions:
- Serious allergic reaction to prior pneumococcal immunization
- Patient/caregiver refuses vaccine
- Patient is receiving chemo/radiation during this hospital stay
- Patient has received chemo/radiation in the past 2 weeks
- Patient has had a bone marrow transplant within the last 12 months
- Patient has received shingles vaccine in the past 4 weeks
- Patient is 6 years of age and has received a conjugate vaccine in the past 8 weeks
- Organ transplant during this hospital stay

Smoking cessation advice
Every smoker and recently quit smoker will receive smoking cessation advice (Learning for Life)

Oxygenation Assessment
Oxygen assessment will become another vital sign that is measured in the ED

Influenza vaccine
Every acute care hospitalized in-patient age 6 months and greater will be screened and vaccinated with the flu vaccine during the flu season as determined by CDC/CMS (in general, months of October – March) if no acceptable contraindication.

Rehabilitation evaluation
Rehabilitation referral will be initiated 24 hours post admission on all stroke patients

Hospice Evaluation
For each patient given “Do not resuscitate” status, the attending physician will be asked if a hospice evaluation is appropriate. If affirmed, the hospice evaluation will be requested.

Ventilator Liberation Protocol
Protocol will be initiated on all ventilated patients in the adult critical care units

Sedation and Analgesia Orders
The appropriate sedation/analgesia orders will be initiated on all ventilated patients in the adult critical care units

5.9 Requirement to Specify Numerical Gestational Age
Numerical gestational age/estimated numerical gestational age should be documented in the mother’s Hospital medical record by the obstetrician prior to or at the time of delivery.

5.10 Imaging & Radiology Studies Requiring Interpretation by Radiologist
Below is a list of tests that require credentialed radiologist interpretation:
General diagnostic radiology (x-ray), diagnostic ultrasound, diagnosis and treatment using radionuclides, nuclear medicine studies including PET, diagnostic neuroradiology, diagnostic invasive procedures and diagnostic body imaging, computerized tomography, MRI, mammography, and myelography.

A full procedure list for this scope of practice can be found under the radiology DOPs and special privileges.

Exception: If granted privileges for limited diagnostic radiology interpretation, primary care providers in designated provider-based clinics may interpret the following diagnostic x-rays performed in their clinic: chest x-ray, extremities, spine, skull, and sinus.

Exception 2: If granted the privilege, maternal fetal medicine attendings may interpret targeted obstetrical ultrasound.

5.11 Qualifications of Non-Medical Staff ordering Diagnostic Tests or Imaging

A provider who is neither credentialed nor privileged by MLH may order diagnostic and imaging studies when the following are verified:

- National Provider Identifier number
- valid provider license
- no sanctions through OIG (Office of the Inspector General)

6.0 Physician Professional Conduct

6.1 Physician/Associate Grievance Policy

To provide a process for Associates which allows review and documentation of problems between Associates and physicians (including house staff members). Complaints may be related to behavior, harassment, or other issues, which may not fit the Associates grievance procedure or other formal avenues. The complaint must be work related and occur within MH-MH or MH-OBH facilities, or Provider-based clinics. This process is in addition to the Occurrence Reporting Procedure or procedures provided for pursuant to the medical staff bylaws. It is preferable that Associates always attempt to solve problems informally through discussion with their supervisors. This process is for the occasion when informal discussion does not resolve the complaint.

Step 1: The Associate discusses the incident with the appropriate supervisor within five calendar days following the occurrence. The Associate and supervisor attempt to resolve the issue at this point, if appropriate. If the problem is not resolved, the supervisor notifies the MSSD which will be responsible for setting up a meeting with the physician involved in the complaint and the appropriate Medical Staff Department Chair (or Resident Program Director) and the appropriate administrative representative depending upon the location of the incident.

The Associate's supervisor will attend the meeting and the Associate may attend at his or her discretion. This meeting is to occur within 30 days. If the physician involved has no discrepant information in regard to the complaint and/or a concurrence of the complaint can be obtained between the physician and Associate, the Medical Staff Department Chair (or Resident Program Director) and the administrative representative will...
attempt to resolve the problem with appropriate action. This resolution must meet the approval of both the Associate and the physician. If such resolution is not, possible at this level, the process proceeds to Step 2.

Step 2: Human Resources is notified of the situation and begins data collection and then submits a complete report to the MSSD (to be forwarded to the appropriate Medical Staff Department Chair or Resident Program Director), the appropriate administrative representative, and the Associate Chief of Staff. The complaint is reviewed by this 3-member committee (appropriate Departmental Chair or Resident Program Director, administrative representative, and the Associate Chief of Staff). A unanimous vote of this committee is required to declare the complaint valid or invalid. One dissenting vote will forward the complaint to the Senior Leadership Council (SLC). If at the committee level or SLC level the complaint is deemed invalid, the issue is terminated at this point. If at the committee level or SLC level the complaint is deemed valid, steps outlined in the medical staff bylaws are initiated for appropriate action.

6.2 Physician Health Policy

Purpose
The hospital and the medical staff leadership has an obligation to protect patients from harm. In this regard, the medical staff leaders design a process that provides education about physician health, addresses prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of physicians who suffer from a potentially impairing condition.

The process is to assist and rehabilitate, rather than discipline and to aid the physician in retaining or regaining optimal professional functioning, consistent with protection of patients.

Reporting and investigating
If any individual working in the hospital has a reasonable suspicion that a physician appointed to the medical staff is impaired, the following steps should be taken:

1. The individual who suspects the physician of being impaired must provide a written report to the Department Chair, Chief of Staff, Associate Chief of Staff, MEC or the Board of Directors. 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 making the report does not need to have proof of the impairment, but must state the facts that led to the suspicions.

2. If after discussing the incident(s) there is enough information to warrant an investigation and/or assessment, the CEO, Medical Staff President, or Chief of Staff shall request an investigation and/or assessment. Depending on the severity of the problem or nature of the impairment the investigation and/or assessment can be performed by either:
   a) the Medical Staff Well Being Committee; or
   b) an outside consultant; or
   c) another individual or individuals appropriate under the circumstances, or
   d) the MEC

3. If the physician refuses to have an assessment, the assessment will be changed to the disciplinary tract according to the medical staff bylaws.

4. A report of the investigation and/or assessment will be presented to the MEC if the findings produce sufficient evidence that the physician might be impaired.
5. If the investigation and/or assessment produce sufficient evidence that the physician is impaired, the physician shall be told that the results indicate that the physician may suffer from impairment that affects his or her practice. The physician need not be told who filed the report, and does not, necessarily need to be told the specific incidents contained in the report.

6. A physician may make a self-referral to the Department Chair, Chief of Staff, Associate Chief of Staff, MEC or the Board of Directors.

7. Depending upon the severity of the problem and the nature of the impairment, the MEC and the hospital has, but is not limited to, the following options:
   a) require the physician to undertake a rehabilitation program as a condition of continued
   b) impose appropriate restrictions on the physician's practice; or
   c) Immediately suspend the physician's privileges in the hospital until rehabilitation/advocacy has been accomplished, if the physician does not agree to discontinue practicing voluntarily.

8. Any official actions must be in accordance with the medical staff bylaws, rules and regulations.

9. The physician’s confidentiality of the self-referral, other referral and assistance will be maintained except as limited by law, ethical obligation, or when the safety of the patient is threatened.

Rehabilitation
The MEC shall not recommend reinstatement of a physician until it is established, that the physician has entered or successfully completed a rehabilitation program and maintains advocacy with the Tennessee Medical Foundation – Physicians Health Program (TMF-PHP) or Mississippi Professionals Health Program (MPHP).

Reinstatement
Upon sufficient proof that a physician who has been found to be suffering an impairment has entered or successfully completed a rehabilitation program, the MEC may recommend reinstatement of the physician to the medical staff.

When considering an impaired physician for reinstatement, the hospital and its medical staff leadership must consider patient care interests.

As proof of the physician having entered or completed a rehabilitation program, the MEC must obtain a letter from the program director or his/her designee of the rehabilitation program where the physician was treated. The physician must authorize the release of this information and it is the responsibility of the physician to obtain this letter. The letter from the program director/designee of the rehabilitation program shall state:
   a) whether the physician is participating in the program;
   b) whether the physician is in compliance with all of the terms of the program and has received advocacy
   c) whether the physician attends program meetings regularly (if appropriate);
   d) to what extent the physician's behavior and conduct are monitored;
   e) whether, in the opinion of the rehabilitation program physicians, the physician is, or has the potential to be rehabilitated;
   f) whether an after-care program has been recommended to the physician and, if so, a description of the after-care program; and
g) whether, in the program director's opinion, the physician is capable of resuming medical practice and providing continuous, competent care to patients.

