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Approved: MSEC 12/1/08, Board: 12/23/08

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ADMINISTRATIVE POLICIES
RESPONDING TO INQUIRIES FROM OFFICIAL AGENCIES REGARDING MEDICAL STAFF MEMBER STATUS

I. PURPOSE:
To describe the mechanism of responding to inquiries from official agencies and to assure consistency.

II. POLICY:
Written guidelines shall direct the processing of all inquiries from official agencies.

III. DEFINITION:
An "official agency" is an agency of the federal or state government, or a private agency which by law has been authorized to act for and on behalf of government, which, acting under color of law, seeks information regarding a practitioner's credentials, practice, or other comparable practitioner information.

IV. PROCEDURE:
Upon receipt of an inquiry from an official agency regarding a Medical Staff member's status (which contains no signed physician's authorization to release and report), and following verification of the legitimacy of the request, the following processes will be used for responding:

1. The Medical Director of Performance Improvement or Credentialing will inform the Medical Staff Member for whom the inquiry was made and the Department Chairperson.

2. The necessary information in the physician's credentials file will be reviewed by the Medical Director of Performance Improvement or Credentialing, or their designee.

3. The Medical Director of Performance Improvement or Credentialing will draft a response, which is accurate, concise, and limited to the legitimate request made. If necessary, legal advice will be obtained to verify the legitimacy of the request.

4. Upon completion of a response, the Medical Director of Performance Improvement or Credentialing will send a response to the requesting agency. Copies of the response will be placed in the physician's credentials file and sent to the physician and Department Chairperson.

5. No information from a physician's peer review file, nor any other peer review information or data, which are protected from disclosure pursuant to the provisions of MCL 333.20175, MCL 333.21515, MCL 331.531, MCL 331.533, and other state and federal laws, will be released, whether
in response to informal or formal requests from agencies of other organizations, or in response to subpoenas. For purposes of this policy, peer review information shall mean records, data, and knowledge collected by or for individuals or committees of the hospital or the hospital Medical Staff assigned or performing a function of professional review, peer review, review of morbidity and mortality, preventability of deaths and complications, quality and necessity of care, and improvement of care. It may include, but is not necessarily limited to, performance improvement information, credentialing information, morbidity and mortality reports, peer review committee records and minutes.

6. When an inquiry from an official agency is made the Hospital will query the National Practitioners Data Bank.

**CONTENT OF THE CREDENTIALS FILES**

A separate file shall be kept on each member of and each applicant to the Sparrow Health System Medical Staff. The file shall be secured within the Medical Staff Office and access limited to those individuals who are specifically authorized to do so within the current Medical Staff Policy and Procedure Manual. Office staff shall supervise the review of a Credentials File by any non-Medical Staff Office personnel.

Material may be placed within the file only by the Medical Staff Office personnel.

Duration of retention of material with the file shall be determined by current policy on retention of documents within the Credentials File. The term “physician” from this point forward in this document shall refer to any member of the Sparrow Hospital Medical Staff, whether M.D., D.O. D.P.M., D.M.D., or D.D.S.

The file shall contain all previous and current Medical Staff appointment and re-appointment applications with all additional required supporting documentation. This shall include copies of all documents which are produced or acquired by the Medical Staff office in the course of processing the application in the manner described in the current Medical Staff Policy and Procedure Manual or as required by the current Medical Staff Bylaws.

The file shall additionally contain copies of:

1. Committee minutes which described actions or recommendations of actions to be taken on the clinical privileges or staff status of the physician.
2. Board letters which address the physician’s clinical privileges or staff status.
3. Monitoring forms regarding the performance of clinical privileges.
4. Letters or other formal communications from Hospital Administration or Medical Staff Leadership which pertain to the physician’s Medical Staff Membership, staff status or the exercise of clinical privileges.

A blank copy of a current initial / reappointment application is attached as an illustrative example.

MSEC: 8/5/02
BOARD: 8/27/02

CONTENT OF MEDICAL STAFF QI FILE

A separate file will be maintained in the Medical Staff Office on each member of the Sparrow Hospital Medical Staff and will be named the “QI File”. The file shall be secured within the Medical Staff Office, and access to file will be limited to individuals specifically authorized to review the file by the current Medical Staff General Policy and Procedure Manual. Office staff shall supervise the review of a QI File by any non- Medical Staff Office personnel.

Material may be placed into the file only by the Medical Director of Credentialing, the VPMA or by one of their designees.

Duration of retention of material with the file shall be determined by current policy on retention of documents within the QI File. The term “physician” from this point forward in this document shall refer to any member of the Sparrow Hospital Medical Staff, whether M.D., D.O. D.P.M., D.M.D., or D.D.S.

Documents and material to be included in the QI File shall include the following physician-specific documents or information:

1. Periodic general reports of physician performance such as the “Physician Report Card”.
2. Special reports of physician performance which may from time to time be generated by Medical Staff or Hospital Committees.
3. Reports, summaries, or minutes of general or special Peer review activities concerning the physician.
4. Letters of concern, complaint, criticism, or praise, which have been evaluated by the Director of Credentialing, and judged to be appropriate for the QI File. The physician shall be afforded a 30 day opportunity to review such documents and append additional information or comment.
5. Copies of any special awards or certificates of commendation.
6. Memoranda of Understanding
7. Reports of adverse action taken against the physician’s privileges, or summaries of restrictions placed thereupon.
8. Copies of formal or file notes taken by the Medical Director of Credentialing in the course of the discharge of his/her duties regarding special investigations.
9. Copies of documents received from external sources which pertain to the physician’s performance at other hospitals or healthcare organizations which would not ordinarily be included in the physician’s Credentials File.
10. Copies of documents from the external sources which pertain to restrictions, limitations, or sanctions placed on the physician’s license or eligibility to practice or exercise clinical privileges.
11. Summary documents of actions taken as a result of a Fair Hearing.
12. Re-appointment worksheets prepared by the Medical Staff Office which summarize the contents of the file to assist authorized reviewers at the time of physician’s re-appointment.

Additionally, the Medical Director of Credentialing may, at his/her discretion, include other documents or information not specifically described above, if:

The document is accompanied by a note from the Director of Credentialing which explains the rationale for inclusion of the document and the physician has been provided with a copy of the material to be included.

The physician shall be notified in writing of any material of an adverse nature to be placed within the file, and be offered a 30 day opportunity to append additional information or comment.

DOCUMENT RETENTION IN MEDICAL STAFF CREDENTIALS AND QI FILES

It is the policy of Sparrow Hospital that documents placed in a Medical Staff member’s Credentials File or Quality Improvement File remain on file in perpetuity unless the individual document itself specifies a duration of retention or a condition under which the document is to be expunged. In that case, the document will be removed and destroyed on the specified date or after the specified conditions have been met.

CONFIDENTIALITY OF PHYSICIAN SPECIFIC PERFORMANCE IMPROVEMENT FILES AND CREDENTIALS FILES

I. STATEMENT OF PURPOSE:
To describe the mechanisms whereby the confidentiality of the performance improvement and credentials files are maintained.

II. **STATEMENT OF POLICY:**
Performance improvement files are maintained, separate from the credential files, for each practitioner. These files shall not be made available to anyone other than stated in this policy.

III. **PROCEDURE:**

- A performance improvement file and a credential file will be maintained for each practitioner
- The files will be secured in the Medical Staff Office
- The following will have access to the QI files at request
  - The Attending Physician
  - Department Chairperson
  - CEO
  - Vice President of Medical Affairs
  - Chief of Staff
  - Performance Improvement Medical Director
  - Performance Improvement Manager
  - Risk Manager
  - Medical Director of Credentialing
- All other request will be directed through the Departmental Chairperson

IV. **NOTIFICATION OF QUERY:**
If the QI file is queried for any other reason than general administrative functions the attending practitioner will be notified

V. **MAINTENANCE OF FILES:**
The files will be maintained by the Performance Improvement Manager
review function. These documents shall not be duplicated nor made available to anyone without the authority of the peer/professional review committee which generated the document or for which the document was prepared.

III. PROCEDURE
1. Information collected for committees related to the review and analysis of professional practice shall be subject to control measures to ensure confidentiality. Those documents include, but are not limited to memoranda, statistical and other reports, and additional tools used to gather data such as worksheets. Safeguards to ensure confidentiality of documents include:

- Patient and physician names shall be identified by history number and physician number only.
- Documents reproduced and circulated at meetings are for use only during the meeting and shall be collected at the end of each session and destroyed.
- Original documents shall be maintained in a secure location in the Medical Staff Office.
- Access shall be limited to the peer review process and shall be for committee/department use only.

2. Information generated by committees/departments related to the review and analysis of professional practice is also subject to control measures to ensure confidentiality. Those documents include, but are not limited to committee minutes, reports, and correspondence. Safeguards to ensure confidentiality of these documents include:

- Patients' and physicians' identities shall be indicated by history number and physician number only.
- Minutes may be circulated to committee members with notice of meetings and agendas.
- Reports and/or correspondence may also be distributed with minutes provided that code numbers for patient and physician names are utilized.
- Reports and correspondence where code numbers are not used shall be distributed at the meeting; they will be collected again at the end of the meeting and destroyed.
- All original documents shall be maintained in a secure location in the Medical Staff Office.
- Access shall be limited to the peer review process and will be for committee/department use only.

3. Persons with access to the Minutes at request:
- CEO
- Vice President of Medical Affairs
- Chief of Staff
- Department Chairpersons
- Medical Director, Credentialing
- Department/Committee Members
- Risk Manager
- Quality Improvement Personnel

All other request for review of minutes will need to be approved by the Chairperson of the Department involved.
INTERNAL AND EXTERNAL REPORTING OF CHANGES IN PRIVILEGES

PURPOSE:

To describe the mechanisms whereby internal and external reporting of any changes in Medical Staff privileges, Allied Health Professionals' privileges or service authority, or a dentist's privileges are consistent and follow requirements of governing agencies.

POLICY:

Written guidelines shall direct the communication of changes in a physician's medical staff privileges, an Allied Health Professional's privileges or service authority, or a dentist's privileges, internally as well as externally.

PROCEDURE:

A. INTERNAL
   1. When all or part of a physician's, Allied Health Professional's, or dentist's privileges are voluntarily relinquished, suspended temporarily, or revoked permanently the following will be notified in writing:
      a. Admitting
      b. Health Information Management
      c. Nursing Administration
      d. Surgery
      e. The Physician, Allied Health Professional, or Dentist
      f. Chairperson of the Department the physician is affiliated with

   2. When all or part of a physician's, Allied Health Professional's, or dentist's privileges are voluntarily relinquished, suspended temporarily, or revoked permanently the following changes will be made:
      a. Changes will be made in the following computer systems where appropriate, (the physician or health care professional had been previously entered on the computer system):
         1. Medical Staff Line
         2. iSparrow EMR (Epic)

B. EXTERNAL
   1. External reporting will occur as directed in the National Practitioner Data Bank Policy (policy number 06) and The Michigan Public Health Code.

NATIONAL PRACTITIONER DATA BANK

QUERYING THE DATA BANK

I. STATEMENT OF PURPOSE:
To assist the medical staff with privileging decisions through querying of the National Practitioner Data Bank.

To assure compliance with the requirements of the Health Care Quality Improvement Act of 1986 related to facility communications with the National Practitioner Data Bank.

II. STATEMENT OF POLICY:
The National Practitioner Data Bank shall be queried for physicians, dentists, and other health care professionals for disclosure of professional competence or conduct deficiencies.

III. PROCEDURE:

1. The Data Bank will be queried for the following instances:
   A. Screening all initial physician and dentist applicants to the Medical Staff and such categories of allied health professional who (as determined by the CEO or his designated), are to be credentialed by Sparrow Hospital and granted clinical privileges, who request clinical privileges at the hospital;
   B. Reappointment every two years for all physician and dentist members of the Medical Staff and those designated allied health professionals who have been granted privileges;
   C. At other times as the hospital deems necessary. (See reporting to the Data Bank)

2. Assignment of Responsibility for Querying the Bank
   The Director of Medical Staff Resources or the Medical Director of QI and Credentialing will be the officials Authorized to query the Data Bank. The medical Staff credentialing staff shall be responsible for completing and forwarding appropriate forms and for receiving and securing Data Bank reports.

3. Confidentiality and Access
   Reports to/from the National Practitioner Data Bank will become part of the physician's credentialing file, shall be considered confidential and shall be subject to Sparrow Hospital's Peer Review Confidentiality Policy.

4. Administration
   The CEO, or his designee(s), shall be responsible for administering this policy

REPORTING TO THE DATA BANK
I. STATEMENT OF PURPOSE:
To provide a mechanism for reporting adverse peer review actions against medical staff membership/clinical privileges to the National Practitioner Data Bank.

To assure compliance with the requirements of the Health Care Quality Improvement Act of 1986 related to facility communications with the Bank.

II. STATEMENT OF POLICY:
Sparrow Hospital is required to report any professional review action taken by Sparrow Hospital based on reasons related to competence or professional conduct which adversely affects a practitioner's clinical privileges for a period longer than thirty (30) days. The hospital must also report the voluntary surrender or restriction of clinical privileges while under, or to avoid, investigation relating to questions of competence or professional conduct. For purposes of this Reporting Policy, a "practitioner" shall mean physicians and dentists, in accordance with the Act; provided however that if the Health Care Quality Improvement Act is amended to require reporting of additional or other health care practitioners, the definition of practitioner under this policy shall be deemed to be automatically amended to conform to the statutory amendment.

1. REPORTABLE ADVERSE ACTION:
Adverse actions which are reportable to the Data Bank are those affecting a practitioner's clinical privileges for greater than thirty (30) days, and which are based on competence or professional conduct.

Examples of reportable adverse actions include but are not limited to the following, where such actions are based upon review of the practitioner's competence or professional conduct.

A. Denial of request for clinical privileges as a result of assessment/evaluation of professional competence and/or conduct.

B. Revocation, suspension or restriction of appointment or reappointment and/or clinical privileges due to review of practitioner while under observation status;

C. Reduction, restriction, denial, suspension, non-renewal or revocation of clinical privileges for greater than thirty (30) days.

D. Peer review actions resulting in monitoring requirements that require co-management and/or approval of a proctor before medical care is rendered or specified procedures performed;
E. Voluntary restriction or withdrawal of clinical privileges in return for the hospital not taking adverse action, or during investigation relating to circumstances stated above.

F. Non-renewal of clinical privileges for failure to meet reappointment/renewal criteria relating to specific privileges when the criteria are established to assure an expected level of current competence;

2. NON-REPORTABLE ACTIONS:
Adverse actions affecting the clinical privileges of a Staff Member and/or initial applicant which are process/technical in nature and which are not based upon the practitioner's competence or professional conduct shall not be reportable to the Data Bank. These include but are not necessarily limited to the following:

A. Denial, revocation or suspension of clinical privileges and/or non-reappointment to the Medical Staff for failure to provide adequate proof of professional liability insurance;

B. Failure to provide additional documentation as requested in support of initial/renewal request(s) for clinical privileges;

C. Suspension, restriction and/or revocation of clinical privileges for failure to timely complete medical records;

D. Change to Medical Staff status due to failure to comply with meeting attendance or other administrative requirements, which do not reflect upon competence or professional conduct, as determined by the CEO or his designed;

E. Voluntary restriction and/or surrender of clinical privileges and/or withdrawal of request for privileges for personal reasons while not under investigation;

F. Denial of clinical privileges because of the hospital's inability to support such practice (e.g. lack of facilities, technical support etc.).

3. DETERMINATION OF REPORTABILITY:
The determination whether an adverse action which has been taken or recommended is reportable to the National Practitioner Data Bank shall be made by the CEO or his/her designee, following consultation with the Department Chairman of the affected Medical Staff member, Chief of Staff and/or Vice President of Medical Affairs, as deemed appropriate by the CEO (or his/her designee).
4. **SUBMISSION OF ADVERSE ACTION REPORTS:**
   Following the occurrence of an adverse action, the determination that such action is reportable and the preparation of an "Adverse Action Report," the Staff Member will be provided a copy of the proposed report and notified that he may have five (5) days in which to submit any suggested revisions to the proposed report. The CEO (or his/her designee) shall consider any suggested revisions timely submitted by the practitioner and may but is not obligated to, make revisions to the Adverse Action Report which the CEO (or designee) deems appropriate. Sparrow Hospital shall submit "Adverse Action Reports" to the State Medical/Dental Board within fifteen (15) days of the action being taken.

5. **REPORTING OF REVISION TO ACTION:**
   The CEO (or his designee) shall as deemed appropriate by him, report substantive revisions of an adverse action initially reported. Such revisions include reversal of a professional review action or reinstatement of clinical privileges or professional society membership.

6. **REPORTING ERRORS OR DISPUTES:**
   The CEO (or designee) may, in his discretion, submit to the National Practitioner Data Bank information correcting a previously submitted Adverse Action Report of information concerning a dispute with respect to a previously submitted Adverse Action Report.

7. **REPORTING TO STATE**
   Where a report to the State is required under the Michigan Public Health Code but not the National Practitioner Data Bank, the report shall be made by the CEO or designee. Typically such reports may be required for short periods of discipline (15 to 29 days) or other changes in status. Such reports shall be made in a form which meets legal requirements.
ALLIED HEALTH PROFESSIONALS GOVERNANCE POLICY

The purpose of this Policy is to describe the procedures by which Allied Health Professionals are selected and governed within the System.

In addition to those set forth in the "Definitions and Interpretation" section of the Sparrow Health System Medical Staff Bylaws which are incorporated by reference; the following definitions shall apply to this Policy:

“Dependent AHP” means any AHP who is: employed by a Member, a practice entity of Members, or the System. The dependent AHP will practice, if at all, in the System only under the supervision of a Supporting Member; and entitled only to Specified Service Authority.

“Independent AHP” means an AHP who: is licensed to practice independent of supervision by another health professional; if a System employee, is not in an area of practice which traditionally has been credentialed and overseen through Hospital employment mechanisms; will be assigned for professional oversight to a Medical Staff Department; and is eligible to obtain Privileges.

“Sponsoring Member” means a Member who is responsible for supervision of a Dependent AHP.

