Southern Maine Health Care

Medical Staff
&
Advanced Practice Provider

Rules & Regulations

SOUTHERN MAINE HEALTH CARE HOSPITAL
Medical Staff Rules and Regulations – Table of Contents

PART 1: DESIGNATED ADMISSION OF PATIENTS

1-1 TYPES OF PATIENTS

The SMHC hospitals accept for care and treatment patients with either acute and chronic illness without regard to race, religion, age, gender, gender identity, sexual orientation, national origin, disability, or any other basis prohibited by applicable law or ability to pay. The admission of any patient is contingent on the availability of adequate facilities and personnel to care for the patient.

1-2 ADMITTING PATIENTS

Members of the Medical Staff with appropriate privileges and in good standing may admit patients to the Hospital. All admissions are subject to the official admitting policies of the Hospital as may from time to time be in effect and to the conditions provided below. The Chief Medical Officer or his/her designee will submit the names of Medical Staff members not in good standing to the Admitting Office.

1-3 CENSUS MANAGEMENT

When bed availability is limited, it may not be possible to accommodate all admissions scheduled for a specific day. In that event, the Chief Medical Officer or designee will prioritize the cases by condition and will make the ultimate decision regarding admission. In making that decision, the Chief Medical Officer or designee will seek comment from the attending physician, consult with the responsible Quality & Safety Service Leader (QSSL) and the nursing/resource supervisor, and give due consideration to the inconvenience caused the patient and his/her family. Decisions on admissions and discharges will be made based on clinical unit specific criteria.

1-4 TIME OF ADMISSION

Except in emergency cases, the responsible physician or designee shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient observation or outpatient procedures, the responsible physician or designee must comply with Hospital policies concerning pre-surgical laboratory tests, documentation, scheduling, and prior authorizations.

1-5 ATTENDING PRACTITIONER RESPONSIBILITES

In cases of outpatient observation and outpatient procedures the attending practitioner must complete and document an appropriate history and physical examination, but a discharge summary is not required. See Section 5-2

1-6 ADMISSION INFORMATION

Except in an emergency, a patient will not be admitted to the hospital (inpatient or observation status) until a provisional diagnosis or valid reason for admission has been provided by the responsible physician with admitting privileges at the hospital, or his or her designee. The responsible physician is also responsible for providing applicable patient information concerning communicable disease or infection, behavioral characteristics that would disturb or endanger others, incompetence to sign a consent form, and other such information as may influence routine admission policy.

1-7 CLINICAL APPRAISALS AFTER INPATIENT ADMISSION

The responsible physician, or his or her designee, must see and clinically evaluate the patient within twenty four (24) hours or within a shorter time frame if warranted by the patient's condition. A physical examination must be performed as part of the clinical appraisal and documented in the medical record within twenty-four (24) hours of admission. Refer to Section 5-2 for specific history and physical examination requirements.

PART 2: ASSIGNMENT AND ATTENDANCE OF PATIENTS

2-1 ATTENDANCE OF PATIENTS

Consistent with the conditions of Section 2-3 below, each patient may be attended by the physician of his or her choice, provided said physician is a member of the Medical Staff with appropriate clinical privileges. A patient presenting for admission who has no personal physician may request any physician who is a member of the Medical Staff with appropriate clinical privileges. When no such request is made, or when the requested physician chooses not to assume the care of the patient, a member of the Medical Staff with the requisite privileges will be assigned to the patient according to the on-call schedule of the applicable service line. Such assignment shall be made without regard to the patient's ability to pay.

2-2 PARTICIPATION IN THE ON-CALL ROSTER

Each clinical service develops and distributes an on-call roster. Each member of the Medical Staff agrees to participate in the on-call roster. When he or she is the designated practitioner on call, he or she will accept responsibility, during the time specified by the published schedule, for providing care to any patient in any unit of the hospital who is referred to the service for which he or she is providing on-call coverage. If there is a conflict with the published schedule, it is the staff member's responsibility to make provision for change of coverage and to notify the Quality & Safety Service Leader (QSSL) and Emergency Department of such change. A member of the Medical Staff may seek exemption from continued on call roster responsibilities after age 60 if he or she has been a member of the Medical Staff for ten years or more. This request must be made in writing to the MEC, which must seek input from the affected roster members. Approval authority for the exemption will reside with the MEC and Board of Trustees, and, if granted, must be renewed every two years.

2-2.1 Provider Obligations

Members of the Active Staff have an obligation to share on-call duties. To ensure that the hospital is aware of which physicians, including specialists, are available to provide the treatment necessary to stabilize individuals with emergency medical conditions on a twenty-four hour basis, an on-call policy has been adopted.

2-2.2 Procedure

A. On-Call Schedule:
   1. Each service line will designate the person responsible for creating the on-call schedule which must be forwarded to the appropriate areas in a timely manner and no later than seven days prior to the beginning of the month.
   2. The finalized call schedule will be posted on the Intranet no later than five days prior to the beginning of the month. Members of the Medical Staff have an obligation to check the Intranet and be aware of on-call assignments.
   3. Providers involved with the call schedule need to have notification and input before finalization. If a change is made, the provider making the change shall notify the appropriate areas.
   4. If the group, for unforeseen reasons, has trouble filling the call schedule, the Chief Medical Officer or designee or President of the Medical Staff will be contacted for resolution.

B. Response to Call:
   When an on-call physician is contacted and requested to respond, the physician must:

1. Be immediately available, at least by telephone;
2. Respond in person, if so requested, within a reasonable time period. The requesting provider, in consultation with the on-call physician, will determine the appropriate response time;
3. If a dispute arises regarding the need to see a patient in the Emergency Department, the Emergency Department provider's recommendation will prevail;
4. If the scheduled on-call physician is unable to respond due to circumstances beyond the physician's control, the requesting provider will determine whether to attempt to contact another specialist on the Medical Staff or arrange for a transfer pursuant to this policy.

C. Concurrent Call/Elective Surgery:
Notwithstanding an on-call physician's obligation to respond when on call, the on-call physician may perform elective surgery or other patient care services at the hospital while on call, and may be on call at another hospital, provided the on-call physician advises the Chief Medical Officer or designee and CEO, or designee, for notification and approval.

D. Resignation of Privileges:
Members of the Medical Staff will not be permitted to relinquish specific clinical privileges for the purpose of avoiding on-call responsibilities. This may be cause for disciplinary action.

E. Follow-up Care:
An on-call physician is responsible for the care of a patient through the episode that created the emergency medical condition. An on-call physician shall not require insurance information or a co-payment before assuming responsibility for care of the patient.

F. Advanced Practice Providers:
Advanced Practice Providers may participate in the on-call roster as deemed appropriate by each service line, subject to the service's policy to provide physician back-up.

G. Enforcement:
1. An on-call physician's unavailability when on-call, refusal to respond to a call, or any other violation of this policy is a serious matter.

2. Accordingly, a refusal or failure of an on-call physician to respond in a timely manner shall be reported immediately to the Chief Medical Officer or

designee and the CEO, or designee, who shall review the matter. The MEC shall review the matter and determine if there has been a violation of the policy. Confirmed violations of the policy will result in the following disciplinary actions:

a) A first violation will result in a letter of reprimand from the CMO or designee;
b) A second violation will result in a letter of warning and the immediate suspension of clinical privileges for seven calendar days.
c) A third violation indicates an inability and unwillingness to fulfill Medical Staff responsibilities as set forth in the Medical Staff Bylaws and this policy. Accordingly, it will result in the automatic relinquishment of Medical Staff appointment and clinical privileges without the right to a hearing or appeal, after review of the MEC. Automatic relinquishment of Medical Staff appointment and clinical privilege may be reportable to the National Practitioner Data Bank (NPDB).