Assuming all information the hospital receives indicates the physician is in or has completed an acceptable rehabilitation program and is capable of resuming patient care, the MEC and/or the hospital must take the following additional precautions when restoring clinical privileges:

a) Require the physician to provide the MEC with quarterly reports from the rehabilitation program stating that the physician is continuing treatment or therapy, as appropriate, and that his or her ability to treat and care for patients in the hospital is not impaired.

b) Failure to complete the program or the prescribed after care program will result in further action by the MEC.

c) Failure to report loss of advocacy will result in further action by the MEC

d) The physician will be monitored during the rehabilitation phase

All actions should be pursuant to the medical staff bylaws, rules and regulations and policies.

6.3 Conflicts of Interest Policy

Medical staff officers, department chairs, and all medical staff members serving on committees and as committee chairs are obliged to represent the interests of the Hospital’s medical staff in upholding the quality of care provided at the Hospital. To meet this obligation and to enable discerning decision-making, officers, department chairs, and all medical staff members serving on committees must disclose potential conflicts of interest relevant to the position held and the circumstances. Members shall not use or disclose any information obtained as a result of his/her medical staff leadership position for any purpose other than the furtherance of quality medical care in the Hospital.

Members of the medical staff and LIPs shall disclose conflicts of interest to the medical staff leaders when he/she becomes aware that such a conflict of interest exists.

When and How Disclosures are Made:

When assuming office/position: At time of election as medical staff officer or department chair; or
At time of appointment to a medical staff committee chair

Annually: All Medical Staff Leaders, Department Chairs and Committee Chairs

How: Complete and sign the Conflict of Interest Statement Form accompanying the appointment letter or other agreement evidencing willingness to serve in the role(s).

As necessary: For all medical staff members serving on committees, including ad hoc committees, when a member has a conflict of interest with any matter that is brought before the committee for discussion and/or vote.
For all medical staff members and LIPs, when he/she becomes aware that such a conflict of interest exists.
How: Verbally at any time before the discussion begins on the matter or at the earliest time in the discussion when a potential conflict of interest occurs.

Meeting Agenda:
All committee meeting agenda shall include, at least a reference to or reminder of the following statement by the committee chairperson at the beginning of the meeting: If a member has a conflict of interest relating to an item on the agenda, medical staff policy requires the member to excuse him/herself from vote and/or discussion; and, if appropriate, leave the room during the discussion.

6.4 Professional Conduct of Physicians

Purpose
It is the policy of Methodist Healthcare (MH) that all individuals within its facilities shall be treated courteously, respectfully and with dignity. To that end, MH requires all individuals, Associates, medical staff and other practitioners to conduct themselves in a professional and cooperative manner in MH facilities. The purpose of this policy is to address inappropriate conduct by a medical staff member.

Policy
It is the policy of MH that all individuals within its facilities be treated with courtesy, respect, and dignity. This section establishes a mechanism whereby the conduct, condition, or action of a member of the medical staff, which could compromise delivery of quality patient care, be identified, reviewed and resolved.

The mechanism whereby incident reports addressing professional conduct of physicians will be reviewed and resolved will be through Provider Quality with reporting to the appropriate committees charged with peer review and professional conduct review. Individuals authorized by this policy to act on behalf of committees charged with peer review and professional conduct review are entitled to immunity afforded to these committees and committee members under federal and state statutes.

It is MH’s intention that actions taken and data produced pursuant to this policy are confidential and privileged and subject to all applicable peer review protections under law.

Definitions
Behaviors that undermine a culture of safety may include, but may not be limited to:

- Obstruction of the operation of the hospital
- Interference with the ability of others to do their jobs
- Creation of a hostile work environment for Methodist Associates, medical staff members, affiliated staff members and clinical students
- Interference with an individual’s ability to practice competently
- Professional conduct adversely affecting or impacting the community’s confidence in the hospital’s ability to provide quality patient care
- Attacks—verbal or physical—leveled at any medical staff, affiliated staff members, clinical students, Methodist Associates, patients, or visitors, that are personal or beyond the bounds of fair professional conduct
- Inappropriate comments (or illustrations) made in patient medical records or other official documents unfairly impugning the quality of care in the hospital, or attacking particular practitioners, nurses, or hospital policies
- Criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or suggest stupidity or incompetence.
- Throwing of charts, medical instruments, or other objects at an associate, clinical student, or other medical staff member.
• Deliberately damaging or destroying medical instruments, equipment or facilities.

Procedure

A. Report
Any practitioner, employee, patient, or visitor may report behaviors that undermine a culture of safety. Documentation of the behavior is critical because ordinarily no one incident leads to disciplinary action; there is usually a pattern of conduct. The Occurrence Report Form shall be the mechanism whereby such conduct shall be documented and reported. The Occurrence Report should include, at a minimum, the following:

• The date and time of the incident
• A statement of whether the incident affected or involved a patient in any way, and if so, the patient’s name
• The circumstances that precipitated the situation
• A factual and objective description of the behavior as it related to patient care or hospital operations
• A record of any action taken to remedy the situation, including the date, time, place, action and name(s) of those intervening.

B. Review and Evaluation of Complaint:
1. INITIAL PROCESS: Upon receipt of the Report, a member of the Provider Quality Department shall notify the Chief Medical Officer (CMO) at the facility where the incident occurred. The CMO (or designee) and Corporate Director of Provider Quality (or designee) shall verify the need for a further review of the complaint. They will coordinate a plan and process to review pertinent information, notify and interview the practitioner and interview other appropriately identified witnesses.

In evaluating the complaint, the practitioner may be asked to provide information regarding the complaint. He/she shall also be informed that retaliation, even subtle retaliation, will not be tolerated. In the event the practitioner retaliates against the complainant or the complaint is sufficiently egregious, a precautionary suspension may be invoked against the Practitioner in accordance with the medical staff bylaws, rules and regulations.

After completion of the interviews and other applicable inquiry, the elected medical staff leadership (as designated by the Medical Staff President and/or Chief of Staff), CMO or designee shall determine whether the report is credible. If the report is determined not to be credible and if the practitioner had been informed of the complaint, he/she shall be informed that the complaint was not substantiated

PLAN TO RESOLVE COMPLAINT: The Medical Staff President (or designee) and the CMO (or designee) shall confer and develop a plan for resolution of the complaint. In addition, other Medical Staff leaders (as designated by the Medical Staff President) and the Corporate Director of Provider Quality (or designee) may be involved as deemed necessary by the Medical Staff President. In developing the plan, the decision makers shall consider whether the alleged conduct may be a product of an impairment or another health problem (and therefore subject to resolution under the medical staff rules and regulations), whether the alleged conduct may constitute harassment or behaviors that undermine a culture of safety, the severity of the conduct, the impact on patient care, the nature and type of previous conduct allegations, previous actions taken by Methodist Healthcare against the practitioner, and other pertinent information. The Medical Staff President after consultation with the CMO shall
determine whether informal action under this policy or formal action pursuant to the medical staff rules and regulations is warranted.

If it is believed that the alleged conduct is a result of an impairment or another health problem, the practitioner may be referred to the Tennessee Medical Foundation (TMF) or Mississippi Professionals Health Program (MPHP) for further evaluation. In cases where the behavior of the practitioner is sufficiently egregious participation in TMF or MPHP may be a condition of continued appointment.