“Advanced Practice Professional” means an individual who is licensed to practice independent of immediate direct supervision by another health Professional; and may be eligible to obtain Authorized Function. This is another term for AHP. These include Nurse Practitioners, Physician Assistants, Clinical Psychologists, Audiologists, and CRNAs and are eligible for privileging through the Medical Staff.

“Practice Assistants” are by virtue of their license not entitled to make independent medical decisions or write orders, and their education and training will be verified; and their competency assured, through Human Resources channels, utilizing job descriptions and competency evaluations rather than privileges.

Examples of these fields would include, not limited to:
Clinical Academic Affiliates
Medical Assistants
Nurses (RN, LPN)
Occupational Therapists
Orthotists
Professional Counselors
Genetic Counselors
Perfusionists
Pharmacists (Clinical)
Physician Therapists
Surgical Assistants
Social Workers (Medical)
Technicians (Laboratory, Ophthalmic, Radiologic, Research, Surgical)

AHPs shall not be Members and, therefore, shall not be eligible to vote or hold office in the Medical Staff organization nor shall they be entitled to the procedural rights specified in the Review Procedures Appendix. Procedural rights of AHPs are those specifically provided in this Appendix.

HOSPITAL CERTIFICATION

Hospital Certification Based Area of Practice

Unless otherwise decided by the Board, before AHPs in any field of practice will be approved, the President or designed after consultation with the AHP Credentialing Committee, must certify that the inclusion of AHPs from that field:
- is consistent with Hospital long-range planning including human resource plans;
- is consistent with Hospital-focused considerations
- is consistent with efficient System operations;
- will improve the quality and/or cost-effectiveness of System operations;
- will not materially impair the viability or effectiveness of System services and programs.

Limit of Numbers. Unless otherwise decided by the Board, at any time the President or designed may, after consultation with the AHP Credentialing Committee, and based upon the consideration set forth above, place a limit on the number of persons in a particular field of practice who may be AHPs; provided that such limit may not, unless otherwise decided by the Board, be applied to require the termination of appointment of existing AHPs.

Recognized Types of AHPs.
The following are recognized as approved AHP fields of practice subject to the President's certification and any limits of numbers:

Independent
- Audiologist
- Psychologists (Clinical)

Dependent
- Nurse Practitioners (NP)
- Certified Nurse Midwives (CNM)
- Certified Registered Nurse Anesthetists (CRNAs)
- Certified Nurse Specialists (CNS)
- Physician Assistants (including Certified Anesthesiologist Assistants)
The AHP fields listed above are examples not meant to serve as an all-inclusive list. All clinical privileges are given to AHPs through Medical Staff channels 
and upon recommendation to the Board of the Sparrow Health Care System.

REQUIREMENTS FOR APPOINTMENT AND PRIVILEGES

APPLICATIONS

Each individual AHP shall provide:

* Non-refundable application fee
* Completed application
* Curriculum vitae or resume
* Copy of certified transcript of grades and dates from each professional school attended
* Copy of diploma or certified of completion of training.
* List of requested Privileges Service Authority/Summary of Job Responsibilities in the Hospital
* Copy of current certification or license
* Copy of DEA registration and state controlled substance license (if Applicable)
* Required references
* Evidence of the required professional liability insurance.
* Copy of a PPD skin test taken in the past year, with no evidence of active pulmonary tuberculosis.
* Copy of a driver’s license with a photograph

APPLICATION PROCESS

The Application. Each person seeking to be an AHP in the System will complete and submit an initial application form for either privileges or service authority. Each application must be supported by three professional references. Applications for a Dependent AHP also require a co-signature by the Sponsoring Member that employs or will otherwise sponsor the AHP. APRNs require a signed collaborative agreement with the sponsoring physician consistent with current Sparrow institutional policy. The applicant's responsibilities shall be the same as that of an applicant to the Medical Staff as specified in the Bylaws and Procedures Manual.

Unapproved Field. When an applicant seeks appointment as an AHP in a field for which is not already an approved field of practice, the applicant shall have the burden of including with his application a request that his/her field be approved and the best support for that position he/she can provide. Such support may include: a narrative description of the types of services provided by the applicant; medical or professional literature describing the field, including the kinds of services its practitioner offer (in contrast to services already available in the System); information relevant to quality and cost-effectiveness data; and/or verifiable experience with other health care institutions (e.g., signed statements). The AHP Credentialing Committee shall have discretion to decide whether consideration of such field approval will precede or be contemporaneous with consideration of the applicant as an individual.
Verification of the Application. Following verification of education, training, and receipt of required professional references, assessment of the application and related documents will occur. NPDB will be accessed when applicable and application contents verified as required of a medical staff applicant as specified in the Credentials Policy & Procedure Manual. If necessary, a follow-up deficiency letter is sent to the reference requesting additional information promptly after receipt of the application. If reference responses are still not received, another request for outstanding references will be generated with simultaneous involvement with the applicant to assist in promptly obtaining references. If 30 days after that request, the application is still not verified, a letter indicating the application is considered withdrawn is sent to the applicant and, if applicable, the Sponsoring Member.

Committee Recommendations and Board Action. Upon receipt of all references and required credentialing documents in the Medical Staff Office, the application is forwarded to the AHP Credentialing Committee. As a designee of the Chief Nursing Officer, an APRN will review and recommend to the AHP Credentialing Committee all APRN applications. If Hospital certification has occurred, the Committee will evaluate the application, may interview the applicant and will make a report to the Credentials Committee. The Credentials Committee will consider all of the foregoing and make a recommendation to the MSEC which shall review the material and forward the application along with a recommendation to the Board for consideration. The Board will then grant or deny final approval of Privileges or Service Authority, with a letter sent to the applicant and copy to the Sponsoring Member, if a Dependent AHP applicant. Notice to Medical Staff Departments of newly appointed AHPs is also provided. A period of 30 days is reasonably expected at each step of the review process once the application has been verified.

TEMPORARY PRIVILEGES OR SERVICE AUTHORITY

Temporary Privileges or Service Authority are an extraordinary measure utilized to provide skills of an AHP needed by or in the Hospital on an expedited basis. They shall not be granted solely for the convenience of an AHP or a Member.

Circumstances. Upon the concurrence of the Chair of the Department in which the Privileges or Service Authority will be exercised and the Physician Administrative Officer, the President acting on behalf of the Board may grant temporary Privileges in the following circumstances:

- **Care of Specific Patients:** Temporary Privileges for the care of one or more patients to an appropriately licensed Independent AHP upon delivery of a written request to the President from the AHP. Such Privileges shall be restricted to the treatment of not more than 4 patients in any one-year by any AHP. This limitation may be modified by Departmental rules or upon the specific approval of the MSEC.
- **Locum Tenens:** When the service of an AHP in the joint judgment of the President and COS is necessary to continue appropriate operation of the Hospital or a Service Line, an AHP qualified to provide such services may be granted temporary Privileges or Service Authority as were granted to others he/she is temporarily replacing or of whom he/she is working as peer. Each Department where locum tenens practice is authorized shall establish its own requirements in the Department rules.
Community Disaster: In the event of a disaster in the community that requires additional AHP services, AHPs may be granted temporary privileges limited to treatment of patients at the request of and under the supervision of a sponsoring appointee of the medical staff. Unless terminated earlier for reasons related to competency or conduct, the temporary privileges shall terminate at the point the need for services subsides, as determined by the President and either the Chief of Staff or VPMA.

Credentialing Review. An AHP seeking temporary Privileges or service authority may be interviewed by the Department Chair or Physician Administrative Officer. In case of an APRN, an APRN designee of the Chief Nursing Officer will review and recommend prior to the Department Chair. The AHP must submit adequate evidence of his/her identity and qualifications, which at minimum shall include a copy of his/her driver's license with photo, a copy of current license, a copy of his/her authority to prescribe restricted drugs if applicable, and a favorable reference from a physician from a reputable healthcare facility concerning his/her capabilities. The reference requirement may be waived by the President or Physician Administrative Officer when temporary Privileges or service authority are granted solely for the care of specific patient at the request of the attending Member.

Before temporary Privileges or Service Authority are granted, the AHP must acknowledge in writing that he/she has received and read those sections of the Bylaws, the Rules and this Policy and Department rules which would govern his/her temporary activities within the Hospital.

Supervision and Termination. AHPs who are performing services in the System pursuant to temporary Privileges or Service Authority granted in accord with this section shall be under the supervision of the Sponsoring Member. Special requirements such as mandatory consultation may be imposed by the Chair of the Department responsible for supervision of the AHP granted temporary Privileges or Service Authority. The COS, the President, the Physician Administrative Officer or Department Chair, or the MSEC shall be entitled to suspend or revoke such temporary Privileges or Service Authority when the conduct of the AHP holding such temporary Privileges or Service Authority so indicates. In the event of any such termination, the Department Chair responsible for supervising that AHP shall assign any of his/her patients in the Hospital to another AHP or Member. The wishes of the patient shall be considered where feasible in choosing a substitute.

PRIVILEGES OR SERVICE AUTHORITY
For those categories of AHPs for whom a Privileges or Service Authority list has been developed, an applicant will be asked to indicate which Privileges or Service Authority from that list he/she wishes. If the applicant wishes Privileges or Service Authority not on the list, they will be considered individually by the AHP Credentialing Committee. For those categories for whom a privileges list has not been developed, the applicant will be asked to indicate, in detail, what they wish to do as part of their duties in the System and that list will be considered in the delineation of privileges or authority.
**Monitoring.** When an applicant is granted provisional privileges or service authority, his/her clinical competency will be evaluated by a monitoring process. Unless the AHP Credentialing Committee believes for good reason more or fewer cases should be monitored, six cases of substance shall be monitored to include evidence of competency for privileges requested. Monitoring forms will be forwarded to the applicant along with the name of the assigned monitor. The assigned monitor will be the Sponsoring Member, a Member from the specialty department closely related to the specialty of the AHP applicant, or designated AHP member. The monitor shall submit in writing to the AHP Credentialing Committee, the information which pertains to the monitored cases. The monitoring evaluation will recommend:

- Removal from monitoring with privileges or authority requested; or
- Reason for continued monitoring; or
- Exception(s) and limitation(s); or
- Complete denial of privileges or authority in a specific category.

When there is a pre-defined Privileges or Service Authority list for the AHPs field, the applicant will be monitored according to criteria included in the list. If requested Privileges or Service Authority are not included in a pre-defined list, the specific monitoring requirements will be set at the time and to the extent that Privileges or Service Authority are provisionally granted.

**Appointment Decision.** The AHP Credentialing Committee will review and report in writing to the Credentials Committee. The Credentials Committee will make recommendation to the MSEC and the recommendation of both bodies shall be forwarded to the Board. The Board will communicate to the AHP and his/her Sponsoring Member, in writing, the final decision. Dependent AHPs, granted Service Authority regardless of monitoring completion, will continue to perform under the supervision of the Sponsoring Member.

**REAPPOINTMENT/RENEWAL OF PRIVILEGES**

After an AHP has successfully completed the provisional period, AHP Privileges will be renewable for a two-year period in September of each odd numbered year. Renewal application for a Dependent AHP shall be co-signed by his/her Sponsoring Member. An Independent AHP shall apply for renewal of Privileges on his/her own behalf. The renewal of AHP Privileges or Service Authority will be based in part upon written evaluation of the AHP’s performance by his/her Sponsoring Member, if any, and any supervising AHPs who have used his/her services. All requests for renewal must be submitted on the prescribed form as developed by the AHP Credentialing Committee and/or appropriate Department and approved by the MSEC. Providing the information on the appropriate form is the specific responsibility of the Independent AHP or the Sponsoring Member of the Dependent AHP. Action on the renewal application will ordinarily take place within 90 days and the recommendations forwarded to the MSEC.
SERVICE AUTHORITY TIE TO SPONSORING MEMBER

In the event a Dependent AHP is no longer employed by his/her Sponsoring Member or the AHPs Sponsoring Member no longer holds Privileges in the System which would permit supervision of the Dependent AHP, all Service Authority of the Dependent AHP shall cease. Further activity in the System, thereafter, shall be conditioned upon the AHP either arranging for another Sponsoring Member or meeting other criteria established by the MSEC on a general or case-by-case basis.

RESPONSIBILITIES

GENERALLY

Each AHP providing services within the System must:
- Provide patients with care at the level of quality and efficiency recognized as appropriate and required by the Medical Staff and System;
- Abide by the existing Bylaws, appendices and Rules of the Medical Staff as they apply to AHPs, and abide by System policies including any additional rules and policies which may be specifically developed for AHPs;
- Have a residence and office, where applicable, located sufficiently close to the Hospital in order to enable prompt and continuous care to his/her patients, and to comply with other required System-related responsibilities;
- Be trained on iSparrow electronic medical record.
- Prepare and complete in a timely fashion appropriate portions of all required records for patients he/she provides services to in the Hospital;
- Abide by generally recognized standards of professional ethics;
- Refrain from any conduct or acts that are or could reasonably be interpreted as being beyond or attempting to exceed the scope of practice authorized for him/her in Hospital;
- Be subject to and participate in quality review program activities and in discharging such other functions as may be required from time to time by the MSEC or the Board;
- When appropriate, attend educational programs of the Medical Staff;
- Notify the President or his/her designed and/or the Sponsoring Member in the event of any investigative, disciplinary, or limiting action of the AHP by any state licensing board or healthcare facility; and
- Immediately report to the MSEC any change in professional liability insurance covering him/her.

ADDITIONAL RESPONSIBILITIES OF INDEPENDENT AHPs

Independent Allied Health Professionals shall:

Exercise independent judgment in their areas of competence, provided that a member of the Medical Staff shall have the ultimate responsibility for patient care. The actions of independent AHPs shall be the responsibility of the members of the Medical Staff who request their services.
Participate directly in the management and care of patients under the general supervision or direction of the Medical Staff.
Record reports and progress notes on the patients' records and write orders for treatment, provided that such orders are within the scope of their license, certificate or other legal credential.
Not admit or discharge patients to the Hospital.
Serve on appropriate committees of the Medical Staff, as appointed by the COS, and exercise voting privileges on such committees.

CORRECTIVE ACTION

INITIATION

Grounds. Corrective or administrative action may be instituted as to an AHP for any of the grounds that are specified in the Bylaws.

Initiation of Corrective Action for Hospital Employees. Any member of the Medical Staff who reasonably believes that one or more of the grounds set forth in Article VII of the Medical Staff Bylaws are present with respect to an AHP employed by the Hospital shall report that belief to the office of the President. Any action on the foregoing shall be in a manner which is consistent with established Hospital personnel policies and procedures. The action in accordance with such personnel practices shall be final.

Corrective Action for Non-Employees of the Hospital. Any two of the following: the President or designee; the Chair of a Department or division; Physician Administrative Officer; COS; or COS-elect; who reasonably believe that the grounds set forth in Article VII of the Medical Staff Bylaws are present may jointly initiate corrective action by suspending the specified service authority of the AHP with a written notice to the AHP of such action, or if immediate action is not required, issuing a written notice of the pendency of the corrective action to the AHP. If not involved in the corrective action, a copy of the written notice shall be promptly given to MSEC, the President and, where applicable, the Sponsoring Member of the AHP.

Investigation and Hearing. Within thirty (30) days of a suspension, the MSEC shall appoint a qualified person or persons to conduct an investigation. The AHP Credentialing Committee shall then provide an opportunity for the persons initiating corrective action, witnesses to any events and the affected AHP to appear and make informal presentations of the respective positions and/or observations. Minutes shall be kept of this informal hearing.

AHP Credentialing Committee Action. Following its investigation, the AHP Credentialing Committee shall then make any one or more of the following recommendations:
rejecting corrective action;
issuing a written warning;
issuing a letter of admonition or reprimand;
imposing a probationary period;
issuing suspension or revocation of AHP status;
other action deemed appropriate.

The report of the investigation, the minutes of any hearing and the recommendation of the AHP Credentialing Committee shall then be provided to the affected AHP, the Credentials Committee, the COS, the MSEC and the Board. The affected AHP may submit a written statement for consideration by the MSEC. The Credentials Committee may issue its own written statement concerning the AHP Credentialing Committee recommendation to the MSEC.

MSEC AND BOARD ACTION

The MSEC shall make its recommendation to the Board upon receipt of the AHP Credentialing Committee's recommendation, the informal hearing minutes and any written statements which the initiators of the corrective action, the affected AHP or the Credentials Committee elect or provide.
If the MSEC's recommendation is for corrective action then the COS will forward that recommendation to the Board who shall review the record and take action.

If the Board's proposed action would have the effect of substantially changing the MSEC's recommendation, the matter shall be referred to the Board Quality Committee whose action shall be the final action when ratified by the Board.
At any step in the process, the MSEC or the Board may refer the matter back to the AHP Credentialing Committee or Credentials Committee with directions for further review, report and/or the conducting of any further hearing procedures the Board deems appropriate. The Board's action shall be final.

NOTICE TO THE AHP

When the Board's action is determined, the President shall notify the affected AHP in writing within 30 days. That action shall be final.

GENERAL PROVISIONS FOR ALLIED HEALTH PROFESSIONALS

PROFESSIONAL LIABILITY INSURANCE

Each AHP granted Privileges in the Hospital shall have and maintain in force professional liability insurance in not less than the minimum amounts as shall be determined by resolution of the MSEC and approved by the Board. AHPs shall be subject to the same obligations regarding professional liability insurance as set forth in the Bylaws.
PHYSICAL AND MENTAL HEALTH QUALIFICATIONS

Each AHP who requests or is granted Privileges or Services Authority within the System may be required upon request of the AHP Credentialing Committee, the MSEC or the Board to receive a physical or mental health examination to assist the AHP Credentialing Committee, MSEC or the Board in determining the ability of the AHP to safely exercise the Privileges or Service Authority requested or granted. If such examination(s) shall be required, the authorized body requesting the examination(s) shall select two practitioner(s) to perform such examination(s) of which the AHP involved shall choose one. The expense for the examination(s) shall be the responsibility of the System. The findings of the examination(s) shall be directly reported to the chair of the requesting authorized body.

FORMS
Forms required for use in connection with AHP privileges, renewal requests, corrective action, reports and other applicable matters shall be adopted by the MSEC and approved by the Board.

