
LOS ALAMOS MEDICAL CENTER

MEDICAL STAFF

RULES & REGULATIONS

These Rules & Regulations are adopted in connection with the Medical Staff Bylaws and made a part thereof. The definitions and terminologies of the Bylaws also apply to the Rules & Regulations and proceedings hereunder.

ARTICLE I

ADMISSION & DISCHARGE OF PATIENTS

1.1 ADMISSION OF PATIENTS

The admission policy is as follows:

- 1.1(a) All patients admitted to the Hospital shall have a provisional or admission diagnosis.
- 1.1(b) A patient may be admitted to the Hospital only by a Staff Member who has privileges to admit. The privilege to admit shall be delineated, and is not automatic with all Medical Staff categories.
- 1.1(c) A practitioner desiring privileges to attend in a specialty care unit of the Hospital (ICU, Nursery, Operating Room, Delivery Room, Emergency Room) must have specific delineated privileges to do so approved by Credentials Committee.
- 1.1(d) Each patient in the Hospital shall have an attending practitioner with appropriate privileges at this Hospital. The attending practitioner shall be responsible for the medical care and treatment of the patient, for the prompt completeness and accuracy of the medical record, for any necessary special instructions on discharge and for reporting on the condition of the patient to the referring practitioner and to relatives of the patient, as appropriate. Whenever those responsibilities are transferred to another Staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical records. In the case of a group practice, the practitioners within the group may rotate this responsibility without documenting such transfer.
- 1.1(e) Each member of the Medical Staff, who for any reason is not available to attend his Hospital patients shall name and secure the consent of a practitioner with appropriate privileges at this Hospital to attend his Hospital patients during his absence or to be called to attend his Hospital

patients in an emergency. In case of failure to name such associate, the Chief of Staff, the chairman of the service concerned or the CEO shall have authority to call any member of the Active Staff in such event.

- 1.1(f) The attending practitioner and Hospital employees shall ensure that the patient is provided with information on conditions that may result in the patient's transfer to another facility or level of care and alternatives to transfer, if any.
- 1.1(g) In general, Pediatrics will include patients twenty-two (22) years and under; Internal Medicine will include patients twelve (12) and over.
- 1.1(h) Guidelines for hospice and swing bed patients will be established by the Medicine Service.
- 1.1(i) Guidelines for short stay/observation admissions shall be established by the Utilization Review Committee.
- 1.1(j) The care of inpatients, observation, swing bed/hospice patients and outpatient surgery patients shall be reviewed for quality of and appropriateness of care by the relevant review committee.

1.2. ADMITTING PRIORITIES

Priorities for admission are as follows:

1.2(a) Emergency Admissions

Willful or continued misuse of this category of admission will be brought to the attention of the Medical Executive Committee (MEC) for appropriate action.

1.2(b) Preoperative Admissions

If it is not possible to handle all such admissions, the admitting practitioners will be notified to see which cases could be rescheduled. If no agreement is reached, the Chairman of the Surgery Service shall decide the urgency of any specific admission.

1.2(c) Routine Admissions

This will include elective admissions involving all services.

1.3 PATIENT TRANSFERS

- 1.3(a) No patients will be transferred between units without agreement of the attending practitioner except as below.
- 1.3(b) If the Intensive Care Unit (ICU) is full and another patient requires ICU care; all physicians attending patients in the ICU will be called to discuss the possibility of transferring a patient to the med/surg floor. If there is no agreement to transfer, the Chairman of the ICU Committee shall make the decision.

1.4 SUICIDAL AND SUBSTANCE ABUSE PATIENTS

- 1.4(a) This Hospital does not provide psychiatric or substance abuse treatment. The

social worker should be consulted in these cases to assist with placement and adherence to state law.

- 1.4(b) A patient suspected to be suicidal shall have a medical screening examination performed by a physician. If deemed medically stable, the patient may voluntarily agree to transfer to a facility for psychiatric treatment. If the patient refuses such placement, a physician will determine if an involuntary hold is necessary. If so, the physician shall document that the patient is a threat to himself or others on the Physician Certificate for involuntary commitment. Such certification shall constitute authority to have the Los Alamos Police Department transport the patient to the accepting psychiatric treatment facility.
- 1.4(c) When the admission of a suicidal patient is unavoidable, he will be admitted to the ICU for stabilization with one-to-one nursing. Restraints may be used as permitted by Hospital policy.
- 1.4(d) Substance abuse patients will only be admitted to this Hospital for the treatment of medical complications (e.g. delirium tremens). Social work consultation may assist with locating appropriate rehabilitation programs. If a physician certifies a patient a threat to himself or others, an involuntary hold may be instituted until the acute intoxication is resolved.

1.5 DISCHARGE OF PATIENTS

The discharge policy is as follows:

- 1.5(a) Patients shall be discharged on order of the attending practitioner or a consulting practitioner provided the consultant documents the concurrence of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending practitioner. The discharge process shall provide for continuing care based on the patient's assessed needs at the time of discharge.
- 1.5(b) The attending practitioner is required, when requested by the Care Coordination Team, to provide written documentation of the need for continued hospitalization, including:
 - (1) Adequate documentation stating the reason for continued hospitalization. A simple reconfirmation of the diagnosis will not be considered adequate;
 - (2) Estimate of additional length of stay the patient will require; and
 - (3) Plans for discharge and post-hospital care.

If the attending practitioner and the Care Coordination Team member cannot reach agreement, the case will be referred to the Physician Advisor for peer review per the Hospital's Utilization Review Plan.

- 1.5(c) The attending practitioner and hospital staff shall ensure that the patient is provided with information that includes the clinical basis for the discharge and anticipated continuing care needs.

1.6 DECEASED PATIENT

In the event of a patient death the deceased shall be pronounced dead by the attending physician, his designee or the Emergency Department Physician. The body shall not be released until an entry has been made in the medical record by the pronouncing physician. The attending physician will be responsible for filling out the death certificate.

1.7 AUTOPSIES

- 1.7(a) The Hospital will follow the State Office of the Medical Investigator's (OMI) requirements for reportable deaths in compliance with state law.

- 1.7(b) Staff members are expected to be actively interested in securing autopsies. Efforts to obtain permission from the deceased's legal representative shall be documented and consent, if obtained, shall be in writing and placed in the medical record. The Medical Staff has approved the following criteria to identify those deaths that do not fall under OMI jurisdiction for which an autopsy should be requested by the attending practitioner:
 - i Deaths where the cause of death is in question;
 - ii. Autopsy may help explain unknown or unanticipated complications to the attending practitioner;
 - iii. Autopsy may help allay the concerns of the family or public regarding the cause of death.
 - iv. When it is believed that autopsy would disclose information that will be of benefit to survivors or the treatment of other patients.
 - v. The patient participated in a clinical trial and the cause of death is uncertain.
 - vi. The family requests an autopsy to ascertain additional information about the circumstances surrounding the death.

The attending physician will be notified when the autopsy will be performed so he may attend if he so desires. A written report of the autopsy findings shall be filed with the medical record within three (3) months.

ARTICLE II

MEDICAL RECORDS

2.1 PREPARATION/COMPLETION OF MEDICAL RECORDS

The appropriate Staff practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. The record shall include, where appropriate, identification data, chief complaint, past medical history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory results, radiology reports, other diagnostic and therapeutic orders and results thereof, provisional diagnosis, medical or surgical treatments, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note, clinical résumé and autopsy report, when performed. If any of these elements is incomplete, the reason for not including it should be clearly stated.

2.2 ADMISSION HISTORY AND PHYSICAL

Each patient admitted for inpatient care shall have a complete admission history and physical (H&P) examination which shall be recorded by a member of the medical staff with admitting privileges within twenty-four (24) hours of admission. The admission note may be dictated or hand written, if legible.

The admitting physician may delegate the act of performing and recording the H&P, but must countersign the note. The admitting physician retains accountability for the information. The H&P must be completed and on the chart prior to the initiation of surgery, invasive diagnostic or therapeutic interventions, induction of anesthesia or other major high risk procedures.