3. This policy outlines steps that can be taken to address violations under this policy. However, a single violation or pattern of violations may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this policy precludes an immediate referral of a matter being addressed through this policy to the MEC or the elimination of any particular step in the policy.

PART 3: GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3-1 GENERAL RESPONSIBILITY

Members of the Medical Staff with admitting privileges shall be responsible for the medical care and treatment of each assigned patient in the hospital, for the accuracy and prompt completion of those portions of the medical record for which he or she is responsible, for special instructions, for transmitting reports concerning the condition of the patient to the referring practitioner, if any. These several responsibilities belong to the assigned physician, except when transfer of responsibility is affected pursuant to Section 3-2.

3-2 TRANSFER OF RESPONSIBILITY

When the current attending physician intends to transfer the responsibility for a patient's care to another staff member, the transferring physician must document in the

record that the second physician has been notified, and has agreed to the transfer of patient care responsibility. The transferring physician must enter an order transferring the care of the patient to the second physician. In complex cases, the withdrawing attending physician, or designee, shall write a comprehensive progress note at the time of transfer.

3-3 ALTERNATE COVERAGE

3-3.1 Inpatients

Each physician with clinical privileges must assure timely, adequate, professional care for the patients in the hospital by being available or, in the event that the physician is unavailable, by designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for his or her patients. When such designation is absent, or the designated physician is unavailable, the Chief Medical Officer or designee or designee, or the applicable Quality & Safety Service Leader (QSSL), has the authority to assign patient care responsibility to any member of the staff with the requisite clinical privileges.

3-3.2 Outpatients

Each practitioner must assure timely, adequate professional care for the patients in their outpatient practice population by being available or, in the event that the practitioner is unavailable, by designating a qualified alternate practitioner with whom prior arrangements have been made.

3-4 IMMEDIATE QUESTIONS OF CARE

If any non-physician member of the health care team has reason to question the care being provided to an individual patient by a member of the Medical Staff or APP Staff, that is not resolved by first discussing their concerns with the provider, he or she shall bring the matter directly to the attention of his or her supervisor, who, in turn, may refer the matter to the Quality & Safety Service Leader (QSSL) leader, Chief Medical Officer or designee or their designees.

If any non-physician member of the health care team has reason to question the care being provided to an individual patient by a member of the house staff, that is not resolved by first discussing their concerns with the provider, the non-physician member of the health care team shall bring the matter directly to the attention of his or her supervisor who, in turn, may refer the matter, to the supervising resident, the teaching attending, the attending physician or their designees.

The aforementioned physician arbitrators may facilitate resolution of the problem by requesting suitable consultation or offering appropriate advice.

3-5 INPATIENT CONSULTATIONS

3-5.1 Responsibility

The good conduct of medical practice includes the proper and timely use of consultation. When indicated or required, the practitioner is primarily responsible for requesting a consultation from a qualified Staff member. Judgment as to the correct diagnosis and treatment or the severity of the illness generally rests with the practitioner.

3-5.2 Qualifications of Consultant

Any qualified physician who has been granted the appropriate level of clinical privileges at this hospital may be called as a consultant, regardless of his/her staff category assignment.

3-5.3 General Guidelines for Requesting Consultation

Consultation with a qualified physician is required in the following cases:

A. When required by state law;
B. When requested by the patient or family;
C. When consultation is a condition attached to the exercise of a particular privilege.

In addition, consultation is recommended in the following instances:

A. Critical illness in which discussion as to the appropriate therapeutic measures to be utilized would be beneficial;
B. When the risk of surgery requires critical evaluation;
C. Difficult or equivocal diagnosis or therapy.

3-5.4 Documentation of Consultation

3-5.4.1 Consultation Request

When requesting consultation, the practitioner must enter an order for consultation into the patient record, including the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

3-5.4.2 Consultant's Report

The consultant must document, sign, date and time a report of his or her findings, opinions, and recommendations which reflects an actual examination of the patient and the medical record. The consultant must expediently conduct the consultation unless the requesting physician notes otherwise. Such report shall become a part of the patient's medical record.

The consultant should document daily notes, unless another frequency is agreed upon with the requesting provider. If daily assessment is not required of the consultant, the note should indicate when the patient will be evaluated again by the consultant. The consultant may sign-off, in agreement with the requesting provider, when their care is no longer needed. Sign-off should be explicitly stated in the consultant's final note. That note should also include instructions for post-hospitalization follow-up if indicated.

3-5.5 Notification

The practitioner is personally responsible for ensuring that the consultant is properly notified by direct one-to-one personal communication. The consultant will be informed of the reason for the request and the extent of involvement in the care of the patient expected from the consultant.

3-6 TREATMENT OF RELATIVES BY MEDICAL STAFF AND ADVANCED PRACTICE PROVIDERS

3-6.1 Definitions:

Relatives are defined as: immediate family or step family defined as a wife, husband, domestic partner, child, mother, father, brother, sister, grandparents, grandchildren, father-in-law, mother-in-law, son-in-law, daughter-in-law, sister-in-law, brother-in-law.

3-6.2 Policy:

A. Southern Maine Health Care Medical Staff members and Allied Health Professionals are not permitted to be directly involved in the treatment of relatives, except in the following circumstances:
   1. In emergency situations in which there are no other similarly qualified staff available to provide necessary care;
   2. In those circumstances in which no other similarly qualified provider is immediately available to provide the indicated treatment for short-term and minor issues within that practice setting.

B. Any Medical Staff member or Allied Health Professional who recognizes that he or

she is assigned to be involved in the treatment of a relative must notify his or her Quality & Safety Service Leader or other representative of this fact. Whenever possible, arrangements will be made for another provider to be involved in the care of the patient.

C. In those situations in which it is not possible to transfer the care of the patient to another provider.

1. The patient will be informed of the risk of compromised confidentiality that is inherent in the choice to seek treatment from a caregiver who is also a family member;
2. The Medical Staff member or Allied Health Professional will adhere to all applicable confidentiality policies;
3. The care of the patient will be transferred to another provider if at any point the patient or the provider believes that the objective and professional provider-patient relationship has been compromised or feels that care cannot be provided in an objective and safe manner.

PART 4: ORDERS

4-1 GENERAL REQUIREMENTS

The practitioner is responsible for entering all orders for treatment or diagnostic tests into the computerized physician order entry (CPOE) module. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for such administration.

In the case of diagnostic tests, the practitioner ordering the test and the clinical department performing the tests are responsible for the appropriate scheduling of such tests. The ordering practitioner is responsible for conveying perceived urgency.

Despite the presence or absence of dictated reports, it is incumbent upon the attending physician to ascertain the test results.

Notwithstanding the foregoing responsibilities of the attending physician, the physician consultant representing the testing facility should contact the attending physician in the event of an unanticipated abnormal finding which may affect the patient's course of care.

4-2 CLINICAL SECTION ORDER SETS

For information on Clinical Section Order Sets, refer to the Administrative and Medical Staff policy entitled, "Electronic Order Set Development, Approval, and Maintenance."

4-3 VERBAL ORDERS/TELEPHONE ORDERS

The hospital will permit the use of verbal or telephone orders only in certain limited circumstances in accordance with the institutional policy, "Orders in the Medical Record."

4-3.1 Telephone Orders

A privileged prescriber may sparingly use telephone orders only when the prescriber cannot reasonably access the electronic record. Reasonable access may include office, home, or mobile access if made available to the practitioner.

A group of multiple orders, such as admission orders, may not be given by telephone at any time. Limited Emergency Department order set entry is available to "hold" a patient overnight if medically stable and with agreement of the ED and admitting physicians. The admitting physician should complete full orders, medication reconciliation, etc. at the earliest availability in the morning.