TRANSMITTAL OF REPORTS
Reports and other information which these Bylaws require the Medical Staff to transmit to the Board shall be deemed so transmitted when delivered to the President.

S:\MedStaff\MSR\Medical Staff Services\bylaws\CURRENT MANUALS\AHP Governance Policy revised draft 2-11-13.doc
Revised: Bylaws Committee 2-11-13
CCC: 2-19-13
MSEC: 3-5-13
Board: 3-26-13
PATIENT CARE POLICIES
EMERGENCY DEPARTMENT ON-CALL REQUIREMENTS

In keeping with the Bylaws regarding responsibilities of medical staff members, practitioners wishing to exercise clinical privileges and enjoy the benefits of credentialed medical staff status are required to provide on-call coverage for those diseases, infirmities, and injuries as shall be deemed necessary by their departments. There shall be a call schedule for the Emergency Department requiring such personal evaluation and management for both primary and specialty care.

Exceptions, for reasons of health a Medical Staff Member may request exclusion from on-call responsibilities. If their Department or Section denies this, the decision may be appealed to the Medical Staff Executive Committee. In considering such requests the Medical Staff Executive Committee will proceed in the best manner possible that respects the privacy of the individual Medical Staff member and the burden a Medical Staff member from call places on others. Members of the Medical Staff may, on the basis of long service (greater than 25 years of service or 15 years of service and age of 60 years or greater) request that their call be limited to the lesser of one in eight nights or one-half of the responsibility of others in their department or section.

In cases where there are a very limited number of staff members to take call; although staff members may elect to be on-call more often; no staff member should be required to be on-call more often than every fourth night.

Specialists are required to serve the on-call function for diseases, infirmities, and injuries that are traditionally included in the competency requirements of their specialty and, potentially, in other areas for which they have requested and shown proficiency by their credentials and practice. If privileges or scope of practice are limited by an action of the Medical Staff, arranging for on-call coverage for such areas falls to the Department or Section. If a member of the Medical Staff chooses to voluntarily limit their scope of practice or privileges within their specialty, it is the Medical Staff member’s responsibility to arrange back-up on-call coverage for those areas he/she feels they should not practice within their specialty. Continuous ability to meet these requirements is necessary to maintain active Medical Staff Membership and attestation to this requirement is required for both initial appointment and reappointment to the Active Category of the Medical Staff.

All on-call physicians will meet, at a minimum, all EMTALA requirements of an on-call physician in their area of call. All on-call physicians shall respond in person in an appropriate and timely manner to requests from the Emergency Department attending physician. Such requests must be made directly to the on-call physician in person from the attending ED physician who must have examined the patient. Based on the discretion of the Emergency Department Attending and after discussing the case with the on-call physician, the Emergency Department Attending may require the immediate (less than one hour) presence of the on-call physician. When the personal evaluation of the patient in the Emergency Department by the on-call physician is needed and the need is not defined as immediate, the on-call physician must see the patient in a medically acceptable
time frame (less than 8 hours or lesser time frame as agreed upon by the Emergency
department Attending). The timeframe established will be documented by the Emergency
Department Attending in the patient’s chart and clearly communicated to the on-call
physician by the Emergency Department Attending. If an on-call physician does not have
the capability of responding because of non-interruptible physician responsibilities or
other personal emergencies, the Emergency Department will follow their established
protocol for dealing with such events. When the on-call physician feels that the
Emergency Department request to appear has been unreasonable and/or the policy
inappropriately applied, the on-call physician may afterwards request an examination of
the circumstances by the Vice President of Medical Affairs, the attending physician’s
Department Chair or Chief of Staff.

If confronted with an Emergency Medical Condition that is or is potentially outside the
ability of the on-call physician, the on-call physician will participate in the evaluation,
stabilization and disposition of the patient to the degree the Emergency Department
Attending deems is necessary to effectively care for the patient, subject to the previous
paragraphs outlined.

The Medical Director of the Emergency Department will monthly report to the Medical
Staff Committee events that the on-call coverage system may not have adequately
supported so that the Medical Staff Executive Committee may on an on-going basis
review the effectiveness of call coverage. Definite EMTALA violations or other potential
serious breaches of Medical Staff responsibility will be reported within 24 hours to the
Department Chair (or Vice-Chair), the Chief of Staff (or Chief of Staff-Elect), and the
Vice President of Medical Affairs. The Emergency Department Attending will report
immediate issues at the first of their occurrence to the Administrator on Call.

The Sparrow Health System and its Medical Staff have the responsibility for accepting
emergency transfers from other facilities for conditions for which we have the capacity
and capability to treat. When there is any doubt regarding either the capacity or the
capability to treat a condition, appropriate discussion must occur between the nursing
supervisor (and/or the Administration on Call), the on-call physician, and the Emergency
Department Attending physician. After such discussions, it is the responsibility of the
Emergency Department Attending (or the Administrator on Call) to inform the referring
institution the reasons that transfer cannot occur. The on-call physician must be informed
by the Emergency Department that all decision not to accept a patient must be
communicate to the referring institution by the Emergency Department Attending.

The Vice President of Medical Affairs or the Department Chair shall report to the
Medical Staff Executive Committee any significant breach of medical staff responsibility
for remedial action by the Medical Staff Executive Committee. This action may include:

1. Mandatory, in-person meeting with Medical Staff Executive Committee;
2. Warning letter from Medical Staff Executive Committee outlining the consequences
   of a further breach of medical staff responsibility;
3. An entry into member’s file for consideration during re-credentialing;
4. Restriction of privileges related to the medical condition;
5. Mandatory leave of absence;
6. Temporary suspension of all Sparrow Hospital privileges;
7. Loss of medical staff membership and or clinical privileges;
8. Report to receiving hospital regarding possible EMTALA violation.

TRANSFER OF RESPONSIBILITY FROM THE EMERGENCY DEPARTMENT TO AN INPATIENT ATTENDING PHYSICIAN

A patient to be admitted on an emergency basis who does not have a personal physician will receive attending physician care via the on-call mechanisms established by the Departments and Divisions of the Medical Staff.

An attending member from the Emergency Department will discuss the patient’s condition and any interventions completed or begun with the accepting on-call physician.

After the patient has been accepted by the on-call physician, the Emergency Department Member will enter an order to that effect in the emergency department electronic medical record (EMR) application.

The attending practitioner accepting the transfer of responsibility shall acknowledge so within the medical record within 24 hours.

Each Department will furnish the Emergency Department, in a timely fashion, rosters of on-call physicians for its respective Departments of Divisions.

TRANSFER OF INPATIENT/EMERGENCY DEPARTMENT ON-CALL RESPONSIBILITY

Any Staff Member, who is on call, either for unassigned inpatient admissions or for Emergency Department or inpatient consultations, must arrange for an alternate when the Staff Member will be unavailable to take call.

It is the original on-call Member's responsibility to notify his/her Department Chairperson or Division Chief of the identity of the alternate on-call Member and of the arrangement made to contact that alternate on-call Member.

The Department or Division Chief will then notify the Emergency Department of the change of on-call responsibility and will provide to the Emergency Department the means of contacting the alternate on-call Member.
INPATIENT CONSULTATION

An attending practitioner is primarily responsible for requesting consultation, indicating the specific reason for consultation and obtaining the qualified consultant. It is recommended that the attending practitioner speak directly to the consultant. The attending practitioner or his/her agent shall enter an order into the EMR authorizing the consultation, and the time frame within which it is hoped that the consultation will occur.

At the time the consultant is notified of the need for consultation the timeframe will be communicated to the consultant.

- An emergent consultation is a request for the consultant to see the patient as soon as possible, preferably within one hour of notification.
- An urgent consultation is a request for the consultant to see the patient within several hours, preferably within six hours of notification.
- A routine consultation is a request for the consultant to see the patient within 24 hours.

In addition the requesting physician must indicate (preferably, in the order, as well) on the consultation request form whether he/she desires that the consultant:
- Examine, provide opinion and advice only; or
- Assist in management by entering appropriate orders and/or performing appropriate procedures.

When compatible with patient safety, there is the expectation that the attending practitioner must be aware of the consultant’s diagnostic and therapeutic regimen prior to implementation of that regimen.

After evaluation of the clinical situation, if the consultant has determined that he/she is incapable of personally addressing the problem(s) he/she should help direct appropriate disposition of the patient.

In cases where a patient or family requests consultation or requests a specific available consultant, but the attending practitioner does not wish to comply with the request, the matter will be referred to the department chairperson or division chief.

In such cases where the current attending physician desires that a person who previously had been a consultant now take over management of patient care, provided the consultant has hospital privileges, transfer of care to the consultant will be the method whereby this takes place.
INPATIENT CONSULTANT ON-CALL REQUIREMENT (Mandatory)

In keeping with the Bylaws regarding responsibilities of medical staff members, practitioners wishing to exercise clinical privileges and enjoy the benefits of credentialed medical staff status may be required to provide consultant on-call coverage for those diseases, infirmities, and injuries as shall be deemed necessary by their departments or sections. If such a schedule is deemed necessary, the consultant call schedule for hospital inpatient consultation can, at the discretion of the departments, be the same as the emergency department on call schedule.

On-call consultant physicians or their designees shall respond in an appropriate and timely manner to requests from the hospital attending physician. A request for an emergent or urgent consultation must be made directly to the consultant on-call, in-person from the attending physician who must have examined the patient. At that time it will be determined between these two colleagues whether the consultant needs to see the patient emergently, urgently or within a non-urgent time frame.

- An emergent consultation is a request for the consultant to see the patient as soon as possible, preferably within one hour of notification.
- An urgent consultation is a request for the consultant to see the patient within several hours, preferably within six hours of notification.
- A routine consultation is a request for the consultant to see the patient within 24 hours.

The time frame of the consultation request should be made clear to the consultant on-call and documented in the patient’s electronic record. In addition, the requesting physician must indicate in the consultation order whether he/she desires that the consultant:

- Examine, provide opinion and advice only; or
- Assist in management by entering appropriate orders and/or performing appropriate procedures.

When, there is a difference of opinion regarding the need for consultation or timeliness, the hospital attending physician must call the appropriate department chair (chairman of the department in which the consultant on-call is a member) to seek resolution to the problem.

When the consultant on-call physician feels that the attending physician’s request to appear has been unreasonable, either in terms of necessity of consultation or timeliness, the consultant may afterwards request an examination of the circumstances by the Vice President of Medical Affairs (VPMA), by the consulting physician’s department chair or by the Chief of Staff.

After evaluation of the clinical situation, if the on-call consultant has determined that he/she is incapable of personally addressing the problem(s), he/she should help direct
appropriate disposition of the patient. Failure to provide appropriate, timely consultation shall be considered a breach of medical staff responsibility and shall be reported to the VPMA and the consultant’s department chair.

The VPMA or the Department Chair may order an administrative consultation (if appropriate) and/or shall report to the Medical Staff Executive Committee (MSEC) any significant breach of medical staff responsibility for remedial action by the Medical Staff Executive Committee. This report may include the judgment of the on-call consultant’s department chair and/or VPMA regarding the appropriateness of the request for consultation and timeliness. Action may include:

1. Mandatory, in-person meeting with MSEC
2. Warning letter from MSEC outlining the consequences of a further breach of medical staff responsibility
3. An entry into member’s file for consideration during recredentialing
4. Restriction of privileges related to the medical condition
5. Mandatory leave of absence
6. Temporary suspension of all Sparrow Hospital privileges
7. Loss of medical staff membership and or clinical privileges
8. Letter to the physician who requested the consultation regarding the need for consultation and timeliness.

When a Department or Section requires consultant on call participation, exception to consultant on call, for reasons of health, or on the basis of long service (greater than 25 years on staff) is to be recommended by the department after first being determined within the section of the department (when appropriate). If an individual physician wishes to appeal the decision of his/her department or section, the appeal must be heard and acted upon by the department executive committee. Exceptions must be sanctioned by the Medical Staff Executive Committee and the System Board of Directors.

**HISTORY AND PHYSICAL EXAMINATIONS FOR SURGICAL PATIENTS**

All surgical patients, including ambulatory surgery patients, unless emergency surgery is required, shall have a history taken and a physical examination performed, the results of which must be recorded in iSparrow EMR prior to the start of the surgery. In the event that the preoperative history and physical is recorded in a setting in which iSparrow EMR is not available to the practice, a legible copy of the preoperative history and physical examination shall be provided physically or electronically and stored in iSparrow EMR. Even when transmitted or delivered from an outside source, at a minimum the patient’s medications, allergies, relevant diagnoses/problems, and orders not yet completed shall be recorded in the appropriate iSparrow EMR structured data fields.
The proposed operation and, when appropriate, specifics (right leg vs. left leg, etc.) must likewise be recorded in iSparrow EMR or a legible copy provided from the outside preoperative history and physical examination prior to the start of the surgery.

**INFORMED CONSENT FOR SURGERY/PROCEDURE**

**PURPOSE:**

It is the responsibility of the physician performing the procedure or his/her medical associates or other appropriate health care professionals under his/her direction to inform the patient of the proposed surgery/procedure so that patient may make an informed decision.

**PROCEDURE:**

A. To the degree possible, the patient or his/her legally authorized representative should be given a clear concise explanation of:

1. Their condition or diagnosis
2. The purpose of all proposed technical procedures
3. The possibilities of reasonable foreseeable risk of mortality or serious ill effects, problems related to recuperation, and probability of success, unless such explanation is medically contraindicated as documented by the attending/designated physician in the medical record.
4. Any medically significant alternatives for care or treatments.
5. Any proposed treatment that involves human experimentation or other research/education projects affecting his/her care or treatment. The patient has the right to refuse to participate in any such activity
6. Any reasonable foreseeable possibilities for death or disability even though the chance for that outcome is unlikely
7. The foreseeable prognosis for the patient if the proposed procedure is not rendered.

B. Informed consent will be obtained for the following anesthetics, surgeries, and invasive procedures:
1. Any procedure requiring the administration of general, spinal, regional, or local anesthesia or IV sedation, regardless of whether an entry into the body is involved;

2. Any major or minor surgery which involves an entry into the body either through an incision or one of the natural body openings;

3. Any diagnostic or therapeutic procedure which is invasive, risky, controversial and/or experimental. These procedures include but are not limited to:
   - Myelogram
   - Arteriogram
   - Cystoscopy
   - Endoscopy
   - Biopsy (all types)
   - Bone marrow aspiration
   - Colonoscopy
   - Flexible Sigmoidoscopy
   - Thoracotomy
   - Lumbar Puncture
   - Circumcision
   - Amniocentesis
   - Thoracentesis
   - Paracentesis
   - Upper GI Endoscopy
   - Umbilical Artery Line

4. Procedures performed in the Emergency Department elsewhere in the course of urgent or emergent care are covered by the consent for treatment form and do not require a separate consent for surgery/procedure form to be completed.

SURGEON/PHYSICIAN PERFORMING PROCEDURE

The surgery/procedure will ordinarily not be performed until the patient/legally authorized representative understands and signs the "Consent for Operation or Procedure" form.

RN/OTHER APPROPRIATE HEALTH CARE PROFESSIONAL ASSISTING WITH THE PROCEDURE

1. If the consent form is not completed, the RN or other appropriate health care professional assisting with the procedure should verify whether the physician performing the procedure has discussed the surgery/procedure with the patient. If this has not been done, the physician performing the procedure must be contacted
immediately to undertake the task and only after the physician has discussed the relevant consent issues will the consent form be signed and witnessed.

2. If the surgery/procedure has been discussed with the patient and the consent form has been completed, but a misspelled word, omission, or clinical error of significance, is identified the appropriate patient/legal representative will re-sign the consent form.

**TELEPHONE AUTHORIZATION**

Authorization may be obtained by telephone when all of the following circumstances apply:

1. The procedure/surgery is needed on an urgent or emergent basis;
2. The patient is unable to give consent;
3. The legal representative for the patient is unable to come to the hospital in a timely manner;
4. The procedure/surgery has been explained to the legal representative following the guidelines under section A of this policy;
5. The consent is verified by two hospital personnel, and documented on the request and consent to operation and procedure form in the medical record.

**DAILY PATIENT VISITS**

A hospital patient shall be visited daily, or more frequently as needed, by his/her attending practitioner or qualified designee(s). Evidence of daily visits should be found in the patient’s medical record through progress notes, operative reports or medical orders.

**ADMINISTRATIVE CONSULTATION WHEN THE PHYSICIAN RESPONSIBLE FOR PATIENT (S) MANAGEMENT IS NOT AVAILABLE**

I. **PURPOSE:**
To provide guidelines for obtaining necessary care for a patient when the responsible physician is not available, does not respond to a request for assistance, or the quality/appropriateness of care is being questioned.

II. POLICY:

The Medical Staff recognizes its responsibility to provide timely intervention when an attending or responsible physician is not available or does not respond to nursing or staff concerns. The Medical Staff also recognizes the need to respond when the quality or appropriateness of care being provided to a particular patient is questioned. The purpose of medical staff intervention is to assure that necessary care is provided and that preventable adverse patient outcomes are avoided.

III. DEFINITION:

An administrative consultation is a medical consultation requested not by the attending physician but rather by the President of the Hospital, the Chief of Staff, Chairperson of the Department, Vice President of Medical Affairs, or the Administrator on call when, in his/her opinion, information exists to suggest that the welfare of a patient or best interest of the Hospital is being jeopardized and might be better served if another opinion were obtained.

IV. PROFESSIONAL LIABILITY:

Members of the Sparrow Hospital Medical Staff are provided professional liability protection through the Hospital when serving in the capacity of an administrative consultant.

V. PROCEDURE:

A. The nurse or other health care provider involved in the patient's care determines that intervention is needed then he/she will bring the concerns to the attention of his/her immediate supervisor. The supervisor shall follow the administrative chain of communication for resolution of the issue. The Nursing Departments should refer to their respective standard procedures for guidance. The supervisor or administrator on call will make the appropriate referral to Medical Staff leadership:

1. Chairperson of the Department within which the practitioner has clinical privileges
2. Chief of the Medical Staff
3. Vice President of Medical Affairs
4. Medical Director of Performance Improvement  
5. Other available Medical Staff leaders, as appropriate

B. The Medical Staff leader notified (per A above) will either personally evaluate or direct another physician to evaluate and provide care to the patient and serve as an administrative consultant.