The admission H&P shall include an age-specific assessment of the patient and shall include all pertinent findings documenting the need for the admission. In the case of infants, children or adolescents, the report shall include immunization status. If the admission follows within twenty-four (24) hours of a discharge from an acute care facility, the history and physical shall specifically document the circumstances surrounding the need for additional acute care. A copy of a history and physical examination taken by a member of the Medical Staff, for example, an office note, may be used if it is legible and durable and no changes in the patient's condition have occurred. If such a note is more than seven (7) days old or if there have been any changes in the patient's condition have occurred, a brief update will be required.

An interval history and physical may also be used if the patient is readmitted within thirty (30) days for the same or a related problem and all changes in condition occurring during the interval, as well as any other information pertinent to the admission, are recorded.

Failure to record the patient's history and physical within twenty-four (24) hours after admission shall result in the physician being informed by the Chief of Staff, when the Chief of Staff has been notified by the Nursing Supervisor, that he will have twenty-four (24) hours in which to complete the history and physical. Following this, if the history and physical remains delinquent, the Chief of Staff or the CEO may take appropriate steps to enforce compliance.

2.3 SCHEDULED OPERATIONS/DIAGNOSTIC PROCEDURES

A pertinent history and physical exam must be recorded before all Ambulatory Treatment Unit admissions,
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surgical procedures and invasive diagnostic procedures, whether inpatient or outpatient including endoscopy, needle biopsy, or aspiration but excluding procedures (such as MRI or CT with contrast) whose sole invasive characteristic is an I.V. It is recognized that the requirements of Section 2.2 for an inpatient H&P are not always necessary for outpatient cases. The minimum requirements for an outpatient H&P are: the reason for the procedure, significant medical problems, medications, allergies, vital signs and examination of the heart, lungs, and body system or part where the procedure is to be performed. Completion of the Outpatient Record Summary Form or the Short Stay History and Physical Form will suffice. A copy of a note from the primary care physician's office is also adequate if performed within the last seven (7) days or within thirty (30) days with a written interval update.

When a history and physical examination or the pertinent laboratory, x-ray and EKG reports (as determined by the Surgery Service) are not recorded before a scheduled procedure, the procedure shall be canceled unless the attending physician documents that such delay would be a threat to the patient's health.

2.4 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care. Progress notes shall be written at least daily on all inpatients except on the day of admission. Progress notes should be written at least weekly for swing bed or hospice patients. All progress notes must be dated, timed and signed by the appropriate Staff practitioner.

2.5 OPERATIVE/PROCEDURAL NOTES AND REPORTS

An operative/procedural note shall be written immediately following surgery and shall contain the following elements: patient name, date, preoperative diagnosis, postoperative diagnosis, procedure, surgeon, assistant surgeon, anesthesiologist, anesthesia type, estimated blood loss, complications, findings, specimens, blood usage and statement of disposition.

An operative report shall be dictated as soon as possible but no more than seventy-two (72) hours following the surgery and shall include all the elements of the operative note with the inclusion of a detailed account of the findings, the operative procedure, and complications, if any. These notes and reports will be made part of the patient's permanent record. Any practitioner failing to dictate operative reports as required herein will be brought to the attention of the Chief of Staff for appropriate action.

2.6 CONSULTATIONS

It will be the responsibility of the attending physician to obtain consultation in appropriate circumstances and in accordance with Hospital and service policies. Consultations shall have a written order. For physician consults, the attending physician should directly contact the consulting physician. It is not appropriate to have the nurse or unit secretary contact the consulting physician. The consultation report shall include evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient and the consultant's recommendations. The report shall be made a part of the patient's record. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.

It is recommended that the attending consider requesting consultation if so requested by the patient or his family (in compliance with state statutes).

2.7 OBSTETRICAL PATIENT HISTORIES

A copy of the attending's prenatal record shall be accepted as a valid and actual history and physical for obstetrical patients. However, an interval admission note must be written that includes pertinent additions to

the history and subsequent changes in the physical findings. If a prenatal history and physical has not been performed as an outpatient, a complete H&P as outlined in Section 2.2 should be performed.

2.8 CLINICAL ENTRIES/AUTHENTICATION

All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication shall be defined as the establishment of authorship by written signature, identifiable initials or computer key. The use of rubber stamp signature or computer key is acceptable under the following strict conditions:

2.8(a) When the practitioner whose signature the rubber stamp or computer key represents is the only one who has possession and use of it; and

2.8(b) When the practitioner places in the administrative offices of the hospital a signed statement to the effect that he is the only one who has possession and use of the stamp or computer key.

2.9 ABBREVIATIONS/SYMBOLS

Only those abbreviations and symbols approved by the MEC and filed with the Health Information Management Department may be utilized in the medical record.

2.10 COMPLETION OF DISCHARGE SUMMARY

The discharge summary shall include the following: admission diagnosis or reason(s) for hospitalization; principal discharge diagnosis; associated diagnoses reflecting care of the patient this admission, documentation of any operative procedures performed, clinical resume and any complications. The clinical resume should concisely recapitulate the following: significant findings, procedures performed, treatment rendered, and specific instructions to the patient regarding physical activity, medications, diet and follow-up plans. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment plan.

If the hospital stay is less than forty-eight (48) hours in length, a short form discharge summary is adequate. A discharge summary shall be dictated on all patients hospitalized over forty-eight (48) hours except for normal uncomplicated deliveries and normal newborn infants. For these, the standard postpartum or newborn discharge sheet shall be sufficient. All summaries shall be signed, dated and timed by the responsible practitioner.

The dictated discharge summary shall be completed within thirty (30) days of discharge. When final laboratory or other essential results are not received at the time of discharge, a notation shall be made that this information is pending.

2.11 DISCHARGE DIAGNOSIS

The discharge diagnosis pending the results of lab, pathology and other diagnostic procedures shall be recorded on the discharge face sheet. The face sheet shall be dated, timed and signed by the responsible practitioner at the time of discharge of all patients.

2.12 REMOVAL OF MEDICAL RECORDS

Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed

from the premises. Unauthorized removal of records from the hospital is grounds for suspension of the practitioner for a period to be determined by the MEC.

2.13 ACCESS TO MEDICAL RECORDS

Any physician on the Medical Staff may request a release of patient information providing that said patient is under his care and treatment. Such releases, as a routine matter, will not require a Release of Information form to be signed by the patient. The intent of this Rule & Regulation is to address a physician's need to have information available in his office in order to treat patients who may come to his office after having been seen, treated or tested at the hospital.

In cases of patient readmissions, all previous records shall be available for the use of the attending physician. This shall apply whether the patient is attended by the same practitioner or by another.

Persons not otherwise authorized to receive medical information shall require written consent of the patient, his guardian, agent or heirs.

Certain types of information, including, but not limited to, psychiatric medical records, alcohol and drug abuse records and HIV records are protected by statute and require a signed release from the patient or a court order before being released to any person.

Information should not be released to a patient's family member unless a signed consent has been obtained from the patient, guardian, or legally authorized individual.

Access to all patient medical records shall be afforded to members of the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the MEC before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff 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.

2.14 STANDING ORDERS

All standing orders and any revisions thereof must be approved by the Medical Records committee and appropriate service. In order to ensure continued appropriateness, the practitioner(s) utilizing the forms shall review practitioner-specific standing orders at least every two years. Standing orders shall be dated, timed and signed by the practitioner and reproduced in detail on the order sheet of the patient's record. Standing orders shall not replace or void those orders written for a specific patient.

2.15 DELINQUENT MEDICAL RECORDS

Patient medical records are required to be completed within thirty (30) days of discharge. The Health Information Management Department will provide each physician with a list of his incomplete medical records every fourteen (14) days. If the records remain incomplete after thirty days, the practitioner will be referred to the MEC for further action.

2.16 ALTERATIONS/CORRECTION OF MEDICAL RECORD ENTRIES

Only the original author of a medical record entry is authorized to correct or amend an entry. Any correction must be dated and authenticated by the person making the correction. Medical record entries may not be erased or otherwise obliterated, including the use of "white-out". To correct or amend an entry, the author

should cross out the original entry with a single line, ensuring that it is still readable, write the word “error”, enter the correct information, sign with legal signature and title, and enter the date and time the correction was made. Any alteration in the medical record made after the record has been completed is considered to be an addendum and should be dated, signed and identified as such.