Minimal telephone orders may be used for the following types of situations, including but not entirely limited to:

1. Where the prescriber is involved in a procedure or operation where interruption, would be improper;
2. The provider does not have timely access to computer entry;
3. Night-time on-call hours.

4-3.2 Verbal Orders

Verbal orders may be used only in emergency situations only, as outlined in the Administrative and Medical Staff Policy entitled, "Orders in the Medical Record."

4-3.3 Authentication

The responsible practitioner must authenticate telephone or verbal orders within forty-eight (48) hours.

4-4 ORDERS BY ADVANCED PRACTICE PROVIDERS

An Advanced Practice Provider (APP) may enter orders only to the extent, if any, specified in the privileges individually defined for him/her. An admission order entered by an APP must be co-signed by the Attending physician.

4-5 AUTOMATIC CANCELLATION OF ORDERS

Unless a specific order is written otherwise, all previous orders are automatically discontinued when the patient goes to surgery or is transferred to another service or another level of service.

4-6 BLOOD TRANSFUSIONS

Orders for blood transfusion should conform to hospital policy regarding blood usage. The necessity for transfusion must be adequately documented. Transfusions will be tracked and monitored for appropriateness by the Medical Staff.

4-7 SPECIAL ORDERS

4-7.1 Patient's Own Drugs and Self-Administration

Patients may be allowed to use their own drugs, either administered by the nurse or self-administered, only when the following conditions are met:

1. The drugs have been identified by a Hospital Pharmacist, are not-expired. and;
2. There is a written order for each drug by an authorized prescribing practitioner.

4-7.2 Do Not Resuscitate (DNR) and Allow Natural Death (AND) Orders

The responsible physician or designee may write a DNR or AND order, in accordance with established hospital policy.

4-7.3 Hospital Standing Physician Orders

Licensed health professionals at the hospital may implement standing physician orders to facilitate patient care delivery, in accordance with established hospital policy on Standing Physician Orders. Hospital standing physician orders are defined as those physician orders which:

1. May be approved for use in more than one service line.
2. Provide authority and direction for the performance of certain prescribed acts for patients by authorized persons based on defined criteria.

3. Are distinguished from specific physician orders prescribed for a particular patient or individual.

4-8 FORMULARY AND INVESTIGATIONAL DRUGS

4-8.1 Formulary

The hospital formulary lists drugs available for ordering from stock. All drugs and medications administered to patients, with the exception of agents for bona fide clinical investigation, shall be among those listed in the latest edition of the United States Pharmacopoeia: New and Non-Official Drugs, or the American Hospital Formulary Service. Each member of the Medical Staff assents to the use of the formulary as approved by the Pharmacy and Therapeutics Committee. The use of non-formulary drugs should be reserved for infrequently encountered clinical settings or unique circumstances where there are no formulary drugs that are appropriate.

On orders written by physicians for drugs not in stock in the Pharmacy, generic or therapeutic equivalents as approved by the Pharmacy & Therapeutics Committee will be dispensed in accordance with the hospital drug list.

4-8.2 Investigational Drugs

Use of investigational drugs must be in full accordance with all regulations of the Food and Drug Administration and must be approved by the Medical Executive Committee. Investigational drugs shall be used only under the direct supervision of the principal investigator and in accordance with existing nursing policy. The principal investigator shall be responsible for obtaining all necessary consents and for completing all necessary forms. He or she shall prepare and clarify directions for the administration of investigational drugs as to:

1. Untoward symptoms;
2. Special precautions and administration;
3. Proper labeling of the container;
4. Proper storage of drug;
5. Methods of recording doses when indicated; and,
6. Method of collecting and recording specimens of urine and other specimens.

PART 5: THE MEDICAL RECORD

PREFACE:

It is the policy of Southern Maine Health Care that all providers will be required to independently utilize all currently implemented components of the electronic medical record, and such additional components that are implemented in the future.

Demonstrated continued competence, either through frequent independent use of the electronic record, or successful completion of further training, is a requirement for maintenance of Medical Staff privileges.

Failure to comply with this policy will be addressed through the Disruptive Physician policy and/or the Corrective Action & Fair Hearing Manual.

5-1 REQUIRED CONTENT

A medical record shall be maintained for every individual who is evaluated and treated at the hospital. Each practitioner providing services to a patient is responsible for preparing such portions of the medical record which are appropriate and necessary to the services provided. The record shall include:

1. Identification data;
2. Personal and family medical histories;
3. Description and history of present complaint and/or illness;
4. Physical examination report;
5. Diagnostic and therapeutic orders;
6. Evidence of appropriate informed consent;
7. Treatment provided;
8. Progress notes and other clinical observations including results of therapy;
9. Special reports when applicable;
10. Final diagnosis;
11. Condition on discharge. The record at discharge should reflect the final diagnosis, discharge medications and instructions, and disposition of the case;
12. Discharge summary;
13. Autopsy report when appropriate.

5-2 HISTORY AND PHYSICAL EXAMINATION

5-2.1 Generally

A history and physical examination is required for all inpatients and for outpatients undergoing procedures involving the use of general, spinal, or epidural anesthesia, moderate or deep sedation, or those procedures involving an incision into, or puncture of, a body cavity, even in the absence of moderate or deep sedation or anesthesia. A history and physical examination is not required for outpatients undergoing incisions or insertions that are limited to the skin and subcutaneous tissue or for the placement of catheters or devices in tubular epithelial structures (e.g. esophagus, urethra, anus, nose, and bronchus).

If a history and physical is required, a practitioner who has been privileged to do so must dictate or record in the chart a complete history and physical examination within twenty-four (24) hours after admission of the patient or before surgery or procedure, whichever may come first. The history and physical examination may be delegated to the physician assistant, nurse practitioner, or resident provided the responsible physician reviews and countersigns the documentation.

5-2.2 Comprehensive History and Physical Examination

A comprehensive history and physical examination is required for all inpatients whose condition is not of a minor nature, and whose hospital stay is expected to exceed 48 hours. It must include the chief complaint, details of the present illness, all relevant medical, social, and family histories, the patient's emotional, behavioral, and social status when appropriate, and all pertinent findings resulting from a review of systems, evidence of a physical examination, a diagnostic/therapeutic assessment and a plan. A pediatric history and physical must also include developmental assessment.

5-2.3 Short Form

The attending practitioner may use a short history and physical examination form in lieu of a comprehensive history and physical examination, as outlined in Section 5-2.2, for:

1. Outpatient procedures involving the use of general, spinal or epidural anesthesia, moderate or deep sedation, or those procedures involving an incision into, or puncture of, a body cavity, even in the absence of moderate or deep sedation or anesthesia.
2. Patients with problems of a minor nature whose hospital stay is not expected to exceed forty-eight (48) hours.

A short history and physical examination form may be service line-specific and must contain, at minimum, the indication for the procedure, significant medical/surgical history, medications, allergies, vital signs, and examination of the heart, lungs and body system or part where the procedure will be performed.

All required sections of the short form must be completed; it is not permissible to simply make reference to a previous note.

If the patient remains hospitalized over forty-eight (48) hours, additional required elements of the comprehensive history and physical examination as per Section 5-2.2 must be documented in the medical record.

5-2.4 Use of Reports Prepared Prior to Current Admission

1. External to the Hospital: If a member of the Hospital Medical Staff has obtained a history and has performed a physical examination within thirty (30) days prior to the patient's admission to the Hospital, a legible copy of the report may be used in the patient's medical record, provided that a written admission update includes all additions to the history and any changes, or documentation of no changes in the physical findings subsequent to the original report. The history and physical examination and corresponding update completed within 24 hours of admission or prior to surgery or procedure must be signed or countersigned by the physician.
2. During prior admission: When a patient is re-admitted to the Hospital within thirty (30) days for the same or a related problem, an interval history and physical examination reflecting subsequent history and changes in physical findings documented within 24 hours of the patient admission may be used provided the original information is readily available.