C. Resolution of Complaint and Disciplinary Action

1. INFORMAL ACTION:
   a) FIRST EVENT: If a single incident warrants informal action under this policy, the CMO and/or designee(s) shall meet with the practitioner to discuss the complaint. This policy and any other applicable policies shall be discussed with the practitioner. The conversation shall be documented in a letter to the practitioner, a copy of which shall be filed in the Quality Improvement file.
   In cases where the conduct is sufficiently egregious to warrant greater intervention, the practitioner shall be told that a single further incident of harassment or behaviors that undermine a culture of safety will result in initiation of formal disciplinary action pursuant to the medical staff rules and regulations. A letter to the practitioner describing these expectations shall be filed in the Quality Improvement File.
   b) SECOND EVENT: If additional incidents of harassment or behaviors that undermine a culture of safety are reported, they will be evaluated according to the process described above.
   If substantiated, the Medical Staff President or designee and the Associate Chief of Staff (or other designated Medical Staff Leader) and/or the CMO (or designee) shall discuss the matter informally with the practitioner. At the request of the physician, the Department Chair and/or the Department Peer Review Body will be included in the process. The conversation shall be documented in a letter to the practitioner, a copy of which shall be filed in the Quality Improvement file. The letter shall state that the practitioner is required to correct the inappropriate behavior and cooperate with the resolution of the problem that his/her behavior caused.
   c) THIRD EVENT: If additional incidents of harassment or behaviors that undermine a culture of safety are reported, they will be evaluated according to the process described above.
   If confirmed, the Medical Staff President or the CMO (or designee) may discuss the matter with Chairperson of the PROC. The Medical Staff President, CMO (or designee), Associate Chief of Staff (or designee) and a Medical Staff Leader shall meet with and advise the practitioner that such conduct is intolerable and must stop. At the request of the physician, the Department Chair and/or the Department Peer Review Body will be included in the process. This shall be followed with a letter reiterating the conditions applicable to continued appointment, a copy of which shall be filed in the Quality Improvement file. The MEC shall be informed.
   d) SUBSEQUENT EVENT: A single additional confirmed incident shall result in initiation of formal disciplinary action pursuant to the medical staff rules and regulations.

2. FORMAL ACTION: If formal action is deemed to be warranted by the Medical Staff President after consultation with the CMO at any time, the matter shall be referred to the MEC for action pursuant to the medical staff bylaws and Governing Documents. Suspension of the
7.0 Resident Oversight Exceptions

7.1 Resident Oversight During Surgical Cases
A. If a resident or fellow is performing the procedure, the following must apply:
   1. The departmental attending must be notified prior to the scheduling of the procedure
   2. The departmental attending physician must physically be present, within the facility where the
      procedure occurs, for the major components of the procedure and degree of involvement documented.
   3. The anesthesiologist or any member of the surgical team may, at any time, request the presence of the
      departmental attending in the OR.
   4. In Emergent cases where immediate care is initiated to preserve life or prevent impairment, the
      procedure is initiated with the departmental attending contacted and in route.
   5. Resident surgical cases will be tracked monthly for type, service, acuity, attending presence at any
      time during the procedure and clinical outcomes. These will be forwarded to the graduate medical
      education office, the appropriate division heads and the quality management committee.

B. The Departments of Orthopedics and Plastic Surgery have MEC approved exceptions to the above and are
   as follows:
   1. Orthopedic PGY 4 and 5 residents may perform emergency surgery for fractures and infections under
      general supervision (under the attending staff member’s overall direction and control but the attending
      physician’s presence is not required at the time of care).
   2. Plastic Surgery PGY 6 and 7 residents may perform specific emergency trauma surgeries under
      general supervision – nasal bone fracture, facial laceration soft tissue acute repair, and mandible –
      alveolar ridge fracture (PGY 7 only).

C. The University of Tennessee, College of Medicine Graduate Medical Education Resident Supervision
   Policy will be followed in all cases.

7.2 Resident Oversight Exception Policy
When an exception (as outlined above) is invoked, any occurrences of adverse outcomes will be referred to
the Peer Review Oversight Committee (PROC) for review. The PROC may take any/all of the following
actions:
   1. Refer to department for peer review
   2. In the event of an unanticipated complication, mortality, or a trend of complications the PROC may
      recommend to the Chief of Staff that a precautionary suspension (including loss of privileges) be
      issued to the supervising physician. The supervising physician may attend the next MEC Executive
      Session to discuss the case. The MEC may make recommendations to the supervising physician
      and/or revisions to the resident oversight exceptions as a result of their review.

8.0 Graduate Medical Education Policies

8.1 Supervision of Residents
Definitions:
Supervising Credentialed Physician (SCP) is a member of the medical staff who has appropriate credentials and privileges to deliver medical services at the hospital or in a Provider-based clinic, plus a teaching appointment in the graduate medical educational program.

General Supervision means that the care or procedure is conducted under the SCP’s overall direction and control but the SCP’s presence is not required at the time of care.

Direct Supervision requires that the SCP must be immediately available to furnish assistance and direction.

Personal Supervision means that the SCP must be in attendance in the room during the procedure.

I. Supervision by Medical Staff: The MH-MH medical staff assures supervision of graduate medical education residents by a Supervising Credentialed Physician (SCP) with appropriate clinical privileges for the medical care that is being supervised. Patient care responsibilities are not delegated to residents without proper supervision and meeting the medical staff responsibilities of the SCP.

II. Committee Structure: The Graduate Medical Education Committee (GMEC) at the University of Tennessee will have representatives from Methodist. The Graduate Medical Education Operations Committee (GMEOC) is responsible for providing effective communication between professional graduate education programs and the medical staff and Governing Body of Methodist Healthcare.

III. Supervision of Patient Care: The management of each patient’s care (including patients under the care of participants in professional graduate education programs) is the responsibility of a SCP. The medical staff assures that each participant in a professional graduate education program is supervised in his/her patient care responsibilities and by the activities of the GMEC under Methodist’s affiliation with the University of Tennessee. Written descriptions of the role, responsibilities, and patient care activities of participants in professional graduate education programs are provided to the medical staff by the Office of Graduate Medical Education. These descriptions include identification of the mechanisms by which the participant’s supervisor(s) and graduate education program director make decisions about each participant’s progressive involvement and independence in specific patient care activities. Medical staff rules and regulations and policies also delineate those participants in professional education programs who may document patient care orders, the circumstances under which they may do so (without prohibiting SCPs from documenting orders), and what entries, if any, must be countersigned by an SCP. In the State of Tennessee, residents are Institutionally Licensed Physicians according to Tennessee Annotated Section 63-6-201. Thus, under Tennessee law, residents may document orders. No resident’s order requires SCP’s signature unless the medical staff rules stipulate otherwise.

IV. Communication: The GMEC of the University of Tennessee and MH-MH medical staff regularly communicate about the safety and quality of patient care provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs. The GMEC and the MH-MH Governing Body (Board of Directors) periodically communicate about the educational needs and performance of the participants in the program. Graduate education programs will be accredited by the Accreditation Council on Graduate Medical Education, the American Osteopathic Association, or the American Dental Association’s Commission on Dental Accreditation.

V. Supervision of Residents: An appropriate level of supervision is required of all residents during all clinically relevant educational activities by the SCP.

   A. Residents will receive supervision in accordance with the respective ACGME RRC requirements. These must include the following key principles:

      1. Clinical responsibilities must be conducted in a carefully supervised and graduated manner, tempered by progressive levels of independence to enhance clinical judgment and skill.
Although attending physicians who are SCP’s remain ultimately responsible for overseeing management decisions, it is the resident’s responsibility to communicate significant clinical information to the attending physician or a senior level resident. In the event of a critical clinical situation in which the attending physician cannot be notified, the resident should communicate with a member of the full-time teaching faculty (who are available 24 hours/day, 7 days/week) for advice and assistance. At all times, patient safety and care is the highest priority. Residents should document their communications with the attendings concerning management decisions.

2. This supervision must provide timely and appropriate feedback about the resident’s performance, including instructive feedback, which describes deficiencies and provides specific instructions about how to correct these deficiencies.

3. Resident supervision must support each program’s written educational curriculum.

4. Resident supervision should foster humanistic values by demonstrating concern for each resident’s well-being and professional development.

B. Residents are supervised by teaching staff in accordance with established written guidelines.

C. Faculty call schedules are structured to assure that support and supervision are readily available to residents on duty.

D. The quality of resident supervision and adherence to above guidelines are monitored through annual review of the resident’s evaluations of their faculty and rotations by Residency Committees and the GMEC of the University of Tennessee under its affiliation with Methodist Healthcare.

E. For any significant concerns regarding resident supervision, the appropriate Residency Program Director will submit a plan for its remediation to the GMEC for approval. This will be reported to the MEC and governing body by the Chair of GMEOC for any concerns that involve MH.

F. The appropriate Residency Program Director will submit progress reports to the GMEC until the situation or issue is resolved. This will be reported to the MEC and governing body as outlined above.