2.17 COMPLETION OF MEDICAL RECORDS

A medical record shall not be permanently filed until it is completed by the responsible practitioner(s) or is ordered filed by the Medical Records committee. The committee may authorize a Staff member who is knowledgeable or participates in administering patient care to complete a record in the absence or physical incapacitation of the responsible practitioner.

2.18 WRITTEN/VERBAL/TELEPHONE ORDERS

Diagnostic and treatment orders may be written by the attending practitioner and those practitioners authorized to do so by the attending. All orders, including standing orders, must be in writing, dated, timed and have a practitioner’s signature.

Handwritten orders by the practitioner are preferred whenever possible. A verbal or telephone order shall be considered to be in writing if dictated to an R.N. or L.P.N. Physical Therapists, lab technicians, radiology technologists, clinical dieticians, respiratory therapists, and pharmacists may accept verbal orders relating to their area of practice. The physician shall request the verbal order be read back for confirmation. All verbal orders shall be signed by the qualified person to whom the order is dictated. The recipient’s name, the name of the ordering practitioner, and the date and time of the order shall be noted. A staff practitioner shall authenticate, date and time all verbal orders as soon as possible, such as during the next patient visit, and in no case longer than the thirty (30) day chart completion period.

Verbal orders will generally not be accepted for chemotherapy drugs, investigational drugs or devices or Do Not Resuscitate orders. If absolutely necessary, such verbal orders may be given only with two nurses witnessing the order. Withdrawal of life support orders will only be implemented with a written authenticated order from the prescribing practitioner and in accordance with applicable hospital policies regarding advanced directives.

2.19 HIV INFORMED CONSENT

Except as otherwise allowed by New Mexico State law, informed consent shall be obtained when Human Immunodeficiency Virus testing is performed. This includes an explanation of the test, its purpose, potential uses and limitations, and meaning of its results. Consent need not be a formal consent form providing there is documentation in the medical record that informed consent has been obtained.

2.20 ANESTHESIA RECORDS

The anesthesiologist shall maintain a complete anesthesia record to include evidence of preanesthesia evaluation and post anesthesia follow-up of the patient’s condition.

2.21 MEDICAL STUDENT DOCUMENTATION

The supervising staff physician must review and cosign any documentation or order written by a medical student or physician in training. Such orders must be countersigned before implementation.

ARTICLE III

GENERAL CONDUCT OF CARE

3.1 ILLEGIBLE TREATMENT ORDERS

The practitioner's orders must be written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

3.2 DO NOT RESUCITATE ORDERS (DNR)

Resuscitation is defined as any extraordinary or heroic means employed to maintain the life of a patient, including intubation/ventilation, closed chest cardiac massage and defibrillation. The DNR orders are to be written and signed by the attending on the physician's order sheet. The medical record should note the diagnosis and prognosis, and reflect that the attending has discussed the DNR order with the patient and his family and they understand the implications and consent to the order. In the case of an incompetent patient, approval of the legally responsible family member is necessary.

Consultation with another practitioner is not a prerequisite for the issuance of a DNR order. However, if such consultation is obtained, a statement of concurrence should be entered into the medical record. The DNR order is not to be interpreted as discontinuance of medical efforts to relieve suffering, maintain pain control and reverse disease by ordinary and reasonable means.

The DNR order will automatically expire at the time of patient discharge and it may be rescinded at any time by the attending or by the patient (or in the case of incompetence, the patient's legal representative).

3.3 ADMINISTRATION OF DRUGS/MEDICATIONS

All drugs and medications administered to patients shall be those listed in the Formulary of the American Society of Hospital Pharmacists. Drugs for bona fide clinical investigations may be utilized only after approval by the Pharmacy and Therapeutics Committee and the MEC.

The physician must order drugs by name, dose, route and frequency of administration. The indication for the medication should also be noted if it is not otherwise documented in the medical record. Drugs shall be dispensed from the hospital pharmacy. Medications ordered to be "held" will be discontinued after twenty-four hours in the absence of a "resume" order.

The Medical Staff shall develop policies and procedures for appropriate use of patient-controlled analgesia, spinal/epidural or intravenous administration of medications and other pain management techniques.

The Pharmacy and Therapeutics Committee shall annually draw up a list of drugs to be classified as dangerous and may withdraw permission for verbal orders for a particular dangerous drug. All orders for dangerous drugs must be renewed after seventy-two hours if the drug is to be continued. The only exceptions to this will be when the practitioner has ordered an exact number of doses or when an exact period of time has been specified for the medication.

3.4 USE OF HOME MEDICATIONS

When the patient brings medication to the Hospital with him, those medications that are clearly identified may be administered by the nursing staff only if ordered by the physician and verified and identified by the pharmacist on duty or the nursing supervisor after regular business hours. Upon discharge all medications

shall be returned to the patient. The Director of Pharmacy shall be consulted for any deviations from this rule and his decision shall be binding.

3.5 PATIENT CARE ROUNDS

Hospitalized patients shall be seen at least daily by the attending practitioner or his Allied Health Pradtitioner and more frequently if their status warrants. Skilled nursing patients or hospice patients shall be seen at least weekly. Patients admitted to the Intensive Care Unit should be seen by the attending physician as soon as possible after admission to the unit, but in any event no later than six (6) hours after admission.

3.6 QUESTIONING OF CARE

If a nurse or other provider has any reason to question the care provided to any patient, or believes that consultation is needed and has not been obtained, he shall call this to the attention of his supervisor, who in turn may refer the matter to the Chief Nursing Officer. The Chief Nursing Officer shall contact the Attending Physician to attempt to alleviate this question. The Chief Nursing Officer may then bring this matter to the attention of the Chief of Staff. If the circumstances are such as to justify such action, the Chief of Staff may request a consultation.

3.7 DISPUTE RESOLUTION

If a Staff member, whether the attending or a consultant, has serious concerns regarding the status of a patient, the concerned Staff member shall discuss the case immediately with the other party. If, after such discussion, the concerned Staff member still requests the other Staff member to reassess the patient, such a request should not be refused.

3.8 PRECEPTORSHIP

A Staff member may precept a medical student, physician in training or an Allied Health Professional in training. The student must be in good standing with a medical school accredited by the Liaison Committee on Medical Education or with a training program certified by the Liaison Committee on Graduate Education. The preceptor assumes responsibility for the actions of the student.

3.9 PATIENT RESTRAINT ORDERS

All Medical Staff members shall abide by federal law, JCAHO standards, and all hospital policies pertaining to restraints and seclusion.

ARTICLE IV

ALLIED HEALTH PROFESSIONALS

4.1 DEFINITION

The term Allied Health Professional (AHP) refers to any person other than a physician, dentist or podiatrist who is granted privileges at the Hospital. AHPs are not allowed to apply for independent privileges unless the Medical Staff recommends to the Hospital an exception due to extenuating circumstances.

4.2 CONDITIONS FOR PRIVILEGES

AHPs:

- A. are not Medical Staff members.
- B. although not Medical Staff members, must abide by Basic Staff Responsibilities listed in Section 3.3 of the Medical Staff Bylaws and these Rules and Regulations.
- C. unless permitted by state law and Article V of the Medical Staff Bylaws to practice independently, shall be under the supervision of a Staff member.
- D. will be assigned to a service and be subject to its policies and procedures.
- E. may perform only such functions and duties as are allowable under state law, included in the privileges granted by the Board and designated by the supervising Staff member.
- F. are required to clearly identify their professional status to patients and Hospital personnel.