C. Once Medical Staff leadership has accepted responsibility to respond to requests for assistance, they shall be expected to respond in a timely manner. The responding practitioner has authority to review relevant patient information and provide care.

D. The Chairperson of the Department concerned will either personally evaluate and investigate or direct another physician to evaluate and investigate the events surrounding the initial concern to be presented to the Department’s executive committee at its next meeting.

E. The Department’s executive committee will review the report and take an appropriate action. Such an action may be:

1. To determine that the concern did not constitute a valid quality of care issue.
2. To request additional information through a personal appearance of the involved Department member at the Department executive committee.
3. To issue to the Departmental member a written statement of warning, admonition, or reprimand.
4. To refer the issue to the Hospital Medical Staff Executive Committee.

The Committee will keep a written record of the actions taken, and will provide to the Departmental member and the Medical Staff Executive Committee a written summary of both the complaint and the actions taken.
TRANSFER OF PATIENTS TO ANOTHER ATTENDING PRACTITIONER

Transfer of a patient’s care to another physician (not affiliated with attending physician’s practice) or group practice, will be documented by written order after timely, interactive and effective practitioner-to-practitioner communication and consent.

All hand-offs of patient care, for either “on-call coverage” or transfer of care, should include communication points of: diagnosis and current condition, recent changes in condition or treatment plans and potential clinical concerns. All hand-offs should include the opportunity to clarify issues prior to transfer.

NON-HOSPITAL DRUGS

Drugs which have not been dispensed from the Hospital pharmacy under the order of the attending practitioner may not be administered to a patient unless so ordered by the patient's attending practitioner. Before non-hospital medications may be administered, they must be identified and labeled by the attending practitioner or the Pharmacy Department. The attending practitioner must enter an order in iSparrow EMR for every non-Hospital medication, including dosage and frequency in the medical record.

SELF-ADMINISTRATION OF MEDICATIONS

No patient may self-administer medications unless so ordered by the patient’s attending practitioner or, when appropriate, by a consultant involved in the direct management of the patient. It remains the responsibility of the attending practitioner and/or consultant to order in place a method to record and to be aware of the frequency, total amount and reason for use of each self-administered drug.

PATIENT DEPARTURE AGAINST MEDICAL ADVICE

1. Notification and reporting. Should a patient threaten to leave or leave the Hospital against advice of a Physician or nurse or without usual discharge, a notation of the event shall be made to the Chief Executive Officer and the Chief of Staff. The patient’s attending Member shall also be notified as soon as practicable of the patient’s anticipated or actual leaving the Hospital without observing required procedures.

2. Release form. A patient leaving the Hospital against the advice of a Physician or nurse shall be requested to sign the proper release form to be placed in the patient’s medical record. A patient’s failure or refusal to sign the proper release form shall be
recorded within the patient’s medical record. A discharge note shall then be promptly prepared by the attending Member.

3. **Limitations on patient’s right to discharge against medical advice.** A competent patient generally has the right to leave the Hospital against the advice of his/her attending Member. However, the Hospital has the right in its discretion, not to allow the patient departure under certain circumstances (e.g., in the middle of the night when the patient has no transportation or assistance to his/her home or if the patient is mentally incompetent and without assistance from his/her legal guardian). Statutes further restrict the right of mental patients to early discharge. Further, a patient should not be allowed to leave the Hospital at “anytime” if the attending Member reasonably believes the patient’s safety is jeopardized, regardless of the signing of the “Against Medical Advice” form. In the event it is reasonably believed a patient’s safety would be jeopardized by departure from the Hospital, the patient may be restrained chemically or physically, by the attending Member of his/her designee for a specific, limited time which should be set by Administration with Court assistance sought if it appears that the patient may need to be restrained for a period greater than four (4) hours.

**SUICIDAL OR DANGEROUS PATIENTS**

Each attending practitioner shall throughout a patient’s admission be responsible for providing information to the Nursing Staff which may be necessary to ensure the protection of the patient from self-harm and to ensure the protection of others whenever the patient might be a source of danger.

The attending practitioner is responsible in such cases for obtaining appropriate mental health consultation and for ordering appropriate observation and/or restraints.

**SEDATION AND ANESTHESIA**

I. **Purpose:**
The policy on administration of sedation and anesthesia serves as a policy for clinicians to follow in order to provide maximal patient benefits of sedation/analgesia and minimize associated risks in patients of Sparrow Health System. The policy applies to all areas of Sparrow Health System where sedation and anesthesia is administered.

II. **Policy Statement:**
A. The policy applies when patients receive, in any setting, for any purpose, by any route, moderate or deep sedation or anesthesia.
B. Definitions of the four levels of sedation and analgesia from the Joint Commission “Comprehensive Accreditation Manual for Hospitals” and applicable to the Health System include the following:

**Minimal Sedation (Anxiolysis):** (specific credentialing not required)
A drug-induced state during which patients respond normally to verbal commands. Although cognitive functions and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

**Level A privileges (credentialed by each department)**
**Moderate Sedation/Analgesia (“Conscious Sedation”):**
A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patent airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.

**Level B privileges (credentialed through the Department of Anesthesia in conjunction with the Department of which the applicant is a member).**
**Deep Sedation/Analgesia:**
A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain a patent airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained.

**Anesthesia:**
Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimuli. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

III. Oversight and Authority:
A. Oversight
1. The administrative and medical directors of Surgical Services participate with the administrative and medical directors of other departments/services in establishing the institutional policy for the provision of patient care as related to sedation and analgesia, in order to assure consistent care across clinical services.
2. The manager and the Medical Director of a department/service in which sedation is provided are responsible for assuring the quality
and appropriateness of patient care as related to sedation/analgesia are monitored and evaluated.

B. Authority
1. If differences of opinion arise regarding the granting of a practitioner’s sedation/analgesia and anesthesia credentialing privileges within the practitioner’s department that cannot be resolved by the Chair of the Department and the physician, the matter should be taken to Medical Staff Executive Committee for resolution.
2. For **Level A** privileges (see below), if patient care concerns with respect to the provision of sedation/analgesia and anesthesia are identified regarding a physician that cannot be resolved by the Chair of the Department and the physician, the matter should be taken to the Medical Staff Executive Committee for resolution.
3. For **Level B** privileges (see below), if patient care concerns with respect to the provision of sedation/analgesia and anesthesia are identified regarding a physician that cannot be resolved by the Chair of the Department of Anesthesiology and the physician, the matter should be taken to the Medical Staff Executive Committee for resolution.
4. The Medical Staff Executive Committee has the final authority in recommending to the Board the policies and procedures under which sedation and analgesia is provided within the Sparrow Health System.

IV. Credentialing & Competency:

A. Two levels of credentialing for the privilege of ordering, administration and/or monitoring sedation and anesthesia are available in the Health System:

**Level A** privileges for the ordering, administration and/or monitoring of patients receiving moderate sedation/analgesia (“conscious sedation”), credentialed through the Department.

**Level B** privileges for the ordering, administration and/or monitoring of patients receiving deep sedation/analgesia or anesthesia, credentialed through the Department of Anesthesia in conjunction with the Department of which the applicant is a member.

B. Each Department should develop consistent criteria for credentialing physicians for **Level A** (above) moderate sedation/analgesia, and may utilize a skills appraisal test for new staff physicians.
C. Physicians performing a procedure wherein sedation/analgesia is a part of the procedure are credentialed to give the sedation once they are credentialed to perform the procedure, provided the sedation/analgesia is a moderate level (Level A). All physicians providing Level B sedation and anesthesia must be separately credentialed to do so through the Department of Anesthesia.

D. Sufficient numbers of qualified personnel (in addition to the licensed independent practitioner performing the procedure) should be present during procedures using moderate and deep anesthesia.

E. Physicians-in-training (medical residents), when ordering and/or administering sedation/analgesia, should be closely supervised by a credentialed attending physician, and the attending physician should be informed of any complications or adverse effects. Physicians-in-training cannot perform Level B sedation without the direct bedside supervision of an attending physician credentialed for Level B sedation and anesthesia.

F. It is understood that patients already on life support can receive Level B sedation without the direct bedside attendance of an attending physician and orders for the provision of Level B sedation in those patients can be accepted from house staff provided a credentialed attending physician is aware and has agreed with the order.

V. Procedure

Sedation or anesthesia of the patient must be conducted within the standard established by the Sparrow.

ETHICS CONSULTATION

I. INTRODUCTION

One of the functions of the Sparrow Hospital Ethics Committee is to provide consultative services on specific ethical dilemmas to physicians, associates, patients and families. The ethical issues may involve either cases or specific hospital policies.

II. REQUEST FOR CONSULTATION

Any individual directly involved with a particular case, or affected by a particular hospital policy may request that the Committee consider the ethical aspects of the case or policy. Request may be made in writing to the Ethics Committee, in care
of Administration, or by calling 483-2504 during regular business hours, 8:00a.m. - 5:00p.m. After hours and on weekends requests can be made by calling the Nursing Supervisor, 483-2600.

III. CONSULTATION

A. CASE CONSULTATION
Case consultation requests will be promptly referred to a member of the Ethics Committee who will contact the person making the request to determine the exact needs. In the event of a case consultation, it is recommended that information on the patient's current medical status, prognosis, and options for care be available when the Ethics Committee member calls.

Levels of Consultation

1. Some ethical questions can be resolved on an informal basis during the initial conversation between the person making the request and the responding Ethics Committee member. If resolution occurs at this level, the Ethics Committee Consultant will make an appropriate note in the patient's chart.

2. If it is determined that the issues are more complex, a formal case consultation will be arranged. Up to four consultants will meet with the person or persons who requested the consult and appropriate others involved in the case. The purpose of the meeting will be to gather information, identify and clarify moral issues and alternatives for action. If the issues are resolved through this process, a consultation report will be placed in the patient's chart, with a copy to the Ethics Committee file.

3. If resolution does not take place during consultation with the Subcommittee, or if there is not consensus among the consultants, the total Ethics Committee, plus appropriate consultants from outside the Committee, will convene to attempt to resolve the issues.

The Committee provides supportive consultation, but does not make final decisions on care management. Ultimately, decisions rest with the patient, family and physician.

IV. POLICY CONSULTATION

1. Policy consultation requests will be referred to the Hospital Administration representative on the Committee, who will notify the
Committee Chairperson of the request. They will jointly designate an ad hoc group of Committee members to gather information and identify and clarify moral issues and alternatives for action. This group will attempt to facilitate resolution of the problem with the involved parties. If the issues are satisfactorily resolved, a report of the consultation will be given to the appropriate parties and a copy will be placed in the Committee file.

2. If there is no resolution, the total Committee, plus appropriate consultants from outside the Committee, will convene to address the issues and develop a report to be circulated to the appropriate parties.

The information related to consultations is private and confidential regarding committee process and patient care; its use shall be exclusively for the intended purpose, and not shared or reproduced in any form.

DNR GUIDELINES
WITH PEDIATRIC CONSENT SECTION

I. Purpose

A. To provide mentally capable patients or the authorized representative of an incapacitated or a minor patient with the autonomy to refuse treatment which conflicts with his/her value system and to support the attending physician or attending physician's designee when futile treatment is withheld.

B. To provide guidelines for nursing and medical care professionals in decision-making, documenting, and communicating DO NOT RESUSCITATE (DNR) orders.

II. Definitions

Adult: Any person who is 18 years of age or older.

Advance Directive: Written directives in which a patient with decision making capacity indicates what medical interventions he/she would refuse or accept when unable to participate in medical treatment decisions. Conversations between the patient and another person, though not an advanced directive, may be considered when determining a patient's wishes. However, such conversations are to be considered secondary to any written directive. Furthermore, the only advance directive recognized under Michigan law is a Durable Power of Attorney for health care. Therefore, written directives other than DPAs are to be considered secondary to a DPA.
Attending Physician: The physician selected by or assigned to a patient in the hospital who is knowledgeable of the patient's condition and who has accepted primary responsibility for the care and treatment of the patient.

Attending Physician's Designee: A physician acting with the approval of the attending physician.

Capacity: The ability to understand the nature and consequences of one's illness and the relative risks, benefits and alternatives of treatment, and to make and communicate informed, deliberate choices about one's treatment.

Cardiac Arrest: The cessation of cardiac rhythm and/or contraction.

Cardiopulmonary Resuscitation (CPR): The use of established Basic Cardiac Life Support and Advanced Cardiac Life Support protocols and any other measures deemed necessary to restore cardiac and/or respiratory function in the presence of a cardiac or pulmonary arrest.

Do Not Resuscitate (DNR): The decision to forego CPR in the event of a cardiac or pulmonary arrest.

Durable Power of Attorney for Health Care: A document recognized under Michigan law in which an adult appoints a patient advocate to make medical treatment decisions when he/she is unable to participate in such decisions.

Emancipated Minor: Any person who is less than 18 years of age and (a) is married, (b) is on active duty with the Armed Forces of the United States, or (c) is emancipated by virtue of court order.

Minor: Any person who is less than 18 years old and does not meet at least one criteria for emancipation.

Surrogate Decision Maker: The person, either a patient advocate or legal guardian, selected to make a health care decision on behalf of a patient pursuant to section IV.B.4. of this Policy.

Respiratory Arrest: The cessation of spontaneous respirations.

III. General Principles

A. This Policy applies to any inpatient at Sparrow Hospital, but only while the patient is an inpatient at the Hospital.

B. Every effort should be made by the attending physician, or designee, as early as possible after admission, to identify those patients for whom a
DNR order may be appropriate. In all such cases, discussion, patient concurrence or other decision, and documentation required by this Policy shall be completed as soon as possible.

C. A DNR order may be entered only after discussion with the patient or surrogate decision-maker. The attending physician, or his/her designee, is responsible for obtaining patient concurrence and advising the patient or surrogate decision maker of the risks, benefits, and potential harm of CPR, the option of non-treatment and the ramifications of a DNR order. A recommended course of action may be appropriate to help guide decisions.

D. This Policy does not require health care professionals to perform CPR on every patient who arrests, in the absence of a DNR order. There is, however, a presumption that every patient who does not have a DNR order desires CPR in the event of a cardiopulmonary arrest.

1. If the attending physician or his/her designee are in personal attendance at the time of cardiopulmonary arrest and it is the physician's considered medical judgment that CPR will be unsuccessful in restoring cardiopulmonary function, then the attending physician or designee is not obligated to provide, and may proscribe, CPR in the absence of a DNR order. Such decisions should be documented in the medical record. Decisions made in this manner should not, however, constitute a policy of unwritten DNR orders. Patient concurrence to a DNR order should be obtained in advance whenever this is appropriate and possible.

2. In the absence of a DNR order and in the absence of the attending physician or his/her designee, CPR will be initiated on all patients in the event of a cardiopulmonary arrest.

E. The attending physician may advise, or a patient or surrogate decision maker may request, that only certain components of resuscitation be withheld. This type of DNR order should be specific, its rationale and patient's or surrogate decision maker's concurrence/request documented and, if possible, such order should be entered into the EMR by the attending physician or his/her designee.

F. Concurrence to a DNR order by or for a patient is not consent to forgo other care or treatments. It is strictly a decision regarding CPR. A DNR order may be compatible with otherwise maximal therapeutic care.

IV. Guidelines for DNR Decision Making

A. Mentally Capable Adult Patients
1. Where the patient is a mentally capable adult, no substituted decision-maker is necessary.

2. Capacity is presumed in the adult patient for decision making regarding cardiopulmonary resuscitation, unless it is demonstrated otherwise.

3. Prior to writing the DNR order, the attending physician or his/her designee will discuss with the patient his/her diagnosis, prognosis, the reasonably foreseeable risks and benefits of resuscitation and the effects of a DNR order. If concurrence is obtained, the physician or his/her designee will document this discussion in the medical record.

B. Adult Patients Without Capacity

1. The patient's capacity to participate in the decision making process for the DNR status will be determined by the attending physician or his/her designee. If appropriate or in questionable situations, a consult from another physician or psychologist should be obtained.

2. The determination of lack of capacity should be communicated by the attending physician or his/her designee to the patient, if appropriate, to the family and, if a durable power of attorney has been executed or a guardian has been appointed, to the surrogate decision maker.

3. If there is a dispute as to whether the patient is incapacitated, risk management should be contacted to determine whether court intervention is necessary.

4. If the patient concurred with the DNR status prior to becoming incapacitated or made his/her wishes known regarding CPR in an advanced directive, that decision should be respected and followed, unless circumstances relevant to the decision have changed.

5. If there has been no DNR decision, a determination should then be made regarding whether the patient executed an advanced directive or a surrogate decision-maker to make health care decisions should be identified.

a. In identifying an appropriate surrogate decision-maker, the physician should first honor any person the patient has specified in a durable power of attorney for health care. Other advance directives may be used as evidence of a patient's desire to appoint a particular surrogate decision-
maker. This should be documented in the patient's medical record.

b. If a surrogate decision-maker has not been specified by the patient, then the goal is to identify the person who is most knowledgeable about the patient's present and past feelings and preferences regarding health care. The primary function of the surrogate decision-maker is to express those preferences that the patient would if he/she were able. Documentation of such identification should be entered in the patient's medical record. The attending physician or his/her designee should discuss medical treatment decisions with the surrogate decision-maker.

(1) Although there is legal debate on the issue, family members are not, by such relationship alone, necessarily the most appropriate surrogate decision-maker. It is the position of this hospital that it is always appropriate to consider the input of available family members when making health care decisions for an incapacitated patient.

(2) If the most appropriate decision-maker is not a family member, it may be advisable to request that this person seek guardianship.

(3) There is legal debate over whether a guardian or other surrogate decision-maker not specified in a DPA has the authority to withhold medical treatment, including CPR. Therefore, in the absence of a DPA, it is advisable to seek consensus among the guardian or surrogate decision-maker and available family members. If a dispute arises, mediation should be sought as delineated in section VIII.

