Medical Staff Policies and Procedures

June 12, 2007

Revised September 11, 2007

Revised 04/15/2008

Revised 10/14/2008

Revised 03/10/2009

Per Article XII of the Medical Staff Bylaws

> Medical Staff policies and procedures as may be necessary to implement more specifically the general principles of conduct found in these Bylaws shall be adopted in accordance with this Article. Policies and Procedures shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital and shall act as an aid to evaluating performance under, and compliance with, these standards. Policies and Procedures shall have the same force and effect as the Bylaws.
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> Particular Policies and Procedures may be adopted, amended, repealed or added by vote of the Executive Committee, or at any regular or special Medical Staff meeting. Copies of the proposed amendments, additions or repeals must be made available to all members of the Executive Committee 14 calendar days before a vote occurs on the proposed changes. Written comments on the proposed changes by members shall be brought to the attention of the Executive Committee before any vote.

The policies and procedures described in this document pertain to all licensed independent practitioners with privileges to treat patients at Children's Hospital in all Centers of Excellence and Divisions. It is meant to inform practitioners of their responsibilities in relation to providing care to patients at Children's Hospital.

The medical staff office is responsible for the implementation of these policies and procedures and the orientation/education of physicians who are new to the medical staff.

The Chief Medical Officer is the Accountable Executive of these policies and procedures. The Chief Medical Officer in conjunction with the President of the Medical Staff shall provide an annual review and/or revision. The medical staff office is responsible for identifying the timeframes for revision, assuring that the timeframes for approval are met, and providing dissemination and education of the policy.

APPROVED by the Medical Executive Committee: June 12, 2007

Amendments APPROVED by the Medical Executive Committee: September 11, 2007

Amendments APPROVED by the Medical Executive Committee: 4/15/2008

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Amendments APPROVED by the Medical Executive Committee: 05/12/2009

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President of the Medical Staff

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Chief Medical Officer

Chapter 1: Admissions

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated, objective guidelines governing the care of patients being admitted to appropriately credentialed and licensed providers at Children's Hospital or to provide for such alternative arrangements, as may be necessary by the patient's condition, when the services are not available at Children's Hospital.

II. Procedure

A. Roles/Responsibilities:

Medical Staff members who are appointed to the Attending Staff have been chosen to recommend medical care policy, assume the responsibility for medical care of patients, monitor the delivery of patient care, and guide House Staff members in the various aspects of child health. The attending physician shall be responsible for communicating with the referring physician in the community or in the Hospital as appropriate.

Medical Staff members shall provide assurance of immediate availability of adequate professional care for patients by responding to a page not longer than 30 minutes, and arriving on site, if necessary, within 90 minutes or be able to assure coverage from another attending physician who can respond within that time.

The attending physician is responsible for documenting the admission assessment and plans and is responsible for updating this information as needed including documentation of changes in the plan of care as they occur. These responsibilities may be delegated to the house staff or licensed independent practitioners with the appropriate privileges. Whenever these responsibilities are transferred to another house officer, an order covering the transfer of responsibility shall be entered on the order sheet of the medical record.

Registration and Admissions staff must receive an admission order from the attending physician or designee, obtain consent for treatment, identify the patient, and verify the registration and admission demographic data as dictated in their policies and procedures.

The attending physician and the division chief are responsible for ensuring that the appropriate resources required for continuing care of the patient are available and if not then providing alternative arrangements as may be necessary for the patient's condition.

B. Admission Priorities:

Admissions to the hospital shall be categorized and receive priority according to this list:

1. First Priority: Emergency Admissions – The patient is in immediate danger or at risk for serious or permanent harm if no treatment or a delay in treatment were to occur. The history and physical examination should be performed as soon as possible after admission and justify the emergency nature of the condition.
2. Second Priority: Routine Admissions - non-emergency patients who may be seriously, though not critically, ill.
3. Third Priority: Elective Admissions - any patient presenting for medical or surgical procedures or treatments that are neither emergent nor routine.

If there is any question concerning the admission of a patient, the Chief Medical Officer or designee, in consultation with the Chief of the appropriate division, shall determine the necessity for or deferment of the admission.

C. Admission Attestation

The admitting order shall contain the following information

1. Admission Status: Observation (23 hour admission) or Inpatient,
2. Physician attestation as to the necessity of the admission, surgical procedure or potentially hazardous diagnostic procedure,
3. The tentative discharge plan,
4. The estimated Length of Stay, and
5. The tentative plan of care.

D. Pre-admission and Post-admission Laboratory Tests

Laboratory testing shall be authorized by a physician on the basis of the patient's pre-operative condition, accepted medical principles and their medical judgment. The results of such testing will be valid for up to 30 days provided that the patient's condition has not changed.

1. For healthy ambulatory patients, who are not menstruating females, scheduled for elective same day surgery **NO** "routine" pre-operative testing will be mandatory. For menstruating females, a pregnancy screen shall be required when the menstrual history suggests the possibility of pregnancy.
2. In-patients and those having emergency surgery will, at a minimum, have a complete blood count (CBC).

Laboratory test results performed by the accredited and licensed laboratories outside the Hospital shall be accepted provided:

1. The report slips with the results are received by the Hospital prior to the initiation of anesthesia and surgery; and
2. The test results are normal; and
3. The condition of the patient has not changed between the time the tests were analyzed and the date of surgery.

E. Infectious Patients

Patients with infections or communicable diseases must enter the Hospital through the emergency department and must be held there until an appropriate bed with appropriate isolation is available. The final authority for placement of such patients rests with the Infection Control Officer.

The attending physician will inquire about recent exposure to communicable diseases in any patient to be admitted on an elective basis. Admission shall be postponed, if necessary, until such time as the incubation period has passed, and the patient is free of the communicable disease.

Registration and Admissions and AMSAC personnel will also screen patients for exposure to communicable diseases and immunization history at the time of admission.

F. Continued Hospitalization

The attending physician is required to see that the medical record demonstrates the need for continued hospitalization including a record of the reason(s) for continued hospitalization, the estimated duration of hospitalization and the plans for post-hospital care.

The attending physician must also provide a report, when requested, within 24 hours of receipt justifying the continued hospitalization. Failure to comply shall be brought to the attention of the Medical Executive Committee for appropriate review and recommendations. Patients remaining in the Hospital over two months must have the stay reviewed every two months and approved.

III. Reference to applicable procedure or other pertinent policy.

Policy: Medical Staff Admissions Policy

Authority to Admit Patients

Chapter 2 Orders

I. Policy Statement

It is the policy of Children's Hospital to have clearly articulated guidelines related to the provision of medical care through medical orders.

II. Procedure

A. Specific standards in the order writing process:

Where electronic entry of patient care orders is available, orders shall be so entered and will not be carried out until they are understood by the nurse or other dependent practitioner charged with carrying out the order. For orders that remain in a written format, they must be clear, legible and complete. The use of "renew," "repeat," and "continue" orders is not acceptable for orders entered on paper.

Where an electronic means for entering the orders does not exist, preprinted orders, authorized by the appropriate Division chief and approved by the Pharmacy and Therapeutics Committee, may be used, provided each order is signed and placed on the patient's chart by the ordering physician.

All previous orders are canceled at the time patients are taken to surgery or to a potentially hazardous diagnostic procedure. Post-operative or post-procedure orders must be re-entered or reaffirmed, electronically when available, including those pre-operative medication and treatment orders that are still required by the patient's condition.

All orders will be completely reaffirmed when a patient is transferred from one clinical service to another or from one patient care unit to another.

Orders for all liquid medications containing a single drug shall be written by weight in the metric system. Orders for liquid medications containing mixtures of drugs shall be calculated by volume in the metric system. Orders for parenteral narcotics will contain both the milligram dose and the milligram per kilogram equivalent. Medication policies approved by the Pharmacy and Therapeutics Committee and the Executive Committee shall be applicable to all members of the Medical Staff and the house staff.

Prohibited abbreviations, signs, or symbols shall not be used in medical orders.

B. Permission to Write Orders:

Medical Staff members shall have the authority to write orders as permitted by their licensure, clinical privileges, and scope of practice. They shall be competent in the use of the electronic provider order entry system. All orders shall be dated, timed, and signed or authenticated electronically by the responsible practitioner. If the order requests a diagnostic procedure or test requiring an interpretation, the order shall also contain a statement of the reason(s) for the procedure or test.

House staff members acting under the direction of the attending physician may enter orders commensurate with their level of training.

Medical students acting under the direction of a member of the house staff or attending physician may enter medical orders. These orders do not become active until countersigned by an appropriate member of the house staff or attending staff.

C. Verbal or Telephone Orders

Verbal Orders shall be accepted only under urgent or emergent circumstances when it is impractical for such orders to be entered by the responsible practitioner.

Verbal or telephone medication orders shall be dictated to a member of the house staff, a registered nurse, pharmacist or certified respiratory therapist who can accept verbal orders relevant to their scope of practice and who shall enter the orders electronically into the provider order entry system when such system is available. The recipient of the verbal or telephone order shall continue communication (in the case of a telephone order, keep on the telephone) until the order is completely entered and all alerts from the provider order entry system have been read back to the prescriber with the provider's indication to the transcriber of the appropriate actions to take based on the alerts. Any written orders shall include the date, time and full signature of the person taking the verbal or telephone order and all orders should be read back to the prescriber in order to validate the correct patient, medication, dosage, and route as required. (Verbal Order Read Back) Such an entry shall be made on paper or in electronic format.

The identity of the prescriber shall be validated before the order is accepted.

Authentication of verbal orders

1. Telephone or verbal orders entered through the electronic provider order entry system shall be sent to the physician's electronic in-box for co-signature and must be electronically signed at the next log-in. Verbal or telephone orders transcribed using paper order sheets shall be co-signed within 24 hours. Orders that are not countersigned by house staff shall become the responsibility of the attending physician upon hospital discharge (and shall be a documentation deficiency).
2. Verbal orders for restraints must be signed within the timeframe specified for the child's age as stipulated in the Restraint and Seclusion policy.
3. The use of non-medication verbal orders and telephone orders shall follow the same procedures as those set forth in this section.

III. Reference to other applicable procedures or other pertinent policy.

Policy: Medical Orders Policy

Medical Staff Bylaws

Children's Hospital Medication Policies and Procedures

Chapter 3: Consultations

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated, objective guidelines governing the care of patients being admitted to appropriately credentialed and licensed providers at Children's Hospital. The attending physician is obliged to call for consultation from appropriate specialist providers, as needed, to assist with patients under their care. Consultants are equally obliged to adhere to objective procedures in providing their opinions.

II. Procedure

A. General Requirements

It is the duty of the Chief Medical Officer, Executive Directors of the Centers of Excellence, Division chiefs, and the President of the Medical Staff to see that members of the Medical Staff do not fail to call consultants as needed.

Each consultant must be well qualified to give an opinion in the field in which his opinion is sought.

1. Any physician or other qualified health care practitioner who has been granted Medical Staff appointment and clinical privileges in this Hospital is considered to be well qualified and may provide a consultation within his area of expertise in any patient care unit.
2. In special circumstances, the President of the Medical Staff, the Chief Medical Officer, Executive Director, or the appropriate Division Chief shall have the authority to call in a consultant or consultants in the care of a particular patient.