G. Any quality question concerning patient care in which a resident’s clinical activities are involved will be addressed to the SCP responsible for directing the patient care. In addition, the SCP will notify the resident and the residency program concerning the quality question. The SCP’s response to the quality question will include resolving any question about the actions of a resident. In addition, the SCP will report to the PROC the action of the residency program concerning the quality question. Appropriate actions may be individual counseling, individual educational remediation, a conference using the quality concern as a case study, or a “Morbidity and Mortality” conference that will address the quality question in detail. The residency program is given the responsibility of determining the most effective manner of addressing the quality concern and reporting it via the SCP. In the event the SCP lapses in the reporting of the response of the residency program, the PROC will ask the Site Director of the residency program to report the response of the program. If needed, the Chair of GMEOC for MLH will use the GMEC of the University of Tennessee affiliation and the budget process of the Office of Medical Education to assure that residency programs respond to the PROC.
VI. **Resident Responsibilities:** Responsibility on teaching service will begin with the first year resident, who is responsible for obtaining and recording the history and physical examination and documenting admission orders. On teaching services with an educational team, the first year resident is supervised by an upper level resident, who is also responsible for obtaining a history and performing a physical examination and documenting a summary of these findings. The final responsibility on all teaching services rests with the SCP, who is responsible for making management rounds seven days per week and being accessible, or delegating that responsibility to another SCP at all times.

With each year of training, the degree of responsibility accorded to a resident, both professional and administrative, will be increased progressively. This includes responsibility in such areas as patient care, leadership, teaching organization and administration. This goal is achieved by having senior residents supervise junior residents or act as consultants to junior residents, particularly in the subspecialty areas. Although SCPs remain ultimately responsible for overseeing management decisions, it is the resident’s responsibility to communicate significant clinical information to the SCP or a senior level resident. In the event of a critical clinical situation in which the SCP cannot be notified, the resident should communicate with a member of the full-time teaching faculty (who are available 24 hours/day, 7 days/week) for advice and assistance. At all times, patient safety and care is the highest priority. Residents should document their communications with the SCPs concerning management decisions.

Decisions regarding increasing clinical responsibility are made on the basis of written evaluations (monthly, CEX’s) by SCPs and senior residents.

Procedures must be directly supervised by the SCP or senior resident who is certified to perform the procedure. Certification is dependent on the documented supervised performance of a minimum number of procedures as outlined in the Procedure Documentation Logs of the respective programs and listed on the Program’s UT Website.

VII. **General Policy:** The program director of the resident and the chair of the department to whom the resident is assigned are responsible for monitoring of the resident’s educational progress. Responsibility for specific monitoring of an educational rotation may be assigned to the SCP supervising the resident on an academic rotation.

All patients receiving care at Methodist are assigned to a member of the active staff as the Attending Physician. The SCP responsible for the care of the patient will provide the appropriate level of supervision based on the nature of the patient’s condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment demonstrated by the residents being supervised. If quality concerns about patient care arise, those quality concerns will be addressed and assigned to the Attending Physician or the SCP supervising a specific component of management.

As part of the training program, residents should be given progressive responsibility for the care of patients and to act in a teaching capacity and provide supervision to less experienced residents and students. It is the decision of the SCP, with advice from the program director, as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient.

VIII. **Inpatient Areas:** Approved Teaching Services will be designated by the Medical Executive Committee (MEC). Teaching Services will consist of organized physician teams led by a supervising credentialed physician (SCP). Teaching Services will meet all guidelines for the Supervision of Resident Activities as approved by the MEC and the medical staff rules and regulations. Each
Teaching Service will designate a Senior Resident who is qualified by clinical experience and progression in the educational program to evaluate patients, communicate with attending physicians, and supervise junior residents. The Senior Resident on the Teaching Service will document his/her direct involvement by evaluating an admission or consultation and signing the admission or consultation note within 24 hours. Interaction with the SCP is required within the first 24 hours as evidenced by a note documented in the patient record by the SCP. Every hospital inpatient on an Approved Teaching Service will be visited by a resident assigned to the Approved Teaching Service directing the patient care at least once a day and progress of patient care will be documented daily.

The SCP will see the admitted inpatient at a minimum of every calendar day and document his/her visit in the medical record. The SCP will see consults within 24 hours and then every 72 hours at a minimum or daily if in ICU. The SCP will document his/her visit in the medical record. In addition, the SCP will sign all admission history and physicals, operative notes, initial consultation notes, and discharge summaries.

Approved Teaching Services at Methodist University Hospital are:

- Cardiology
- Consultative Dermatology
- General Internal Medicine
- General Surgery
- Gynecology
- Endocrinology
- Hematology/Oncology
- Infectious Disease
- Plastic Surgery
- Nephrology
- Neurology
- Neurosurgery

- Orthopedic Surgery
- Ophthalmology
- Otolaryngology
- Pathology
- Plastic Surgery
- Pulmonary/Critical Care Medicine
- Radiology
- Thoracic Surgery
- Urology

Approved Teaching Services may be added or deleted by action of the MEC.

**IX. Outpatient Clinic:** Residents seeing patients in an outpatient clinic, including provider-based clinics, will receive appropriate supervision. Management plans for new patients or revision of management plans will be reviewed before the patients have left the clinic.

**X. Emergency Department:** Residents assigned to the emergency room service will receive Direct or Personal Supervision, depending on the severity of the problem and experience of the resident. Residents providing consultation or care to patients followed by their respective services receive General Supervision by the staff of the ED or of their service. Supervision will be documented by the SCP, who may be a member of the ED staff. Dispositions of these patients may be discussed by phone with the appropriate staff member and/or reviewed on return to an outpatient facility.

**XI. Operating Room or Special Procedure Facility:** Residents performing operative, therapeutic or special diagnostic procedures will receive General, Direct, or Personal supervision by an SCP, depending on the experience and proficiency previously demonstrated by the resident, certification by the Approved Teaching Service as documented on the Website, and as determined by the SCP. That supervision will be documented by signing the operative note or note from a special procedure area.
XII. **Emergency Care:** In an emergency, defined as a situation where immediate care is necessary to preserve life or prevent serious impairment of health, residents are permitted to perform everything possible to save a patient from serious harm pending arrival of more qualified staff. The appropriate medical staff practitioner will be notified as soon as possible.

XIII. **Affiliation with University of Tennessee College of Medicine:** MH has an Affiliation Agreement with the University of Tennessee. This affiliation stipulates that the University of Tennessee is responsible for overall educational administration of the affiliated graduate medical education programs that exist at MH. The University of Tennessee is also responsible for obtaining and maintaining ACGME accreditation of all programs. However, Methodist medical staff and governing body retain the right and responsibility to develop and enforce any rule or regulation appropriate for patient care and quality assurance.

XIV. **Resident Supervision Policy**

The following are minimum standards for resident supervision and documentation in patient care settings. They are designed to promote patient safety, provide educational excellence but maintain autonomy based on demonstrated education competence. These requirements are effective in all training sites without regard to patient insurance status or time of day. Residents and Faculty members in training programs under the auspices of ACGME will abide by the supervision and documentation schema as noted below:

<table>
<thead>
<tr>
<th>Supervision Setting/Clinical Activity</th>
<th>Required Supervision Level/Description</th>
<th>*Minimum Level of Supervision Documentation</th>
</tr>
</thead>
</table>
| A. Operating/Delivery Room                                 | • **Direct Supervision by Attending Physician**  
The departmental attending must be **physically present**, within the facility where the procedure occurs and **immediately available** to the resident and patient, for the major components of the procedure. The departmental attending physician must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident. | Degree of involvement documented            |
| B. Non-Routine, Non-Bedside, Non-OR Procedures (e.g. Cardiac Cath, Endoscopy, Interventional Radiology, etc.) | • **Direct Supervision by Attending Physician**  
The departmental attending must be **physically present**, within the facility where the procedure occurs and **immediately available** to the resident and patient, for the major components of the procedure. The departmental attending must be notified prior to the scheduling of the procedure and must be aware of the documented competency level of the resident. | Degree of involvement documented            |
| C. Emergency Department                                    | • **Direct Supervision by Attending Physician**  
Departmental attending must be physically present in the facility where the procedure occurs and immediately available to the patient. | Level 4                                      |
<table>
<thead>
<tr>
<th>Supervision Setting/Clinical Activity</th>
<th>Required Supervision Level/Description</th>
<th>*Minimum Level of Supervision Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>D. Emergency Care – Immediate care is initiated to preserve life or prevent impairment. The procedure is initiated when the departmental attending physician is contacted</td>
<td>The departmental attending must be notified prior to the scheduling of the procedure.</td>
<td>Degree of involvement documented.</td>
</tr>
</tbody>
</table>
| E. Inpatient Care/ New Admissions | • **Indirect Supervision with Direct Supervision Available.**
• **Oversight**
The departmental attending physician will see and evaluate the patient within 24 hours of admission. | Level 2 |
| Inpatient Care/ Continuing Care | • **Oversight** | Level 4 |
| Inpatient Care/ Intensive Care | • **Indirect with Direct Supervision immediately available** | Level 4 |
| Inpatient Care/ Hospital Discharge and Transfers | • **Oversight**
The attending must be involved in decision to discharge or transfer patient. | Level 3 |
| F. Outpatient Care / New Patient Visit | • **Indirect with Direct Supervision immediately available** | Level 2, |
| Outpatient Care / Return Patient Visit | • **Oversight** | Level 5 |
| Outpatient Care / Clinical Discharge | • **Oversight** | Level 5 |
| G. Consultations Inpatient, outpatient and Emergency Department | • **Oversight**
Post-hoc review with feedback by supervising faculty/resident physician | Level 4 |
| H. Radiology/Pathology | • **Oversight**
Post-hoc review with feedback by supervising faculty/resident physician | All reports verified by departmental attending physician prior to release |
<table>
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<tr>
<th>Supervision Setting/Clinical Activity</th>
<th>Required Supervision Level/Description</th>
<th>*Minimum Level of Supervision Documentation</th>
</tr>
</thead>
<tbody>
<tr>
<td>I. Routine Bedside and Clinic Procedures</td>
<td>• Indirect Supervision with Direct Supervision available</td>
<td>Level 4</td>
</tr>
</tbody>
</table>