5-3 PRE-OPERATIVE DOCUMENTATION

5-3.1 History and Physical Examination and Re-Assessment

In addition to the history and physical examination, the chart shall also show documented evidence that the operating physician or designee has reviewed the chart, examined the patient and recorded findings and recommendations, including the basic nature of the proposed surgery/procedure and the condition for which it is to be done, the condition of the heart and lungs, and allergies known to be present, within twenty-four (24) hours of the surgery or procedure and must be authenticated by the responsible practitioner. This re-assessment by the responsible practitioner within 24 hours of surgery meets the history and physical update requirements outlined in Section 5-2.4, above.

Except in an emergency, documented by the operating physician in the chart, surgery or any other potentially hazardous procedure, which includes those involving the use of general, spinal or epidural anesthesia, moderate or deep sedation, shall not be performed until after the preoperative diagnosis, history and physical examination have been recorded in the chart. In case of emergency, the responsible practitioner must enter a note regarding the patient's condition prior to induction of anesthesia and start of the procedure. This note must include critical information about the patient's condition, including pulmonary status, cardiovascular status, blood pressure and vital signs. The practitioner shall record the history and physical examination immediately after the emergency surgery has been completed.

5-3.2 Diagnostic Tests

Appropriate diagnostic tests must be performed prior to surgery and must be current. Results of such tests must be available prior to the induction of anesthesia. Except in an emergency documented by the operating physician, surgery or any other potentially hazardous procedure shall not be performed until the appropriate diagnostic test~~s~~ results have been recorded in the chart or are readily available (such as radiologic images).

5-3.3 Pre-operative Anesthesia Evaluation

The anesthesiologists (or other licensed independent professional responsible for the patient's anesthesia care), must conduct and document in the record a pre-anesthetic evaluation of the ~~p~~patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent drug and allergy history, other pertinent anesthetic experience, any potential anesthetic problems, American Society of Anesthesiology patient status classification, condition of the patient prior to anesthesia, and orders for pre-operative medication within forty-eight hours of inpatient or outpatient general, spinal or epidural anesthesia, moderate or deep sedation. Except in cases of emergency, this evaluation will be recorded before pre- operative medication has been administered and prior to the patient's transfer to the operating area. A re-evaluation of the patient is documented immediately before moderate or deep sedation and before general, spinal or epidural anesthetic induction. This re-evaluation typically includes vital signs, status of airway and response to pre-procedure medications.

5-4 PROGRESS NOTES

5-4.1 Generally

The attending physician or the designated Advanced Practice Provider is responsible for creating pertinent daily progress notes. Notes must be timed and dated at the time of observation. Notes should contain sufficient information to permit continuity of care and provide an accurate description of the patient's progress. Each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders/tests/treatments. Electronic documentation of notes (typed or dictated into the EMR) is required because it allows for remote access to the notes during the hospitalization.

Progress notes can be documented by an Advanced Practice Provider working under the supervision of a physician.

Progress notes shall be documented currently and shall be sufficient so that the clinical course can be followed from the record. Minimum requirements are for daily physician

notes in the case of patients classified as acute care; and notes as needed, but no less than monthly, in the case of patients classified as sub-acute care (e.g., patients awaiting placement to a long term care facility).

It is the physician's responsibility to create a daily progress note for patients who are critically ill. The Advanced Practice Provider may perform rounds on these patients, but such rounds do not satisfy or change the supervising physician's responsibility to make daily rounds and record progress notes. For patients whose diagnosis or management is difficult, the physician should consider creating a separate progress note.

5-4.2 By Responsible Physician When House Staff Involved

At appropriate intervals during hospitalization, the responsible physician will personally write a note indicating involvement in the care of the patient, as required by regulatory and licensing agencies and as may be amended from time to time. If the patient's condition warrants, more frequent notes by the responsible physician are expected.

The supervising physician must document review of House Staff entries. This may be accomplished by:

1. Countersigning a note written by a member of the House Staff indicating that the supervising physician concurred with the observations recorded by the member of the House Staff;
2. An independent note by the supervising physician indicating review of the House Staff entries in the medical record.

5-5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

5-5.1 Operative and Special Procedure Reports

A full operative or special procedure report must be documented within 24 hours following the procedure, and promptly authenticated by the primary performing physician.

A full operative or special procedure report must contain, as applicable:

A. The name(s) of the licensed independent practitioner(s) who performed the procedure, and his or her assistant;
B. The name of the procedure performed;
C. A description of the procedure;
D. Findings of the procedure;
E. Any estimated blood loss;
F. Any specimen(s) removed;

G. The post-operative diagnosis

When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure (i.e., dictation awaiting transcription), a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note must contain:

A. The name(s) of the primary surgeon(s) and his or her assistant(s);
B. The procedure performed and a description of each procedure finding;
C. Estimated blood loss;
D. Specimens removed; and
E. Post-operative diagnosis.

The medical record must also contain the following postoperative information:

A. The patient's vital signs and level of consciousness;
B. Any medications, including intravenous fluids and any administered blood, blood products, and blood components;
C. Any unanticipated events or complications (including blood transfusion reactions) and the management of those events.

The medical record must contain documentation that the patient was discharged from the post-sedation or post-anesthesia care area either by the licensed independent practitioner responsible for his or her care or according to discharge criteria.

5-5.2 Tissue Examination and Reports

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy, shall be properly labeled, and packaged in preservative as designated, identified in the Operating Room or Special Procedures Suite at the time of removal as to patient and source, and sent to the Pathologist. The Pathologist shall document receipt, and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the pre-operative and post-operative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

5-6 OBSTETRICAL RECORD

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the responsible practitioner's office or clinic

record, provided that the record contains all pertinent information as defined in Section 5-2.1. Such record may be transferred to the hospital before admission, but an interval admission note must be written which includes pertinent additions to the history and any subsequent changes in the physical findings. All obstetrical patients undergoing surgery must have a history and physical examination recorded as required under Sections 5-2 and 5-3 of these Rules and Regulations.

5-7 ENTRIES AT CONCLUSION OF HOSPITALIZATION

5-7.1 Diagnoses and Procedures

The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure, any additional procedures must be recorded in full in the medical record and must be signed, dated, and timed by the responsible practitioner at the time of discharge. The following definitions are applicable to the terms used herein:

A. Principal diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
B. Secondary Diagnoses (if any): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the responsible practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
C. Co-morbidities (if any): A condition that co-existed at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one (1) day for about seventy-five percent (75%) of patients.
D. Complications (if any): An additional diagnosis that describes a condition arising after the beginning of hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one (1) day.
E. Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes, or was necessary to take care of a complication.
F. Additional Procedures (if any): Any other procedures, other than the principal procedure, pertinent to the individual's stay.

5-7.2 Discharge Summary

A. General: A discharge summary must be recorded for all inpatients. The summary must recapitulate concisely the reason for hospitalization, the significant findings including complications, the procedures performed, treatment rendered, the condition of the patient on discharge, discharge diagnoses and the disposition of the patient.

B. Exceptions: A final progress note may be substituted for the discharge summary for the following categories of patients:

1. Those with problems of a minor nature that require less than forty-eight (48) hours of hospitalization;
2. Normal newborn infants;
3. Patients having uncomplicated vaginal deliveries.

5-7.3 Instructions to Patient

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant others relating to physical activity, medication, diet, and follow-up care. Alternatively, the chart must contain documentation of instructions given to the patient and/or significant others in the form of a standard instruction sheet. If no instructions were required, a record entry must be made to that effect.