In the circumstance where an attending physician requests a consultation from a practitioner that is not a member of the Medical Staff, the attending physician requesting the consultation

1. Is required to ascertain the status of the consultant's license and his professional liability insurance; and
2. Is required to introduce the consultant to the appropriate Division Chief and Chief Medical Officer for their approval.

Such consultant may render an opinion on the patient's care. If care extends beyond rendering an opinion, privileges shall be obtained.

Any consultant rendering a second opinion as an agent of the patient or the patient's parent(s) or legal guardian, shall not be allowed any patient care privileges in the Hospital. Such consultant must, however, come with the knowledge of the attending physician and the approval of the Division Chief.

A satisfactory consultation shall include examination of the patient, when appropriate, and a written opinion signed by the consultant and entered into the patient's record.

B. Required and Recommended Consultations

Appropriate consultations shall be obtained at the discretion of the attending physician to meet the clinical needs of the patients. Mandatory concurrent care from Intensive Care Attending Staff (Neonatology or Critical Care Medicine) is required for all patients admitted to any Intensive Care Unit.

A consultation from the Hospital's Child Protection Services is required on any child who is suspected of having been a victim of physical, emotional, and/or sexual abuse and/or neglect.

Evaluation of these patients by the Hospital's Child Protection Services will follow the guidelines and requirements as set forth in the Child Protection policies and in keeping with the laws of the District of Columbia and surrounding jurisdictions.

All therapeutic interventions and/or diagnostic procedures shall be performed only by those individuals qualified, credentialed, and privileged to perform such activities, even if such individual's privileges contain mandates for a consultation.

If a health care worker employed by the hospital has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this matter to the attention of the supervisor who, in turn, may refer the matter to the Vice President, Patient Services, or designee. The Vice President, Patient Services, or designee, may bring the matter to the attention of the Chief of the Division in which the practitioner in question has clinical privileges. In all situations that require it, the Chief of the Division may request a consultation after appropriate discussion with the attending practitioner. In circumstance where there is a disagreement that arises between an attending physician and a consulting physician that in the opinion of either physician has the potential for an adverse outcome, each physician has the affirmative duty to solicit additional consultations and if necessary escalate the matter to the Chief of the Division, the Chief Medical Officer or the President of the Medical Staff for resolution. Such resolution may result in the ordering of additional consultations as the situation may require.

Additional requirements or recommendations for consultation may be established by the Hospital, as required. It shall be the responsibility of all individuals exercising clinical privileges to obtain any required consultations, and requests for a consultation shall be entered on an appropriate form in the medical record. The consultation form shall provide the information requested of the consultation. It is the responsibility of the practitioner requesting the consultation to provide this information to the consultant. The attending physician requesting consultation should communicate results to parent/guardian unless the attending directs the consultant to speak directly to the parent/guardian. In all consultations, the attending physician and the consultant should discuss results before talking to the parent/guardian.

C. Contents of Consultation Report

The primary content of the written consultation report shall include:

1. The opinion and recommendations of the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record;
2. The consultant's report shall be made a part of the patient's record. The report shall elaborate the consultant's findings including a physical examination, pertinent points of the patient's history, pertinent laboratory testing, the conclusions and recommendations. A limited statement, such as "I concur," does not constitute an acceptable consultation report; and
3. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified within the record.

D. Special Consultations:

Pathology consultations — It shall be the responsibility of both the pathologist performing an operating room consultation and the operating surgeon to have a personal consultation between them during the operation whether the procedure requires a "frozen section" or not.

Psychiatric Consultations — Psychiatric consultation shall be obtained for all patients who present self-destructive behavior. Evaluation of such patients shall follow those guidelines and requirements of the Department of Psychiatry. If psychiatric care is required, evidence that such care has been offered and/or appropriate referral made to such patient or his parent(s) or legal guardian must be documented in the medical record. All patients with self-destructive behavior shall be referred to a mental health program.

III. Reference to applicable procedure or other pertinent policy.

Formerly Rules and Regulations of the Medical Staff Article 3

Chapter 4 Surgical Care and Other Invasive Procedures

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated, objective guidelines governing the medical staff's provision of care to patients requiring or undergoing surgery or other invasive procedures.

II. Procedure

A. Scheduling Surgery

At the time of the scheduled surgery, the Anesthesia team members and a member of the surgical team must be physically present in the operating suite. Anesthesia shall not be started until it is ascertained that the attending surgeon or fellow is present in the institution and immediately available. The attending surgeon or surgical fellow must be available to come to the operating room immediately upon notification that he/she is needed. The attending surgeon or surgical fellow must be named when the case is scheduled and are responsible for the surgical care of the patient before, during and after the operation. If the operating surgeon is more than fifteen minutes late for any scheduled case and the operating surgeon has not contacted the Director of Peri-operative Services, or designee, that case shall be canceled and the patient returned to his room by the operating room staff. Operating time will be released promptly when a case is canceled because the patient and surgical team are not available on schedule.

Specific, contemplated procedures must be described on the Operating Room schedule and must include the patient's name, age, and diagnosis. Unrelated elective procedures may not be added to a case after it is posted if other cases are already posted to follow. The case will be done as originally posted or rescheduled. Cases where frozen sections can be anticipated should be posted as such at the time the case is scheduled.

An emergency case shall take precedence over an elective surgical case not in progress. Schedules for Sundays and holidays are limited to emergencies.

B. Universal Protocol

1. General

The Universal Protocol covers all surgical and invasive procedures performed at Children's Hospital, including invasive procedures performed outside of the OR that require an informed consent. This includes procedures that involve puncture or incision of the skin or insertion of an instrument or foreign material into the body, including percutaneous aspirations, biopsies, cardiac and vascular catheterizations and endoscopies (except for minor procedures such as venipuncture, peripheral IV line placements, insertion of NG tubes or Foley catheters).

The Universal Protocol includes these three steps:

(a) A P**re-procedure Verification** to ensure all relevant documents and studies are available prior to the start of the procedure, that they have been reviewed by team for congruency and that they are consistent with the patient's expectations and the team's understanding of the intended patient, procedure, site and, as applicable, any implants. Missing information and discrepancies are addressed before starting the procedure.

(b) Unambiguous **Site Marking** of the intended site of incision or insertion when the planned procedure involves right/left distinction, multiple

structures (such as fingers or toes), or multiple levels (as in spinal procedures) so that the site marking is visible after the patient has been prepped and draped

(c) A **Time Out** immediately prior to the start of the procedure to verify that the correct patient is receiving the correct procedure, at the correct site/side/structure/level of spine, is in the correct position for the procedure and the needed correct implant or special equipment are available and that special requirements are met.

2. Pre-Procedure Verification Process

The purpose of the pre-procedure verification process is to confirm the correct patient, procedure and site/side/structure/level for the procedure and to verify that all relevant documents, studies, equipment and supplies are available prior to the start of the procedure.

(a) The pre-procedure verification process will be implemented for all invasive procedures performed in the O.R. and non-O.R. settings and shall be completed before the patient leaves the preoperative area or enters the procedure/surgical room. When the procedure is performed at the bedside the pre-procedure verification process is completed before the start of the procedure.

(b) The following must be completed during the pre-procedure verification, with patient/family involvement whenever possible:

i. Identification of the patient;

ii. Verification of the procedure;

iii. Verification of the site and, when applicable, the side, structure, and/or level of spine, through confirmation with the patient/parent, reference to appropriate documents such as progress notes and other documents that detail the procedure, site/side/level, or confirmation with the LIP and/or other care team members; and

iv. Verification that required documentation, forms and/or supplies are present, including the informed consent form, the history & physical, pertinent x-rays, other diagnostic studies, special equipment and supplies, and/or implants required for the procedure.

Exceptions to the pre-procedure verification process include urgent, emergency situations or life-threatening situations and shall be documented in the patient's medical record.

3. Site Marking

Marking of the intended site of the procedure shall be performed when the planned procedure involves right/left distinction, multiple structures (such as fingers or toes), or multiple levels (as in multi-level spinal procedures)

For the purposes of performing site marking, a surgical house officer may be deemed the LIP that may perform site marking, if they remain present for the duration of the surgical procedure, If a surgical house officer performs the site marking, the attending surgeon shall verify during the procedural time-out the correctness of the site marking.

(a) The LIP performing the invasive procedure or the surgical house officer as

defined above shall mark the site using the following guidelines:

i. An indelible marker shall be used to mark the site;

ii. The initials of the individual marking the site shall be used to indicate the procedure site;

iii. The mark shall be made at the incision/insertion site or as close to the site as possible;

iv. The mark shall be positioned to be visible after the patient is draped and prepped for the procedure;

v. The patient/parents shall be involved in the site marking (when possible);

vi. At a minimum, sites shall be marked for all cases that involve:

(1) Sides/laterality (i.e. right, left),
(2) multiple structures (i.e. toes, fingers, lesions) or
(3) multiple levels of the spine. (In addition to preoperative skin marking of the general spinal region, an intraoperative radiographic marking technique will be used for marking the intravertebral level).

vii. The mark shall be placed at or near the proposed site for mid-line insertion/incisions for procedures that involve laterality, in order to indicate the correct side for the procedure.

viii. If a procedure is being performed through a laparoscopic midline approach and involves laterality, the side shall be marked on the skin and be visible after prepping and draping.

(b) Exceptions to Site Marking:

i. The LIP performing the procedure is in continuous attendance with the patient from the time of decision to do the procedure and obtaining informed consent, to the performance of the actual procedure.

ii. Single organ cases such as cardiac surgery.

iii. Sites in which the catheter/instrument insertion site is not predetermined (e.g. cardiac catheterization, angiography, ECMO, lumbar punctures, or bone marrow aspirations).

iv. Interventional Radiology procedures performed under direct imaging guidance such as PIC and central venous catheters, drainage catheters, gastrostomies, cecostomies, biopsies, needle localizations, aspirations, angiograms, arterial catheterizations, and vascular interventions, etc.

v. Teeth. For these cases, the correct operative tooth name(s) must be identified on supporting documentation or the operative tooth/teeth must be marked on the dental radiographs or ADA diagram.

vi. Infants less than 36 weeks gestational age.

vii. Patient/parent refuses site marking. When site marking is refused, the LIP should review the intended site with the patient/parent and obtain their verbal confirmation of the correct site/side/structure/level.

The pre-procedure verification and time out must still be completed for cases covered under site marking exceptions.

4. Time Out

i. Immediately prior to the start of any invasive procedure a time out process must be completed by all members of the operative team using active communication to confirm their agreement that the five rights of the Universal Protocol are met. e.g.:

The correct patient is having
(a) the correct procedure,
(b) at the correct site/side/structure/level of spine,
(c) with the patient in the correct position and
(d) any required equipment, supplies, implants are present and/or special requirements are met.

ii. The Time Out will be conducted in the location where the procedure is performed.

iii. To conduct the Time Out, the following steps are followed:

a. One member of the invasive procedure team will read out loud the patient's name, the procedure, and the procedure site/side/structure/level of the spine from the "Consent for Surgery, Treatment, Diagnostic Procedure, Use of Blood and Blood Products, Sedation, or Anesthesia" form and, when applicable, state out loud the presence of any required equipment, supplies or implants and/or that special requirements are met.

b. ALL members of the invasive procedure team will independently determine if the correct patient is having the correct procedure at the correct site/side/structure/level of spine, with the patient in the correct position and that required equipment, supplies, implants are present and/or special requirements are met and verbally state their confirmation of with the information read to them

c. After ALL members of the invasive procedure team have verbally stated their agreement, one member of the team will document completion of the Time Out by one of the following methods:

i. Complete the "Time Out Verification" section on the electronic record or substitute when the electronic record is not available.

ii. Complete the Perioperative Protocol segment on the electronic surgical record (or surgical form during downtime)

iii. Complete the "Universal Protocol Checklist for Patient Safety"

iv. Document the completion of the Time Out in the Procedure Note

v. Complete the "Invasive Procedure Verification Process" section of the Emergency Treatment Record.

iv. If there is any disagreement among team members participating in the invasive procedure during the Time Out process, the start of the invasive procedure will be immediately suspended until the correct information is obtained and agreed upon by all members. Following this agreement, the process may continue.

v. The Time Out process must be completed for cases classified as "exemptions", including urgent/emergency cases and site marking exemptions, unless the invasive procedure is performed in a life-threatening situation.