6. If no DNR decision has been made, no advance directive executed, no guardian appointed and no surrogate decision maker or family member is available, the attending physician may write a DNR order only in the presence of an irreversible medical condition for which resuscitation would only prolong the death process. A second physician should also establish lack of capacity and the irreversible medical condition and document this information in the medical record.
7. If the patient is a female of childbearing age, a determination must be made that she is not pregnant. If the patient is pregnant, no DNR order should be considered without first consulting Hospital Risk Management.

C. Mentally Capable Emancipated Minors

1. If the attending physician determines that a patient is an emancipated minor with decision making capacity, the concurrence of only the emancipated minor patient is required for a DNR decision. (Note that if a minor patient has a guardian, then the minor cannot be emancipated.)

2. Nevertheless, it may be advisable to include the parents of the emancipated minor patient in the deliberation process if the former can be ascertained, are available, and are willing to participate. The emancipated minor will be informed that his/her parents may be included in the deliberation process. If the emancipated minor objects to inclusion of the parents, then this should be documented in the medical record and Hospital Risk Management should be notified.

3. The minor patient (and, if appropriate, the parents) will be provided with information about diagnosis, prognosis, the reasonably foreseeable risks and benefits of resuscitation, and the effects of a DNR order. The attending physician or his/her designee will address the DNR order personally with the minor patient (and parents) and document this discussion in the medical record (see section V. Documentation). Both the criteria for emancipation (see section II. Definitions) and determination of mental capacity must be documented in the medical record.

4. If the attending physician is unwilling to participate in a DNR decision for an emancipated minor patient without the involvement of the parents; or if concurrence cannot be obtained among the emancipated minor patient, the parents, and the attending physician; then the guidelines delineated in section VIII, Dispute Resolution, apply.

5. If the emancipated minor patient is a female of childbearing age, a determination must be made that she is not pregnant. If the patient is pregnant, no DNR order should be entered into the EMR without consulting Hospital Risk Management.

D. Non-emancipated Minors
1. The parents or guardian will participate in DNR decisions regarding their child based upon the provisions of this section and this policy.

Note: a) Concurrence of both parents will be sought. If the attending physician or his/her designee has reason to believe an available parent has not been involved in and informed of the DNR decision, then the attending physician or his/her designee shall make an effort to notify and obtain the concurrence of that parent prior to issuing the DNR order. These efforts will be documented in the medical record.

b) Concurrence of foster parents is neither sufficient nor necessary for a DNR decision, unless they are the legal guardians of the minor [see d) below].

c) Concurrence of a stepparent is neither sufficient nor necessary for a DNR decision, unless he/she is the legal guardian of the minor.

d) If parental rights have been terminated by court order, consult Hospital Risk Management to determine whether probate court intervention is necessary.

2. The attending physician, in consultation with the minor's parents or guardian, will determine to what degree the minor will be involved in the DNR decision and what standard will be applied in determining whether the DNR order is appropriate:

a) Substituted Judgment Standard: This standard is generally utilized when the patient is a minor of mature judgment but is not legally able. A physician and parent or guardian will consider whether or not to implement the DNR order based upon what the minor patient would decide if he or she were legally able to do so. One could look to the existence of any trustworthy evidence which may exist (i.e., statements, conversations, writings) which indicates that the patient would refuse treatment. Further it should be clear that the burdens of prolonging life outweigh the benefits.

b) Best Interests Standard: This standard is utilized when the patient has never been competent, in cases of immature minors, or when it cannot be ascertained what choice the mature minor would have made. Factors to consider include, but are not limited to:
(i) the minor's present level of physical, sensory, emotional, and cognitive functioning;

(ii) the degree of physical pain resulting from the medical condition, treatment, and termination of the treatment, respectively;

(iii) the degree of humiliation, dependence, and loss of dignity resulting from the condition and treatment;

(iv) the life expectancy and prognosis for recovery with and without treatment;

(v) the various treatment options;

(vi) the risks, side effects, and benefits of each of those options.

3. The attending physician or his/her designee will address the DNR order personally with the parents or guardian (and the minor if appropriate) and document this discussion in the medical record (see section V. documentation). The parents or guardian will demonstrate the ability to understand their child's condition. They will be provided with information about the minor's diagnosis, prognosis, the reasonably foreseeable risks and benefits of resuscitation, and the effects of a DNR order.

4. In some instances, the parent's or guardian's judgment may be open to challenge with regard to the best interests of the minor. The burden, however, is on the challenger to demonstrate the minor patient's best interests or desires are not being appropriately considered. In this case, consultation with Social Services and/or the Ethics Committee is advisable.

5. If concurrence cannot be obtained among both parents or guardian, the minor (as appropriate) and the attending physician or his/her designee, then the guidelines delineated in section VIII, Dispute Resolution, apply.

6. If the minor patient is a female of childbearing age, a determination must be made that she is not pregnant. If the patient is pregnant, no DNR order should be considered without first consulting Hospital Risk Management.

V. Documentation
A. The DNR decision should be discussed with the patient or surrogate decision-maker and concurrence for such order should be obtained.

B. The DNR order should be entered in the patient's record on the Physician's Order sheet.

C. The decision and the concurrence should be summarized in the Progress Notes and this documentation should include:
   1. Who participated in the decision and that they concurred;
   2. The medical condition and prognosis of the patient;
   3. A description of the patient's decision making capacity;
   4. A description of the circumstances relevant to the decision;
   5. Documentation supporting the decision from consultants such as medical specialist, psychiatrist, or the ethics committee when appropriate.

D. Verbal orders for DNR may be taken by phone by a Registered Nurse from the attending physician or his/her designee, and are effective immediately, but must be signed by the physician within 24 hours. The nurse should document the interaction including a statement referring to discussion with the patient and/or proxy. Appropriate physician documentation should follow at the time the DNR order is signed.

VI. Review/Renewal of DNR Decisions/Orders

A. Indications for Review/Renewal:
   1. DNR decisions should be reviewed with the patient or surrogate decision-maker whenever the circumstances relevant to the decision change, but at least every week. Times at which this is likely to be the case include prior to invasive diagnostic or operative procedures, prior to a transfer to an area of different acuity, at discharge, and at readmission. If a consultant is performing an invasive diagnostic or operative procedure, the consultant should review the DNR decision with the attending physician and/or the patient or surrogate decision-maker to determine whether it would be appropriate to suspend such order during the procedure. The consultant is best able to explain how the risk and benefits of CPR during the procedure might differ from those relevant to the original DNR decision. The attending
physician and/or patient or surrogate decision-maker best
understand the factors relevant to the original DNR decision. DNR
orders cannot be suspended or revoked during invasive diagnostic
or operative procedures without the consent of the patient.

2. The DNR decision should also be reviewed with the patient if
he/she regains decision-making capacity after a guardian or other
surrogate decision-maker has consented to the DNR order.

3. Absent of the above circumstances, the DNR decision must be
reviewed once per week. The deliberations, in Sections 1, 2, and 3
immediately above, may result in the renewal, the suspension, or
revocation of the DNR order.

B. Documentation

1. Review of the decision must be documented in the medical
record.

2. a. If the circumstances or decision remains the same, the
DNR order must be rewritten.

   b. If consent is revoked, see section VII.B., below.

C. If a DNR order is not renewed or revoked within one week, the attending
physician must be notified and then renew or revoke the order within 24
hours of notification. The DNR order remains in effect during this time.
If the attending physician fails to renew or revoke the order within 24
hours, the chief-of-service must be notified.

VII. Revocation of Patient or Surrogate Decision Maker Concurrence for DNR
Orders

A. Generally, a patient or surrogate decision-maker may at any time revoke
his/her own concurrence to a DNR order. If the attending physician, or
designee, disagrees with the decision to revoke the DNR order, then the
physician or designee should follow the "Dispute Resolution" Procedure,
section VIII of this Policy.

B. Any physician informed of a revocation of a patient's or surrogate decision
maker's concurrence to a DNR order pursuant to this section and who
agrees that such revocation is medically appropriate shall immediately:

1. Record the revocation in the patient's chart.

2. Cancel any orders implementing the DNR decision.
3. Notify the hospital staff directly responsible for the patient's care of the revocation and cancellation.

C. Any member of the nursing staff informed of a revocation made pursuant to this section shall immediately notify the attending physician or his/her designee of the revocation.

D. If a physician disagrees with a patient or surrogate decision-maker's revocation of a DNR order, "Dispute Resolution," delineated in section VIII below should be considered.

VIII. Dispute Resolution

A. Whenever a patient or surrogate decision maker requests a DNR order or revocation of such order, the attending physician or designee must review the decision with the patient or surrogate decision maker (see IV.A.2.) and

1. Implement the decision; or

2. Promptly make his/her objection and the reasons for same known to all interested parties and, if the objection or disagreement cannot be resolved, either:

   a. Promptly request an Ethics Consultation, or

   b. Make all reasonable efforts to arrange for the transfer of the patient to the care of another physician.

B. If a patient or surrogate decision maker refuses a DNR recommendation made by the attending physician or designee when he/she cannot in good conscience offer CPR, because it (1) would be medically futile or ineffective; (2) fails to offer a minimum quality of life or a modicum of medical benefit; (3) cannot possibly achieve the patient's goals; or (4) does not offer a reasonable chance of survival, then the physician must make his/her objection to CPR and the reasons for same known and, if the objection or disagreement cannot be resolved, either

   1. Promptly request an Ethics Consultation, or

   2. Make all reasonable efforts to arrange for the transfer of the patient to the care of another physician.

C. Loss of capacity cannot be used as the sole basis for revoking a decision previously made by a patient to forego CPR. However, if a reasonable surrogate decision maker objects to such a decision without a change in
the circumstances relevant to the patient's original decision and he/she cannot be dissuaded, then the attending physician should notify risk management. The attending physician should also consider requesting an Ethics consultation.

D. If a consultant physician objects to a patient's DNR order, he/she should promptly make his/her objection known to the attending physician. If the objection or disagreement cannot be resolved, either:

1. The consultant should decline the consultation or withdraw from the patient's care in order to allow another consultant to be sought, or
2. The attending should request an Ethics Consultation.

GUIDELINES FOR WITHHOLDING AND WITHDRAWAL OF TREATMENT

I. PURPOSE:

A. To provide mentally capable patients or the authorized representative of an incapacitated or a minor patient with the autonomy to refuse medical treatment which conflicts with the patient's values and life goals.

B. To support the attending physician or attending physician's designee to withhold or withdraw medical treatment that will be or has become ineffective and/or harmful.

C. To provide guidelines for healthcare professionals in formulating, documenting, and communicating decisions to withhold or withdraw medical treatment.

D. To provide advice regarding the withdrawal of medical treatment from patients who have died while some organ functions remain supported artificially.

II. DEFINITIONS:

Adult: Any person who is 18 years of age or older.

Advance Directive: Written directives in which a patient with decision making capacity indicates medical interventions he/she would refuse or accept if unable to participate in medical treatment decisions and/or appoints a surrogate to make health care in this case. Conversations between the patient and another person,
though not an advance directive, may be considered when determining a patient's wishes. The only advance directive recognized under Michigan law is a Durable Power of Attorney for Health Care (DPAhc). Therefore, written directives other than DPAhcs are to be considered secondary to a DPAhc.

**Assisted Suicide:** The facilitation of a patient's death by providing the necessary means and/or information to enable the patient to perform a life ending act.

**Attending Physician:** The physician selected by or assigned to a patient in the hospital who is knowledgeable of the patient's condition and who has accepted primary responsibility for the care and treatment of the patient.

**Attending Physician's Designee:** A physician acting with the approval of the attending physician.

**Capacity:** The ability to understand the nature and consequences of one's illness and the relative risks, benefits and alternatives of treatment, and to make and communicate informed, deliberate choices about one's treatment.

**Death:** Either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem.

**Durable Power of Attorney for Health Care (DPAhc):** A document recognized under Michigan law in which an adult appoints a surrogate to make medical treatment decisions if he/she is unable to participate in such decisions.

**Emancipated Minor:** Any person who is less than 18 years of age and (a) is married, (b) is on active duty with the Armed Forces of the United States, or (c) is emancipated by virtue of court order.

**Euthanasia:** The medical administration of a lethal agent in order to relieve the patient's intolerable and untreatable suffering. It is emphasized that the intent of euthanasia is to cause death as a means by which relief of suffering is achieved. Although palliative care may sometimes result in death, the intent of palliative care is to relieve suffering in spite of the possibility of fatal side effects. Euthanasia and assisted suicide differ in the degree of physician participation. Euthanasia entails a physician performing an immediate life ending action (see assisted suicide).

**Minor:** Any person who is less than 18 years old and does not meet at least one criteria for emancipation.

**Palliative care:** Care directed at improving comfort by reducing symptoms and providing support.
Surrogate Decision Maker: The person designated by a patient or appointed legal guardian by the court to make a health care decision on behalf of a patient pursuant to section V.B.4. of this Policy.

III. GENERAL PRINCIPLES

A. Autonomy and Decision Making

1. Competent patients have the right to self-determination, including the right to accept or refuse medical treatment. Autonomous choice implies the opportunity to make informed choices, which are consistent with the life goals and values of the patient.

2. Medical treatment decisions should be considered in the context of the overall objective(s) of the care plan for the patient rather than in isolation.

3. In order to exercise self-determination, the patient is entitled to all information necessary to make an informed decision, including diagnosis, prognosis, the range of alternatives and the risks and benefits associated with each.

4. A patient with decision-making capacity has the right to refuse care, even care that is considered medically beneficial.

5. A patient does not have a right to care that is ineffective or harmful.

6. The patient's right of self-determination survives incapacity. This right may be effectuated by an appropriate surrogate as he/she is guided by:
   a. the patient's explicit advance directive;
   b. in the absence of a., the surrogate's judgment about what the patient would have wanted substituted judgment;
   c. in the absence of a. and b., the patient's best interests.

   The more ambiguous the patient's best interests, the more knowledge one should have about what the patient wants/wanted/would have wanted before life sustaining medical treatment is withheld/withdrawn or before particularly burdensome treatment is provided.

B. Withholding/Withdrawing Medical Treatment

1. Decisions to withhold are not fundamentally distinct from decisions to withdraw medical treatment. The distinction between foregoing and discontinuing therapy is not itself of moral importance. A justification that is adequate for not commencing a medical treatment is also sufficient for ceasing it.
2. The distinction between "ordinary" and "extraordinary" medical treatments is not useful in differentiating ethically obligatory from ethically optional treatments. The decision to initiate, maintain, or forego a treatment depends on the likely benefits versus burdens of the treatment in the light of the preferences and values of the patient. Therefore, treatments are not objectively ordinary or extraordinary.

3. When comfort and dignity are maintained, respecting a patient's (or surrogate's) decision to forgo artificial nutrition and hydration does not constitute an abandonment of the patient, symbolic or otherwise.

4. Under all circumstances, medical professionals have an obligation to relieve pain and suffering and to promote the dignity and autonomy of patients in their care.

5. Health care professionals must not perform euthanasia or participate in assisted suicide.

IV. APPLYING THE PRINCIPLES:

A. The approach to decisions concerning effective care involves determining the answers to the following questions:

1. What is/are the overall objective(s) of the care plan?

2. Is this objective(s) achievable?

3. What care might achieve this/these objective(s)?

4. Is it worth it in terms of anguish/pain/suffering entailed by the patient, family, and other relevant persons?

The first question should be answered by the patient, or surrogate if the patient lacks capacity to make health care decisions. These objectives may be short-term, intermediate, and/or long-term. The physician is primarily responsible for advising the patient with regard to whether the objective(s) is/are medically achievable and what medical treatment might contribute to its/their achievement. The patient or surrogate and physician must then come to agreement regarding A.4., based on information provided by the physician. Agreement is necessary because the physician is not compelled to participate in medical treatment that he/she does not believe, in good conscience, to be in the patient's best interests and cannot be compelled to provide medical treatment that he/she believes will harm the patient. (see VIII A. and B.)

Note: While the principle of justice requires that limited resources be fairly allocated, health care providers must take great care in decisions regarding
resource distribution in individual cases. In most cases, this should be done only with the clear and explicit direction of the community.

B. The patient's wishes/best interests are paramount; however, there are circumstances in which it is appropriate to consider the wishes and interests of others.

C. No matter how bad the prognosis, the "minimum care" any person requires is that necessary to achieve what should be the minimum objectives for any person:

1. Minimization of anguish, pain and suffering
2. Maintenance of the patient's dignity as a person

No other care is ethically required. Moreover, there may be situations that are so burdensome that the care required to achieve these minimum objectives is all that it is ethically permissible to provide.

D. Withdrawal of medical treatment from a patient determined to be dead as defined by Michigan law in accordance with acceptable medical standards (see II. Definitions) does not require an order, specific procedures, or consent of the patient's surrogate, family, or guardian.

V. GUIDELINES FOR DECISION TO WITHHOLD OR WITHDRAW MEDICAL TREATMENT

A. Mentally Capable Adult Patients

1. Where the patient is a mentally capable adult, no surrogate decision-maker is necessary.

2. Capacity to make health care decisions is presumed in the adult patient unless it is demonstrated otherwise.

3. The attending physician or his/her designee will discuss with the patient his/her diagnosis; prognosis; the reasonably foreseeable risks, benefits, and consequences of each treatment option. The physician or his/her designee will document this discussion in the medical record.

B. Adult Patients Without Capacity

1. The patient's capacity to participate in the medical decision making process will be determined by the attending physician or his/her designee. If appropriate, or in questionable situations, a consult from another physician or psychologist should be obtained.
2. The determination of lack of capacity should be communicated by the attending physician or his/her designee to the patient, if appropriate, to the family and, if a durable power of attorney has been executed or a guardian has been appointed, to the surrogate decision maker.

3. If there is a dispute as to whether the patient is incapacitated, risk management should be contacted to determine whether court intervention is necessary.