5-8 AUTHENTICATION

All clinical entries in the patient's records must be accurately dated, timed and individually authenticated. Authentication means to establish authorship by written signature, identifiable initials, or computer key.

5-9 USE OF SYMBOLS AND ABBREVIATIONS

An inventory of banned symbols and abbreviations is listed in hospital policy

5-10 FINALIZING

No medical record shall be finalized until it is complete and properly authenticated and closed. In the event that a chart remains incomplete by reason of the death, resignation, or other inability or unavailability of the responsible physician to complete the record, the Chief Medical Officer or designee shall consider the circumstances, may enter such reasons in the record and order it finalized.

5-11 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including x-ray images, pathologic specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena, statute, or in accordance with established procedure designed to facilitate continuing or follow-up patient care. Unauthorized removal of a medical

record or any portion thereof from the hospital including its outpatient offices is grounds for disciplinary action.

5-12 ACCESS TO RECORDS

Members of the Medical Staff shall not access any patient information through health information systems and/or patient databases unless required to access such information in connection with their obligation to provide medical care to a patient or for bona fide research or educational purposes consistent with preserving the confidentiality of patient information. No member of the Medical Staff shall give or allow another to use his or her password or other user identification, whether or not such individual is an authorized user. Each member of the Medical Staff understands that his or her password or other user identification shall constitute his or her legal signature and shall be accountable for all actions taken as a result of the use of such password or other user identification. In the event that members of the Medical Staff reasonably suspect or become aware of any unauthorized use or disclosure of their password or other user identification, they shall immediately change such password or other user identification, and immediately report such unauthorized use or disclosure to the Chief Information Officer. Each member of the Medical Staff shall log-off the health information systems and/or patient databases or pass-word protect his or her computer screens, regardless of where the screens are located, to ensure that a computer session cannot be used by any other individual when left unattended. No member of the Medical Staff shall print, copy or download patient information from the health information systems and/or patient databases to any hard drive, portable memory device, tape or other storage device for purposes other than to provide medical care to a patient or for bona fide research or educational purposes. Unauthorized removal of a medical record or any portion thereof from the hospital, including its outpatient offices, is grounds for disciplinary action.

Each member of the Medical Staff shall become solely responsible for protecting the security, confidentiality and integrity of any information so printed, copied or downloaded.

5-12.1 By Patient

Any patient may, upon written request, have access to all information contained in his or her medical record, unless access is specifically restricted by the responsible practitioner for medical reasons. An inpatient may, upon oral request, review the record with consent of, and in the presence of, the attending physician. The attending physician may waive the condition requiring his or her presence.

5-12.2 By Third Parties

Written authorization by the patient or his or her legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section, 5-12, or by law to receive this information. Release of information shall be in accordance with the existing policy of the HIM Department as may from time to time be established.

5-12.3 For Statistical Purposes and Required Activities

Patient medical records shall also be made available to Medical Staff members or authorized personnel with an official hospital-approved interest in order to facilitate:

1. Automated data processing of designated information;
2. Activities concerned with assessing the quality, appropriateness, and efficiency of patient care;
3. Clinical unit/support service review of work performance;
4. Official surveys for hospital compliance with accreditation, regulatory and licensing standards;
5. Approved educational programs and research studies;
6. Continuing care by another physician or health care provider.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification. Confidential personal information extraneous to the purposes for which the data is sought shall not be used.

5-12.4 For Re-Admission

In the case of re-admission of a patient, the responsible physician or designee(s) shall have reasonable access to all previous records.

5-12.5 To Former Medical Staff Members

Subject to the approval of the Chief Medical Officer or designee and with appropriate reason, former members of the Medical Staff shall be permitted access to information from the medical records of their patients for all periods for which they attended such patients in the hospital.

5-13 STANDARDS FOR COMPLETION

The appropriate practitioner must complete or sign the medical records within fourteen (14) days of discharge. A record is considered complete when the discharge summary or discharge note, history and physical, consultative report, operative note, catheterization report, other procedure report, and final diagnoses are assembled and authenticated. Additional documentation to facilitate hospital billing or accreditation may also be required; examples of such documents including cancer staging forms or

billing queries. Records remaining incomplete thirty (30) days after being made available to the appropriate practitioner shall be considered delinquent.

5-14 ADMINISTRATIVE WITHDRAWAL OF PRIVILEGES

Should a delinquent record exist, a practitioner's privileges to admit or perform elective surgical or medical procedures shall be suspended until all delinquent records are complete. The practitioner may continue to provide services to current inpatients. This suspension shall be termed an administrative withdrawal of privileges. For all legal and medical practice purposes, the practitioner shall continue to retain all clinical privileges, but shall be deemed to have agreed not to exercise any such retained privileges until the administrative withdrawal shall be terminated.

5-14.1 Notification

Seven (7) days prior to an incomplete record being considered delinquent, the physician will be notified in writing by the HIM Department of the existence of potential delinquent records and the projected date of the withdrawal of privileges.

Forty-eight (48) hours prior to the anticipated suspension of privileges, the physician's office will be notified by telephone by the HIM Department of the availability of records and the anticipated suspension of privileges.

5-14.2 Withdrawal

Should records remain incomplete as described above, the physician or representative will be notified, on the morning of the day in which the records become delinquent by the office of the Chief Medical Officer or designee, that if the records are not completed by 5:00 p.m. that afternoon, the practitioner's privileges will be withdrawn. Should records not be completed by that afternoon, the HIM Department will notify the Admitting Office, the ASU, the Endo Suite, the Cardiac Cath Lab and the Operating Room (and other sites that may be identified from time to time) and the physician's office that admitting, elective surgery, and medical procedures privileges have been withdrawn.

5-14.3 Appeal

The affected practitioner may appeal the imposition of such administrative withdrawal to the Chief Medical Officer or designee with no further right of Fair Hearing. If the practitioner demonstrates, to the satisfaction of the Chief Medical Officer or designee or designee, justifiable reasons for the delinquent records which caused the administrative withdrawal or other extenuating circumstances, then the Chief Medical Officer or designee will immediately rescind or modify the withdrawal. Justifiable reasons for

delinquent records shall include, but not be limited to:

1. The practitioner or any other party necessary for completion of the record was ill, on vacation, or otherwise unavailable; or,
2. The practitioner was waiting for the results of a late report and the record is otherwise complete except for the final diagnosis or discharge summary or both.

5-14.4 Non-Compliance

If a practitioner shall exercise any retained clinical privileges during such administrative withdrawal, he shall be subject to the processes related to questions of professional behavior as provided for in the Medical Staff Bylaws.

PART 6: CONSENT TO MEDICAL TREATMENT

6-1 GENERAL REQUIREMENT

The performing physician or designee is responsible for obtaining the informed consent in accordance with hospital policy prior to performing any procedures or treatments involving anesthesia, surgical or other invasive procedures, use of experimental drugs, radiation therapy or chemotherapy and other procedures set forth in Section 6-2, below. The form shall provide a reasonable person under all surrounding circumstances with a general understanding of:

A. The nature and purpose (including potential benefits) of the intended procedures or treatments, and
B. The usual and most frequent risks and hazards inherent in the proposed procedures or treatments, and
C. Any medically significant and acceptable alternatives, including the usual risks and hazards inherent in those alternatives.

Such physician performing any procedure or treatment for which informed consent is required represents to the Hospital by the undertaking of such procedure or treatment that he or she has previously obtained informed consent as required by this rule.

6-2 CONSENT FORM REQUIRED

The physician is responsible for obtaining a properly signed, hospital-approved informed consent form. This form shall be completed in a manner consistent with the general requirement above. An executed copy of such form shall be placed in the

medical record prior to undertaking any treatments or procedures performed in the hospital, as per hospital Informed Consent policy.