C. Specimens

Any specimen removed from a patient in the Hospital during a procedure shall be sent to the Pathology Laboratory for examination by the hospital pathologist. Exceptions are limited to the list below at the discretion of the physician when the quality of care is not compromised. When an exception is made, documentation is required. Exceptions are limited to

- Orthopedic hardware or appliances;
- Extraneous, normal bone removed for bone grafting or bone such as a rib, which has been removed for the purpose of operative exposure;
- Foreign bodies such as coins, organic foreign bodies in the airway unless the District of Columbia Medical Examiner requests the foreign body for its investigation;
- Foreskin from a circumcision;
- Inguinal or umbilical hernia sacs;
- Cataracts;
- Normal muscle removed during an ophthalmologic or orthopedic procedure;
- Scar tissue removed for cosmetic purposes only;
- Teeth extracted by dentists or oral surgeons;
- Specimens removed from the patient solely for testing in the Department of Laboratory Medicine; and
- Broviac or other percutaneously routed catheters

D. Surgical Records

Except for documented emergencies as recorded by the attending surgeon in the medical record, the following data shall be recorded in the medical record prior to surgery, or the operation shall be canceled:

- Verification of the identity of the patient;
- Medical history and supplemental information regarding drug sensitivities and other facts (with an appropriate notation that the history and examination have not changed if the H and P has been performed within 30 days before the procedure),
- General physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;
- Provisional diagnosis;
- Laboratory test results;
- Consultation reports;
- Informed consent obtained and signed by the surgeon and the patient or the patient's parent(s) or legal guardian and witnessed;
- X-ray reports, if applicable; and
- Other ancillary reports, if applicable.

The patient shall not be taken to the Operating Room until his chart is complete or, if testing results are pending, when the Operating Room has received a telephone message stating the results of the tests performed. In an emergency situation before the operation may begin, the

attending surgeon or surgical fellow shall make certain that there is a note on the patient's condition stating that delay in recording this information would constitute a danger to the health or safety of the patient and that the attending surgeon accepts responsibility for the patient's physical condition. If the history and physical have been transcribed but not yet entered in the chart, an admission note and statement to that effect shall be entered in the chart.

The Attending shall sign the History and Physical Exam form acknowledging that the indications for surgery have or have not changed. This may be accomplished in the Operating Room after anesthesia has been administered, but before the surgery commences.

All operations performed shall be fully described by the surgeon in the medical record. At least the following information shall be recorded immediately following the procedure as a progress note and be immediately available after surgery to provide pertinent information for use by any practitioner who is required to attend the patient:

- the name of the primary surgeon and any assistants;
- the pre- and post-operative diagnoses; and
- the surgical indications for the procedure;
- a description of the findings, the technical procedures used, and the specimens removed;
- the estimated blood loss;
- the method of anesthesia; and
- the status of patient upon leaving the operating room.

The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible following the procedure.

E. Anesthesia Rules and Records

The surgeon shall identify his patient prior to administration of the anesthetic and remain in the Operating Room area in operating attire during induction. He may be asked to assist or supervise the position of his patient on the operating table and must be available in the event of an emergency.

The anesthesiologist shall verify that there has been a recent preoperative physical examination with appropriate laboratory data in the clinical record on all patients referred to him. This may be accomplished by medical personnel (fellow, resident, nurse practitioner or other licensed independent practitioner with the appropriate privileges) designated by the Attending surgeon who will then co-sign this document before surgery begins. The pre-anesthesia evaluation shall include appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated. This evaluation shall include the patient's previous medication history, other anesthetic experience and any potential anesthetic problems. The anesthesiologist shall review the patient's condition immediately prior to induction of anesthesia and record any changes on the anesthesia record. The findings of a pre-anesthesia assessment by an anesthesiologist shall be recorded within 48 hours of surgery.

A record shall be maintained of all events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other medications, intravenous fluids, and blood or blood components.

The recording of post-anesthetic visits shall include at least one note describing the presence or absence of anesthesia-related complications. The number of visits will be determined by the status of the patient in relation to the procedure performed and anesthesia administered.

Complete recovery shall be determined by the anesthesiologist. Post-anesthesia follow-up findings shall be recorded by an anesthesiologist within 24 hours after surgery.

Each post-anesthesia note shall specify the date and time. It is recommended that a post-anesthesia medical record entry be made by the anesthesiologist who provided the care when appropriate. However, all anesthesia personnel are encouraged to make pertinent post-anesthesia entries in the medical records of patients whose conditions they have evaluated or to whom they have provided care.

F. Recovery Room and Short Stay Recovery Unit

The surgeon shall remain in the Operating Room area until his patient is admitted to the Post Anesthesia Care Unit. The surgeon or a designated resident/fellow must write post-operative orders before the patient leaves the Operating Room suite. An anesthesiologist shall write orders discharging the patient from the Recovery Room. In some circumstances, the discharge of patients from the short stay recovery unit is performed by a nurse and shall be governed by established discharge criteria.

At least one professional registered nurse shall be on duty in the Recovery Room whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.

G. Dental Patients

A patient admitted for dental surgery is the dual responsibility of the attending dentist and attending physician. Oral surgeons who are deemed qualified by the Credentials Committee, on the recommendation of the Executive Director, and are granted appropriate privileges may admit patients without underlying health problems, perform the complete admission history and physical examination and assess the medical risks of the proposed procedure on the patient.

Dentist's responsibilities shall include:

- a detailed dental history justifying Hospital admission;
- a detailed description of the examination of the oral cavity and preoperative diagnosis;
- a complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the identity by name and the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologist for examination;
- progress notes pertinent to the oral condition;
- clinical summary or statement; and
- discharge order.

Physician's responsibilities shall include:

- medical history pertinent to the patient's general health;
- a physical examination to determine the patient's condition prior to, and suitability, for anesthesia and surgery; and
- supervision of the patient's general health status while hospitalized;

The medical history and physical examination may be delegated to a member of the medical staff who has the appropriate privileges.

H. Operating Room Records

A roster of physicians and dentists currently possessing surgical privileges, with a delineation of the surgical privileges of each, shall be maintained in the surgical suite and available to the Director, Perioperative Services. There shall be an on-call schedule of physicians established and posted at the communications center of the Hospital to ensure that there is 24-hour emergency care or post-operative follow-up care, or both, available.

An Operating Room register/log shall be provided and maintained on a current basis. The Operating Room register/log shall contain the date and time of each operation, name and medical record number of the patient, names of surgeons and surgical assistants, name of anesthesiologists, type of anesthesia given, pre-and post-operative diagnosis, type of surgical procedure, and the presence or absence of complications in surgery.

I. Operating Room Attire

Proper attire is essential for all persons entering restricted areas. Anyone entering the Operating Room suite shall wear a scrub suit, a cap, which completely covers the hair, and, if supplies are open, a mask that completely covers the nose and mouth. All members of the surgical team must perform a surgical scrub, using one of the recommended procedures described in the Surgical Hand Scrub Policy.

J. Pathology Report

All tissues removed during a surgical procedure shall be properly labeled and sent to the Pathology Department for examination by the pathologist, who shall determine the extent of examination necessary for diagnosis as set forth in Section D of this procedure. All specimens must be accompanied by pertinent clinical information, including its source and the pre-operative and post-operative surgical diagnosis. Operating room nursing staff shall maintain a record of all specimen submissions and shall reconcile such list with the Pathology Division to ensure the specimen has been properly received and logged-in after the specimen had left the operating room. The Pathologist shall sign the report which shall become a part of the patient's medical record.

K. Incident/Patient Care Variance Reports

When an unusual incident occurs in the Operating Room, a report shall be made to the Director of Perioperative Services at once through the use of the Incident/Patient Care Variance Report. The report shall contain at least the following information:

- Time, place, and circumstances of the incident;
- The names of all persons involved in the incident and the names of all witnesses to the incident, if any;
- The condition of the patient; and
- The signature of the individual making the report.

III. Reference to applicable procedure or other pertinent policy.

Medical Staff Surgical Care Policy

Center for Surgical Care Policies and Procedures

Chapter 5: Intensive Care

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated, objective guidelines governing the care of critically ill patients.

II. Procedure

To provide a process for ensuring that patients are appropriately admitted and cared for in an intensive care unit (NICU, PICU or CICU).

A. Definitions

Intensive Care Unit is a hospital designated inpatient unit that provides critical care to patients whose condition warrants such critical care. Such units are the PICU, CICU and the NICU.

Designated Intensive Care Attending Physician is that member or members of the Attending Medical Staff who are members of the Neonatology Division or Critical Care Medicine Division and who are "on service" providing physician coverage in an intensive care unit, such as the CICU, NICU or the PICU.

B. Care of Intensive Care Unit Patients

A designated intensive care attending physician (neonatologist or critical care physician) shall aid in the care of critically ill children or neonates throughout the Hospital. There shall be a designated intensive care attending physician for all intensive care units (ICUs) within the hospital.

All patients admitted to an ICU (NICU, CICU or PICU) will be followed by an intensive care attending physician or designee appropriate to the needs of the patient and the setting of the patient's care. The intensive care physician will be responsible for supervising the provision of direct patient care, reviewing the course of each patient in the particular ICU at periodic intervals, communicating with referring physicians or their team and providing updates on the patients care to the family as needed. The intensive care attending physician shall be available at all times for consultation on specific patients or to answer specific questions about any given patient.

The designated intensive care physician may admit patients directly to the ICU where they have responsibilities in which case they shall become the attending physician with full authority and responsibility. An intensive care physician may accept admissions to the ICU where they have responsibilities by certain other medical services in which case the intensive care physician will provide co-care. A decision not to accept an admission to an intensive care unit shall be made by the designated intensive care physician. All designated intensive care physicians shall cooperatively make triage decisions for placement of patients into an ICU when resources are constrained.

The intensive care physician shall periodically review the course of selected former ICU patients on other patient care units, and shall direct questions and/or suggestions regarding such patients to the attending physician or his team.

C. Physician Staffing of an Intensive Care Unit

Physician staffing of an ICU will include in-house physician coverage 24 hours per day. After normal working hours, such coverage shall be provided by members of the particular ICU service, including fellows, nurse practitioners or other licensed independent practitioners, assigned to in-house call. An intensive care attending physician may be outside the Hospital

but shall be available through the paging system, and readily available to return to the hospital as needed.

A call roster for after hours, weekend and holiday duties shall be maintained as part of each ICU's staff coverage and provided to the hospital.