**Levels of Supervision Documentation:**

<table>
<thead>
<tr>
<th>Level 1. Departmental attending Physician Note</th>
<th>Level 2. Departmental attending physician Addendum to the resident’s note (not a co-signature)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Level 2. Departmental attending physician Addendum to the resident’s note (not a co-signature)</td>
<td>Level 3. Departmental attending physician Co-signature implies that the departmental attending physician has reviewed the resident’s note, and absent an addendum to the contrary, concurs with the content of the resident’s note.</td>
</tr>
<tr>
<td>Level 3. Departmental attending physician Co-signature implies that the departmental attending physician has reviewed the resident’s note, and absent an addendum to the contrary, concurs with the content of the resident’s note.</td>
<td>Level 4. Resident documentation of departmental attending physician supervision (e.g., “I have seen and/or discussed the patient with my departmental attending physician, Dr. _, who agrees with my assessment and plan.”)</td>
</tr>
<tr>
<td>Level 4. Resident documentation of departmental attending physician supervision (e.g., “I have seen and/or discussed the patient with my departmental attending physician, Dr. _, who agrees with my assessment and plan.”)</td>
<td>Level 5. Documentation to be determined by individual program director</td>
</tr>
</tbody>
</table>

**9.0 New Medical Technology**

**9.1 Introduction and Approval Process**

**Objective**
To outline the structure for a systematic review process that is designed to:
- Assess emerging technologies
- Approve only appropriate and proven technologies
- Promote resource management
- Support clinically effective care
- Support and drive standardization

**Definitions**
“Clinical Standards Committee (CSC)/New Technology” means the multidisciplinary committee charged with the initial review of all requests for New Medical Technology and is responsible for presenting its recommendations for approval or rejection thereof to the MEC.
“Clinically Effective Care” means the application of interventions which have been shown to be safe and efficacious to appropriate patients in a timely fashion to improve health and secure the greatest value for the use of resources.

“New Medical Technology (NMT)” means a new drug or medication*, a new invasive procedure or technique or new device or medical equipment that: (a) has final approval for prescribed use from the applicable regulatory body; (b) has not previously been reviewed and approved for use within the Institution; and (c) will be used in offering a treatment modality or service type previously unavailable or promoted for a different delivery venue. New Medical Technology includes devices that are determined to be Substantially Equivalent Devices by the Food and Drug Administration (FDA).

“Medical Devices Management Committee (MDMC)” means the multidisciplinary committee charged with the oversight and management of new and existing medical devices utilized within the Hospital and the review and follow-up of medical device incidents, recalls and communication thereof to all affected departments and end users. All New Medical Technology must be approved by the Hospital in accordance with the procedures outlined below prior to its introduction and use within the Hospital.

*New drugs and medications are reviewed by the Pharmacy and Therapeutics Committee and will not be subject to the review process outlined in this Policy.

“Substantially Equivalent Devices” means devices that are substantially equivalent to legally marketed devices with respect to the device’s intended use, design, energy used or delivered, materials, performance, safety, effectiveness, labeling, bio-compatibility, standards and other applicable characteristics and has FDA final approval through the 510(k) process.

Policy
All New Medical Technology must be approved by the Hospital in accordance with the procedures outlined below prior to its introduction and use within the Hospital. Any medical technology that does not have full and final approval by the applicable regulatory body must be reviewed and approved by the MH Institutional Review Board in accordance with its established policies and procedures.

Approval Process
1. All applications and supporting documentation for approval of New Medical Technology shall be submitted to the MSSD on the Request Form attached hereto as Exhibit A within 6 weeks prior to the next scheduled meeting of the CSC. All NMT that is not a Substantially Similar Device must be brought to the Medical Staff Department for approval prior to the application process. Following such approval, Practitioners shall submit their applications on complete and accurate forms, accompanied by relevant and well-recognized scientific information and literature. The material should include a summary of analyses regarding the NMT’s safety, effectiveness and effect on health outcomes in sufficient detail and volume, to allow the CSC to conduct a clinical assessment of the NMT in accordance with the criteria outlined in Item 5 below. If the NMT is deemed a Substantially Equivalent Device by the FDA, then the only supporting documentation required is a copy of the 510k approval letter from the FDA and the CSC shall defer review and recommendations for approval or rejection of such device to the MDMC.

2. The MSSD shall distribute copies of the Request Form and supporting documentation to the CSC and a copy of the Request Form only to the MDMC, as applicable for applications requesting approval of new medical devices and/or medical equipment.

3. The CSC and MDMC shall review the application at the next scheduled meeting of each such Committee.
4. The MDMC shall perform its review of the application for approval of new medical devices and/or medical equipment in accordance with the policy and procedures set forth in the Medical Device Management Committee Policy and shall report its findings and present its recommendations to the CSC.

5. The CSC shall review the NMT in accordance with the following assessment criteria:

   a. The NMT must have final approval from the appropriate government regulatory bodies. This criterion applies to biological products, devices and diagnostics;

   b. The scientific evidence submitted with the application should permit conclusions concerning the effect of the NMT on patient health outcomes. Such evidence should:
       (1) consist of well-designed and conducted investigations published in peer-reviewed journals. Scientific evidence and expert opinion provide the basis for assessing the potential net patient health outcome.
       (2) demonstrate that the NMT can measure or alter the physiological changes related to a disease, injury, illness or condition. There should be evidence that such measurement or alteration positively affects patient health outcomes.
       (3) include opinions and evaluations by national medical associations, consensus panels or other technology evaluation bodies.

   c. The NMT must improve the net health outcome—the NMT should outweigh any harmful effects on health outcomes;

   d. The NMT must be as beneficial as any established alternatives;

   e. The improvement must be attainable outside the investigational settings;

   f. The NMT should not negatively impact the management of available resources disproportionately to the net health outcome gained by the introduction of the NMT. The findings and recommendations from the MDMC regarding capital requirements, reimbursement approval from third party payors and hospital staff training requirements shall be considered in such assessment.

6. All applicants must be available to present the NMT before the CSC and when requested, before the MEC. Other non-members may be invited by the CSC to the assessment meeting for advisory purposes.

7. CSC shall recommend to the MEC to either approve or reject the NMT. If the NMT is rejected, the applicant may appeal such decision to the MEC.

8. NMT that requires physician privileging will require notification to the Credentials Committee.

9. The CSC reserves the right to recommend provisional approval only for certain NMT based upon certain facts and circumstances that would warrant a second review and approval of the NMT following a conditional period of use.

10. All approvals for NMT are subject to approval by the governing body in accordance with established Hospital policy and practice.
10.0 HIPAA Privacy Compliance – Joint Notice of Privacy Practices

MH-MH, MHOBH, its medical staff and other licensed independent practitioners granted any privileges at such Hospitals (collectively, “Hospitals and LIPs”) support the rights of all patients to have their protected health information secure from unauthorized viewing, use and disclosure.

Hospitals and LIPs shall comply with all applicable federal and/or state laws, rules and regulations that govern the use and disclosure of such information, including, but not limited to the Standards for Privacy of Individually Identifiable Health Information, 45 C.F.R.Parts 160 and 164 which requires compliance therewith effective April 14, 2003 (“HIPAA Privacy Standards”).