4.3 APPLICATION CONTENT

A Staff member may request from the CEO an application for privileges for an AHP to assist him with patient care in the hospital. Clinical Psychologists and Certified Registered Nurse Anesthetists may directly request an application from the CEO. The application and supporting documents shall include:

- A. **Statement by Supervising Staff Member:** The application for all AHPs except clinical psychologists and Certified Registered Nurse Anesthetists must specify the Staff member(s) who assumes responsibility for supervising the AHP. If no Staff member is listed, the application will be rejected as incomplete.
- B. **Insurance:** a current certificate of insurance showing that the applicant is covered by professional liability insurance in the amounts required by Section 14.2 of the Bylaws.
- C. **Requested Privileges:** a list of the specific privileges desired, including the proposed duties, procedures and responsibilities to be assumed by the AHP.
- D. **Letters of Reference:** three letters from physicians, dentists or podiatrists (as appropriate for the AHP's category) with whom the AHP has worked.

E. **Statement of Release and Immunity for Liability:** as delineated in Section 6.3 of the Bylaws.

F. **Health Status, Professional Sanctions, Felony or Fraud Charges and Malpractice Claims:** in the same manner as outlined in Article VI of the Bylaws for Staff member applications.

G. **Continuing Education:** evidence of the CME credits required by the relevant state agency.

4.4 BASIC QUALIFICATIONS: All applications will include an outline of all previous education, training and experience in health care. Specific qualifications for each classification of AHP are listed below.

A. Clinical Psychologist

- i. completion of a clinical internship approved by the American Psychological Association or its equivalent.
- ii. certification by the New Mexico Psychologists Examiners Board.

B. Physician's Assistant-Certified

- i. graduation from an approved school with a P.A. degree.
- ii. current licensure by the New Mexico Medical Board.
- iii. licensure by the National Commission of Certification of Physicians Assistants, Inc.

C. Certified Nurse Midwife

- i. approval by the Health Services Division of the New Mexico Health and Environment Department for meeting the state statutory requirements for a midwife.

D. Certified Registered Nurse Anesthetist

- i. graduation from a program approved by the American Association of Nurse Anesthetists' Council on Accreditation.
- ii. current New Mexico licensure as a registered nurse.
- iii. documentation of having passed a qualifying exam as directed by the AANA Council on Accreditation.
- iv. approval of the NM Board of Nursing for meeting the state statutory requirements for CRNAs.

E. Nurse Practitioner

- i. current NM licensure as a registered nurse.
- ii. approval of the NM Board of Nursing for meeting the state statutory requirements for Nurse Practitioners.

F. Optometrist

- i. graduation from an approved school with an O.D. degree.
- ii. completion of hospital based residency training.
- iii. licensure by the State of New Mexico.

G. Ophthalmic Assistant

- i. successful completion of an institutional or home study course or equivalent approved by the Joint Commission on Allied Health Personnel in Ophthalmology.
- ii. successful completion of this commission's certification examination.

H. For all Surgical First Assistants

- i. ACLS certification.
- ii. ability to perform effectively as a member of the operative team under stressful and emergency situations.
- iii. documented manual dexterity and technical proficiency as a scrub tech/nurse and/or circulator with at least two years experience.
- iv. approval by the appropriate state agency.

a. for Certified Scrub Technologist/First Assistant (CSTFA)

- i. completion or current enrollment in a CSTFA program approved by the Committee on Allied Health Education and Accreditation. (CAHEA)
- ii. documentation of three hundred and fifty (350) cases as either scrub tech or first assistant.

b. for Registered Nurse First Assistants (RNFA)

- i. current NM RN license.
- ii. completion of a one year RNFA program that meets the recommended standards of the Association of periOperative Nursing (AORN).
- iii. documentation of at least one hundred and twenty (120) cases experience as a first assistant.

I. Registered Nurse

In the case of a nurse licensed in New Mexico as a Registered Nurse who is not a Nurse Practitioner as such, but who has obtained advanced training (e.g. Certified Enterostomal Therapist), those documents should be submitted which support the advanced training plus evidence of competence in those skills for which application is being made.

4.5 PROCESSING THE APPLICATION

The application will be processed according to the procedure outlined in Section 6.3(d) – 6.3(j) of the Medical Staff Bylaws. An AHP denied privileges that are within the allowable scope of practice shall be entitled to the procedural rights delineated in Section 5.5 of the Bylaws.

4.6 DURATION OF INITIAL APPOINTMENT

Initial privileges shall be provisional for a period of up to twelve months. At the end of this provisional period, the service chair shall forward a service evaluation form to the Credentials Committee, which shall send a written recommendation to the MEC. The MEC can make one of the following recommendations to the Board:

- a. end the provisional status and approve the AHP's privileges for up to two years.
- b. recommend extending the provisional period for another six months if the Credentials Committee is unable to make a satisfactory appraisal of the AHP's performance.

- c. revocation of the privileges. In this case, the AHP would be entitled to the procedural rights outlined in Section 5.5 of the Bylaws before this recommendation is forwarded to the Board.

4.7 REAPPOINTMENT

The reappointment process will follow the procedure outlined in Section 6.4 of the Bylaws. In general, AHPs will be reviewed for reappointment in concert with their supervising Staff member and at least every two years. A denial of reappointment can be appealed as outlined in Section 5.5 of the Bylaws.

4.8 RULES GOVERNING STAFF MEMBERS AND SUPERVISED AHPs

- A. The Staff member is directly and entirely responsible for all of the acts and omissions of the AHP.
- B. The AHP must sign all entries made in the medical record. All AHP entries in the medical record shall be reviewed as soon as possible and countersigned by the Staff member within forty-eight (48) hours.
- C. Treatment and diagnostic procedures performed by the AHP shall be under the direct supervision of the Staff member. It is understood that whenever good medical practice dictates, the Staff member shall be present.
- D. Any questions from Hospital personnel concerning orders written in the chart by an AHP will be referred to the supervising Staff member.

4.9 ALLOWABLE SCOPE OF PRACTICE

A. PHYSICIAN ASSISTANTS AND NURSE PRACTITIONERS

- i. may assist the Staff member including performing and dictating the admission history and physical, dictating the discharge summary, making hospital rounds, and counseling patients.
- ii. are permitted to diagnose a patient's condition, initiate orders for treatment or change treatment.
- iii. shall not serve on the Emergency Room on-call roster and shall not see patients in the Emergency Room except when accompanied by the supervising Staff member.
- iv. if they have fulfilled state and DEA requirements, may prescribe drugs included in Schedules II through V of the Controlled Substances Act.
- v. may not admit patients independently.

B. CERTIFIED NURSE MIDWIVES

- i. may only be supervised by obstetricians.
- ii. may function in the Hospital only if the supervising obstetrician is readily available in Los Alamos County.
- iii. shall not serve on the Emergency Room on-call roster.

C. CERTIFIED REGISTERED NURSE ANESTHETISTS

- i. may serve as an anesthetist on first call.
- ii. may assess the medical needs of the patient and administer or prescribe preoperative medication as required to perform the function of an anesthetist.

D. OPTOMETRISTS

- i. may only be supervised by ophthalmologists.
- ii. may perform complete or partial ocular examinations as requested by the attending.
- iii. may initiate medical treatment as allowable under state statutes.
- iv. may, if so qualified, assist with surgery.

E. OPHTHALMIC ASSISTANTS

- i. may only be supervised by an ophthalmologist.
- ii. may take ophthalmic histories, perform lensometry, basic tonometry, and instrument maintenance and repair.
- iii. may, if so qualified, assist with surgery.

F. SURGICAL FIRST ASSISTANTS

- i. will function solely as the first assistant and not be expected to simultaneously serve as the scrub tech/nurse.
- ii. will be under the direct guidance and in the physical presence of the primary surgeon, facilitating only the technical aspects of the surgery.
- iii. may assist in providing exposure through retraction and suction, in providing hemostasis including ligation of structures and handling tissues.

G. CLINICAL PSYCHOLOGISTS

- i. are eligible for consulting privileges only and may not admit, discharge or assume sole responsibility for a patient's care.

ARTICLE V

GENERAL RULES REGARDING OBSTETRICAL CARE

5.1 HIGH-RISK PEDIATRIC CARE

Only by those physicians who have training in high-risk infant resuscitation and care will provide pediatric care for newborns at high risk for complications. High risk for these purposes will be defined as:

- (a) all cesarean sections;
- (b) premature infants less than thirty-seven (37) weeks gestation;
- (c) infants weighing less than two (2) kilograms; and
- (d) full term infants with complications requiring invasive intervention.