D. ICU Attending/Consultant Determination

Surgical attending physicians may serve as the patient's attending physicians when their patients are admitted to an ICU. The determination of such status shall depend on the patient's status on admission and the presence of additional medical problems. Such patients will receive routine care and co-management by the designated intensive care attending physician. Plans for patients care will be communicated between Surgical Attending and the ICU medical staff at periodic intervals. The Surgical Attending physician will retain ultimate authority and responsibility for their patients in an ICU.

Each ICU medical staff shall establish guidelines to enable the determination of the Attending or Consultant role that the designated intensive care attending physician fulfills in caring for patients admitted to an ICU.

Change of Attending (service) may be accomplished if both involved physicians agree and record such in the patient's medical record.

E. Admission Criteria

Patients shall be admitted to the ICUs according to the Admission and Discharge Policies that are available for this purpose.

F. ICU Admissions

All admissions to an intensive care unit shall be approved by designated intensive care attending physician or designee. In the event of a resource shortage, conflicting requests for admission will be resolved by the other designated intensive care attending physicians, the medical directors of the particular ICU or designee, the chiefs of the Neonatology or Critical Care Medicine Divisions or Chief Medical Officer, if necessary.

Requests for routine admissions to an ICU shall be communicated to the designated intensive care attending physician or designee. Requests for transportation to an ICU from another facility, another inpatient unit or from the Emergency Department to an ICU shall be coordinated through the designated intensive care physician for the intended ICU where the patient may be admitted. In the event that the surgeon or the anesthesiologist feels that emergency admission of a patient not previously planned for postoperative intensive care is required, the designated intensive care attending physician shall be notified and shall, when appropriate, authorize that the patient be admitted to the PICU as soon as arrangements can be made to transfer the patient from surgery or the Recovery Room. In all circumstances the designated intensive care attending physician shall communicate to the Hospital's Admitting Office of the patient's admission to an ICU.

Following certain major surgical procedures, the patient shall be admitted routinely to an ICU. At the time the surgeon schedules such a case with the Operating Room, a request for admission will be transmitted to the designated intensive care attending physician or designee by the surgeon. Need for postoperative PICU care should be noted on the daily Operative Schedule and pre-scheduling of such admissions is mandatory.

G. Transfer From an Intensive Care Unit to Another Inpatient Unit

As soon as the patient's condition warrants, the patient will be transferred to another patient care unit in the Hospital. The designated intensive care attending physician or his designee shall inform the particular ICU's charge nurse of the pending transfer. Registration and

Admissions shall be notified as soon as the attending physician determines that such a transfer may be accomplished. Registration and Admissions when necessary, shall find an appropriate bed for the patient in the care area so designated by the transfer orders.

H. Discharge From an ICU

In the event that a discharge is made directly from an ICU, it will be processed in the same manner as discharges from other Hospital units. The discharge will include a multidisciplinary approach to discharge planning and family teaching. Decision for either back-transfer to the referring hospital or transfer to a transitional care facility, will be made by the designated intensive care attending physician in consultation with the clinical care team. (see Admission and Discharge Policies for the NICU, CICU or PICU).

III. Reference to applicable procedure or other pertinent policy.

Admission Policy for NICU, CICU, PICU

Chapter 6 Medical Records

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to ensure that patients receiving treatment at any facility of Children's Hospital or under the care of CNMC-employed providers will have an adequate account of the care provided by those providers in the medical record.

II. Procedure

A. General Rules

An adequate medical record shall be maintained for each patient who is evaluated and/or treated at this Hospital as an inpatient or ambulatory patient or who is treated by a CNMC-employed provider in a consultative setting at another facility. A single attending physician shall be identified in the inpatient and ambulatory medical record as responsible for the patient at any given time. The attending physician shall be responsible for the preparation of a complete and legible medical record for each patient under his care. The contents of the medical record shall at all times be pertinent and current. Electronic documentation shall be used as the primary method for recording patient information. When the electronic system is unavailable (downtime) or unimplemented for a particular hospital service, handwritten entries in the medical record shall be made in black ink Symbols and abbreviations may be used in the medical record only when there is a legend to explain them. Prohibited abbreviations and symbols shall not be used in the medical record. All forms to be inserted in the patient's record must be approved by the Director of Health Information Management.

Transcribed reports that have been dictated by a trainee or other supervised provider shall be signed and forwarded to the supervising provider within 10 days of dictation. Reports that have not been authenticated by the supervised provider shall be automatically forwarded to the supervising provider on the 11th day if left unsigned.

B. Authentication

All entries in the record shall be dated, timed and authenticated by the person making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry in the medical record must be individually authenticated by the signature and title of the individual making the entry and the printed name, doctor #, or pager # or by the use of an "electronic authentication".

When rubber stamp signatures are authorized, the individual whose signature the stamp represents shall place in Health Information Management a signed statement to the effect that he is the only one who will use it. There is no delegation of the use of such a stamp to another individual.

Members of the Medical Staff who are issued electronic PINs (Personal Identification Numbers) or passwords for the purposes of authenticating orders or documents recorded electronically shall not divulge their PINs or passwords to other individuals. Unauthorized divulgence of the PIN shall constitute grounds for summary suspension from the Medical Staff and referral to the Medical Executive Committee for investigation and possible sanction. The sanction for divulgence of the PIN or password shall be expulsion from the Medical Staff of the Hospital.

C. Inpatient Medical Record Contents

A complete inpatient medical record shall include, when appropriate:

1. patient identification data;
2. date of admission and discharge;
3. history, including:
    a. chief complaint,
    b. details of the present illness,
    c. relevant past, social, and family histories;
4. provisional admitting diagnosis;
5. physical examination;
6. management plan;
7. medication reconciliation;
8. diagnostic and therapeutic orders;
9. consultation reports, if appropriate;
10. evidence of appropriate informed consent;
11. clinical observations, progress notes and nursing notes; and
12. reports of procedures, tests and the results, if appropriate, including:
    a. preoperative diagnosis and operative report,
    b. pathology reports,
    c. clinical laboratory reports,
    d. radiology and nuclear medicine examination and treatment reports,
    e. anesthesia records;
13. final diagnosis, condition on discharge, summary or discharge note; and
14. autopsy report, when performed.

D. History and Physical

For inpatient admissions, a complete history and physical examination shall be performed by a licensed independent practitioner with the appropriate privileges or a member of the house staff. The H&P shall be recorded, signed and dated within 24 hours of inpatient admission or before an inpatient undergoes surgery or an invasive diagnostic procedure. Whenever a house officer completes the H&P, the attending shall countersign the document within 24 hours or before surgery or an invasive diagnostic procedure. Unless specifically stated elsewhere, all members of the Medical Staff of Children's Hospital shall be privileged to perform and record a History and Physical on any patient admitted or contemplated for admission.

For ambulatory surgery or ambulatory invasive diagnostic procedures, the medical record shall document a thorough physical examination performed by a licensed independent practitioner within 30 days prior to the performance the procedure. The physical examination for ambulatory surgery patients shall contain, at a minimum, examination of the heart and lungs. A menstrual history shall be obtained on female patients.

For patients that are admitted by a dentist either as inpatients or as ambulatory surgery patients, the attending dentist shall record the dental history and dental examination as well as appropriate elements of the patient's record. Unless the attending dentist has been granted privileges to complete a history and physical examination, another member of the

medical staff with the appropriate privileges shall complete the history and physical examination consistent with the preceding paragraphs.

24 Hour Update: Surgical indications for the procedure and the H&P shall be updated within 24 hours of the ambulatory surgery or invasive diagnostic procedures by a licensed independent practitioner with the appropriate privileges at Children's Hospital. Within 24 hours of surgery, the attending surgeon shall document that the indications and plans for surgery have or have not changed.

The 24 hour update shall include documentation of a focused review of the patient (consisting of vital signs; relevant past medical history; anesthesia history; relevant review of systems; medications; allergies; as well as examination of the airway, heart, and lungs). An Anesthesia Assessment shall then be made regarding the severity of the patient's condition (American Society of Anesthesiology Physical Status). The Anesthesia Assessment shall not be an assessment of the surgical condition or need for surgery. The anesthesia preoperative assessment shall be completed and signed by an attending anesthesiologist within 24 hours of surgery. Immediately prior to induction, the patient shall be reassessed by the attending anesthesiologist who shall document that there are no changes or there are changes from the pre-operative status in the Anesthesia Record. As such, the anesthesia preoperative assessment along with the reassessment part of the anesthesia record may suffice for the 24 hour update of the history and physical exam. .

The H&P or admitting order shall contain the following information

1. Admission Status: Observation (23 hour admission) or Inpatient
2. Attending physician attestation as to the necessity of the admission, surgical procedure or potentially hazardous diagnostic procedure
3. The tentative discharge plan,
4. The estimated Length of Stay, and
5. The tentative plan of care

When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical examination reflecting any subsequent changes may be used in the medical record, provided the a copy of the original information is placed into the medical record. However, the admission attestation shall be completed for each hospital admission.

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the attending physician states in writing in the medical record that an emergency situation exists.

E. Progress Notes

Progress notes made by members of the Medical Staff and house staff should give a pertinent chronological report of the patient's course in the Hospital. Progress notes shall be legible, recorded, and dated and timed at the time of observation, and should contain sufficient content to ensure continuity of care if the patient is transferred. Daily progress notes shall be entered in the patient's medical record every 24 hours. Progress notes should be completed by the patient's care management team consisting of resident physicians, fellows, licensed independent practitioners and/or attending physicians to reflect changes in condition and any other necessary documentation. Pertinent progress notes shall also be made, when appropriate, by other practitioners who have been granted clinical privileges, and specified professional personnel, as approved by the Medical Executive Committee.

F. Operative Reports

All operations or potentially hazardous diagnostic procedures performed shall be fully described by the operator in the medical record. A preliminary operative or procedure report consisting of at least the following information will be recorded immediately following the procedure as a progress note and be immediately available after surgery or the procedure to provide pertinent information for use by any practitioner who is required to attend the patient:

1. a description of the findings, the technical procedures used, and the specimens removed;
2. the pre- and post-operative diagnoses; and
3. the surgical indications for the procedure;
4. the estimated blood loss;
5. the name of the primary surgeon and any assistants;
6. the method of anesthesia; and
7. the status of patient upon leaving the operating room

The completed report of an operation of a potentially hazardous diagnostic procedure shall be authenticated by the operator and filed in the medical record as soon as possible following the procedure. Any surgeon whose full operative report(s) is not dictated or written within 24 hours after surgery and not completed with 5 days shall have admitting, treatment, consulting, and operating privileges deferred, unless that surgeon is without fault.

G. Inpatient Admission Discharge Summaries

All relevant diagnoses established by the time of discharge, as well as all operative procedures performed and complications, shall be recorded in the electronic Diagnosis List, Procedure List and Discharge Summary note with no abbreviations, using acceptable disease and operative terminology. A discharge summary note shall be included in the medical records of all patients. All discharge summary notes should be authenticated (signed) by the attending physician.

The discharge summary note shall include the

1. reason for hospitalization;
2. the significant findings; any complications;
3. the procedures performed and treatment rendered;
4. the condition of the patient on discharge stated in terms that permit a specific measurable comparison with the condition on admission
5. the condition of the patient on discharge;
6. medication reconciliation; and
7. any specific instructions given to the patient or the patient's parent(s) or legal guardian, as pertinent.