In non-emergent situations, the HIPAA Privacy Standards require the provision of a Notice of Privacy Practices by Healthcare Providers to patients with whom such providers have direct treatment relationships on the date of first service following the April 14, 2003 compliance date. Pursuant to such requirement, MH-MH & MHOBH will provide a Notice of its Privacy Practices (“NPP”) to each individual patient presenting on and after the compliance date.

Hospitals and LIPs are considered an Organized Health Care Arrangement in accordance with the applicable provisions outlined in the HIPAA Privacy Standards. In order to streamline the provision of the NPP and preclude the necessity for each medical staff member rendering direct patient care to issue a separate NPP to his/her patient for delivery of care rendered in the hospital on and after the April 14th date, the Hospitals and LIPs shall issue a joint NPP which will be provided to patients by staff designated by MH-MH and MHOBH. Hospitals and LIPs agree to comply with the provisions contained in such joint NPP, including amendments thereof, as approved by the Medical Staff Executive Committee.

The joint NPP only covers the provision of care rendered by a LIP for patients attended in a MH-MH hospital, MHOBH and/or its outpatient departments, clinics and facilities.

11.0 Scopes of Practice

Registered Dietitian Scope of Practice

In accordance with the Mississippi Regulations Governing Licensure of Dietitians and the Tennessee Rules of The Board of Dietitian/Nutritionist Examiners, a Registered, Licensed Dietitian/Nutritionist may provide medical nutrition therapy that includes standardized order choices approved by the Methodist Le Bonheur Healthcare Medical Staff, nursing leadership, and pharmacy leadership (including the Nutrition Care Committee). Such orders are based on guidelines of the American Dietetic Association and Academy of Nutrition and Dietetics.

Registered/Certified Respiratory Therapist Scope of Practice

Respiratory Care is the allied health profession responsible for treatment, management, diagnostic testing, control and care of patients with deficiencies and abnormalities associated with the cardiopulmonary system pursuant to the orders of a physician licensed in the state. (T.C.A. 63-27-102, Miss. Code Ann. 73-57-5) The practice of respiratory care includes direct and indirect services such as the administration of pharmacological, diagnostics, therapeutic agents and medical gases necessary to implement treatment; promote disease prevention; provide pulmonary rehabilitation or diagnostics prescribed by a physician. It also includes transcription and implementation of written and verbal orders pertaining to respiratory care; observing and monitoring signs, symptoms and responses to determine whether such signs and symptoms warrant implementation of appropriate reporting, referrals, respiratory care protocols or change in treatment. (T.C.A. 63-27-102, Miss. Code Ann. 73-57-5)
The practice of respiratory care includes establishment and maintenance of airways, initiation of emergency procedures, bronchopulmonary hygiene, cardiopulmonary resuscitation, as well as cardiac and respiratory life support, and the development and implementation of care plans and protocols as pertains to respiratory care. All can be performed in an inpatient and outpatient setting, clinic, hospital, nursing home, private dwelling or any other place deemed appropriate and necessary pursuant to orders of a physician licensed in the state. (T.C.A. 63-27-102, Miss. Code Ann. 73-57-5)

Registered/Certified Respiratory Therapist Scope of Practice

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12.0 Observership Program

Purpose
To provide guidelines for the establishment of an observation program, which would permit qualified licensed practicing physicians and qualified international applicant physicians to visit MH-MH, MHOBH or Provider-based Clinics for the purpose of observing certain activities at MH-MH on a temporary, restricted basis.

Policy
In keeping with its commitment to global exchange, MH-MH and MHOBH establish an Observership Program. Such program shall be open to any qualified licensed practicing physician or qualified international applicant physician trained in a specialty represented at MH-MH or MHOBH who wishes to visit MH-MH or MHOBH for a short period of time to observe the activities of a particular department, division, center or institute at MH-MH or MHOBH. Upon recommendation by the Department Chair and with the approval of the Credentials Committee, a qualified licensed practicing physician or qualified international applicant physician at the postdoctoral level who is not a member of the medical staff can apply for an observership experience under the supervision of a current medical staff member for educational purposes as an Approved Observer. Because Approved Observers are not members of the medical staff, they may not participate in direct or indirect patient care or management. As the name implies, an Observership is an informal observational experience and does not constitute training. Approved Observers do not receive any form of certification from MHMH or MHOBH.

Observership Guidelines
1. Applicants should submit a letter to the MSSD indicating the goals of the applicant, as well as the time period when the applicant would like to come, a current curriculum vitae indicating training, and an official letter from the applicant’s school of medicine certifying receipt of a medical degree.

2. Applicants will be contacted by a credentialing liaison from the MSSD to complete other forms as necessary to complete the certification process to verify education, training and professional qualifications.

Additional Observership Guidelines for International Applicants

1. **B-1/B-2 Visa or Visa Waiver Program Status:** A foreign national wishing to participate in the Observership Program (hereinafter referred to as “Participant”) shall be responsible for obtaining a B-1 (Visitor for Business) or B-2 (Visitor for Tourism) non-immigrant visa from the appropriate authorities or for entering the United States under the VWB (Visa Waiver for Business) or VWT (Visa Waiver for Tourism) Program, and for maintaining and complying with all legal requirements of such status during the entire duration of a Participant’s observation. Any and all costs incurred in obtaining or maintaining a Participant’s visa status shall be borne by the Participant. A Participant may use the invitation letter or other materials regarding the Observership Program given to the Participant by the Department in support of the Participant’s application for a B-1/B-2 visa or to enter in VWB/VWT status, but MH-MH and MHOBH shall not be required to sponsor or otherwise support the application of a Participant for such visa or status.

2. **Other Non-Immigrant Visas:** Other foreign nationals who are in the United States in non-immigrant status obtained through or dependent on their spouses’ non-immigrant status (e.g., H-4, L-2, F-2, etc.) shall be eligible to participate in the Observership Program under the same terms and conditions as a foreign national participating in the Observership Program on a B-1/B-2 visa or through the VWB/VWT Program, as set forth in this policy and procedure.

3. **Length of Observership:** The length of time for a Participant’s observership shall depend upon the particular activities the Participant shall be observing at MH-MH or MHOBH, but an observership shall not last longer than three (3) months unless an extension or renewal of an observership in previously approved by MSSD. Upon the expiration of a Participant’s observership, he/she will no longer be permitted access to MH-MH & MHOBH facilities. An observership is strictly a voluntary program and can be terminated at any time by either a Participant or Facility, with or without cause.

4. **Observership Activities:**

   a. **Observation only.** An observership shall be strictly an observational tutorial program. Accordingly, each Participant shall only be permitted to observe the activities for which they have applied to observe and to discuss his/her observations with applicable MLH medical staff members. A Participant shall in no way be permitted to actively participate care or contact, examination, research or other work during his/her observership. A Participant shall at all times be treated by MH-MH or MHOBH as a visitor and any medical staff member that allows a Participant to do more than observe may be denied the privilege of having observership Participants in the future.

   b. **Compensation.** At no time should a Participant be considered or held out to be an agent, servant or employee of MH-MH or MHOBH. Any and all expenses incurred by a Participant during his/her observership shall be borne by the Participant.
c. **Confidentiality.** Each Department shall ensure that a Participant maintains the confidentiality of records and files of MH-MH and MHOBH and observe all confidentiality policies of the Facility during a Participant’s observership.

d. **Expiration of Observership.** Each Department will be responsible for ensuring that the Participant’s observership ceases at that time.

5. **Medical Insurance.** A Participant whose observership will last longer than two (2) weeks shall be required to show proof, upon arrival at the Facility, of medical insurance adequate to cover the Participant’s expenses in the event the Participant becomes ill or is injured in the United States during his or her observership, including expenses of repatriation should it become necessary. If the Participant does not have such insurance in his or her home country, the Participant will be required to purchase such insurance in the United States, in order to participate in an observership. Each Department will be responsible for forwarding proof of such insurance to for insertion in the Participant’s file.

**Observation Only Authorization**

Observation only authorization may be granted to a licensed physician, dentist or allied health professional who is not a member of the medical staff but requests to observe a specified diagnostic or therapeutic event(s) or process(es).

Observation authorization shall be granted only at the request of a member who shall assume full responsibility for the actions of the physician, dentist or allied health professional during the course of the observation period. An individual granted observation authorization may not admit, treat, examine, consult, document or give verbal orders, perform or assist with procedures, document in the medical record, or otherwise participate directly or indirectly in the care of any patient. Such individuals shall not be a member of the medical staff, shall not have access to any of the rights or prerogatives of membership, and shall agree to abide by all rules, policies and conditions required for observation participation.