5.2 EMERGENCY MEDICAL SCREENING OF WOMEN IN LABOR

Obstetric patients of twenty (20) weeks gestation or greater presenting to the Emergency Room with complaints of abdominal pain, back pain, amniotic fluid leakage, vaginal bleeding, contractions or decreased fetal movement are to be triaged as emergent cases. They should be registered and then taken to the Labor and Delivery Unit by qualified medical personnel. On arrival to Labor and Delivery, a qualified R.N. will initiate the orders of the obstetrician of record, or in the case of a patient presenting with no prenatal care or care by a physician who is not a member of this Medical Staff, the orders of the physician on-call for obstetrics. The medical screening examination required under Article VI may be performed by a qualified R.N. under the orders of and in telephone contact with the obstetrical provider. In the case of a patient who is determined not to be in active labor, she may be discharged home by telephone order if the obstetrical on-call provider concurs with the assessment of the R.N.

Obstetric patients with isolated extremity trauma, respiratory or head, ear, nose or throat complaints will be seen in the Emergency Room first. An Ob/Gyn consult will be called if deemed necessary by the Emergency Room physician.

Obstetric patients involved in Motor Vehicle Accidents or other trauma will initially be evaluated in the Emergency Room. Once the obstetric patient is medically cleared, she will be admitted to the Ob unit for fetal monitoring.

5.3 ANESTHESIA SERVICES

Anesthesia services must be available according to the relevant Hospital policies for emergent, urgent or standard cesarean sections.

ARTICLE VI

EMERGENCY MEDICINE

6.1 EMTALA OBLIGATIONS

Physicians who are found to have violated the Emergency Medical Treatment and Active Labor Act (EMTALA) regulations run the risk of termination from the Medicare/Medicaid program (which is reportable to the National Practitioner Data Bank) and/or fines up to \$50,000. Such fines are not covered by malpractice insurance. It is imperative that all Staff members be familiar with their obligations under EMTALA.

6.1(a) EMTALA Definitions For the purpose of this article, the following EMTALA definitions are included:

- (1) **Emergency Medical Condition (EMC)**: a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical attention could be reasonably expected to result in serious impairment to bodily organs or functions or serious jeopardy to the health of the individual or an unborn child. Regarding a pregnant woman who is having contractions, an EMC exists if there is inadequate time for a safe transfer to another hospital before delivery or if the transfer may pose a threat to the health or safety of the mother or the unborn child.
- (2) **Medical Screening Examination**: the exam and tests necessary to determine if an Emergency Medical Condition exists.
- (3) **Stabilization**: to provide such medical treatment of the Emergency Medical Condition as may be necessary to assure, within a reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer or discharge of the patient. In the case of pregnant woman having contractions, stabilization is defined as when the woman has delivered the baby and the placenta.

6.1(b) Screening

- (1) Any individual who presents to the Emergency Department of LAMC for care shall be provided with a Medical Screening Examination to determine whether that individual is experiencing an Emergency Medical Condition.
- (2) Examination and treatment of emergency medical conditions shall not be delayed in order to inquire about the individual's method of payment or insurance status, nor denied on account of the patient's inability to pay.
- (3) For the purpose of compliance with EMTALA, the following persons are designated qualified medical personnel able to perform an initial medical screening examination to determine whether or not an emergency medical condition is present:

The ED physician, the patient's private physician, or, in the case of a woman in labor, a registered nurse trained in obstetric nursing pursuant to hospital policy, Medicare and other applicable federal regulations.

6.1(c) Stabilization

- (1) Any individual experiencing an emergency medical condition must be stabilized prior to transfer or discharge, excepting conditions set forth below.
- (2) A patient does not have to be stabilized when:
 - (i) the patient, after being informed of the risks of transfer and of the hospital's treatment obligations, requests the transfer and signs a transfer request form; or
 - (ii) based on the information available at the time of transfer, the medical benefits to be received at another facility outweigh the risks of transfer to the patient, and a physician signs a certification that includes a summary of risks and benefits to this effect.
- (3) If a patient refuses to accept the proposed stabilizing treatment, the Emergency Department Physician, after informing the patient of the risks and benefits of the proposed treatment and the risks and benefits of the individual's refusal of the proposed treatment, shall take all reasonable steps to have the individual sign a form indicating that he has refused the treatment. The Emergency Department Physician shall document the patient's refusal in the patient's chart, which refusal shall be witnessed by another Emergency Department staff member. If the patient so desires, the patient will be offered assistance in finding a physician for outpatient follow-up care.

6.1(d) Transfer

- (1) The Emergency Department Physician shall obtain the consent of the receiving hospital facility before the transfer of an individual. Said person shall also make arrangements for the patient transfer with the receiving hospital.
- (2) The condition of each transferred individual shall be documented in the medical records by the physician responsible for providing the medical screening examination and stabilizing treatment.
- (3) Upon transfer, the Emergency Department shall provide appropriate medical records regarding its treatment of the individual including, but not limited to, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any test, informed written consent or transfer certification, and the name and address of any on-call physician who has refused or failed to appear within a reasonable period of time in order to provide stabilizing treatment.
- (4) All reasonable steps shall be taken to secure the written consent or refusal of the patient (or the patient's representative) with respect to the transfer. The Emergency Department Physician must inform the patient of the risks and benefits of the proposed transfer.

6.2 EMERGENCY DEPARTMENT CALL

6.2(a) When the Emergency Department Physician determines that a consultation or specialized treatment beyond his capability is needed, he shall consult the appropriate physician. The time of contact will be documented in the patient's medical record.

6.2(b) An appropriate attempt to contact the physician will be considered to have been made when the Emergency Department has:

- (1) attempted to reach the physician in the hospital or through the answering service;

- (2) called the physician at home;
- (3) called the physician at his office; and
- (4) called once on the physician's pager.

Twenty minutes will be considered a reasonable time to carry out this procedure. In the event that 1) the patient does not have a private physician, 2) the private physician refuses the Emergency Department physician's request to come to the Emergency Department, or 3) the physician cannot be contacted within twenty (20) minutes of the initial request, the on-call roster shall be used to select another physician to provide the necessary consultation or treatment for the patient. Physicians called are required to respond to an Emergency Department call by telephone immediately. If requested to come in, they are required to do so within thirty minutes after responding by telephone.

A physician who has been called from the rotation list may not refuse to respond. Any such refusal shall be reported to the Chief of Staff and CEO for further action and may constitute grounds for revocation of the physician's Medical Staff appointment and clinical privileges.

6.2(c) The on-call roster shall be maintained by the PBX operator, and shall be posted in the Emergency Department. Any changes in the call schedule should be reported to the PBX operator and the Emergency Department.

6.2(d) The on-call physician shall be held responsible for the care of a patient until the problem prompting the patient's assignment to that physician is satisfactorily resolved or stabilized to permit disposition of the patient. This responsibility shall include follow-up care of the referred patient in the physician's office. If the physician who is consulted or is called from the rotation schedule feels that a consultation with another specialist is indicated, it will be that physician's responsibility to make the second referral. The first physician consulted retains responsibility for the patient until the second consultant accepts the patient.

6.2(e) All members of the Active and Provisional Staff are expected to participate in the on-call roster for the Emergency Department unless exempted by their service. Any specialty with more than three providers with Active Staff privileges is expected to provide LAMC with on-call coverage for their specialty. The individual groups or services can agree to share call responsibility.

6.3 DISASTER PLAN

6.3(a) The Emergency Medicine Service shall have the overall responsibility for establishing rules of conduct, treatment and care in the Emergency Department; including development of a mass casualty plan.

6.3(b) There shall be a plan for the care of mass casualties in the event of a major disaster based on LAMC's capabilities in conjunction with other area facilities. In the event of a disaster, all notified practitioners should report to the Emergency Room for assignment.

6.3(c) The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill with other community emergency services participate. The drills should be realistic, involve the Medical Staff, administrative and nursing personnel. Active evacuation of patients during drills is not necessary. Written reports and evaluation of all drills shall be made.