When preprinted instructions are given to the patient, the patient's parent(s) or legal guardian, those instructions should be signed by the patient, the patient's parent(s) or legal guardian indicating receipt. A copy of the instruction sheet used shall be filed in the medical record.

In the event of death, a summation statement shall be added to the patient record either as a final progress note or as a separate record item. The final notation shall indicate those

findings required for discharge summaries as defined in this section and shall also include the exact time of death and the events leading to the death.

H. Ambulatory Medical Records

A medical record shall be maintained for every patient receiving ambulatory care services within the Hospital, Primary Care Centers, Regional Outpatient Centers or other satellite facilities or from a CNMC-employed licensed independent practitioner providing consultative services at another facility. The ambulatory record shall contain sufficient information to document the procedures performed and level of services rendered to the patient. The ambulatory medical record shall contain, where appropriate:

1. patient identification data;
2. date of ambulatory care and discharge;
3. relevant history of the illness or injury and physical findings;
4. diagnostic and therapeutic orders;
5. clinical observations, including results of treatment, where appropriate;
6. reports of procedures, test and results, where appropriate;
7. diagnostic impressions;
8. patient disposition and any pertinent instructions given to the patient or the patient's parent(s) or legal guardian for follow -up care;
9. immunization history, where appropriate;
10. allergy history, including drug allergy, if any;
11. adverse drug reactions, if any;
12. medication reconciliation;
13. pain assessment;
14. safety assessment;
15. informed consent, where appropriate;
16. growth chart, where appropriate;
17. consultation reports, where appropriate;
18. referral information to and from outside agencies as appropriate; and
19. patient summary list.

At the time of each ambulatory care visit, the licensed independent practitioner shall record on the ambulatory treatment record pertinent clinical observations, relevant patient history, treatment rendered, and follow-up care recommended. Except for primary care treatment records, such treatment record shall be forwarded to HIM for incorporation into the Electronic Patient Record System within 21 days of the outpatient encounter. Transcribed documents or reports, if prepared per divisional policy, of an ambulatory encounter shall be completed and authenticated within 30 days of the encounter.

The licensed independent practitioner shall maintain a legible patient summary list that includes known significant diagnoses; known significant operative and invasive procedures; known adverse and allergic drug reactions; and, medications prescribed for and/or used by the patient. A computer-based summary list shall suffice to meet this requirement.

Reports of laboratory tests, radiology examinations, and other diagnostic reports must be completed promptly and forwarded to HIM for incorporation into the Electronic Patient Record System by Health Information Management within 48 hours of receipt.

Upon death of an ambulatory patient, a summation statement shall be added to the patient record either as a final progress note or as a separate recorded item.

I. Access, and Release of Medical Records

All medical records are the physical property of the Hospital and shall not be taken from the confines of the Hospital. Copies of the Medical Records may be furnished in accordance with a court order, subpoena, or statute.

Upon written approval of the Institutional Review Board, access to the medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research.

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

Written consent of the patient, his parent(s) or legal guardian is required for release of medical information to those not otherwise authorized to receive this information.

Copies of a patient's medical record, if required, shall be available for use in Hospital or Medical Staff activities concerned with the monitoring and peer review. Clinical division/section chairmen may review patient care records to assess the quality of performance of each practitioner in their division. Medical record access shall be afforded to all medical staff members who are participating in the care of a patient. During the course of an ambulatory encounter medical information about that encounter may be released at the request of the patient.

J. Filing of Medical Record

All original records must be forwarded to Health Information Management for incorporation into the Electronic Patient Record System. An exception to this practice will be that original ambulatory medical records of primary care delivered at the Children's Health Centers will be filed in the medical records rooms of those respective clinics. A primary care medical record shall not be permanently filed until the practitioner completes it.

K. Delinquent Medical Records

(See also Patient Care Policy: Delinquent Medical Records for Inpatients and SSRU Patients)

On the day of discharge of a patient, that patient's medical record shall be sent to Health Information Management. HIM will notify the practitioner of any incomplete medical record. Medical Staff members should complete any medical records within 14 days of original allocation. Any practitioner with incomplete medical records at 30 days after patient discharge will be in non-compliance and such inaction will result in immediate deferral of the Medical Staff member's admitting, treatment, consulting, and operating privileges for both inpatient and outpatients, unless the practitioner is without fault. If deferment continues for three months, the Medical Staff member's clinical privileges and appointment to the Medical Staff may be relinquished. (See Medical Staff Bylaws, Article X, Part E, Section 1).

Ambulatory treatment records and other documentation for outpatient encounters are to be completed and filed with HIM with 30 days of the patient's encounter. Transcribed reports of ambulatory encounters, if required by divisional policy, shall be completed within 30 days. The Division Chief shall monitor the division compliance with completion of the documentation of an ambulatory encounter by providers in his division.

The Division Chief shall be responsible for completion of Medical Records that are not completed by a Medical Staff member due to resignation or disability.

L. Copying of Medical Records

Only authorized personnel may create official copies of medical records from the electronic medical record systems. The correspondence section of the HIM shall be responsible for the creation of medical record copies upon receipt of properly completed patient authorization or in fulfillment of appropriate governmental requests. In the event a patient transfers to another facility, Health Information Management shall be notified, where possible, two days in advance to enable the correspondence section to create a copy of the record. Members of the nursing staff may be authorized to create copies of medical records for emergency transfers or for transfers occurring on weekends and holidays. The creation of a copy of medical records by an unauthorized individual in any area of the hospital is specifically prohibited. Creation of copies of medical records for third party payors shall be under the direction of the Director of HIM.

M. Confidentiality

All members of the Medical Staff shall respect the confidentiality of patient information at all times. Accesses to medical information embodied in electronic form shall be recorded by the electronic medium and these accesses shall be monitored by the Director of HIM or his/her designee. Breaches of confidentiality shall be referred to the Medical Executive Committee for investigation and possible corrective action

III. Reference to applicable procedure or other pertinent policy.

Chapter 7: Informed Consent

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated guidelines governing informed consent for hospital admission, diagnostic or therapeutic procedures, administration of blood and blood products, and experimental or unproven therapies.

II. Procedure

A. Definitions

General Consent to Treatment: An authorization given by a person legally authorized to give consent on behalf of the patient or the patient him or herself, if he/she is legally authorized to consent on his/her own, at the time of registration or admission to perform diagnostic procedures or to provide medical treatment. (See Patient Care Policy CH PC# CO:1 General Consent to Treatment)

Informed Consent: The process by which special consent to a procedure and/or administration of blood or blood products is obtained from a person legally authorized to give consent on behalf of patient and/or the patient him or herself, after being informed of the nature, risks and consequences, alternatives, prognosis if the procedure is not done, and probability of success. Surgical or diagnostic procedures for which informed consent should be obtained have been approved by the medical staff and are appended below.

Emergency: A condition, which in the judgment of the health care provider, manifests symptoms of sufficient severity, including severe pain, such that absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy or result in serious impairment or dysfunction of bodily organ functions or unduly prolong suffering.

B. Responsibility for Obtaining Consent

The hospital's admission/registration consent form, inpatient or outpatient, must be signed by the patient's parent, guardian or adult authorized caregiver, or by the patient him or herself if legally authorized. Registration and Admissions should notify the attending physician whenever such consent has not been obtained.

After admission, it is the responsibility of the appropriate physician(s) to obtain informed consent from the parent, guardian, or adult authorized caregiver or the patient him or herself as follows:

1. The surgeon performing the surgical procedure.
2. The physician performing a potentially hazardous diagnostic or therapeutic procedure which carries a significant risk of complication.
3. The anesthesiologist administering general anesthesia.
4. Any physician administering conscious sedation.
5. Any physician for the administration of blood or blood products.

Additional procedures contemplated to be performed that fulfill the above criteria require an additional informed consent. If two or more specific procedures are to be done at the same time and this is known in advance, they may all be described and consented to on the same form. If a series of diagnostic and/or therapeutic procedures is anticipated during an in-patient hospitalization, one consent for the hospital stay may be obtained.

Consent for the administration of blood and blood products should be obtained by the attending physician or designee and a blood information sheet should be provided. Consent for blood products is effective for 6 months.

A durable, written consent may be given for serial, minor invasive procedures, such as lumbar punctures or bone marrow aspirates, that are part of an ongoing treatment plan. Such consent shall be effective for 6 months. A material change in the ongoing treatment plan shall require a new durable written consent.

C. Who May Consent

In general, a parent, guardian or adult authorized caregiver must give consent to treatment. A competent adult (18 years of age or older) or an emancipated minor, in the jurisdiction where a procedure is being performed, may authorize his own medical care and treatment, including surgery, and the consent of no other person is required or valid. See Patient Care Policy, General Consent to Treatment for definitions and list of who may consent, including emancipated minors and adult authorized caregivers.

Written informed consent shall be obtained from the parent, legal guardian or adult authorized caregiver of a minor patient before any surgical or medical procedure is performed or for the administration of blood or blood products on the minor except for emergency care and care for which a minor may consent on his or her own behalf (treatment of sexually transmissible disease, pregnancy, substance abuse, and psychological disorders. See Patient Care Policy, Role of Minors in Health Care Decision Making.)

Whenever the patient is unable to legally execute an informed consent because of his age (a minor) or his condition (an emancipated minor but unconscious), every effort shall be made and documented to obtain the consent of the patient's parent(s) or legal guardian prior to the procedure.

D. Implied Consent for Emergencies

Consent to treatment is implied for emergency care. A physician or dentist may provide treatment to any patient suffering from an emergency medical condition without first obtaining the consent of the parent, guardian, or patient and if that is the case it should be documented in the medical record. The note should be signed by the treating physician and another physician involved in the care, preferably, an attending physician.

Consent to treatment is also implied for care in the intensive care units. The intensive care units should provide a written information sheet outlining generally the nature of invasive treatments expected in the intensive care unit.

When treatment for an emergency medical condition is begun, on the basis of implied consent, attempts should be made to contact the parent or guardian as soon as possible. Telephone consent is permissible as long as it is obtained by a physician and witnessed and documented by a hospital employee.

Potentially hazardous diagnostic or therapeutic procedures involving serious risks and the use of anesthesia will not be permissible without parental or legal guardian consent unless the attending physician or attending surgeon believes that such treatment is the only alternative to prevent probable death, permanent serious physical damage, or serious complications which might result from delay caused in obtaining parental or legal guardian consent. Before potentially hazardous diagnostic or therapeutic procedures are begun without parental or legal guardian consent, the written concurrence of another physician shall be obtained and documented in the patient’s medical record with each physician stating why such treatment is immediately necessary.

E. Unusual Cases

Where questions or unusual circumstances arise regarding informed consent, the physician may consult with hospital management, either legal or medical, concerning the ability to secure consent, the presence of an emergency condition or the need for the appointment of a guardian in general. However, obtaining informed consent is the ultimate responsibility of the attending physician.

III. Reference to applicable procedure or other pertinent policy.

Policy: Medical Staff Informed Consent Policy

Children's Hospital Informed Consent Policy and Procedure

Procedures requiring informed consent

Chapter 8: Medications

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated guidelines related to the ordering and delivery of medications.