When a series of such procedures is to be performed as part of a course of therapy, then one executed consent form may be used for all procedures performed pursuant to the course of therapy described in such executed consent form.

Alternatively, certain specified service lines have created specific consent forms which have been approved and authorized for use within that division. These consent forms may be used in place of the standard form.

6-3 EXECUTION OF CONSENT FORM

The consent form required by the hospital shall be signed by the patient; if the patient has been determined to lack capacity, or if the patient or a court has designated another person to make decisions for the patient, consent should be obtained from the appropriate patient representative as defined within the Hospital Informed Consent policy. The form must be completed, dated and signed. The form may be witnessed by the physician or designee providing the information and obtaining the informed consent. If he or she relies on a designee for any part of the process, the physician shall assume responsibility for determining the sufficiency of information supplied by the designee and the capacity of the patient or his or her representative to execute the form. When necessary, the physician may obtain telephone consent from an authorized representative as listed above if properly witnessed by a third party, and such consent is documented on a standard consent form.

6-4 TIME FOR PLACING CONSENT FORM IN THE RECORD

The fully executed form shall be appended to the medical record, as specified under 6-2 above, before the patient is given pre-operative sedation, local or general anesthesia.

6-5 COPIES

Electronic copies may be obtained of fully executed forms, photocopied or printed, and the photocopy appended to the medical record in order to satisfy the requirements of this rule.

6-6 EMERGENCIES

If circumstances exist where the performing physician determines that probable health hazards or increased risk of harm will result from delayed treatment or procedures,

even for the time reasonably anticipated to obtain informed consent from the patient or his or her authorized representative in accordance with the general requirement, then he or she may proceed with the procedure or treatment. The physician must document such circumstances in the medical record.

6-7 COMPLIANCE WITH OTHER INFORMED CONSENT REQUIREMENTS

The provisions of this rule are in addition to other hospital policies governing the requirements and process for obtaining informed consent, with or without specific consent forms, for example, abortions, autopsies, photography, treatment of minors, medical treatment orders, obstetrical services, sterilization, mental health services, radiology, anesthesiology, and HIV testing.

6-8 REPORTING LACK OF INFORMED CONSENT FORM

If the performing physician attempts to perform procedures or treatment without filing an executed informed consent form when required, hospital personnel aware of both the attempt and the lack of an executed form shall report the matter to the performing physician. If the properly executed informed consent form is not immediately provided, the hospital personnel shall report the matter directly to his or her supervisor, who, in turn, may refer the matter, to the Quality & Safety Service Leader (QSSL), the Chief Medical Officer, or their designees.

PART 7: HOSPITAL DEATH AND AUTOPSIES

7-1 HOSPITAL DEATHS

7-1.1 Pronouncement

The attending physician, Advanced Practice Provider, or registered nurse, in accordance with hospital policy, must pronounce the death of the patient within a reasonable period of time.

7-1.2 Reportable Deaths

Reporting of deaths to the Office of the Medical Examiner shall be carried out when required by, and in conformance with, state law, which upon the adoption of these rules provides that the following deaths are medical examiner cases:

1. Deaths by violence or poisoning;
2. Suddenly when a person is in good health and with no specific natural diseases sufficient to explain death;
3. During diagnostic or therapeutic procedures under circumstances indicating

gross negligence or when clearly due to unrelated trauma or poisoning unrelated to the ordinary risks of those procedures;

4. Death of a person under arrest or in custody at a governmental facility;
5. Death of a person while a patient or resident of a Department of Mental Health or residential care facility unless certified by the attending physician as due to natural causes;
6. Death suspected of being due to a threat to the public health, and the medical examiner is needed to study the case for public health reasons;
7. Death involving bodies brought into the state and buried remains uncovered unless by legal exhumation;
8. Deaths suspected of being medical examiner cases certified by other than medical examiners;
9. SIDS deaths and all other deaths of children under the age of 18 unless clearly certifiable by an attending physician as due to specific natural causes unrelated to abuse or neglect;
10. Whenever human remains are discovered not properly interred or disposed of; or
11. Deaths by any cause without an attending physician capable of certifying the death as due to natural causes.

7-1.3 Death Certificates

The Attending Physician or his or her physician designee must sign the death certificate, unless the death is a Medical Examiner's case, in which event the death certificate can be issued only by the Medical Examiner. When a reported case is not accepted by the Medical Examiner, the attending physician issues the death certificate.

7-1.4 Release of Body

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the Medical Staff or his or her physician designee. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel except upon the receipt from the Medical Examiner of authorization to release the body. All other policies with respect to the release of dead bodies shall conform to state law.

7-2 AUTOPSIES

It is the responsibility of every member of the Medical Staff to secure autopsies whenever indicated. Proper consent for an autopsy shall be in accordance with applicable state law. Autopsies should be considered in those deaths that meet, but are not limited only to, the following criteria:

A. Unanticipated deaths;

B. Death occurring while the patient is being treated under a new therapeutic trial or regimen;
C. Intra-operative or intra-procedural death;
D. Death occurring within forty-eight (48) hours after surgery or an invasive procedure;
E. Death incident to surgery or an invasive diagnostic procedure;
F. Any death on the psychiatric service;
G. Death where the cause is significantly obscured to delay completion of the death certificate;
H. Death in infants and children with congenital malformation;
I. Death in which the autopsy may help allay concerns of the family and/or the public regarding the death;
J. Natural deaths which were subject to, but waived by, forensic medical jurisdiction such as, but not limited to, death on arrival at the hospital, death occurring within twenty-four (24) hours of admission, death in which the patient sustained, or apparently sustained, an injury while hospitalized;
K. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs;
L. Cancer patients in who there is no prior tissue diagnosis, or the site of origin of the primary tumor is unknown;
M. Obstetric (maternal and fetal) and pediatric deaths, according to state law.

All autopsies shall be performed by a hospital pathologist or by qualified designee. The provisional anatomic diagnoses must be recorded on the medical record within seventy- two (72) hours, and the preliminary report in thirty (30) working days. The complete protocol shall be made a part of the medical record within ninety (90) days. These rules do not apply to cases which, according to law, must be referred to the Medical Examiner's Office.

7-3 ORGAN DONATIONS

It is the responsibility of any member of the Medical Staff to discuss the possibility of organ donations with family members when appropriate and otherwise comply with the Maine Uniform Anatomical Gifts Act and the Hospital Procedure on Organ Procurement for Clinical Transplantation.

PART 8: MEDICAL EDUCATION

8-1 MEDICAL STAFF PARTICIPATION

Members of the medical staff may, by mutual consent, serve in a teaching and/or supervisory capacity in any Medical Staff-approved educational programs for medical students, residents, staff physicians and other personnel. Medical Staff members have the option of not participating in the education program without jeopardizing their privileges or staff membership.

8-2 TEACHING SERVICE PATIENTS

A teaching service patient is managed by a team effort. The responsible physician is the team leader and retains the ultimate responsibility for the care of the patient. Resident physicians and medical students will participate in the patient's care as provided in Section 8-3 of these Rules and Regulations.

8-3 SUPERVSISION OF RESIDENT PHYSICIANS AND MEDICAL STUDENTS

Residents must be supervised by the responsible physician in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience. The responsible physician must determine the level of responsibility accorded to each resident. The responsible physician may elect to participate in the education program by agreeing to supervise residents in accordance with the hospital's medical education policies. The responsible physician retains ultimate responsibility for decision making, patient care and the execution of assigned care responsibilities by resident physicians. Progress notes written by a resident physician must be co-signed by the supervising teaching attending. The responsible physician is not prohibited from writing orders on those patients assigned to resident physicians on the teaching service.