Requests for observation only authorization must be submitted to MSSD on the designated form prior to the desired observation date. Observation authorization may be granted by the President of the Medical Staff, Chief of Staff or Credentials Committee Chair. Such limited authorization may be extended for a period of up to ninety days.

**Procedure**

**PART 1 – BEFORE THE OBSERVER ARRIVES IN THE US**

If a medical staff member is interested in inviting a foreign national to participate in the Observership Program, the medical staff member should contact the MSSD for a letter of invitation to the Participant, which will be substantially the form as attached hereto as Attachment 1. The letter should be signed by the medical staff member inviting the Participant and the Department Chair.

**PART 2 – AFTER THE OBSERVER ARRIVES IN THE US**

Upon arrival, the medical staff member should have the Participant complete the Agreement and Release Form, Participant Contact Information, and Participant’s Documents form. The sponsoring medical staff member should fax these forms to the MSSD along with copies of the Participant’s passport biographical information page, passport expiration date page, B-1/B-2 visa (where applicable), front and back of Form I-94 (small white or green card usually located in the passport),
and proof of medical insurance specifying beginning and ending dates of coverage if observership will last longer than two weeks. If the Participant’s documents are in order, MSSD will notify the Department that the Participant may engage in the MH-MH or MHOBH Observership Program.

Upon the expiration date of the Participant’s observership, the sponsoring medical staff member should inform the MSSD of the Participant’s departure from the Facility.

13.0 Medical Student Documentation

Medical students rotating in 3rd and 4th year clerkships will be granted onsite access to the Electronic Medical Record using their own unique access code and will be allowed to document in the electronic medical record. All documents will be clearly labeled as “Medical Student Documentation” and grouped together in a “Medical Student” folder or designated section of any ambulatory electronic medical record. Medical student documentation cannot be used to fulfill documentation requirements.

14.0 Copy and Paste Policy

**Purpose:**

This policy provides guidance on the use of the copy and paste function in the electronic health record to ensure quality documentation. For the purpose of this policy, the term copy means any one of the following synonyms: copy and paste, cloning, copy forward, reuse, carry forward, and save note as a template and any intent to move documentation from one part of the record to another. Quality documentation supports patient care, continuity of care, record integrity, and accurate professional fee and facility billing.

**Risks associated with the misuse of copy and paste functionality:**

1. Inaccurate, contradictory, duplicative, inapplicable, erroneous, or misleading information
2. Over-documentation with clinically irrelevant facts
3. Questions regarding the validity of entries
4. Potential for inaccurate billing claims due to billing for a different level of service than was provided
5. Lack of individuality of entries from one visit to the next creating questions regarding medical necessity

**Policy:**

1. Providers are responsible for the total content of their documentation, whether the content is original, copied, pasted, imported, or reused.

2. Progress notes shall provide an accurate depiction of treatment surrounding a specific date of service. Any information that is copied and pasted shall be updated with current information. Copy and paste into the record only that information needed to support clinical decisions or illustrate direct impact on care. Notes should be succinct to make them more readable and prevent loss of pertinent information. Notes created for different encounters should not be identical.
3. Providers are responsible for correcting any errors identified within the copied documentation. Contact Health Information Management if it is necessary to delete an incorrect note (i.e. entered under the wrong patient) or regarding any error(s) in the source note.

4. Do not copy and paste between different patient’s records.

5. If the provider references a prior section within the record (IE. review of systems) he/she must reference the note with sufficient detail to uniquely identify the source. Example: “For review of systems, see note dated 1/11/14.”

6. Material copied from a note authored by another provider should be attributed to the author and reference the date and note type from which the information was copied. Consider use of a different font, italics, or quotation marks to help identify the copied information. Never copy data or information that falsely identifies a provider as involved in that patient’s care.

7. Providers are responsible for summarizing applicable lab data, pathology, and radiology reports rather than copying such reports in their entirety into the note.

8. Reviewers of the record, including but not limited to Health Information Management and Quality Management Staff, are responsible for referring any cases of inappropriate copying and pasting to the Medical Records Committee for review. The Medical Record Committee will refer violations to the Compliance Officer for possible review by the Peer Review Oversight Committee.

15.0 Influenza Vaccination
Medical Staff Members, Allied Health Practitioners, and Allied Health Caregivers are required annually to receive the influenza vaccination unless they provide a documented medical or religious declination. If the vaccination is not administered, individuals will be required to wear a mask in all patient care settings during the flu season. If an individual does not comply, the provider’s privileges/authorization will be placed in abeyance until documentation of vaccination or appearance before MEC occurs.