II. Procedure

A. General Rules

All drugs and medications administered to patients shall be listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Service," "A.M.A. Drug Evaluations," or in the electronic provider order entry system, with the exception of drugs for bona fide clinical investigations whose use is in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and approved by the Pharmacy and Therapeutics Committee and/or Institutional Review Board. A copy of the Hospital Formulary shall be located in each patient care area or available from hospital electronic information systems. Additions and deletions to the Hospital Formulary shall be governed by the Pharmacy and Therapeutics Committee consistent with its charter in the Medical Staff Bylaws.

When drugs not in the Formulary are ordered for patients by medical staff members licensed to prescribe drugs, each drug will be secured and a special charge made to the patient as set forth in the Hospital's medication policies. The Pharmacy may require 24-48 hours to obtain a supply for the patient.

Medications used for patients in Children's Hospital shall be supplied by the Hospital Pharmacy Service, except as provided in the Medication Patient Care Policy. A pharmacist shall prepare or supervise the preparation of intravenous solutions with additives, injectables, or unit dose medications for administration by appropriately licensed practitioners. When ordered electronically, each drug dose shall be recorded electronically in the electronic medication administration record (MAR) of the patient, and properly signed after the drugs have been administered. No unattended medications, including pre-filled syringes, shall be kept at the bedside of a patient, except medications used in the treatment of patients highly susceptible to anaphylactic reactions and topical preparations used in routine diaper care (See Medication Policy).

B. Patient's Own Drugs

No patient or other individual may bring his own medications to the Hospital or order from an outside source any medication for his use, except in those situations specified in the Medication Policy and those for controlled research. Clinical supplies or drugs for investigational use must be recorded with the Pharmacy Service before they may be used in the Hospital.

If a patient has in his possession medications which are not ordered by the attending physician, they shall be taken from the patient at the time of admission, packaged, sealed and returned to the patient, his parent(s) or legal guardian at the time of his discharge from the Hospital. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act shall not be returned to the patient without approval of the attending physician.

C. Medication Errors and Adverse Reactions

Any medication error or apparent drug reaction shall be reported immediately to the physician who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall be properly recorded in the adverse reaction portion of the

medical record of the patient. Any adverse drug reaction shall be immediately reported to the Pharmacy by telephone or in writing and recorded in the medical record of the patient in a conspicuous manner, in order to notify everyone treating the patient throughout the duration of his hospitalization of this drug sensitivity. (See Adverse Drug Reaction Patient Care Policy)

D. Medication Orders

All medications orders that can be entered in the electronic provider order system shall be so entered. The order must be charted so that it may become part of the patient's permanent record. If the medication order must be written, it must be signed legibly by the medical staff member licensed to prescribe medications initiating such an order, dated and timed when written. Each medication order must comply with the requirements set forth in the Medication Policies patient care policy including the following:

1. the medication requested;
2. the route of administration;
3. the dosage utilizing the metric system;
4. the frequency of administration; and
5. the date and time the medication order was written.

The pharmacist may make necessary changes in the medication orders after consulting with the prescribing medical staff member. The pharmacist shall record the physicians' verbal order in the electronic provider order entry system or on a written order sheet that will be sent with the medication to the nursing unit. All medication order forms and medication clarification forms shall be filed as a permanent part of the patient's medical record.

Outpatient medication orders shall comply, to the extent possible, with the requirements for all medication orders.

A medication order for a narcotic or Class II drug shall have an automatic soft stop order after 48 hours unless the order contains a specific duration of time or a specific number of doses. Ketorolac orders shall automatically stop after 5 days. Antibiotic orders shall have an automatic soft stop after 7 days unless the order contains a specific duration of time or a specific number of doses. The Pharmaceutical and Therapeutics Committee may specify additional medications that require hard or soft stops within the provider order entry system.

All orders for medication renewals must be entirely rewritten or reviewed by computer-generated renewal list with the physician's signature.

When a patient transfers from surgery to another service, or when the level of care changes necessitating the transfer of the patient from one unit to another, all previous medication orders shall be authenticated, canceled and any renewals must be entirely rewritten. When a patient is transferred with no change in service or level of care the medication orders need not be rewritten.

E. Administration of Medication

A patient may self-administer medication or a parent(s) or legal guardian of a patient may administer medication to the patient when such administration is ordered by a medical staff member licensed to prescribe drugs and when such administration is under the appropriate supervision and documentation by the nursing staff. If medications are allowed to be self administered, hospital procedures governing the safe self-administration of medications must be followed. These include assuring adequate training and competence of the patient or caregiver (including the nature of the medications, how to administer, including dose,

frequency, route, expected actions and complications, and monitoring the effects of treatment), supervision and documentation of administration

III. Reference to applicable procedure or other pertinent policy.

M1 and Other Hospital Policies and Procedures (M1-34) governing medication administration

Chapter 9: Discharges

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated, objective guidelines governing the care of patients being discharged by appropriately credentialed and licensed providers at Children's Hospital.

II. Procedure

A. Discharge Responsibilities

The discharge summary note shall be completed prior to discharging a patient. Patients shall be discharged on a written order of the attending physician or his designee. The unit nurse may accept a telephone order for discharge, but such order must be countersigned within 24 hours of discharge.

Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record. When possible, the patient, his parent(s) or legal guardian shall be asked to sign the Hospital's release form.

B. Discharge Planning

Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission.

1. Tentative discharge plans shall be written in the progress notes, History & Physical, and/or the Admission order upon patient admission.
2. Discharge plans shall be written in the progress note 24 hours prior to impending discharges when possible.
3. Patients should have their prescriptions, final instructions, and any referrals finalized and reviewed with the patient, his parent(s) or legal guardian at least 24 hours prior to discharge when possible.
4. Discharges should follow the priority discharge process when applicable to the particular patient.
5. Information given to the patient, parent(s) and/or legal guardian on matters such as the patient's condition, health care needs, activities, medical regimens, if any, including drugs, diet, or other forms of therapy, sources of additional help from other agencies, and procedures to follow in case of complications shall be provided by the attending physician or his designee, and should be stated in non-technical, layman's language so that it may be easily understood and followed. This information and the discussion shall be documented in the medical record.

C. Discharge from Post Anesthesia Care Unit

The surgeon shall remain in the Operating Room area until his patient is admitted to the Post Anesthesia Care Unit. The surgeon or a designated resident must write post-operative orders before the patient leaves the Operating Room suite. An anesthesiologist shall write orders discharging the patient from the Recovery Room. In some circumstances, the discharge of patients from the short stay recovery unit may be performed by a nurse and shall be governed by established discharge criteria. (See Discharge Criteria Recovery Room Patients Patient Care Policy.)

D. Transfer of Patients

A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient. The transporting of patients shall comply with the Transport of Patients Patient Care Policy.

E. Discharge of Minors

Any patient who cannot legally consent to his own care shall be discharged from the Hospital only to the custody of his parent(s) or legal guardian, or a person standing in loco parentis, unless otherwise directed by the parent(s), legal guardian or court order.

If the parent(s) or legal guardian directs that discharge be made otherwise, that individual shall so state in writing, or by telephone consent where approved, and the statement shall become a part of the permanent medical record of the patient.

When the originally authorized person indicated on the Hospital consent to admission form is unable to receive the patient at discharge, the following procedures must be implemented:

1. The person coming to take the child home must be 21 years of age or older and must have a written document from the person who authorized the child's hospitalization granting the discharge and the bearer of the document by name permission to receive the child;
2. The consent form must be signed in the appropriate place by the person receiving the child, and that person's identity must be noted on the form as well as the relationship to the patient (i.e., sister, uncle, grandmother, etc.); and
3. The permission document must be securely attached to the consent form and must be placed in the patient's medical record.

F. Autopsies and Disposition of Bodies (See also: Death of a Patient Patient Care Policy)

Consent to autopsy should be sought from the patient's nearest blood relative, and thus should follow the patient's line of consanguinity. If the patient's parents are living together, either may give consent; if they are living apart by court decree, the parent having legal custody of the patient must give consent. If there are no parents, the following persons may consent in order of preference shown below:

1. patient's legal guardian;
2. grandparents;
3. brother or sister, if 21 year of age or older; or
4. aunts and uncles.

Parents with legal adoption papers have legal guardian status and may consent to an autopsy.

The remains of any deceased patient, including a neonatal death, shall not be subjected to disposition until:

1. The death has been officially pronounced by a physician or resident;
2. The event has been documented adequately within a reasonable period of time by the attending physician or another designated Medical Staff member or resident; and

3. Consent has been obtained from the parent(s) or legal guardian, or responsible person.

Completion of the death certificate shall be the responsibility of the attending physician and shall be completed within 24 hours of death.

It shall be the duty of all Medical Staff members to request consent to autopsies of every patient dying in the Hospital whenever possible. An autopsy may be performed only with proper consent in accordance with District of Columbia law and Hospital policy.

G. Medical Examiner

It shall be the responsibility of the attending physician or his designee to notify the Medical Examiner of any of the following:

1. All cases, even with physician care, which suggest that death was violent, suspicious in nature, or was the result of other than natural causes.
2. All cases of death from suicide or homicide, poisoning or other criminal act.
3. All deaths from accidents of any type (auto, industrial, home, burns, shock, etc.) where the death occurs within a period of one year and one day following the accident.
4. All cases of criminal assault or any cases in which external violence acted as a contributing cause and where death occurred within a period of one year and one day after such violence.
5. Any death occurring in the Operating Room or within twenty-four (24) hours of an anesthetic.
6. All cases where the cause is under reasonable suspicion or in which a definitive diagnosis cannot be made with reasonable certainty.
7. Any death which has occurred without medical attendance, including DOA's.
8. Any deaths required under District of Columbia law, codes, rules and regulations to be reported to the medical examiner.

Chapter 10 Resident Supervision

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to have clearly articulated guidelines governing the care of patients provided by medical trainees including the documentation of such oversight in the medical record. This oversight is in accordance with the requirements established by the JCAHO.

II. Procedure

A. Definitions:

The term House Officer is used as a generic term to include interns, residents and fellows in a physician training program at Children's Hospital.

B. Roles/Responsibilities:

1. Medical Staff Members

Medical Staff members are responsible for guiding House Officers in the various aspects of child health care delivery. The attending physician shall be the responsible party for all care that is delivered to patients under their care and shall be immediately available to House Officers for questions or care concerns related to the attending physician's patients. House Officers must be supervised by teaching staff in such a way that the House Officer assumes progressively increasing responsibility according to their level of education, ability and experience. On-call schedules for teaching staff must be readily available to ensure that supervision is accessible to House Officers on duty. The level of responsibility accorded to each House Officer must be determined by the attending physician.

2. House Officer

The House Officer, in conjunction with the attending physician, is responsible for the care of the patient. The House Officer may participate in all aspects of caring for the patient commensurate with their education and training. This includes but is not limited to performing the admission history and physical examination, writing medical orders, obtaining consent, performing procedures, calling for consultations, discharging patients, communicating with the patient's family or other members of the healthcare team, and documenting their care in the medical record.

House Officers must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. The House Officer must know the graduated level of responsibility described for their level of training and not practice outside of that scope of service. Failure to function within graduated levels of responsibility or to communicate significant patient care issues to the responsible attending physician may result in the removal of the resident from patient care activities.

The House Officer caring for a patient is responsible for notifying the attending physician of changes in condition, transfers to a higher level of care, and adverse outcomes occurring to the patient. The House Officer also communicates with the patient's attending physician for consultation regarding the care plan and alterations in the care plan related to changes in a patient's status.