6.4 MEDICAL RECORDS

6.4(a) An appropriate medical record shall be kept for every patient receiving care in the Emergency Department and shall be incorporated in the patient's hospital record. This shall include identification data, chief complaint, history of present illness, vital signs, pertinent physical examination, diagnosis, treatment plan, and patient acknowledgement of instructions. Follow-up visits for the same problem may be recorded on progress notes.

6.4(b) A written informed consent shall be obtained for those procedures as determined by the Emergency Medicine Service. In life-threatening or other dire emergencies where it is not feasible to obtain informed consent, procedures and treatment may be carried out as needed without informed consent.

ARTICLE VII

GENERAL RULES REGARDING SURGICAL CARE

7.1 SURGICAL CONSENT

A written, informed, signed and witnessed surgical consent shall be obtained and placed on the patient's chart prior to all operative procedures, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The consent form shall be signed by the patient only after the risks and benefits of the procedure, alternative treatment methods and other information necessary to make a fully informed consent has been explained to the patient by the surgeon. In those cases involving a minor or an unconscious patient in which consent cannot be immediately obtained from parents, guardians or next of kin, the circumstances should be fully explained in the patient's medical record. A consultation in such circumstances is desirable before the emergency procedure is undertaken, if time permits. Consent shall be obtained within one week prior to surgery. If it is known in advance that two (2) or more specific procedures are to be carried out at the same time, said procedures may be described and consented to on the same form.

7.2 EXAMINATION OF SPECIMENS

In general, specimens removed during a surgical procedure shall be evaluated by a pathologist. A list of specimens exempt from this requirement shall be determined by the Surgery Service and be reviewed annually.

7.3 ELECTIVE SURGERY SCHEDULING

Policies and guidelines for the scheduling of surgical procedures, including surgeon and service "Block Time" shall be established by the Surgery Service. The granting of Block Time shall take into account OR utilization, demand, staff availability, and other factors to facilitate efficient use of the operating room facilities.

7.4 PRIORITY CASES

Emergency procedures shall take priority above all other cases. It is the responsibility of the surgeon to determine if his case is an emergency. Such emergent add-on cases will be subject to review for appropriateness. Priority cases shall include emergent or urgent cesarean sections, open bone work, latex allergic patients and contaminated cases last whenever possible.

7.5 ANESTHESIA

Anesthesia includes general, regional and conscious sedation given in the OR, delivery rooms, Emergency Department, or any other location within the hospital where such services are administered including during special procedures (imaging) or endoscopy. The Surgery Service shall establish guidelines consistent with JCAHO standards for individuals providing moderate or deep sedation or anesthesia. Only those practitioners granted specific privileges by Credentials Committee to do so are allowed to administer such sedation or anesthesia.

The hospital must be able to provide anesthesia services within thirty (30) minutes after the determination that such services are necessary.

The practitioner administering the sedation/anesthesia shall maintain a complete sedation or anesthesia record including evidence of the pre-sedation/anesthesia evaluation used to determine whether the patient is an appropriate candidate for the planned sedation/anesthesia and a post-sedation/anesthesia follow-up of the patient's condition by the anesthetist upon admission to and discharge from the recovery area.

7.6 DNR ORDERS CANCELLED IN OR

In order to ascertain the patient's wishes as they relate to the continuance of advanced directives, said advanced directives and DNR orders will be discussed with the patient by the anesthetist or anesthesiologist or the Attending Physician prior to surgery. If the patient's wishes have changed, documentation signed by the patient and the surgeon or other physician participating in the discussion must be obtained and witnessed as required by state law applicable to advance directives.

7.7 DNR ORDERS CANCELLED IN OR

The hospital shall refer all inpatient deaths, emergency room deaths and dead on arrival cases (term birth to age 75) to the designated organ procurement agency and tissue and eye donor agency in order to determine donor suitability, and shall comply with all HCFA conditions of participation for organ, tissue and eye procurement. No physician attending the patient prior to death or involved in the declaration of death shall participate in organ removal.

7.8 ORDERS TO BE REWRITTEN

All previous orders are canceled when patients go to surgery.

7.9 DISCHARGE FROM THE RECOVERY ROOM

Patients may be dismissed from the recovery room by the recovery room nurse when the patient fulfills predetermined criteria approved by the Surgery Service. When patients fail to fulfill the predetermined criteria, the patient may be discharged from the recovery room by verbal or written order of the attending anesthesiologist.

Article VIII Disruptive Physician Policy

Article VIII Disruptive Practitioner Policy

8.1 Purpose and Objective: It is the policy of the Hospital for all individuals working in the Hospital to treat others with respect, courtesy and dignity, and to conduct ourselves in a professional, cooperative manner. This Disruptive Practitioner Policy sets forth the requirement that all Medical Staff members and AHPs who work in the Hospital will act in a professional and respectful manner at all times. Further, this policy defines Disruptive Conduct and outlines how to report and address it.

The objectives of this policy are to ensure quality patient care by promoting a safe, cooperative and professional health care environment and to provide Hospital employees with a work environment based on respect and one that encourages personal and professional growth. This policy is applicable to all Medical Staff members and all AHPs (collectively referred to in this policy as “Practitioners”).

Conduct of a criminal nature by a Practitioner, including but not limited to assault, battery, rape or theft shall be handled through local law enforcement officials in accordance with local and state laws, in addition to application of this policy to address the Practitioner’s staff membership and privileges.

Any employee who engages in Disruptive Conduct, including employed Practitioners, may be dealt with in accordance with the Hospital’s Human Resource policies. Practitioners or Hospital employees who observe Disruptive Conduct on the part of a Hospital employee shall follow the reporting mechanisms set forth in the Human Resource policies.

8.2 Definition: For purposes of this policy, “Disruptive Conduct” is any conduct that disrupts the smooth operation of the Hospital, adversely affects the ability of others to perform their jobs appropriately, poses a threat or potential threat to safe, quality patient care or exposes the Hospital and/or Medical Staff to potential liability. Such Disruptive Conduct may include, but is not limited to, behavior such as:

- Rude or abusive behavior or comments to Hospital personnel, other Practitioners, visitors, patients or their families, or other conduct that negatively affects the ability of others to do their jobs.
- Attacks– verbal or physical – directed at other Practitioners, Hospital personnel, patients or visitors, that are personal, inappropriate, irrelevant or beyond the bounds of fair professional conduct.
- Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, impugning the quality of care in the Hospital, or attacking particular Practitioners, nurses, other Hospital employees or Hospital policies.
- Refusal to accept – or disruptive acceptance of – medical staff assignments or participation in committee or service affairs.
- Disruption of Hospital operations, Hospital or Medical Staff committees, or service affairs or placing quality care at the Hospital in jeopardy.
- Knowingly making false accusations or falsifying any patient medical records or Hospital documents.
- Verbal or physical maltreatment of another individual, including physical or sexual assault or battery, or retaliation of any kind for making a report under this policy.
- Sexual, racial or other harassment, including words, gestures and actions, verbal or physical, that interferes with a person’s ability to perform his job.

- Conduct that adversely affects or impacts the community's confidence in the Hospital's ability to provide quality care.

8.3 Reporting of Disruptive Conduct: Hospital employees who observe or are subject to Disruptive Conduct by a Practitioner shall notify their supervisor about the incident. Any Practitioner who observes Disruptive Conduct of another Practitioner shall notify the CEO and Chief of Staff directly. Supervisors who have received a report of Disruptive Conduct shall report the same to the CEO and Chief of Staff.

If a reporting individual is uncomfortable with reporting Disruptive Conduct directly, then a report of the incident must be made to the Hospital's Ethics & Compliance Officer or the LifePoint Ethics Line at 1-877-508-LIFE(5433).