Residents doing clinical rotations at SMHC must:

1. Be assigned to a supervising physician
2. Have documentation that they are enrolled in an accredited residency program (ACGME or AOA) and possess an "Education Certificate" issued by the Maine Board of Licensure in Medicine or the Osteopathic Board of Licensure;
3. Have a "Plan of Supervision" for each resident developed by their training program and the supervising physician for each resident OR have "Plans for Resident Supervision" developed by each service line. In both cases, the plan

should outline the scope of clinical activity (similar in form and substance to those developed for Advanced Practice Providers).

Medical Staff members may participate as preceptors for medical students enrolled in an accredited medical school. When assigned a medical student the Medical Staff member will submit appropriate paperwork to the Medical Staff Office regarding this student and his/her rotation. This paperwork must include a certificate of insurance and a statement regarding the student's hepatitis immunization and tuberculosis testing status.

Medical students under the supervision of a staff physician may complete and write a history and physical examination for review by the supervising physician. The student's written history and physical will NOT become part of the medical record. At the discretion of the preceptor, and only under his or her direct supervision, the trainee may undertake diagnostic or therapeutic procedures. It shall be the responsibility of the preceptor to inform the patient of the student's in training status, and to secure the patient's permission.

PART 9: ENFORCEMENT

Violations of any of these General Rules and Regulations by the Medical Staff may constitute grounds for initiation of the processes relating to questions of professional competence or conduct provided for in the Medical Staff Bylaws, which states that these processes may be initiated by the President of the Medical Staff, the Chief Medical Officer or designee or the leader of the relevant service line.

PART 10: AMENDMENT

These General Rules and Regulations may be amended, or repealed, in whole or in part, by a resolution of the Medical Executive Committee recommended to and adopted by the Board.

ATTACHMENT A: IMPAIRED PRACITTIONER POLICY

Background

An impaired practitioner is one who is unable to exercise prudent medical judgment with reasonable skill and safety because of alcoholism or other forms of substance abuse, mental illness (functional or organic), a behavioral illness or a medical condition leading to cognitive impairment. In the interest of safety to patients and fairness to practitioners, and because the issues associated with impairment are complex, an impaired practitioner would generally be dealt with, at least initially, under this Policy and not under any corrective action, peer review or similar policies or procedures. This policy is intended to provide overall guidance and direction on how to proceed, recognizing that specific circumstances may be more appropriately handled in different ways.

Professional competence committees and physicians have a duty under Maine law to report to the appropriate licensing board relevant facts relating to a physician if the Committee or physician has reasonable knowledge of acts of the physician amounting to misuse of alcohol, drugs or other substances that may result in the physician performing in a manner that endangers the health or safety of patients. A report is not required if a physician is participating in or agrees to participate in the Maine Medical Professionals Health Program.

In dealing with impaired practitioners, SMHC will take into account any mandatory reporting requirements as well as the Americans with Disabilities Act. The responsibility for implementation of this policy rests with the Medical Staff President, the Chief Medical Officer or designee, and the CEO, as well as Medical Staff leadership.

Hospital Policy Regarding Impaired Practitioners

It is the Policy of SMHC to place the highest priority on the protection of the patient's right to competent medical care through prompt, effective and comprehensive identification, evaluation, referral and rehabilitation of practitioners who are or may be impaired.

Report and Investigation

If any individual has a reasonable suspicion that a practitioner appointed to the Medical or Advanced Practice Provider Staff is impaired, the following steps should be taken:

A. The individual who suspects the practitioner of being impaired should give a written report to the CEO, the Medical Staff President or the Chief Medical Officer or designee. The report must be factual and shall include a description of the incident(s) that led to the belief that the practitioner 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. An individual practitioner may, and is encouraged to, self-refer if there is concern about whether impairment exists.

B. If, after discussing the incident(s) with the individual who filed the report, the CEO, Medical Staff President, or Chief Medical Officer or designee believes there is enough information to warrant further investigation, the CEO, or his or her designee, and the Medical Staff President, or his or her designee, will appoint an individual or individuals to conduct an investigation and report their findings to the Medical Executive Committee. The investigation may include requiring one or more physical, mental, cognitive, substance abuse or other evaluations, tests and reports as the person investigating determines appropriate.

C. If the investigation produces sufficient evidence that the practitioner is impaired, the CEO or Medical Staff President or Chief Medical Officer or designee shall meet personally with that practitioner or designate another appropriate individual to do so. The practitioner will be told that the results of the investigation indicate that the practitioner suffers from an impairment that affects his or her practice. The practitioner should not be told who filed the report, but will be told the specific incidents contained in the report. All persons involved should be informed that there should be no retribution for reporting and that the reports and investigations are confidential.

D. Depending on the severity of the problem and the nature of the impairment, the Medical Executive Committee has the following options:

1. If the investigation reveals that there is no merit to the report, the report shall so state, shall state the basis of its findings, and the report shall be maintained in a separate confidential and peer review protected file.

2. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a confidential portion of the practitioner's credentials file and the practitioner's activities and practice shall be monitored until it can be established whether there is an impairment problem.

3. Require the practitioner to undertake an acceptable supervised recovery program as a condition of continued clinical privileges.

4. Impose appropriate restrictions on the practitioner's privileges at the hospital and require the practitioner to undertake and successfully complete an

acceptable supervised recovery program as a condition for removal of restrictions.

5. Immediately suspend the practitioner's privileges in the hospital until rehabilitation has been accomplished, if the practitioner does not agree to discontinue practice voluntarily.

E. The Medical Executive Committee shall seek the advice of Risk Management and hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

F. The original report and a description of the actions taken by the CEO, Medical Staff President or Chief Medical Officer or designee should be included in the practitioner's credentials file.

G. The CEO, Medical Staff President, or Chief Medical Officer or designee shall inform the individual who filed the report that follow-up action was taken, but not the nature of that action.

H. Throughout the investigation and reporting process, all parties should maintain confidentiality and objectivity and refrain from any gossip and any discussions of this matter with anyone outside those described in this policy.

I. Investigations, discussions, recommendations and action taken under this policy do not constitute corrective action within the meaning of the Medical Staff Bylaws and do not afford the healthcare practitioner the due process rights of the Medical Staff Bylaws. While it is the intent and purpose to deal with an impaired practitioner under this policy, nothing precludes the initiation of a corrective action, to the extent that the conduct of a practitioner warrants the commencement of a corrective action under the Medical Staff Bylaws. An impaired practitioner investigation that may reduce, suspend or revoke clinical privileges or Medical Staff membership gives the practitioner due process rights under the Medical Staff Bylaws. In addition, at any time the practitioner may access their due process rights under the Medical Staff Bylaws

J. Medical Staff leadership will be informed about the status of potentially impaired and impaired practitioners.

Rehabilitation

Hospital and Medical Staff leadership shall assist the practitioner in locating an acceptable supervised recovery program. Any physician or Advanced Practice Provider who has or could potentially develop alcohol and/or psychoactive drug abuse or dependency that could interfere with the practice of medicine must agree to enter the Maine Medical Professionals Health Program at the request of the President and CEO. Other healthcare practitioners may be required to enter into comparable programs. If privileges have been suspended, the hospital shall not reinstate a practitioner until it is established, to the hospital's satisfaction, that the practitioner has undertaken or successfully completed an acceptable supervised recovery program in which the hospital has confidence

Reinstatement

A. When considering an impaired practitioner for reinstatement, the hospital and its Medical Staff leadership must consider patient care interests to be paramount.