3. Training Program Director

Each Training Program Director is responsible for the quality of overall trainee education and for ensuring that their program is in compliance with the policies of the respective accrediting and certifying bodies. The Program Director defines the levels of responsibility for each year of training by preparing a description of types of clinical activities residents

may perform and those for which residents may act in a teaching capacity. The Program Director monitors resident progress and ensures that problems, issues, and opportunities to improve education are addressed.

4. Graduate Medical Education Committee

The Graduate Medical Education Committee of the Medical Staff provides oversight to the physician educational programs in the institution.

C. Documentation:

Evidence of resident supervision must be documented in the form of signed notes in patient records. These include attending physician countersignature on history and physical exams, attending physician countersignature on operative reports, and attending physician countersignature on the discharge summaries. Attending physicians do not need to countersign progress notes if they are providing their own note on the patient's progress

The Chief Medical Officer, Chief Academic Officer, and Medical Executive Committee are responsible for assuring adequate monitoring of resident supervision. Each Program Director is responsible for monitoring resident supervision, identifying problems, and devising plans of action for their remedy.

At a minimum, the monitoring process will include:

- Compliance with documentation requirements, as part of medical record reviews;
- A review of all serious risk events with complications to ensure that the appropriate level of supervision occurred;
- A review of all accrediting and certifying bodies' concerns and follow-up actions;
- A review of resident evaluations of their faculty and rotations; and
- A review of all tort claims involving residents, to determine if there was an appropriate level of supervision.

III. REVIEW OR REVISION DATE

The policy and procedure were originally approved on 05/04 and revised 11/04 and 04/07

IV. Reference to applicable procedure or other pertinent policy.

Policy: Medical Staff Resident Supervision Policy

Chapter 11 Peer Review

I. Policy Statement

The Hospital provides clinical services that are consistently of the highest quality and that are streamlined in their delivery. Medical Staff Members are accountable to themselves, each other, their patients, and to the organization for the care that they provide. Constructive comments from practitioners with a similar professional background will assist the provider in identifying opportunities and methods for improvement.

The Peer Review Process is designed to provide a systematic, intradisciplinary method of improving patient care by identifying opportunities for members of the medical staff and other licensed independent practitioners to improve their clinical performance. It is meant to be part of a review of quality that is impartial, privileged and confidential. There are two components to the peer review process

- Ongoing professional practice evaluation (OPPE) which provides for semi-annual evaluations of a member's practice in the context of the privileges granted and of the member's adherence to applicable hospital and medical staff policies and procedures.
- Focused professional practice evaluation which provides for review of a member's particular performance of a granted privilege during the initial exercise of a newly granted privilege and whenever questions are raised about a member's ability to exercise a particular privilege.

In some circumstances a special peer review process may be utilized to ascertain whether a member's has provided care that has deviated from accepted standards. To assist in making this determination, a Division Chief may use an event-based peer review methodology that assists in assessing culpability.

II. Procedure

To provide a process for ensuring that appropriate procedures are in place for peer review activities.

A. Definitions:

Medical staff member: Physician and non-physician professionals who are appropriately licensed and credentialed to provide clinical services to patients at the Hospital.

Licensed independent practitioner: A member of the medical staff who has clinical privileges, including physicians, dentists, psychologists, and nurse practitioners.

Peer: Healthcare practitioners with similar training, experience, and credentials.

External peer: Peer from outside of the discipline or Hospital asked to consult on a peer review issue.

Core Privilege(s): Shall be those privileges designated as Core Privileges on the Delineation of Privilege Document.

B. Responsibilities of participants:

Chief Medical Officer:

- Provides direction and guidance to the Executive Directors of the Centers, Division Chiefs and practitioners in regard to routine peer review activities.

- Assures an impartial, evidenced-based process that is thorough and confidential.
- Intervenes if immediate action regarding an individual's performance is necessary to protect patients, staff, or the hospital, which could include summary suspension.
- In the event of a special circumstance review, the Chief Medical Officer or his designee can convene a peer review team to help determine if an action lies outside of the standard of care and to what degree.
- Notifies the Medical Staff President if a physician performance issue is of concern.

Executive Director:

- Is responsible for implementation, monitoring, consistency, and oversight of peer review process at the level of individual disciplines as it relates to the Center's performance improvement initiatives.
- Intervenes if immediate action regarding an individual's performance is necessary to protect patients, staff, or the hospital.
- In the event of a special circumstance review, the Executive Director can serve as a member of the peer review team to help determine if an action lies outside of the standard of care and to what degree.

Medical Staff President:

- Helps to assure an impartial, evidenced-based process that is thorough and confidential.
- Is responsible for the medical staff process of peer-review including notification of the Medical Staff Credentials Committee, the Medical Executive Committee and the Board of Director's Professional and Affairs Committee if practitioner performance is an issue.
- In reviewing and reporting Clinical Effectiveness Committee Minutes to the Medical Executive Committee, may recommend actions in regard to routine peer review activities.

Division Chief:

- Identifies criteria and mechanisms for peer review. May delegate the peer review to a "peer" of the practitioner.
- Evaluates the medical staffs' performance.
- Helps to assure an impartial, evidenced-based process that is thorough and confidential.
- May utilize an event-based methodology that assesses potential culpability through a guided classification of human error.
- Communicates to the Center Executive Director and to the Clinical Effectiveness Committee circumstances where a patient event may have been caused by system error.
- Provides guidance and counseling to the medical staff member where variances in care are identified and identifies opportunities and strategies for improvement.

- Implements the peer review recommendations through performance improvement initiatives.
- Provides peer review documentation to Center Executive Director, which will be considered, when appropriate in the practitioner's reappointment.
- Shall oversee and conduct a program of Ongoing Professional Practice Evaluation in accordance with this policy and procedure.
- In the event of a special circumstance review, the Division Chief may serve as a member of the peer review team to help determine if a member's action lies outside of the standard of care and to what degree such action is outside of the standard of care.
- If the member is deemed "Impaired" appropriate referral is instituted (See Medical Staff Bylaws).

Member:

- Is informed of and held accountable to the Hospital and Division's peer review activities.
- Has the right to receive notification, guidance and counseling in the event of identified variances of care and the opportunity to participate in that process.
- Is entitled to an impartial, evidenced-based process that is thorough, confidential, and timely.
- Works with the Division Chief to identify opportunities for improvement.
- Recognizes a personal responsibility to provide quality care that is efficient.

Peer:

- May be solicited to provide an impartial evaluation of the performance of a medical staff member.

Medical Executive Committee:

- Is responsible for the oversight and monitoring of the peer review process as it involves practitioner performance issues that may require corrective action including a restriction of the practitioners privileges or medical staff membership

C. Ongoing Professional Practice Evaluation:

Each Division shall select, document and monitor specific performance criteria at the provider level and report them to the Medical Executive Committee through the Center Executive Director on a semi-annual (every 6 month) basis. The Chief Medical Officer or delegate may implement a uniform tool for the Ongoing Professional Practice Evaluation. The assessment of the member's clinical activities are part of the Ongoing Professional Practice Evaluation may be delegated to a member's peer.

Criteria for consideration, where the data is available, include:

- morbidity and mortality data;
- patient and colleague complaints;
- patient/parent satisfaction issues;
- medication errors;

- adverse drug events;
- other data or activities of interest and importance to the Division including assessment and measurement of improvement activities with clinical importance;
- procedure use and complication rates; or
- adherence to appropriate practice standards-i.e. immunization rates, timeliness of documentation.

Data collected and reported to the Performance Improvement Department shall also be analyzed for trends that may provide opportunities for improving the performance of individual practitioners. Such data may include:

- documentation variances;
- autopsy requests;
- tissue discrepancies;
- blood use;
- surgical case review;
- length-of-stay outliers;
- division chief and Medical Unit Director assessments, where applicable, of the member's performance in areas designated by the ACGME pillars of graduate medical education;
- denials ; or
- ORYX and other indicators of clinical importance

The Division Chief is responsible for identifying areas of potential improvement pertinent to quality of care that arise from the Division's peer-review and ongoing professional practice evaluation process. If a trend is identified, a strategy for follow-up, that may include a Focused Professional Practice Evaluation, shall be incorporated into the Division's performance improvement activities and reported through the appropriate Center to the Clinical Effectiveness Committee and to the Medical Executive Committee of the Medical Staff. If a trend is identified with a particular privilege a Focused Professional Practice Evaluation may be implemented.

A Focused Professional Practice Evaluation may also be implemented when the OPPE identifies trends in objective practice measures that lie outside of two standard deviations from the mean of all practitioners.

D. Focused Professional Practice Evaluation (FPPE)

For newly granted privileges to a practitioner or for privileges that a practitioner infrequently exercises, a focused professional practice evaluation shall be implemented for a specific number of patients' cases where this privilege is exercised. The FPPE shall be conducted by the division chief. For Core Privileges the FPPE shall consist of a retrospective chart review of the first 10 cases where the new core privilege or privileges were exercised. The FPPE of specifically delineated privileges shall be accomplished through either retrospective chart review or direct observation of a designated, in advance, number of cases where the privileges are exercised Direct observation shall be conducted by the division chief or designee The FPPE criteria for specially delineated privileges (retrospective review or direct observation and the number of cases) shall be established by the division chief and shall be approved by the Credentials Committee, Medical Executive Committee and the

Board of the Hospital, and may be implemented after approval by the Credentials Committee.

E. Issues giving rise to a Focused Professional Practice Evaluation

Concerns regarding individual practitioner performance may be identified by standing committees or Departments from within the organizational structure of the Hospital that have responsibility for patient care. They include:

- Medical Executive Committee
- Clinical Effectiveness Committee
- Office of the Chief Medical Officer
- Risk management
- Human resources
- Nursing administration
- Customer relations

F. Special Circumstances

In addition, concerns regarding member performance and behavior may also arise from individual employees, or members of the nursing and medical staffs. These concerns represent special review circumstances that may be clarified by the use of a peer-review process. In these cases, a member's peers may be the best judges of whether or not a standard of care was upheld and to what degree.

The member has the right to request external peer review, through an appeals process, if the expertise or objectivity of the Department or Institution is felt to be inadequate or if the medical fact is considered a "minority view".

On occasion, the Division Chief may be informed about variances in care regarding one of the members in their Division from a source located outside of the Division. Under these circumstances, it is incumbent upon the complainant to provide the Division Chief with the data substantiating these allegations. Upon review, if an immediate threat to patients, employees, or the institution is perceived, the Division Chief shall notify the Chief Medical Officer and the Center Executive Director so that corrective action may be implemented as directed under summary suspension.

For concerns that do not require immediate attention, the Division Chief shall notify the member and discuss the concerns directly with that practitioner. In these discussions, the Division Chief shall provide the practitioner with the documentation provided in order to allow the practitioner to explain the circumstances surrounding the event. During this meeting, if the concerns are substantiated, a plan for improvement may be outlined. After reviewing and considering all information and insight from the physician, the Division Chief shall make recommendations for improvement. This process including data review, member discussion, and plan for improvement should not exceed four weeks.

If in the opinion of the member the complaints are not substantiated, the member has the opportunity to justify their actions by providing appropriate evidence to the contrary. This evidence can include textbooks, journal reviews or peer consultation. The member has four weeks to provide this documentation and follow-up with the Division Chief.