4. When a patient has been determined to lack the capacity to make health care decisions, determination should then be made regarding whether the patient executed an advance directive, whether a legal guardian has been appointed, or whether a surrogate decision-maker should be identified.

   a. In identifying an appropriate surrogate decision-maker, the physician should first honor any person the patient has specified in a DPAhc or any person appointed as the patient’s legal guardian. In the absence of these, other advance directives may be used as evidence of a patient’s desire to appoint a particular decision-maker. This should be documented in the patient's medical record.

   b. If a surrogate decision maker has not been specified by the patient and no legal guardian has been appointed, then the goal is to identify the person who is most knowledgeable about the patient's present and past feelings and preferences regarding health care. The primary function of the surrogate decision-maker is to express those preferences that the patient would if he/she were able. Documentation of such identification should be entered in the patient's medical record. The attending physician or his/her designee should discuss medical treatment decisions with the surrogate decision-maker.

   (1) Although there is legal debate on the issue, a family member is not, by such relationship alone, necessarily the most appropriate surrogate decision-maker. However, it is the position of this hospital that it is always appropriate to consider the input of available family members when making health care decisions for an incapacitated patient.

   (2) If the most appropriate decision-maker is not a family member, it may be advisable to request that this person seek guardianship.

   (3) There is legal debate over whether a guardian or other surrogate decision maker not specified in a DPAhc has the authority to withhold or withdraw medical care that may result in the death of the patient absent clear and convincing evidence of the patient’s
wishes. Therefore, in the absence of a DPAhc, it is advisable to seek consensus among the guardian or surrogate decision-maker and available family members. If a dispute arises, mediation should be sought as delineated in section VIII.

5. If the patient had specified a plan of care prior to becoming incapacitated or made his/her wishes known in an advance directive, that decision should be respected and followed, unless circumstances relevant to the decision have changed.

6. If no care plan was formulated by the patient prior to loss of capacity, no advance directive executed, no guardian appointed and no surrogate decision maker or family member is available, the attending physician may withhold or withdraw medical treatment only in the presence of an irreversible medical condition for which such treatment would only prolong the death process. A second physician should also document lack of capacity and the irreversible medical condition in the medical record.

7. Risk Management should be consulted before withholding or withdrawing medical treatment that could result in the death of a pregnant patient.

C. Mentally Capable Emancipated Minors

1. If the attending physician determines that a patient is an emancipated minor with decision-making capacity, the agreement of only the emancipated minor patient is required to formulate and implement a plan of medical care decision. (Note that if a minor patient has a guardian, then the minor cannot be emancipated.)

2. Nevertheless, it may be advisable to include the parents of the emancipated minor patient in the deliberation process if the former can be ascertained, are available, and are willing to participate. The emancipated minor will be informed that his/her parents may be included in the deliberation process. If the emancipated minor objects to inclusion of the parents, then this should be documented in the medical record and Hospital Risk Management should be notified.

3. The minor patient (and, if appropriate, the parents) will be provided with information about diagnosis; prognosis; the reasonably foreseeable risks, benefits, and consequences of each medical treatment option. The attending physician or his/her designee will address care plan personally with the minor patient (and parents) and document this discussion in the medical record (see section VI. Documentation). Both the criteria for emancipation (see section II. Definitions) and determination of mental capacity must be documented in the medical record.
4. If the attending physician is unwilling to formulate a care plan for an emancipated minor patient without the involvement of the parents; or if agreement cannot be obtained among the emancipated minor patient, the parents, and the attending physician; then the guidelines delineated in section VIII, Dispute Resolution, apply.

5. Risk Management should be consulted before withholding or withdrawing medical treatment that could result in the death of a pregnant patient.

D. Non-emancipated Minors

1. The parents or guardian will participate in the formulation of a medical care plan for their child based upon the provisions of this section and this policy.

   **Note:**
   a) Concurrence of both parents will be sought. If the attending physician or his/her designee has reason to believe an available parent has not been involved in and informed of the deliberation, then the attending physician or his/her designee shall make an effort to notify and obtain the agreement of that parent prior to withholding or withdrawing medical treatment that could result in the child's death. These efforts will be documented in the medical record.

   b) Concurrence of a step-parent is neither sufficient nor necessary for implementation of a plan of care, unless he/she is the legal guardian of the minor.

   c) In the case of a child in foster care, consult Hospital Risk Management to determine whether the parent(s) retain the right to make health care decisions for their child and whether Child Protective Services and/or probate court intervention is necessary. Concurrence of foster parents is neither sufficient nor necessary to allow implementation of plan of care, unless they are the legal guardians of the minor.

2. The attending physician, in consultation with the minor's parents or guardian, will determine to what degree the minor will be involved in the formulation of a plan of care and what standard will be applied to do so:

   a) **Substituted Judgment Standard:** This standard is generally utilized when the patient is a minor of mature judgment but is not legally able. A physician and parent or guardian will consider whether or not to implement a care plan based upon what the minor patient would decide if he or she were legally able to do so. One could look to the existence of any trustworthy evidence which may exist (i.e., statements, conversations, writings) which indicates that the patient
would refuse treatment. Further, it should be clear that the burdens of prolonging life outweigh the benefits before medical treatment that could result in death are withheld or withdrawn.

b) **Best Interests Standard**: This standard is utilized when the patient has never been competent, in cases of immature minors, or when it cannot be ascertained what choice the mature minor would have made. Factors to consider include, but are not limited to:

(i) the minor's present level of physical, sensory, emotional, and cognitive functioning;
(ii) the degree of physical pain resulting from the medical condition and/or its treatment;
(iii) the degree of humiliation, dependence, and loss of dignity resulting from the medical condition and/or its treatment;
(iv) the life expectancy and prognosis for recovery with and without treatment;
(v) the various treatment options;
(vi) the risks, side effects, and benefits of each of those options.

3. The attending physician or his/her designee will address the medical care plan personally with the parents or guardian (and the minor if appropriate) and document this discussion in the medical record (see section VI. Documentation). The parents or guardian will demonstrate the ability to understand their child's condition. They will be provided with information about the minor's diagnosis, prognosis, the reasonably foreseeable risks, benefits, and consequences of care options.

4. In some instances, the parent's or guardian's judgment may be open to challenge with regard to the best interests of the minor. The burden, however, is on the challenger to demonstrate the minor patient's best interests or desires are not being appropriately considered. In this case, consultation with Social Services and/or the Ethics Committee is advisable.

5. If concurrence cannot be obtained among both parents or guardian, the minor (as appropriate) and the attending physician or his/her designee, then the guidelines delineated in section VIII, Dispute Resolution, apply.

6. Risk Management should be consulted before withholding or withdrawing medical treatment that could result in the death of a pregnant patient.

**VI. DOCUMENTATION**

A. The discussion of the plan of care and the agreement of the patient/surrogate should be documented in the medical record and include the following:
1. Who participated in the discussion;

2. The medical condition and prognosis of the patient;

3. A description of the patient's decision making capacity;

4. A description of the circumstances relevant to the decision, including the objective(s) of the patient or surrogate;

5. The medical care options presented;

6. A detailed description of and rationale for the plan of care agreed to by the patient/surrogate, including (to the extent that can be anticipated) what specific medical treatment will be provided, withheld, and/or withdrawn. If death is an anticipated and accepted outcome of the care plan, this should be specified.

7. Documentation supporting the decision from consultants such as medical specialist, psychiatrist, or the ethics committee when appropriate.

B. Instructions for medical treatment to be withheld may be entered in the form of an order, but this may not be necessary in the presence of Progress Note documentation delineated above.

C. Orders must be entered into iSparrow EMR to withdraw medical treatment.

D. If death is an anticipated and accepted outcome of the care plan, a "Do not resuscitate" is not necessary.

E. Verbal orders may be taken by phone and entered into iSparrow EMR by a Registered Nurse to withhold or withdraw medical treatment from the attending physician or his/her designee, and are effective immediately, but must be signed by the physician within 24 hours. The nurse should document the interaction including a statement referring to discussion with the patient and/or surrogate. Appropriate physician documentation (as delineated in VI.A.) should follow at the time the order is signed.

VII. REVIEW

A. Decisions to withhold medical treatment should be reviewed with the patient or surrogate decision-maker whenever the circumstances relevant to the decision change.
B. The decision to withhold medical treatment should also be reviewed with the patient if he/she regains decision-making capacity after a surrogate agreed to the decision originally.

C. If review of the decision to withhold medical treatment is indicated, documentation that this has been done should be made in the Progress Notes.

VIII. DISPUTE RESOLUTION

A. Whenever a patient or surrogate decision maker requests the withdrawal of a treatment(s), the attending physician or designee must review this decision with the patient or surrogate decision maker (see III.A.) and

1. Implement the decision; or

2. Promptly make his/her objection and the reasons for same known to all interested parties and, if the objection or disagreement cannot be resolved, either:

   a. Promptly request an Ethics Consultation, or

   b. Make all reasonable efforts to arrange for the transfer of the patient to the care of another physician.

B. If a patient or surrogate decision maker refuses a recommendation to withhold or withdrawal a medical treatment made by the attending physician or designee when he/she cannot in good conscience offer/provide that treatment because it (1) would be futile or medically ineffective, (2) fails to offer a minimum quality of life or a modicum of medical benefit, (3) cannot possibly achieve the patient’s goals, then the physician must make his/her objection and the reasons for same known. If the objection or disagreement cannot be resolved, the attending physician or designee should

1. Initiate or continue the treatment in dispute, if such treatment is necessary to and may be effective in sustaining the patient’s life.

2. Promptly request an Ethics Consultation or make all reasonable efforts to arrange for the transfer of the patient to the care of another physician.

C. Loss of capacity cannot be used as the sole basis for modifying a plan of care previously made by a patient. However, if a reasonable surrogate decision maker objects to such a decision without a change in the circumstances relevant to the patient's original decision and he/she cannot be dissuaded, then the attending physician should notify risk management. The attending physician should also consider requesting an Ethics Consultation.
GUIDELINES FOR DETERMINATION OF DEATH BY NEUROLOGIC CRITERIA IN ADULT PATIENTS

Purpose:
To assist in the determination of death by neurologic criteria (“brain death”) consistent with Michigan law and accepted standards of care.

Policy Statement:
“Brain death” is defined as the irreversible loss of the clinical functions of the brain, including the brain stem. A medical staff member, under the supervision of an attending physician, must make the determination of “brain death” consistent with Michigan law and the following guidelines.

Procedure:
Temperature should be greater than 32°C, blood glucose ≥ the normal range, most recent administration of paralytics, sedative and/or hypnotics greater than 6 hours prior to exam, level of barbiturates or phenytoin < the therapeutic range, and blood pressure within normal range.

- Clinical Determination:
  - GCS of 3
  - Absence of spontaneous or induced movements excluding spinal cord events such as reflex withdrawal or spinal myoclonus
  - Absence of brain stem reflexes
    a) No pupillary response to light
    b) No oculocephalic (doll’s eyes) response (tested only when no injury or instability to the cervical spine is present)
    c) No response to cold caloric testing with: patient’s head flexed 30°, use iced water (60 cc/ear canal), allow 5 minutes to elapse between ears (tested only after visual examination of tympanic membranes).
    d) No corneal response
    e) No cough or gag
  - Apnea must be present
    a) No muscle relaxants for greater than six hours or positive spinal cord reflexes or a positive response to electrical neuromuscular stimulation at 0.75 watt-seconds for four seconds duration.
    b) Pre-oxygenation with 100% oxygen for five minutes
    c) pCO₂ ≥ 40 mmHg immediately prior to discontinuing assisted ventilation
    d) No assisted ventilation on 100% oxygen for either 15 minutes or until pCO₂ is ≥ 60 mmHg.
    e) ABG’s to be tested every 3 to 5 minutes during the test
    f) test terminated if organ donation is a consideration and arterial saturations fall below 85% or significant fall in blood pressure.
g) Apnea is determined if no spontaneous respirations after either 15 minutes of apneic oxygenation or after pCO₂ reaches 60 mmHg (with or without apneic oxygenation).

- **Confirmatory Tests** (optional)
  - Cerebral perfusion study:
    a) 4 vessel cerebral angiogram showing absence of cerebral blood flow
    b) technetium 99 cerebral perfusion study showing absence of intracranial arterial blood flow

  **Confirmatory testing is mandatory for all cases of drug induced coma; when cause of brain death has not been determined or when apneic oxygenation test cannot be performed due to inability to sustain oxygenation or blood pressure.**

- **Observation Period**
  - Following a cerebral perfusion study consistent with brain death, no further period of observation is necessary
  - If the cause of brain death is unknown, a 6-hour observation period between clinical examinations for brain death is recommended prior to a cerebral perfusion study.

- **Documentation**
  - Etiology and irreversibility of condition
  - Absence of brain stem reflexes
  - Absence of motor response to pain
  - Absence of respiration with pCO₂ 60 mmHg
  - Justification for and results of any confirmatory testing
  - Result of any repeat brain death examination

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**BRAIN DEATH DETERMINATION PROCEDURE IN CHILDREN ≥ SEVEN DAYS OF AGE**

A. Temperature greater than 32ºC, blood glucose ≥ the normal range, last administration of paralytics, sedatives and hypnotics greater than 6 hours prior to exam, levels of barbiturates or phenytoin # the therapeutic range* and blood pressure within the normal range for age.

B. Clinical determination of brain death:
   1. GCS of 3;
   2. Absence of spontaneous or induced movements excluding spinal cord events such as reflex withdrawal or spinal myoclonus;
   3. Absence of brain stem reflexes
      a) no pupillary light response
b) no oculocephalic (doll’s eyes) response  
c) no response to cold caloric testing with: patient’s head flexed  
   30º; and ice water used (60 cc/ear canal); and 5 minutes  
   allowed to elapse between ears.  
d) no corneal response;  
e) no cough or gag.

C. Clinical determination of brain death – Apnea:

1. Apneic oxygenation  
   a) Intact skeletal muscle function: no muscle relaxants for greater than 
      six hours or positive spinal cord reflexes or a positive response to 
      electrical neuromuscular stimulation at 0.75 watt-seconds for four 
      seconds duration.  
   b) five minutes pre-oxygenation with 100% oxygen prior to discontinuing 
      assisted ventilation.  
   c) control (that is, immediately prior to discontinuing assisted ventilation) 
      arterial pCO₂ ≥ 40 mm Hg.  
   d) ABG’s to be tested q 3 to 5 minutes at the bedside  
   e) no assisted ventilation on 100% oxygen for either 15 minutes or until 
      the arterial pCO₂ is ≥ 60 mm Hg.  
   f) test terminated if organ donation is a consideration and arterial 
      saturations fall below 85%. 

2. Apnea is determined if:  
   a) intact skeletal muscle function;  
   b) no spontaneous respirations after either 15 minutes of apneic 
      oxygenation or after arterial pCO₂ reaches 60 mm Hg (with or without 
      apneic oxygenation).

D. Confirmatory Tests  
1. EEG(s) (optional)  
2. Cerebral perfusion study  
   a) 4 vessel cerebral angiogram showing absence of cerebral blood flow;  
   b) technetium 99 cerebral perfusion study showing absence of intracranial 
      arterial blood flow;  
3. confirmatory technetium 99 cerebral perfusion scan is recommended for 
   children of all ages where there has been the clinical determination of brain 
   death.  
4. a confirmatory technetium 99 cerebral perfusion scan or a 4 vessel angiogram 
   is mandatory for all cases of drug induced coma; or when the cause of brain 
   death has not been determined; or when the apneic oxygenation test has been 
   unable to be performed because of inability to sustain oxygenation.

E. Observation Period
1. Once a cerebral perfusion study has shown absence of cerebral blood flow, no further observation period is necessary;
2. If a cerebral perfusion study is not available;
   a) Age seven days to 2 months:
      two examinations and EEGs separated by 48 hours;
   b) Age 2 months to 1 year:
      two examinations and EEGs separated by 24 hours.
   c) Older than one year:
      corroborative testing is not required if an irreversible cause is identified. An observation period of 12 hours is recommended except when assessment of extent and irreversibility of brain damage is difficult (specifically after hypoxic-ischemic insults) an observation period of at least 24 hours is recommended.

AUTOPSY POLICY

PURPOSE:
To provide guidelines for documenting and obtaining permission for autopsy.

POLICY:
The following policy provides guidelines performing an autopsy for Medical Examiner Cases and Non-Medical Examiner cases. The policy is intended to recognize criteria when the medical examiner must be notified and to obtain permission for autopsy in cases that are not medical examiner cases yet should be considered for autopsy.

DEFINITIONS:

PROCEDURE:

MEDICAL EXAMINER MUST BE NOTIFIED IN THE FOLLOWING CASES:
(*Michigan Act 181, P.S. 1953, as amended, provides for the Medical Examiner to investigate and determine "the cause and manner of death in all cases of persons who have come to their death" under any of the following circumstances:

- **Violence:** Asphyxiation, Shooting, Stabbing, Poisoning, etc.
- **Accident:** Traffic, Fall, Drowning, Industrial, and Drugs
- **While in Custody:** Prisoners
- **Sudden and unexpected:** Where deceased was in apparent good health.
- **Without medical attendance within 48 hours:**
  In cases of chronic illness, the attending physician may sign the death certificate if he can be reasonably certain of the cause of death. However, he should examine the body to satisfactorily determine that no foul play is involved.
- **Suspicious Circumstances Including Unidentified bodies.**
- **Administration of Drugs, Therapeutic Procedures, Anesthesia,** etc.
- **Death occurring days, months or years after a traumatic injury.**
Evaluation and disposition (transfer, removal, and release) will be made by the medical examiner. The need for autopsy examination in certain cases will be determined by the medical examiner.

FOR NON-MEDICAL EXAMINER CASES:

Autopsy permission from the appropriate next-of-kin should generally be sought by the attending physician in the following circumstances:

- Death under age 50.
- Death within 48 hours of surgical or invasive procedure (which is not otherwise ordered by the medical examiner).
- Death possibly associated with drug reaction.
- Death associated with any adverse event (which is not otherwise ordered by the medical examiner).
- Death within 48 hours of admission.
- Death in the Emergency Department (unless the death is clearly the outcome of a longstanding, well-documented medical/surgical disorder).
- All deaths in the outpatient setting (which are not otherwise ordered by the medical examiner).
- All deaths in which the admission diagnosis suggests death was not expected (which are not otherwise ordered by the medical examiner).
- Deaths in which there is a high degree of medical interest with respect to confirmation of diagnosis, evaluation of diagnostic procedures, and/or evaluation of therapeutic modalities.
- Deaths in which confirmation of diagnosis may be of importance to other family members (e.g. asymmetrical myocardial hypertrophy, colonic polyposis, etc).
- All obstetric deaths.
- All perinatal and pediatric deaths.