8.4 Documentation of the Behavior: Documentation of Disruptive Conduct is critical since it is ordinarily a pattern of conduct, rather than one incident, which justifies disciplinary action. Practitioners, nurses and other hospital employees who observe Disruptive Conduct by a Practitioner must document the conduct or the supervisor or CEO shall document the incident as reported. That documentation shall include:

- The date and time of the questionable behavior;
- A statement of whether the conduct affected or involved a patient in any way; and if so, the medical record number of the patient;
- known circumstances which precipitated the situation;
- A description of the questionable behavior limited to factual, objective language;
- known consequences, if any, of the Disruptive Conduct as it relates to patient care or Hospital operations;
- the names of other witnesses to the incident; and
- a record of any action taken to remedy the situation including date, time, place, action and name(s) of those intervening.

The report shall be submitted to the Chief Executive Officer and the Chief of Staff. In performing all functions hereunder, the Chief Executive Officer and Chief of Staff shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law. The original report shall be included in the physician's confidential file. If a subsequent investigation reveals that there is no merit to the report, the report shall be destroyed.

After a report of Disruptive Conduct, the CEO shall ensure those making the report are aware of the Hospital's Standards of conduct and process for assuring professional and appropriate behavior in the Hospital. This follow-up will occur as soon as practical after any report of Disruptive Conduct.

8.5 Investigation: Once received, a report will be investigated by the Chief Executive Officer and the Chief of Staff. The CEO may delegate this investigation to the Chief Nursing Officer or other individual who may have the applicable expertise or skill. This investigation may include meeting with the individual who reported the conduct and any other witnesses to the incident. If the Chief Executive Officer and Chief of Staff determine after investigation that the report lacks merit, this conclusion shall be documented and no further action is necessary and the report shall be destroyed. Those reports considered accurate will be addressed through the procedure set out below. This documentation shall be placed in the Practitioner's confidential peer review file. If at any time it appears to the Chief of Staff, the CEO or the Medical Executive Committee; that a

Practitioner's behavior may result from impairment, the procedure set forth in the Impaired Physician Policy shall be followed. Following the investigation, the CEO or Chief of Staff shall consult with legal counsel (corporate and/or Hospital) to determine whether further reporting to law enforcement authorities or other governmental agencies is necessary.

8.6 Meeting with the Practitioner: A first confirmed incident warrants a discussion with the offending Practitioner. The Chief of Staff and Chief Executive Officer shall initiate a meeting with the Practitioner and emphasize that such conduct is inappropriate and violates Hospital policy and Medical Staff Bylaws. These individuals shall discuss the matter informally with the Practitioner, emphasizing that if the conduct continues; more formal action will be taken to stop it. The identity of the individual who made the report of Disruptive Conduct shall not be disclosed at this time unless the CEO and Chief of Staff agree in advance that it is appropriate to do so. The following guidelines shall be followed regarding the meeting:

- The initial approach should be collegial and designed to be helpful to the physician.
- The parties should emphasize that if the behavior continues, more formal action will be taken to stop it.
- Informal meetings shall be documented with a written summary of the meeting. This documentation shall be maintained in a confidential peer review file of the Practitioner.
- A follow-up letter to the Practitioner shall state that the Practitioner is required to behave professionally and cooperatively, along with a copy of this Disruptive Practitioner Policy.
- Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident should the Chief of Staff and/or the Chief Executive Officer determine that the seriousness of the incident justifies such action.

If an additional incident of Disruptive Conduct occurs, or if the Chief of Staff or the Chief Executive Officer determines it to be necessary, the CEO and Chief of Staff shall meet with and advise the Practitioner that such conduct is intolerable and must stop. This meeting constitutes the Practitioner's final warning. It shall be followed with a letter reiterating the warning and summarizing the meeting. The MEC shall be informed. The Practitioner may prepare a written response to the letter. These letters shall be maintained in the Practitioner's confidential peer review file. More formal corrective action may be pursued at this juncture if deemed warranted by the Chief of Staff and/or Chief Executive Officer.

All meetings with the Practitioner shall be documented. After each meeting with the Practitioner, a letter shall be sent to the Practitioner confirming the Hospital's and Medical Staff leadership's position- that the Practitioner is required to behave professionally and cooperatively, which also shall include the potential consequences of continued non-compliance.

8.7 Disciplinary Action Pursuant to Bylaws: A single additional incident after the above process shall result in initiation of formal corrective action pursuant to the Medical Staff Bylaws. The Chief Executive Officer and Chief of Staff shall be responsible for presenting the history of conduct to the Medical Executive Committee. Summary suspension may be appropriate pending this process, depending upon the seriousness of the offense.

The Medical Executive Committee must be fully apprised of all of the previous meetings and warnings, if any, and must take them into account so that it may pursue whatever action is necessary to terminate the Disruptive Conduct.

The Medical Executive Committee must take action or refer the matter to the Board with a recommendation as to action. This recommendation shall be processed as provided in the Corrective

Action section of the Medical Staff Bylaws. The Board will review and may initiate action if the MEC fails to take action or make a recommendation as to action regarding the matter.

Although the above outline is a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single egregious incident, including but not limited to physical or sexual harassment, a felony conviction, assault, a fraudulent act, stealing or intentionally damaging hospital property or jeopardizing patient care may result in immediate corrective action. As such, if any deem it appropriate based upon the circumstances, the CEO, Chief of Staff or Board Chairperson may initiate formal corrective action under the Bylaws for a single incident of Disruptive Conduct without first resorting to the progressive disciplinary approach set forth herein.

This Article was originally adopted in July, 2005 and this is the current revision requested by LifePoint 11/07

Article IX Impaired Physician Policy

9.1 Report: It is the policy of Los Alamos Medical Center to properly investigate and act upon concerns that a physician is suffering from an impairment. The hospital will conduct its investigation and act in accordance with pertinent state and federal law, including, but not limited to, the Americans with Disabilities Act. In the event of any apparent or actual conflict between this policy and the Bylaws, Rules and Regulations, or other policies of the hospital or its medical staff, including the due process sections of those Bylaws and policies, the provisions of this policy shall control. Nothing herein shall preclude commencement of corrective action, including summary suspension under the Bylaws, in the event that the physician's continued practice constitutes a threat to the health or safety of patients or any person.

If any individual in the hospital has a reasonable suspicion that a physician appointed to the Medical Staff is impaired, the following steps shall be taken:

A written report shall be given to the Chief Executive Officer or the Chief of Staff. The reporting individual shall otherwise keep the report and the facts related thereto confidential. The report shall include a description of the incident(s) that led to the belief that the physician may be impaired. The report must be factual. The individual making the report need not have proof of the impairment, but must state the facts leading to the suspicions. A physician who feels that he may be suffering from impairment may also make a confidential self-report. Impairment, as used in this policy, includes both physical and mental impairment, as well as impairment due to drugs or alcohol.

Notwithstanding the foregoing, in the event that any person observes a physician who appears to be currently impaired by drugs or alcohol, that person shall report the events to the Chief of Staff and/or CEO immediately. The Chief of Staff and CEO may order an immediate drug or alcohol screen if, in their opinion, circumstances warrant. If the impairment is severe, the Chief of Staff shall immediately make arrangements for another physician to assume care of that physician's patients.

9.2 Investigation: If, after discussing the incidents with the individual who filed the report, the Chief Executive Officer and Chief of Staff believe there is sufficient information to warrant further investigation, the Chief Executive Officer and Chief of Staff may:

- Meet personally with the physician or designate another appropriate person to do so; and/or
- Direct in writing that an investigation be instituted and a report thereof be rendered by an ad hoc Wellness Committee to be appointed by the Medical Executive Committee of three (3) physicians to investigate the issue within five (5) days of receipt of the request.

In performing all functions hereunder, the Chief Executive Officer and Chief of Staff shall be deemed authorized agents of the MEC and the Wellness committee and shall enjoy all immunity and confidentiality protections afforded under state and federal law.

9.3 Wellness Committee Investigation

Following a written request to investigate, the Wellness committee shall investigate the concerns raised and any and all incidents that led to the belief that the physician may be impaired. The committee's investigation may include, but is not limited to, any of the following:

- A review of any and all documents or other materials relevant to the investigation
- Interviews with any and/or all individuals involved in the incidents or who may have information relevant to the investigation, provided that any specific inquiries made regarding the physician's health status are related to the performance of the physician's clinical privileges and medical staff duties and are consistent with proper patient care or effective operation of the hospital

- A requirement that the physician undergo a complete medical examination as directed by the committee, so long as the exam is related to the performance of the physician's clinical privileges and medical staff duties and is consistent with proper patient care or the effective operation of the hospital; and
- A requirement that the physician be tested to determine if the physician is currently using drugs illegally or abusing legal drugs, including alcohol.