If corrective action that could affect either the medical staff membership or privileges is possible, the Division Chief will refer the matter to the Center Executive Director and the Chief Medical Officer, who shall notify the Medical Staff President. Once referred, a Special Circumstance peer review team may be commissioned. The peer review team will consider

the facts, circumstances, and issues of the case in order to determine if the standard of care was maintained. If in the peer review team's opinion the quality of the care can be improved, specific suggestions will be provided. The member is entitled to an objective and timely review that is confidential and non-judgmental. This process including data review, identification and consultation of a peer review team, and plan for improvement should not have a duration that exceeds six weeks. Official results of the peer review team's consultation will be provided to the member, Division Chief, the Executive Director, Medical Staff President, and the Chief Medical Officer. Upon renewal of medical staff privileges, the Medical Executive Committee will determine what, if any, corrective actions need to be imposed.

The Division Chief shall review the information and recommendations of the Peer-Review team, act upon them as appropriate and provide counseling to the member.

G. Non-physician licensed independent practitioners:

Performance or quality of care issues related to non-physician members of the medical staff shall be referred to the Division Chief for review and disposition. Non-physician members shall be required to participate in ongoing and focused professional practice evaluations according to the privileges granted.

Performance or quality of care issues related to hospital policies, procedures, or other processes shall be referred to the appropriate department or to the Performance Improvement Committee when appropriate.

H. Timeliness of Peer Review Activities

Each Division shall define the frequency of peer review activities. However, a summary of these activities should be incorporated into the performance improvement reports from the Division to the Executive Director at least quarterly. The Executive Director will report this information to the Clinical Effectiveness Committee at their scheduled update. In the event of a patient-related review the time frame should be within one month of the occurrence or the month following discharge.

I. External Peer Review

An external peer reviewer may be considered and requested in the event that the member, Division Chief, the Executive Director or the Chief Medical Officer identifies the need for expertise or objectivity not available within the Department or Institution.

J. Credentialing

At reappointment and in an ongoing manner any concerns with member competence, patient care results or confidential physician activity profiling activities shall be forwarded to the Credentials Committee by the Division Chief and considered for use in the credentialing and reappointment process. The President of the Medical Staff shall report to the Board of Directors on performance and maintenance of quality of care of the professional medical staff.

III. Reference to applicable procedure or other pertinent policy.

Sentinel Event Policy, Peer Review Policy, and Impaired Physician Chapter of the Medical Staff Bylaws

Chapter 12 Privilege Deferment

I. Policy Statement

It is the policy of Children's Hospital and its Medical Staff to ensure that when a Medical Staff member's membership and privileges are deferred for failure to complete all Medical Records, or for expiration of licenses or malpractice insurance, that to the greatest extent possible such deferrals shall not disrupt patient care.

II. Procedure

This procedure provides a process for ensuring that ensures that deferment of a Medical Staff member's privileges shall minimize the disruption to ongoing patient care.

A. Deferral Due to Medical Record Deficiencies

1. The deferred individual and the division chief shall be notified of the impending deferment by e-mail. Failure to read e-mail shall not constitute an excuse for failure to be notified.
2. At the time that a member is placed on the deferment list due to Medical Record Deficiencies, the division chief or designee shall be notified by the President of the Medical Staff or designee. The deferred member shall be allowed to complete any scheduled patients for that day and be allowed to perform scheduled patient care activities for the next business day. The member's schedule for patients shall be "frozen" at the time of placement on the deferment list.
3. If by 12:00 noon on the first business day after the member's privileges are deferred, the member has remained on the deferment list, the member's scheduled cases shall be cancelled for the next business day and cascading each day for the next business day as long as the deferment continues. The admitting office of the hospital and surgical scheduling office shall be notified of the frozen schedule and the possibility of case cancellation.

   For example, if Dr Smith is deferred for medical record deficiencies at 10:00 AM Monday, Dr Smith shall be allowed to complete any scheduled patients for Monday and all patients for Tuesday. If Dr Smith is still on the deferment list at 12:00 noon Tuesday, his cases for Wednesday shall be cancelled. If Dr Smith is still on the deferment list at 12:00 noon Wednesday, his cases shall be cancelled for Thursday, and so on.

B. Deferral Due to Lapse of Malpractice Insurance or Lapse of principal occupational license

1. The division chief and the member shall be notified by the President of the Medical Staff or designee when a member's privileges are deferred for lack of malpractice insurance or expiration of principal occupation license.
2. The Member's privileges shall be deferred immediately for the jurisdiction where the lapse has occurred, and any scheduled patient care shall be cancelled or performed by another member of the medical staff in good standing. The member's scheduled future cases or patients shall be cancelled for either the jurisdiction where the license has lapsed or for all patients when malpractice coverage has lapsed.

C. Due to Lapse of Narcotics Licenses for the jurisdiction

1. The division chief and the member shall be notified by the President of the Medical Staff or designee when a member's privileges are deferred for expiration of a jurisdictional narcotics license.
2. The affected member shall be required to provide proof of application for the lapsed license within 2 business days after notice of the potential deferment. After 2 business days without proof of application, the member's privileges shall be deferred for the jurisdiction where the narcotics license has lapsed with cancellation of any scheduled patients until such time as evidence of application has been supplied.
3. If it is determined that a member is unable to obtain a narcotics license, then the individual's membership and privileges shall be suspended pending an investigation of the circumstances.

D. Due to Lapse of Health Attestation

1. The division chief and the member shall be notified by the President of the Medical Staff or designee when a member's privileges are deferred due to expiration of the health attestation certificate.
2. The member shall be required to provide the required attestation of health within 7 days of notification. Absent provision of the certificate of health attestation within 7 days, the member's privileges shall be deferred until such time as the attestation of health has been supplied.

Chapter 13: Medical Staff Code of Conduct

I. Policy

It is the policy of Children's Hospital and its Medical Staff that all individuals be treated with courtesy, respect and dignity. To that end, all members of the Medical Staff must conduct themselves in the manner set forth below. Members of the Medical Staff shall conduct themselves with dignity and professionalism at all times. Offensive, insulting language or inappropriate physical behavior toward colleagues, nurses, employees, patients, their families, or visitors will not be tolerated. It is recognized that stressful situations may arise constituting a challenge for the Medical Staff member. Nonetheless, the Medical Staff member's response must always be expressed with dignity, patience, insight, and professionalism. Collegial interactions should be calm and polite. Performance critiques of a Medical Staff member or any other member of the hospital staff should be discussed in an appropriate setting and directed toward a positive learning experience. This policy and procedure outline procedures to follow when members of the Medical Staff do not appropriately conduct themselves. The Medical Staff shall enforce this policy in a firm, fair and equitable manner. Members of the Children's Hospital Medical Staff who are also employees of Children's Hospital shall also be subject to the Children's Hospital Human Resources Policies and Procedures regarding conduct and discipline and, in addition to actions taken under this Policy and Procedure, shall be subject to corrective action and discipline by Children's Hospital for conduct that may be covered by this policy and procedure.

II. Procedure

A. Definitions

Disruptive Conduct: Disruptive conduct is defined as conduct that adversely affects the Hospital's ability to accomplish the objectives stated above including, but not limited to, the following:

a) Verbal attacks;

b) Any type of physical attacks of any sort or behavior that threatens a physical attack;

c) Destruction or theft of property;

d) Denigrating or inappropriate comments or illustrations made in patient medical records or other official documents that impugn the quality of care in the hospital or attack particular physicians;

e) Abusive language;

f) Refusal to accept medical staff assignments or refusal to participate in committee or department affairs in a professional and appropriate manner when such assignments comport with the Bylaws of the Medical Staff and the Hospital and these policies and procedures; and

g) Derogatory comments that go beyond differences of opinion that are made to patients or patients' families about caregivers. (This is not to prohibit comments that deal constructively with the care given.)

Disruptive Conduct includes but is not limited to sexual harassment and behavior demonstrating or promoting discrimination:

a) **Sexual harassment** is defined as an unwelcome advance, a request for sexual favors and any other verbal, visual, or physical conduct of a sexual nature when

i) submission to or rejection of this conduct by an individual is used as a factor in decision affecting hiring, evaluation, retention, promotion, or other aspects of employment, or

ii) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment.

Sexual harassment will not be tolerated.

b) Discrimination on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation shall not be tolerated.

Examples of egregious situations include threatening the health or safety of a patient, visitor, or employee; conduct that actually impedes or delays the delivery of patient care; conduct that places the hospital or an employee in a position of unwanted media attention or public ridicule; physical attacks; intentional destruction of valuable hospital property; or intentional destruction of any personal property of a physician, employee or visitor.

B. Implementation

Education and Awareness

All members of the Medical Staff and Hospital Staff will receive educational information regarding this code of conduct.

The education will include information about the process for reporting the suspected violations of this policy.

Report and Investigation

A report of unprofessional behavior may be reported by any medical staff member, house staff member, nursing staff member, hospital employee or visitor

i) orally to the CMO or designate,

ii) in writing to the Hospital's HR department, or

iii) in writing by filing an incident report to the Hospital's Risk Management department.

A report of unprofessional behavior shall be forwarded promptly to the affected division chief who shall immediately commence investigation of the complaint. Within 7 days after receipt, the complainant shall receive a written acknowledgement of the complaint from the CMO or designate.

All complaints of disruptive conduct shall be investigated by the Division Chief. The Division Chief shall consult with the CMO and President of the Medical Staff regarding any egregious issue, as defined above.

The Medical Staff member who is the subject of the complaint shall be notified that

i) a report has been submitted,

ii) advised of the Medical Staff's strict policy against disruptive conduct and

iii) reminded that any retaliatory action will be an independent cause for discipline regardless of the merits of the underlying charge.

Conversations with the Medical Staff member who is the subject of the complaint shall be documented and the subject will be given a written summary including any remedial actions taken.

Action Response Guidelines

Actions taken may vary according to the nature of the complaint and the subject's (recipient of the complaint) response to the complaint. These actions may vary from simple discussion with the Division Chief to, in particularly egregious situations, summary suspension.

In less than egregious cases, the discussion and documented response may constitute the entire action on the complaint. Other corrective actions, including summary suspension in egregious cases, will be based upon the seriousness and repetition of the conduct giving rise to the complaint. Any Corrective Action Plan will be presented to the practitioner by the Division Chief in the presence of the Center Executive Director or designee.

In the event of three or more complaints regarding a Medical Staff member's behavior or one egregious issue, the Chief Medical Officer and the President of the Medical Staff shall consult with the Division Chief and the Center Executive Director as to the recommended disposition of the case.

The fourth issue involving a member of the medical staff may prompt Corrective Action as defined in the Bylaws of the Medical Staff.

When a complaint has been resolved, the Division Chief receiving the complaint shall write a concluding report for the Chief Medical Officer who in turn shall provide the complainant with an explanation in sufficient detail to document that the issue has been resolved.

Records of the proceedings shall be kept by the Division Chief for the first complaint who in turn may provide an explanation of the resolution to the complainant.

Records of any egregious issues or more than three issues shall be made available to the Credentials Committee for consideration at time of reappointment.

If the practitioner's privileges are stake, he may request a hearing as described in the Bylaws.

III. Reference to applicable procedure or other pertinent policy.

Medical Staff Peer Review Policy and Procedure

Medical Staff Bylaws Impaired Provider Chapter