Revision Log

<table>
<thead>
<tr>
<th>Revision #</th>
<th>Document</th>
<th>Reference</th>
<th>Subject of Revision</th>
<th>Board Approval</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>MS Policies</td>
<td>4.4 C, V</td>
<td>Revisions to conform with the Quality and Safety Plan</td>
<td>August 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td>G, 6.1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>UT Resident</td>
<td>5.1, XIII</td>
<td>UT Policy was adopted for use</td>
<td>September 2008</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
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<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Oversight Policy</td>
<td>at MLH with clarification for new admission supervision that the attending physician must evaluate the patient within 24 hours</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Moderate &amp; Deep Sedation policy / Location for Administration</td>
<td>1.1, 2.7</td>
<td>The MEG area at Le Bonheur has been added as an appropriate procedural area for both moderate and deep sedation</td>
<td>December 2008</td>
</tr>
<tr>
<td>4</td>
<td>Observation Only Authorization</td>
<td>8.0</td>
<td>Delineates requirements for authorizing “observation only” status for physicians licensed in the US and Canada. The application form supporting those requirements was also approved.</td>
<td>March 26, 2009</td>
</tr>
<tr>
<td>5</td>
<td>Guidelines for Appropriateness of Adult Transfusion</td>
<td>3.4</td>
<td>Addition – this policy delineates guidelines for appropriateness of blood products transfusions for adults. Notable is lowering of Hgb/Hct levels to 7/21 for less acutely ill or younger patients.</td>
<td>May 28, 2009</td>
</tr>
<tr>
<td>6</td>
<td>Return to Practice</td>
<td>4.5 &amp; Attachment 7</td>
<td>Addition – Guidelines for granting/renewing privileges for practitioners returning to practice after a period of absence from clinical activity.</td>
<td>August 27, 2009</td>
</tr>
<tr>
<td>7</td>
<td>Medical Screening Exam</td>
<td>3.3</td>
<td>This policy modification allows trained RN’s to conduct medical screening exams in particular emergency situations based upon temporary surges in volume.</td>
<td>September 24, 2009</td>
</tr>
<tr>
<td>8</td>
<td>MS Policies</td>
<td>5.1</td>
<td>Maintenance changes</td>
<td>March 12, 2010</td>
</tr>
<tr>
<td>9</td>
<td>Conflicts of Interest Policy</td>
<td>4.3</td>
<td>Clarification or reflect practice</td>
<td>March 25, 2010</td>
</tr>
<tr>
<td>10</td>
<td>Neonatal &amp; Pediatric Massive Transfusion Guidelines</td>
<td>3.5 &amp; 3.6 Addition</td>
<td>Guidelines for transfusion</td>
<td>April 29, 2010</td>
</tr>
<tr>
<td>11</td>
<td>Supervision of Residents: Inpatient Areas</td>
<td>5.1, VIII</td>
<td>Modified the requirement that the SCP will see patients every 24 hours instead of 72 hours.</td>
<td>June 16, 2010</td>
</tr>
<tr>
<td>12</td>
<td>Maintenance</td>
<td>6.1</td>
<td>Formatting to mirror the policy.</td>
<td>September 9, 2010</td>
</tr>
<tr>
<td>13</td>
<td>Addition</td>
<td>1.0 &amp; 2.0</td>
<td>MS.01.01.01, a new Joint Commission (TJC) standard, requires several modifications to our medical staff policies. 1.0 Amendment and adoption of governance documents by the organized medical staff 2.0 Conflict management between organized medical staff and MEC</td>
<td>11.2010</td>
</tr>
<tr>
<td>14</td>
<td>Renumber document</td>
<td>Due to insertion of 1.0 and 2.0 Medical Staff Policies has been renumbered.</td>
<td>11.2010</td>
<td></td>
</tr>
<tr>
<td>15</td>
<td>5.4</td>
<td>Addition of 5.4 renumbered document</td>
<td>Addition of on call physicians and emergency transfers</td>
<td>Provisional Board date: July 28, 2011 Board date: August 18, 2011</td>
</tr>
<tr>
<td>16</td>
<td>5.8</td>
<td>Revision to Clinical</td>
<td>Updated immunization protocols to reflect patient age changes per</td>
<td>August 18, 2011</td>
</tr>
<tr>
<td>#</td>
<td>Policy Area</td>
<td>Policy Section</td>
<td>Description</td>
<td>Date</td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>17</td>
<td>Graduate Medical Education Policies</td>
<td>7.0</td>
<td>Since there is no longer a Vice President of Medical Education position, the policy verbiage is updated to GMEOC.</td>
<td>October 19, 2011</td>
</tr>
<tr>
<td>18</td>
<td>Professional Conduct of Physicians</td>
<td>6.4</td>
<td>To comply with TJC standards the words “disruptive behavior/conduct” were replaced with behavior or behaviors that undermine culture of safety.</td>
<td>December 15, 2011</td>
</tr>
<tr>
<td>19</td>
<td></td>
<td>5.8</td>
<td>Clinical care and best practice standards as well as acceptable exclusions for Pneumococcal Vaccine have been updated per CMS guidelines</td>
<td>March 21, 2012</td>
</tr>
<tr>
<td>20</td>
<td></td>
<td>3.12, 4.13, 5.1, 7.1, 10.0</td>
<td>Revised write, written, writing with document documented, documenting to align with the electronic environment</td>
<td>June 20, 2012</td>
</tr>
<tr>
<td>21</td>
<td></td>
<td>7.1 XIV</td>
<td>Revised policy to mirror the UT GME policy.</td>
<td>February 20, 2013</td>
</tr>
<tr>
<td>22</td>
<td></td>
<td>11.0</td>
<td>Medical Student Documentation This defines the role and process for 3rd &amp; 4th year Medical Student documentation.</td>
<td>March 20, 2013</td>
</tr>
<tr>
<td>23</td>
<td></td>
<td>6.3</td>
<td>Policy notes the medical staff members and other LIPs should disclose a conflict of interest to a medical staff leader when he/she becomes aware that such a conflict exists</td>
<td>March 28, 2013</td>
</tr>
<tr>
<td>24</td>
<td></td>
<td>3.12 &amp; 4.13</td>
<td>Removed “unless pre-procedure Aldrete is zero in both sections. Per Anesthesia</td>
<td>May 16, 2013</td>
</tr>
<tr>
<td>25</td>
<td></td>
<td></td>
<td>Removed all of the observation forms in the document</td>
<td>May 30, 2013</td>
</tr>
<tr>
<td>26</td>
<td></td>
<td>7.0</td>
<td>Addition to the Policies – a process for any occurrences of adverse outcomes when the exception for Orthopedics &amp; plastics Surgery is invoked.</td>
<td>June 19, 2013</td>
</tr>
<tr>
<td>29</td>
<td></td>
<td></td>
<td>Renumbered document after 7.0 additions.</td>
<td>June 19, 2013</td>
</tr>
<tr>
<td>30</td>
<td></td>
<td>Addition 7.1</td>
<td>Moved from Rules &amp; Regulations section 4.5</td>
<td>July 19, 2013</td>
</tr>
<tr>
<td>31</td>
<td>Return to Practice &amp; Attachment 1</td>
<td></td>
<td>This grid was updated to clarify requirements for CME, concurrent proctoring and retrospective review.</td>
<td>August 20, 2014</td>
</tr>
<tr>
<td>32</td>
<td>Copy &amp; Paste Policy</td>
<td>13.0</td>
<td>Addition – This policy provides educational guidance on the use of the copy and paste function in the HER to ensure quality documentation.</td>
<td>August 20, 2014</td>
</tr>
<tr>
<td>33</td>
<td>Influenza Vaccination</td>
<td>Addition 14.0</td>
<td>Addition – Vaccination requirements for the medical staff</td>
<td>September 17, 2014</td>
</tr>
<tr>
<td>34</td>
<td>Return to Practice</td>
<td>6.5 and Attachment 1</td>
<td>Relocated to the Consolidated Credentials Policies</td>
<td>September 17, 2014</td>
</tr>
</tbody>
</table>

Unification Throughout the document, “and MHOBH” when applicable.
<table>
<thead>
<tr>
<th>Revisions</th>
<th>document</th>
<th>MHMH is referenced</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unification Revisions</td>
<td>2.0 Conflict Management Between Medical Staff and MEC</td>
<td>Reconcile what is currently stated in the MHMH Medical Staff Policies. (See below)</td>
<td>November 19, 2014</td>
</tr>
<tr>
<td></td>
<td></td>
<td>MHOBH states 10%</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>The Conflict Management process applies to, but is not limited to, proposals to amend or adopt a rule, regulation, or policy. The Department Chair or another elected Medical Staff leader will consider issues of conflict between the MEC and the organized Medical Staff (OMS). At least 1% of the OMS should support the issue to initiate the conflict management process</td>
<td></td>
</tr>
<tr>
<td>3.7 Criteria for</td>
<td></td>
<td>Grammatical Corrections – the word “policies” left out. (see credentialing policies)</td>
<td>November 19, 2014</td>
</tr>
<tr>
<td>Administration</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unification Revisions</td>
<td>3.13 Credentialing and Competency</td>
<td>Added this statement “Privileging criteria are delineated in the credentials policies/DOPs” to the following paragraph: Privileging should be based upon a demonstrated record of successful experience in procedures requiring moderate sedation. Privileging criteria are delineated in the credentials policies/DOPs. Sedation should be administered in accordance with the current relevant clinical policies and procedures.</td>
<td>November 19, 2014</td>
</tr>
<tr>
<td>Unification Revisions</td>
<td>3.13 Credentialing and Competency</td>
<td>In addition to a record of experience in successfully administering sedation during procedures (minimum of 10 per year), the physician shall:</td>
<td>November 19, 2014</td>
</tr>
<tr>
<td>5.0 Patient Care</td>
<td>5.0 Patient Care General Principles D.</td>
<td>7. In the event there is not agreement pertaining to para. 6. above, Section 68-1708; (1), p. 8 in the TNHCDA or Section 41-41-215, (7), p. 19 in the MS Uniform Health-Care Decisions Act shall provide further guidance</td>
<td>November 19, 2014</td>
</tr>
<tr>
<td>Requirement to</td>
<td>5.9 Requirement to Specify Numerical Gestational Age</td>
<td>Numerical gestational age/estimated numerical gestational age should be documented in the mother’s Hospital medical record by the obstetrician prior to or at the</td>
<td>November 19, 2014</td>
</tr>
<tr>
<td>Specify Numerical</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gestational Age</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>#</td>
<td>Section</td>
<td>Type</td>
<td>Description</td>
</tr>
<tr>
<td>-----</td>
<td>---------------------------------------------</td>
<td>-------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>1</td>
<td>10.0 HIPAA Privacy Compliance</td>
<td>Revision</td>
<td>This revision identifies all LIPs with privileges as comprising the OHCA.</td>
</tr>
<tr>
<td>2</td>
<td>11.0 Scopes of Practice (renumbered sequential sections)</td>
<td>Addition</td>
<td>These Scopes of Practice enable Dietitians, Respiratory Therapists, Pharmacists to make orderset choices based on approved protocols; standing orders otherwise cannot contain choices.</td>
</tr>
<tr>
<td>3</td>
<td>Entire Document</td>
<td>Revisions</td>
<td>These revisions to the Medical Staff Policies comply with CMS requirements for provider-based clinics licensed under the hospital.</td>
</tr>
<tr>
<td>4</td>
<td>5.10 Imaging &amp; Radiology Studies requiring Interpretation by Radiologist</td>
<td>Addition</td>
<td>A list of tests that require a credentialed radiologist interpretation.</td>
</tr>
<tr>
<td>5</td>
<td>5.11 Qualifications of non-Medical Staff ordering Diagnostic Tests or Imaging</td>
<td>Addition</td>
<td>A provider who is neither credentialed nor privileged by MLH may order diagnostic and imaging studies when qualifications are verified.</td>
</tr>
<tr>
<td>6</td>
<td>5.10 addition</td>
<td>addition</td>
<td>Attendings granted maternal fetal medicine privileges may interpret targeted obstetrical ultrasound. This addition is an exception to the list of radiologic, nuclear, and ultrasound images requiring interpretation by Radiologists.</td>
</tr>
</tbody>
</table>