B. A healthcare practitioner requesting reinstatement must provide a report from the Director of or other responsible person for an acceptable supervised recovery program where the practitioner was treated. The practitioner must authorize the release of all information from any rehabilitation or primary care or other provider treating the practitioner in connection with the impairment. Correspondence from the director of the program or any personal physician must state:

    1. Whether the practitioner is participating in the program;
    2. Whether the practitioner is in compliance with all of the terms of the program;
    3. Whether the practitioner attends program meetings regularly (if appropriate);
    4. To what extent the practitioner's behavior and conduct are monitored;
    5. Whether, in the opinion of the program physicians, the practitioner is rehabilitated;
    6. Whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and
    7. Whether, in the program director's opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

C. The practitioner must inform the hospital of the name and address of the physician(s) overseeing his or her care, and must authorize the physician(s) to provide the hospital with information regarding his or her condition and treatment. The hospital has the right to require an evaluation by a healthcare practitioner of its choice.

D. The hospital shall request the treating or the overseeing physician or other healthcare practitioner to provide information regarding the precise nature of the practitioner's condition, the course of treatment and the answers to the questions:

   1. Whether, in the opinion of the treating or the overseeing physician, the practitioner is rehabilitated;
   2. Whether an after-care program has been recommended to the practitioner and, if so, a description of the after-care program; and
   3. Whether, in the program director's opinion, the practitioner is capable of resuming medical practice and providing continuous, competent care to patients.

C. Assuming all the information the hospital receives indicates that the practitioner is rehabilitated and capable of resuming patient care, the hospital must take the following additional precautions when restoring clinical privileges:

D. The practitioner must identify practitioner(s) who are willing to assume responsibility for the care of his or her patients in the event that he or she is unavailable to care for them;

E. The hospital shall require the practitioner to provide the hospital with periodic reports from his or her treating or overseeing physician or other healthcare practitioner – for a period of time specified by the CEO, Medical Staff President and Chief Medical Officer or designee – stating that the practitioner 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.

F. The service line leader or a designee appointed by the service line leader shall monitor the practitioner's exercise of clinical privileges in the hospital. The MEC shall determine the nature of the monitoring after reviewing all the circumstances.

G. All requests for information concerning the impaired practitioner shall be forwarded to the CEO for response.

ATTACHMENT B: DISRUPTIVE PRACITTIONER POLICY

I. Policy

It is the policy of Southern Maine Health Care that all individuals within its facilities be treated with courtesy, respect and dignity. To that end, and because disruptive conduct may have adverse implications for patient care as well as an adverse impact on staff morale and retention, all members of the Southern Maine Health Care Medical and Advanced Practice Provider Staff are required to conduct themselves in a professional and cooperative manner in the facilities of Southern Maine Health Care.

II. Purpose

It is the purpose of this policy to ensure quality care by promoting a safe, cooperative and professional healthcare environment and to prevent or correct conduct which disrupts the operation of the hospital, affects the ability of others to do their jobs or to practice competently, or creates a hostile work environment for hospital employees, patients or other individuals.

III. Disruptive Conduct

Disruptive conduct includes, but is not limited to:

A. Rude, vulgar, intimidating or abusive conduct (physical, verbal or emotional) toward, or in the presence of patients, nurses, other hospital employees, other practitioners or visitors.

B. Degrading or demeaning comments regarding patients, families, nurses, physicians, hospital personnel, or the hospital.

C. Inappropriate comments spoken or written, in patient records or other official documents, attacking or impugning the quality of care in the hospital, other practitioners, Southern Maine Health Care personnel or hospital policy.

D. Public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital.

E. Non-constructive criticism addressed to its recipient in a way as to intimidate, belittle or to impute stupidity or incompetence.

F. Deliberate destruction or stealing of hospital property, including medical records.

G. Disrupting hospital case management, committee or peer review functions.

H. Disrupting hospital personnel's ability to perform their assigned function

I. Engaging in discrimination or unwelcome harassment of any hospital employee, patients, other practitioners or visitors at the hospital on the basis of the individual's race, color, national origin, sex, age, religion, disability, sexual orientation or any other status protected by law. Unwelcome harassment is defined as verbal or physical contact by any individual that denigrates or shows hostility or aversion toward the other. As part of this prohibition of harassment, no Medical Staff or Advanced Practice Provider Staff member will sexually harass any hospital employee, patient, visitor, resident physician, student, Medical Staff member or other individual performing services at or for the hospital. Southern Maine Health Care's sexual harassment policy includes, but is not limited to, unwelcome sexual advances, sexual jokes or comments, requests for sexual favors or other unwelcome verbal or physical conduct of a sexual nature, when:

    1. Submission to such conduct is made, either explicitly or implicitly, a term or condition of an individual's employment or professional advancement;
    2. Submission to or rejection of such conduct by an individual is used as a basis for employment decisions or professional advancement decisions affecting that individual;
    3. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile, demeaning or offensive environment

J. Unwelcome religious and political proselytizing

K. This policy outlines the steps that can be taken in an attempt to resolve complaints about inappropriate conduct exhibited by practitioners. However, there may be a single incident of inappropriate conduct, or a continuation of conduct, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in this policy precludes immediate referral to the Medical Executive Committee (or to the Board) or the elimination of any particular step in the policy in dealing with a complaint about inappropriate conduct.

IV. Documentation and Reporting

Any person, practitioner, patient, visitor or employee, may make a report. If a person has reasonable grounds to believe a health care practitioner has engaged in disruptive conduct, the person should document and report the following:

A. Names of all parties involved
B. Names of witnesses to the event
C. Date, time and circumstances surrounding the situation
D. A description of the conduct limited to factual, objective language
E. Any known consequences of the conduct

V. Investigation

Upon receipt of a report regarding disruptive conduct, the CEO, the President of the Medical Staff, or the Southern Maine Health Care Chief Medical Officer, or designee, shall review the matter and decide if further investigation is warranted. Reports which are not found to be credible or of merit will be so noted and dismissed. If further investigation is warranted, the CEO or the President of the Medical Staff or Chief Medical Officer or designee may work with others as they determine appropriate and conduct such investigation as they determine appropriate. Persons making reports should be assured that reporting disruptive behavior is appropriate and to be encouraged and that they should not experience retaliation because of a report. Healthcare practitioners who are the subject of a report should be reminded not to retaliate against the reporting individual. All parties involved should be informed of the confidentiality of reports and investigation.

VI. Interventions and Actions

In the sole discretion of the CEO or President of the Medical Staff or the Chief Medical Officer or designee, interventions and actions may include the following:

A. A meritorious report, after reasonable investigation, will (at a minimum) warrant a discussion with the individual. Any of the parties involved in investigating the incident may be chosen to conduct this meeting, which shall be collegial in nature and designed to help the individual and the hospital and to rectify the situation. It should be stressed to the individual that such behavior is unacceptable, and if gross or repeated disruptive conduct is identified, it may constitute grounds for a corrective action because of the potential to disrupt the operations of the hospital. The CEO, President of the Medical Staff, or the Chief Medical Officer or designee has the authority to monitor to determine whether the practitioner's behavior improves.

B. If it appears that the initial intervention was unsuccessful, and a pattern of conduct is developing, the CEO or President of the Medical Staff or the Chief Medical Officer or designee shall meet with the individual and again stress that

the behavior must stop, and that more formal action may be taken to stop it. A letter shall be sent to the individual reaffirming this policy and establishing specific expectations for practitioner conduct, and the Executive Committee of the Medical Staff shall be notified.

C. There is no requirement of progressive discipline and any one incident may be grounds for referral to the Medical Executive Committee for corrective action, pursuant to the Medical Staff Bylaws and associated manuals.

D. At any time, the matter may be referred to the Medical Executive Committee for review.

E. All meetings with the practitioner shall be documented including any rebuttal and such records shall be kept in a separate file by the Chief Medical Officer or designee. Any final actions as defined in the Medical Staff Bylaws and associated manuals will be placed within the practitioner's credentials file.

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