AN AUTOPSY WILL BE PERFORMED:

- Only upon an attending physicians request.
- The requesting physician should be someone who provided direct care to that patient, or the VP of Medical Affairs or designee.
- After an appropriate autopsy permission has been signed.

Acceptance or denial of permission to request/grant autopsy will be documented in the patient record.

A gross autopsy preliminary report will be completed and available with 7 days and placed in the medical record.
GENERAL PATIENT CARE RESPONSE TIMELINES

In order to respond to patient care needs in a timely manner and maintain practice privileges, a physician shall reside within 40 minutes of the hospital. The preferred communication method for contacting a physician on call is first by pager (or cell phone if provided as an alternative to a pager), then answering service. The appropriate time limit when responding to a page is 15 minutes by phone and 55 minutes in person. Physician contacted when a page is not responded to will be first, practice partner; second, department chair and third, hospitalist. If clinical condition warrants, the Rapid Response Team should be alerted.

ADULT CRITICAL CARE PHYSICIAN STAFFING POLICY

1. Statement of Purpose

The purpose of the ICU Physician Staffing Policy is to provide a foundation for optimal care for critically ill patients and to ensure appropriate on-site coverage and physician response time. The goal is to move the Adult Critical Care Services at Sparrow Health System towards the development of a Level I critical care services as defined by the American College of Critical Care Medicine (ACCM)\(^1\). This is consistent with national recommendations as described and supported by:

- Leapfrog Group
- Michigan Health and Safety Coalition
- Society for Critical Care Medicine
- American College of Chest Physician
- Institute for Healthcare Improvement
- American Association of Critical Care Nurses
- American Thoracic Society
- Agency for Healthcare Research and Quality
- John’s Hopkins’s Patient Safety Institute
- Keystone: ICU Initiative
- Michigan Hospital Association

The involvement of intensivists in “high intensity” critical care staffing does not mandate the provision of all care by intensivists but does require an intensivist privileged in critical care medicine to be involved in the assessment and care of designated patients as appropriate, and enables the assumption of complete care if medically necessary.

2. Policy Statement
All patients admitted to the Adult Critical Care areas (ICU, CICU, NCU, and SU) will be cared for by physicians with core privileges in critical care medicine (see Privileges for Adult Critical Care), with specific exceptions as defined below (see “Exceptions to Requirements”). Intensivists may be involved in the care of critical care patients in one of three ways:

A. The intensivist admits the patient as the primary physician and manages the patient.
B. The intensivist accepts the patient in transfer from another physician as the patient enters the critical care area, and assumes the complete care as the attending/primary/admitting physician.
D. The intensivist sees a patient in consultation after an appropriate request from the referring physician for a specific critical care problem or issue (shock, respiratory failure, pneumonia, dyspnea, altered mental status, hypoxia, etc.). Since ICU patients are complex and problems are dynamic, it is anticipated that the intensivist would be on-site or readily available and that depending on patient need and circumstances the assumption of a broader role, or even assumption of complete care of the patient, may be required at times with discussion of the referring physician. This alternative is specifically for patients who attending physicians are in the subsequent category and for specific situations unacceptable to the critical care attending.

The intent of this policy is to insure the earliest possible and continued coordination of the patient’s care directly by the intensivist from the time the patient is considered a potential candidate for admission to critical care and throughout the patient’s stay in critical care. The intensivist will participate in the decision to admit to critical care, be available, and physically present as needed, to provide bedside care.

The decision regarding which of these three options is more appropriate as initial step will depend on the admitting physician’s initial request and judgment.

Those providing intensivist care with intensivist privileges would arrange for appropriate on-site coverage if not present themselves with other qualified personnel who would be physically present and available in the institution during day time hours, and be able to provide appropriate off-site night-time coverage to ensure continuity of care with another intensivist.

3. Exceptions to Policy Requirements

The following patients would not require automatic involvement by an intensivist.

A. Cardiology patients without ventilator support or respiratory failure and in the absence of any other major non-cardiac organ dysfunction.
B. Post-operative surgical patients who are normally sent to the ICU as an expected part of routine post-operative care (EG, uncomplicated open-heart patients who do not require prolonged mechanical ventilator or complicated non-cardiac use).
Post-operative open-heart patients in persistent or complicated respiratory failure, or other post op surgical patients who have a significant organ dysfunction and otherwise meet the admission and discharge criteria to the ICU are not usually considered “stable” or routine and would require involvement by a physician with intensivist privileges.

E. Stroke teams patients admitted to the SU unless the patient has required ventilator support (Greater than 24 hours)

F. Patients who fall into the “exception” category described above may from time-to-time become unstable or require evaluation administratively by the Medical Director or an on-site intensivist to facilitate a rapid response option if needed. This would require immediate contact with the attending physician.

4. Credentialing and Competency

Credentialing for and privileging for Adult Critical Care Privileges is outlined in accordance with the qualifications for Privileges for Adult Critical Care document (see attached).

References:


2. ICU Physician Staffing (IPS) Fact Sheet; The Leapfrog Group; (www.theleapfroggroup.org).

Privileges for Adult Critical Care

Qualifications for Privileges

To be eligible for core privileges in the intensive care unit the applicant must meet the following qualifications, unless waived by exception procedures (see below).

- A member in good standing of the Active staff or Provisional staff working towards Active staff status.

- Board Certified physicians who are additionally certified in the subspecialty of critical care medicine, by way of successful completion of an approved/accredited fellowship program in adult critical care medicine.
• Physicians board certified in Emergency Medicine would be eligible if they have completed a critical care fellowship in a ACEP accredited program.

• Successful Completion of Board examinations within 5 years of completing fellowship training in adult critical care medicine leading to Board eligibility.

• Recent activity in critical care medicine or completion of a Critical Care Fellowship within the last two years sufficient to demonstrate active involvement in this rapidly changing field (active management of 100 cases over the last 2 years or full-time ICU management and consultation activities for 100 patients over the last 2 years or completed critical care fellowship within the last 2 years).

Exceptions

Exceptions to the above criteria for adult critical care privileges may be made for physicians as described below at the discretion of the Centralized Credentials Committee or the Medical Staff Executive Committee acting on the recommendation of the Director of Critical Care and the Department Chair.

1. Physicians who are Board Certified in Medicine, Anesthesiology, or Surgery who completed training prior to the availability of subspecialty certification in critical care and who have provided at least 6 weeks of full-time ICU care annually since 1987 (see Leapfrog definitions for ICU physician staffing).

2. Other physicians who have demonstrated expertise and/or special experience in critical care may require an alternative credentialing process that will help meet the hospital’s ICU staffing plan and assist in the development of a “high intensity” ICU staffing plan as developed by such organizations at the Leapfrog Group and the Society of Critical Care Medicine. This option may be exercised at the discretion of the Medical Staff Executive Committee and the Centralized Credentials Committee and would entail a review of previous cases, type of cases, setting of which previous care was delivered, and extent and nature of previous critical care activities.

Privileges Included in Core ICU Privileges

Privileges to admit, evaluate, diagnose, consult and provide treatment or a consultation to adult patients in need of critical care. Privileges include high-risk, high-volume, problem prone procedures which are commonly performed by the intensivists on critically ill patients such as:

- Central venous access
- Intubation
- Pulmonary artery catheterization
- Cardiopulmonary resuscitation
- Arterial access
- Transports
- Ventilator management
Exercise of critical care privileges requires the ability to work in a cooperative atmosphere and provide a teamwork approach with other physicians with critical care privileges and to collaborate as required patients with complex and difficult management problems (such as patients with the requirements for high-frequency ventilation or other unusual ICU interventions).

Maintenance of Privileges

1. Active participation in quality improvement programs related to critical care including process improvement, quality assurance, and peer review activities.
2. Adherence to policies and procedure related to coverage, etc. as enumerated in the “Critical Care Physician Staffing Policy/Medical Staff General Policy & Procedure Manual”.
3. Maintain sufficient activity in the critical care area to maintain skills and expertise.

References:

1. ICU Physician Staffing (IPS) Fact Sheet; The Leapfrog Group; (www.theleapfroggroup.org).

PERSONAL CONDUCT POLICIES
PRACTITIONER HEALTH & IMPAIRMENT POLICY
(Revised July 31, 2001)

1.0 Purpose

The purpose of the policy is to provide guidelines for the identification and management of practitioners who are unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness or injury, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs including alcohol.

2.0 Reporting of Impairment

2.1 By Others. If an individual working at the Hospital, including a medical staff member, has a reasonable belief that a practitioner is impaired with regard to the practitioner’s ability to provide patient care services, that individual may make a written report to the President or the Chief of Staff. The report shall include a description of the incident(s) that led to the belief that the practitioner may be impaired.

2.2 Self-Report. Any practitioner who believes that he/she may be impaired or who is subject to a recovery contract through the Michigan Health Professional Recovery Program or has had his/her privileges or employment duties limited by any healthcare organization shall report that circumstance to the President or Chief of Staff.

3.0 Action on Report

3.1 Summary Action. The President or the Chief of Staff (or designee of either) shall discuss the circumstances reported with the individual who submitted the report and may require the practitioner who is the subject of the report or self-report to discuss his/her condition with them. If the report appears to be reliable and would justify immediate summary action (e.g., summary suspension) under the Medical Staff Bylaws or Hospital policies and a continuing threat to safety exists as long as the practitioner continues to practice, the Chief of Staff and the President may, acting jointly, immediately take such summary action in accordance with the Medical Staff Bylaws. If they are unsure whether there is a continuing risk to safety, they may defer a decision on summary action pending an investigation.

3.2 Ad Hoc Peer Review Committee. The matter shall be referred to an ad hoc peer review committee appointed by the Chief of Staff. The ad hoc committee must include the VPMA and Department Chairperson, and may include other members and/or outside consultants (such as a representative of the Michigan State Medical Society’s Physician Recovery Network), and may be chaired by the Medical Director of Credentialing.

3.3 Investigation. The ad hoc committee may consult with the practitioner and require independent examinations of the practitioner. The investigation results and the ad hoc committee’s recommendation shall be shared with the practitioner, the Chief of Staff and the President. Action shall be taken on the recommendation in the following manner:

3.3-1 If the ad hoc committee finds that there is no impairment, the matter will be referred back to the Chief of Staff and the President for their determination as to whether the circumstances giving rise to the report justify institution of summary action or corrective action under the Medical Staff Bylaws or, if an employee, Hospital...
employment policies.

3.3-2 If the determination is made that there is potential or probable impairment but the practitioner would not benefit from or does not agree to participate in a rehabilitation process acceptable to the ad hoc committee, the matter will be referred back to the Chief of Staff and President for their determination as to whether the circumstances giving rise to the report justify summary action or corrective action under the Medical Staff Bylaws or Hospital employment policies.

3.3-3 If a finding is made by the ad hoc committee that the practitioner is or may be legally impaired, and the practitioner has not already self-reported his/her impairment status to the State of Michigan Health Professional Recovery Program he/she shall be requested to do so. Thereafter if the subject practitioner fails to provide evidence to the Chief of Staff that he/she has self-reported, the Chief of Staff shall make that report.

3.3-4 If a finding is made by the ad hoc committee that the practitioner is or may be, impaired and would benefit from rehabilitation, and the practitioner agrees that he/she has a probable impairment and is willing to participate in good faith in a rehabilitation process defined by the ad hoc committee, the practitioner shall enter into a memorandum of understanding to ensure compliance with rehabilitation and patient quality of care and safety.

4.0 Rehabilitation Plan

4.1 **Plan Development.** If the practitioner agrees to participate in a rehabilitation process, the ad hoc committee shall define an individualized plan for addressing the practitioner's health issues utilizing internal or external resources for diagnosis and treatment of the condition or concern. The practitioner shall authorize all health professionals providing his/her care to disclose to the ad hoc committee the precise nature of the practitioner's condition, the current course of treatment that the practitioner is receiving, if any, and mental, physical and emotional assessments of the practitioner's ability to safely exercise privileges. Recognizing that patient quality of care and safety are paramount, the plan may provide for, among other things, a leave of absence, imposition of a course of therapy, imposition of periodic mental or physical health examinations by a health care professional selected by the committee, and restrictions or limitations on practice and/or clinical privileges at hospital and/or other practice settings, including a consultation or preceptor requirement.

4.2 **Patient Care.** The practitioner shall identify at least one other practitioner on the Hospital's Medical Staff who is willing and able to assume responsibility for the care of the practitioner's patients in the event of his/her inability or unavailability to render appropriate and safe care and treatment to the patients.

4.3 **Examination and Testing.** If applicable, the practitioner shall agree to immediately submit himself/herself to a physical examination, including blood, breath, saliva, urine and other testing, in order to rule out the presence of drugs or alcohol any time a request is made by the President, the Chief of Staff, or the Department Chairperson when there is reasonable suspicion that the practitioner is impaired while at the Hospital, while on call or while treating or offering treatment advice for a hospitalized patient.
4.4 **Monitoring.** The practitioner must agree to have his/her privileges in the Hospital monitored by the Department Chairperson or other physician appointed by the Department Chairperson.

4.5 **Reporting.** The practitioner shall be required to obtain periodic and other reports necessary and appropriate for the Hospital to monitor the practitioner’s rehabilitation status and continued ability to safely exercise privileges.

5.0 **Non-compliance**

If the practitioner fails to comply with the provisions of the memorandum of understanding, a report of non-compliance shall be submitted by the President, Chief of Staff, or Department Chairperson to the MSEC and considered a request for corrective action.

6.0 **Interpretation and Definitions**

6.1 **Controlling Provisions.** In the event of any apparent or actual conflict between this Policy and Hospital or the Medical Staff Bylaws, including the incorporated Policy Manuals, the provisions of this policy shall control. However, nothing in this policy shall interfere with the right of the MSEC or Board to impose summary action or institute corrective action when warranted. Further, nothing in this policy shall interfere with the obligation of health care professionals to make a report of another health care professional’s suspected impairment, when warranted.

6.2 **Impaired.** For purposes of this policy, the term “impaired” means the diminished capacity of an individual to perform one’s duties while acting in the scope of one’s employment or professional responsibilities while in the Hospital, while on call or while treating or offering treatment advice for a hospitalized patient, which diminished capacity has resulted from aging, physical illness, mental illness, alcohol abuse, drug abuse, or other conditions causing impairment. A person who is impaired for this purpose may not be “legally impaired”.

6.3 **Legally Impaired.** For the purposes of this policy, the term “legally impaired” means the inability or immediately impending inability of a health professional to practice his or her profession in a manner which conforms to minimum standards of acceptable and prevailing practice of that health profession due to the health professional's substance abuse, chemical dependency, or mental illness, or the health professional's use of drugs or alcohol that does not constitute substance abuse or chemical dependency. (MCL 333.16106A)

7.0 **Confidentiality**

7.1. **Peer/Professional Review.** Inasmuch as the ad hoc committee's function is peer/professional review, the records, data and knowledge collected by the ad hoc committee in any form shall be maintained at all times in a confidential manner, consistent with the provisions of state and federal statutes, including but not limited to MCL 331.531, MCL 331.533, MCL 333.20175, MCL 330.1143a, MCL 333.21513 and MCL 333.21515.

7.2 **Disclosure.** Except for actions of which the Board, President, Chief of Staff, and MSEC shall be advised, the records, data and knowledge of the ad hoc committee may be disclosed only to other entities having a professional review function. Except when the Hospital or ad hoc committee members are required by law to respond to state licensing authorities, the
committee will notify the practitioner of its intention to provide information, and the practitioner may, in lieu of the information being disclosed, resign his/her appointment and privileges or request withdrawal of any pending application for appointment or privileges.

DISRUPTIVE BEHAVIOR

PURPOSE: To provide guidelines for addressing concerns regarding the practitioner who has a problem with disruptive behavior (behavior outside professional acceptability). Hospital policy provides that all persons should be treated with dignity and respect. Conduct is not permitted which would unreasonably interfere with an individual’s work performance by creating a disruptive, intimidating, hostile or offensive working environment and/or interfere with patient safety/quality of care.

DEFINITION: The American Medical Association (AMA) has defined disruptive behavior as a style of interaction with physicians, hospital personnel, patients, family members or others that interferes with patient care.

PROCEDURE: A consistent method of reporting a complaint and managing problems related to interpersonal conflicts between physician and associate is necessary. Incidents of unacceptable conduct will be documented on a Physician-Related Compliments & Concerns Quality of Care Referral Form. It will be reviewed and addressed appropriately through the Physician Related Issues Complaint Resolution Process, involving the Medical Director of Credentialing, Department Chair/Section Chief, and VPMA (if Chair is not available). The peer review process will be initiated and other steps taken consistent with Medical Staff Bylaws and Regulating Agencies.

ENFORCEMENT OF MEDICAL STAFF RESPONSIBILITIES AS DEFINED IN THE MEDICAL STAFF BYLAWS

The existing delinquent medical record policies and notification system may be applied to other Medical Staff Bylaws required functions (see Delinquent Medical Record Policy).

The Chief of Staff may at his/her discretion, following a request for assistance by a Department Chair, Section Chief, Medical Director, or the VPMA, invoke the current Delinquent Medical Record Policies and Notifications Systems for a member of the Sparrow Medical Staff who has been determined to be in violation of the Medical Staff Bylaws or who has failed to uphold his/her citizenship responsibilities under the Bylaws. Invoking such policies shall be deemed to be appropriate only if the Medical Staff Member has failed to appropriately respond in a reasonably timely manner to a written request from the respective Department Chair, Section Chief, Medical Director, or VPMA.

A record of the use of this policy for individual physicians shall be available for review and consideration by involved Sparrow staff at the time of physician reappointment.

This policy does not alter or limit in any way other administrative actions which may be appropriate to the situation.
LATE SURGEONS

Surgeons that require correction for being chronically late will be reviewed on an individual basis by the Surgical Executive Committee.