The Wellness committee shall meet informally with the physician as part of its investigation. This interview does not constitute a hearing under the due process provisions of the hospital's medical staff Bylaws or pertinent credentialing policy and is not part of a disciplinary action. At this meeting, the committee may ask the physician health-related questions so long as they are related to the performance of the physician's clinical privileges and medical staff duties and are consistent with proper patient care and the effective operation of the hospital. In addition, the committee may discuss with the physician whether a reasonable accommodation is needed or could be made so that the physician could competently and safely exercise his clinical privileges and the duties and responsibilities of medical staff appointment.

9.4 Wellness Committee Determination

Based on all of the information it reviews as part of its investigation, the Wellness committee shall determine:

- Whether the physician is impaired, or what other problem, if any, is affecting the physician.
- Whether the physician would benefit from professional resources, such as counseling, medical treatment or rehabilitation services for purposes of diagnosis and treatment of the condition or concern, and, if so, what services would be appropriate
- If the physician is impaired, the nature of the impairment and whether it is classified as a disability under the ADA
- If the physician's impairment is a disability, whether a reasonable accommodation can be made for the physician's impairment such that, with the reasonable accommodation, the physician would be able to competently and safely perform his clinical privileges and the duties and responsibilities of medical staff appointment;
- Whether a reasonable accommodation would create an undue hardship upon the hospital, such that the reasonable accommodation would be excessively costly, extensive, substantial or disruptive, or would fundamentally alter the nature of the hospital's operations or the provision of patient care; and
- Whether the impairment constitutes a "direct threat" to the health or safety of the physician, patients, hospital employees, physicians or others within the hospital. A direct threat must involve a significant risk of substantial harm based upon medical analysis and/or other objective evidence. If the physician appears to pose a direct threat because of a disability, the committee must also determine whether it is possible to eliminate or reduce the risk to an acceptable level with a reasonable accommodation.
- The Wellness Committee findings will be presented to the Medical Executive Committee.

9.5 Notification to the Physician and the Reporter

If the investigation produces sufficient evidence that the physician is impaired, the CEO shall meet personally with the physician or designate another appropriate individual to do so. The physician shall be told that the results of an investigation indicate that the physician suffers from an impairment that affects his practice. (The physician should not be told who filed the report and does not need to be told the specific incidents contained

in the report.) The Chief Executive Officer shall inform the individual who filed the report that follow-up action was taken, but shall not disclose confidential peer review information or specific actions implemented.

9.6 Documentation: The original report and a description of the actions taken by the ad hoc committee shall be included in the physician's confidential file. If the initial or follow-up investigation reveals that there is no merit to the report, the report shall be destroyed. If the initial or follow-up investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included in a separate portion of the physician's file and the physician's activities and practice shall be monitored until it can be established that there is, or is not, an impairment problem.

9.7 Reasonable Accommodation

If the Wellness committee determines that there is a reasonable accommodation that can be made as described above, the committee shall attempt to work out a voluntary agreement with the physician, so long as that arrangement would neither constitute an undue hardship upon the hospital or create a direct threat, also as described above. The Chief Executive Officer and Chief of Staff shall be kept informed of attempts to work out a voluntary agreement between the committee and the physician and shall approve any agreement before it becomes final and effective.

If the committee determines that there is no reasonable accommodation that can be made as described above, or if the committee cannot reach a voluntary agreement with the physician, the committee shall make a recommendation and report to the MEC, through the Chief of Staff, for appropriate corrective action pursuant to the Bylaws. If the MEC's action would provide the physician with a right to a hearing as described in the hospital's medical staff Bylaws, all action shall be taken in accordance with the Fair Hearing Plan and strict adherence to all state and federal reporting requirements will be required. The Chief Executive Officer shall promptly notify the physician of the recommendation in by special notice. The recommendation shall not be forwarded to the Board until the individual has exercised or has been deemed to have waived the right to a hearing as provided in the hospital's medical staff Bylaws.

9.8 Confidentiality

- All parties shall maintain confidentiality of any physician referred for assistance, except as limited by law, ethical obligation, or when safety of a patient is threatened. Throughout this process, all parties shall avoid speculation, conclusions, gossip and any discussions of this matter with anyone outside those described in this policy. All requests for information concerning the impaired physician shall be forwarded to the Chief Executive Officer for response.

9.9 REHABILITATION AND REINSTATEMENT GUIDELINES

If it is determined that the physician suffers from an impairment that could be reasonably accommodated through rehabilitation, the following are guidelines for rehabilitation and reinstatement:

- Hospital and medical staff leadership shall assist the physician in locating a suitable rehabilitation program. A physician who may benefit from counseling or rehabilitative services, but who is not believed to be impaired in his ability to competently and safely perform his clinical privileges or the duties of medical staff membership, may be referred for assistance while still actively practicing at the hospital. In cases where the physician's ability is believed to be impaired, the physician shall be allowed a leave of absence if necessary. A physician who is determined to have an impairment which requires a leave of absence for rehabilitation shall not be reinstated until it is established, to the satisfaction of the Wellness committee, the MEC and the Board, that the physician has successfully completed a program in which the hospital has confidence.

- Upon sufficient proof that the physician has successfully completed a rehabilitation program, that physician may be considered for reinstatement to the medical staff.
- In considering an impaired physician for reinstatement, the hospital and medical staff leadership must consider patient care interests paramount.
- The Wellness committee must first obtain a letter from the physician director of the rehabilitation program where the physician was treated. The physician must authorize the release of this information. That letter shall state:
 - - Whether the physician is participating in the program
 - Whether the physician is in compliance with all of the terms of the program
 - Whether the physician attends AA meetings or other appropriate meetings regularly (if appropriate)
 - To what extent the physician's behavior and conduct are monitored
 - Whether, in the opinion of the director, the physician is rehabilitated
 - Whether an after-care program has been recommended to the physician and, if so, a description of the after care program, and
 - Whether, in the director's opinion, the physician is capable of resuming medical practice and providing continuous, competent care to patients.
- The physician must inform the Wellness committee of the name and address of his primary care physician and must authorize that physician to provide the hospital with information regarding his condition and treatment. The committee has the right to require an opinion from other physician consultants of its choice.
- From the primary care physician, the committee needs to know the precise nature of the physician's condition and the course of treatment as well as the answers to the questions posed as above to the physician director of the rehabilitation program.
- Assuming all of the information received indicates that the physician is rehabilitated and capable of resuming care of patients, the Wellness committee, Medical Executive Committee and the Board shall take the following additional precautions when restoring clinical privileges:
 - The physician must identify another Staff physician who is willing to assume responsibility for the care of his patients in the event of his inability or unavailability; and
 - The physician shall be required to obtain periodic reports for the Wellness committee from his primary physician for a period of time specified by the Chief Executive Officer-stating that the physician is continuing treatment or therapy, as appropriate, and that his ability to treat and care for patients in the hospital is not impaired.
- The service chairperson or his designee shall monitor the physician's exercise of clinical privileges in the hospital. The Wellness committee shall determine the nature of that monitoring after its review of all of the circumstances.
- The physician must agree to submit to an alcohol or drug-screening test (if appropriate to the impairment) at the request of the Chief Executive Officer, the Chairperson of the Wellness committee, the Chief of Staff or the pertinent service chief.

Adopted by the Medical Staff June, 2005 and approved by the Board July, 2005.

MEDICAL STAFF RULES & REGULATIONS

APPROVED & ADOPTED:

MEDICAL STAFF:

By: _____

Chief of Staff

Date

BOARD OF TRUSTEES:

By: _____

Chairman

Date

LOS ALAMOS MEDICAL CENTER:

By: _____

Chief Executive Officer

Date

APPROVED AS TO FORM:

By: _____

Corporate Legal Counsel

Date