PROFESSIONAL CONDUCT SECTION

Purpose: Professional medical care is an endeavor built on collegiality and the mutual respect of all those involved in patient care. The principal objective is to ensure high standards and delivery of patient care, promote a professional practice, and safe work environment. The importance of respect among all health professionals as a means of ensuring good patient care is at the very foundation of professional ethics. As a member of this profession, a physician must recognize his/her ethical responsibility not only to patients, but also to society and to other health professionals. This creates the obligation to make relevant information available to colleagues, to interact with other health professionals in a collaborative and respectful manner, and to obtain consultation and use the expertise of other health professionals when indicated.

Disruptive physician behavior has been defined by the AMA as “as a style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.” Personal conduct, whether written, verbal or behavioral, that interferes or could potentially interfere with patient care constitutes disruptive behavior. This includes but is not limited to conduct that interferes with one’s ability to work with other members of the health care team. However, constructive criticism offered in good faith and in a spirit of collaboration, openness and mutual respect with the aim of improving patient care should not be construed as disruptive behavior.

CITIZENSHIP

Definition of Citizenship:

- Responsible, professional behavior is defined by appropriate, timely, and continuous care of patients and may include, but is not limited to:
  - Arranging for professional coverage and on call coverage for his/her patients during time away from the community and providing that coverage information to the hospital
  - Participation with quality and performance improvement activities of the medical staff and hospital
  - Assisting in monitoring activity for new medical staff appointees
  - Participating in coverage of the emergency service and other coverage programs as required by the Medical Staff Executive Committee
  - Thorough, complete and timely medical record documentation, including adoption and meaningful use of the iSparrow Electronic Medical Record (EMR)
  - Completion of required online, classroom or other training and demonstrating proficiency in the use of iSparrow EMR and other relevant clinical information systems, including system updates and enhancements. Specifically, EMR classroom training and demonstration of proficiency are mandatory for the issuance of an EMR ID and password for the live system, and are required for maintenance of privileges.
Process:

- Compliments to physicians may be filed using the “Physician Compliments and Complaints” form located on the Sparrow Intranet or other written form. Completed forms describing the scenario or circumstance will be sent to the VPMA.

- Review of the compliment will be performed by the VPMA or his/her representative, Medical Officer or Medical Director as appropriate as a verification process. The physician named by the compliment will be notified by letter or personal contact from Medical Staff office.

- A copy of the notification letter of good citizenship will be placed in the physician’s recredentialing file.

**DISRUPTIVE BEHAVIOR**

**Definition of Disruptive Behavior:**

- A style of interaction with physicians, hospital personnel, patients, family members, or others that interferes with patient care.”

- Disruptive behavior is any behavior which endangers patient, medical staff or employee safety and may include, but is not limited to:
  
  - Verbal attacks or intimidation or using foul or threatening language;
  - Physical attacks or threats of physical attack;
  - Behavior or remarks which are inconsistent with the policy on sexual harassment;
  - Modeling inappropriate behaviors for students and residents, thereby impairing their ability to achieve clinical skills;
  - Abusive, non-constructive criticism;
  - Willful damage to or theft of organization property;
  - Unauthorized use, possession, or ingestion of mood altering substances on organization property, or when caring for patients in the hospital;
  - Retaliations or retribution to reporting individuals.

Process:

- Reports of disruptive behavior are filed using the “Physician Compliments and Complaints” form located on the Sparrow Intranet or other written form. Such reports will be sent to the VPMA.

- Review of the complaint will be performed by the VPMA or the appropriate Medical Staff Officer as a verification process. Complaints will then be presented to the appropriate Medical Staff Officer or committee for review, action and notification of the involved Medical Staff member.

- When indicated, physicians will be afforded due process through the Fair Hearing Plan. Additionally, the physician may be referred for medical evaluation to rule out physical, mental illness or substance abuse that requires treatment. Physicians may have protection under state statute for impaired physicians and may be subject to reporting activities to the National Practitioner Data Bank.

- While a single incident may not be sufficient for action, a history of verified complaints may be an indication for Medical Staff action.
• Physician may be subject to “Practitioner Health and Impairment Policy”, General Policy & Procedure Manual, Personal Conduct Policies section, page 82.

• Corrective actions will be consistent with Medical Staff Bylaws and be commensurate with the behavior and will be monitored.

• Peer review protection and confidentiality will be appropriately provided for both the physician and the source of the report.

• Interventions will be guided by the welfare and best interest of patients, rather than based on personal friendships and dislikes, antagonisms, jurisdictional disagreements or competitiveness among members of the staff.

• Interventions will allow for self-correction, as well as structured rehabilitation.

• Suspension of responsibilities or privileges may be a mechanism of final resort if the behavior persists despite attempts to intervene.

**ATTESTATION TO PROFESSIONAL CONDUCT**

In keeping with Sparrow Health System’s mission to provide quality, compassionate care to every patient, every time, I understand that as a physician, I have a special responsibility to promote teamwork, the free exchange of ideas, and a collaborative approach to problem solving. I also understand my responsibility to consistently demonstrate collaborative, collegial and respectful behaviors to all persons involved in delivering or supporting patient care.

I further recognize that a style of interaction with other physicians, hospital personnel, patients, family members, or others that interferes with patient care constitutes disruptive physician behavior. Such disruptive behaviors have a deleterious effect on the healthcare system and increase the risk of patient harm. I will adhere to the responsibilities of staff membership as outlined in the Responsibilities Section of the Medical Staff Bylaws, and as endorsed by the AMA, AOA, ADA and APMA.

I understand that I will be held accountable to this standard of conduct set by Sparrow Medical Staff Bylaws. I acknowledge that I am responsible to uphold these standards and always act in a professional, ethical manner while carrying out my duties as a physician at Sparrow Hospital.

I acknowledge that I have received, read and agree to abide by the terms of the Professional Conduct Policy of Sparrow Medical Staff. Further, I understand:

• That disruptive behavior is any behavior which endangers patient, medical staff or employee safety and includes, but is not limited to:
  
  o Verbal attacks or intimidation or using foul or threatening language;
  o Physical attacks or threats of physical attack;
  o Behavior or remarks which are inconsistent with the policy on sexual harassment;
Modeling inappropriate behaviors for students and residents, thereby impairing their ability to achieve clinical skills;
- Abusive, non-constructive criticism;
- Willful damage to or theft of organization property;
- Unauthorized use, possession, or ingestion of mood altering substances on organization property, or when caring for patients in the hospital;
- Retaliations or retribution to reporting individuals.

- That all complaints will be verified before any corrective action and will, if warranted, be referred for peer review.

I acknowledge that if I am found to engage in such disruptive behavior, intervention will occur as described in the Professional Conduct Section of the Policy and Procedure Manual.

Signature__________________________________ Date_____________

Approved: Bylaws: Nov 3, 2008; MSEC: Dec 1, 2008; Board: Dec 23, 2008; Quarterly Staff: March 10, 2009
MEDICAL RECORD POLICIES
MEDICAL STAFF AND THE MEDICAL RECORD

Each attending practitioner is responsible within his/her power for appropriate and meaningful use of iSparrow EMR, the official medical record of Sparrow Health System effective December 1, 2012. Such responsibilities include the overall content, accuracy, completeness, appropriate placement and timeliness of documentation of care in the patient's electronic medical record. The practitioner or his/her agent in overall charge of the patient is responsible for documenting the admitting history and physical examination in iSparrow EMR within the first 24 hours of admission. Any full or partial dictation will be conducted in compliance with Sparrow dictation policy. The practitioner or his/her agent in overall charge of the patient at the time of discharge is responsible for completion of a discharge summary containing any and all elements required to meet criteria for meaningful EHR use. In the event that the EMR is unavailable, physicians will follow established down-time procedures to ensure that appropriate documentation is completed.

PHYSICIAN IDENTIFIER POLICY

When physicians log in to the iSparrow EMR system, their electronic signature is automatically placed in the system whenever they mark an item as reviewed, accepted or signed. All EMR users must log in only using their own individual EMR ID and password (or other authentication method such as a ID smartcard). This ensures that all of their documentation, orders and other actions are appropriately attributed to the correct Caregiver. Under no circumstances is it permissible for a physician to share his or her iSparrow EMR password or allow another individual to log in or document care using the physician’s own ID and password (or other authentication method such as their identification badge ‘smart card’); doing so shall constitute grounds for disciplinary action. To protect patient protected health information, lost or stolen identification badge ‘smart cards’ must be reported to Sparrow Security as soon as they are identified as missing so they can be inactivated until found.

THE ADMISSION HISTORY AND PHYSICAL EXAMINATION/ADMISSION NOTE/PREOPERATIVE NOTE

All patients admitted for inpatient care shall have a history taken and a physical examination performed and recorded in iSparrow EMR within 24 hours after admission. The history shall include the chief complaint, history of present illness, including when appropriate an assessment of the patient's emotional, behavioral, and social status, relevant past medical, surgical, social and family histories, allergies, current medications (including dose, route and frequency), special diets and treatments, technological support, and a Review of Systems. The physical examination shall reflect a comprehensive, current physical assessment. A Principal Diagnosis shall be recorded in a structured manner on the iSparrow EMR Problem List; any additional problems or diagnoses related to the hospitalization should also be entered in the Problem List. An assessment and plan of care for the patient during the Hospital stay drawn from the admission history and physical examination shall be included. If a complete history and physical examination has been completed and documented within one week prior to admission, then a durable, legible copy of the report may be used in the patient's hospital medical record provided the history is confirmed with the patient, there are no subsequent changes, or the changes have been recorded at the time of admission. Even in this situation, the Principal Diagnosis related to the admission, other hospital related problems, medications (with medication reconciliation), allergies, and orders shall be entered as structured data in iSparrow EMR.
Furthermore, if a patient is readmitted within 30 days with the same principal diagnosis, then a short admission note or preoperative note may be used. The short admission note or preoperative note may be entered in the iSparrow EMR Admission Navigator and must reflect the history and physical examination and any changes since discharge. No review of systems is required.

If a complete current history and physical examination is entered directly into iSparrow EMR or a legible copy is available in the EMR from an outside source (e.g., a preoperative office H&P), an admission note is not necessary. Otherwise, an admission note shall be entered into iSparrow EMR by the attending practitioner or designee on any patient admitted into the Hospital. The admission note shall include a concise summary of the patient’s chief complaint, Principal Diagnosis related to the hospitalization, other hospital related problems, any changes or additions to the history and physical examination already performed and a and plan for evaluation and/or therapy. The note should also provide evidence justifying the need for admitting the patient. Practitioners or their designees shall enter Diagnoses related to the hospitalization into the Problem List and Allergies using the Allergies Activity in iSparrow EMR. Providers will use Computerized Provider Order Entry (CPOE) to enter their orders in iSparrow EMR.

In cases of an emergency, a patient may be taken to surgery without the taking and recording of a full history and physical examination present and on the chart. In this case, a preoperative note must be entered into the EMR by the surgeon; the note shall include a preoperative diagnosis, summary of physical findings and the proposed surgical procedure. A preoperative note is not necessary at the time of admission if a current full history and physical examination is present and legible in the patient’s EMR chart at the time of admission. If a preadmission history and physical is used as the history and physical examination for the admission or if a history and physical examination from a patient discharged within the last 30 days is to be used as the admitting history and physical, then a preoperative note is mandatory.

**OPERATIVE REPORT**

An operative report shall ordinarily be dictated or entered directly into iSparrow EMR and signed by the surgeon no later than 24 hours after inpatient or outpatient surgery. The operative report shall include:

- Pre-operative diagnosis
- Post-operative diagnosis
- Technical procedures used
- Operative findings
- Specimens removed
- Estimated blood loss
- Name of the primary surgeon and assistants

If dictation and transcription will result in a delay in the appearance of the operative note, then an operative progress note sufficient to provide pertinent information for use by any other health care professional who is required to care for the patient must be entered into the medical record immediately after surgery.

**PROGRESS NOTES**

Progress notes shall be recorded at least daily in iSparrow EMR on all patients admitted to the hospital and shall be recorded at or near the time of observation. Progress note documentation must not be delayed beyond the date of the observation. Progress notes shall contain sufficient detail to promote patient care quality, safety and
efficiency, permit continuity of care and transferability, address current and potential problems and reflect changes in conditions as well as results of tests and treatments. Progress notes must reflect the number, nature and seriousness of the patient’s hospital-related diagnoses and the status and clinical course of the patient's illness or injuries. Progress notes should be recorded as frequently as the patient’s condition indicates, but must be recorded at least daily.

**PRE-ANESTHESIA AND SEDATION EVALUATION**

A practitioner privileged to perform moderate or deep sedation or anesthesia shall conduct a pre-anesthesia evaluation of the patient before administering anesthesia. The pre-anesthesia evaluation shall be recorded in the patient's medical record, indicating the choice of anesthesia and the procedure anticipated. Except when an emergency does not reasonably permit this evaluation, it shall be recorded prior to the patient's transfer to the operating area and before pre-operative medication has been administered. The pre-anesthesia record entry should include the patient's vital signs, status of airway, previous drug history, other anesthetic experiences, and any potential anesthetic problem and refer to the use of general, spinal, other regional anesthesia, or moderate sedation.

**POST-ANESTHESIA EVALUATION**

The medical record shall contain a record of post-anesthetic visits including at least one note describing the apparent presence or absence of anesthesia-related complications. Each post-anesthetic note must be dated and timed. Evidence that the patient is safe to transfer or discharge, must be present on the record and signed by an appropriate staff member.

**CONSULTATIONS**

A consultant must record a summary of the consultant's findings and recommendations in iSparrow EMR as soon as possible following consultation, but ordinarily not later than 24 hours after the consultation has taken place. The consultation report shall reflect, when appropriate, actual examination of the patient, the consultant’s overall impressions, and recommendations in the patient's medical record. If the consultant recommends surgery, the consultant's recommendation and findings shall be recorded in the patient's record prior to surgery unless an emergency prevents timely recording. Consultations are required on critically ill patients, poor surgical risks and those with difficult or obscure diagnoses when the intervention requires training and experience outside the scope of practice of the responsible physician.

**DISCHARGE SUMMARY**

A discharge or death summary shall be authenticated by the responsible medical staff member and shall be recorded in the patient's electronic medical record in compliance with the policies established through the Medical Records Committee and the Medical Staff Executive Committee. The summary shall recapitulate the reason for the patient's hospitalization, any significant findings, procedures performed and treatment rendered,
the condition of the patient on discharge, and any specific instructions given to the patient and/or family, including physical activity, medication, diet, and follow up care. At the time of completion of the medical record, final diagnoses shall be recorded in full, dated and signed by the responsible medical staff member.

**AUTOPSY REPORT**

When an autopsy is performed, the complete protocol must be made part of the medical record. If because of unavoidable delays, the final protocol is not available within the 30-day period, a provisional protocol shall be put in the chart within the 30-day period. A gross autopsy preliminary report will ordinarily be completed and available within seven (7) days of the completed autopsy, and placed in the medical record.

**VERBAL ORDERS**

Verbal orders should only be used when the ordering provider* cannot reasonably enter the orders directly into iSparrow EMR, the orders cannot be deferred to a later time when the ordering provider can enter them directly, and the orders are necessary for the timely, safe and effective care of the patient. Verbal orders are not allowed for chemotherapy orders or designated biologicals.

Verbal orders must be accepted only by healthcare providers that are authorized to do so by the hospital policies and procedures, consistent with Federal and State Law. Personnel accepting verbal orders must immediately read back the verbal order to the practitioner after entry into iSparrow EMR to verify accuracy before signing. The date and time will automatically be documented in the EMR at the time of Computerized Provider Order Entry (CPOE) by the Caregiver receiving the verbal order. All Caregivers authorized to accept verbal orders will document the identity of the Ordering Provider during the order entry process.

Sparrow Hospital's policy: registered, certified or licensed healthcare providers are authorized to accept prescribing practitioner’s verbal orders pertaining to that provider’s specialty. Providers that are included in this policy are: Registered Nurses, Nurse Practitioners, Cardiopulmonary Technicians, Pharmacists, Physical Therapists, Speech Pathologists, Audiologists, Therapeutic Recreation Specialists, Registered Dieticians, Imaging Technologists (within scope of Radiology) and Physician Assistants.

All verbal orders shall be co-signed by the prescribing practitioner or licensed representative thereof, or attending physician within 48 hours after the verbal orders are entered into the EMR. It is the attending physician’s responsibility to assure all verbal orders are co-signed in the EMR within 48 hours of the issuance of the verbal order. When orders are authenticated by a practitioner other than the ordering provider, the signature reflects only that the order was received and entered in the chart.

*Ordering providers in this policy refer to Medical Staff and Resident physicians, and in addition AHPs who have been credentialed to enter orders directly.
CO-SIGNATURES OF ENTRIES BY MEDICAL STUDENTS, RESIDENTS, AND ALLIED HEALTH PROFESSIONALS

Medical record entries by medical students, residents, and Allied Health Professionals that require the co-signature of the appropriate Staff Member include: the admission note and/or the history and physical, any consultation performed, operative reports, progress notes, the do not resuscitate order, and the discharge summary. Staff members shall be in compliance with CMS Documentation Guidelines for Teaching Physicians, including but not limited to elements of an E/M service documented by a medical student that can be referenced, appropriate use of macros, and teaching physician attestation statements included with resident notes.

USE OF THE MEDICAL RECORD FOR MEDICAL STAFF RESEARCH/QI

Medical Records must be kept confidential and may be released with prior approval of the Medical Staff Executive Committee for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. Unauthorized release or removal of medical records from the Hospital is grounds for corrective action.

DELINQUENT MEDICAL RECORD POLICY

1. Physicians are encouraged to complete all available medical records as they become available in the EPIC inbox.

2. A medical record deficiency is defined as any state of incompleteness related to cardiac catheterization reports, operative notes, consultation reports, history and physicals, (all to be present within 24 hours) and discharge summaries (to be present after 48 hours)

3. Discharge summaries are required for all hospitalizations, regardless of admission or observation status. Outpatient procedures do not require discharge summaries.

4. A medical record deficiency will be delinquent if it has aged to 15 days or more.

5. The privileged physician is responsible for medical record completion. Failure of a resident to complete medical records does not change the physician’s responsibility.

6. Physicians will receive notification of deficiencies in their EPIC inbox as they occur. Physicians will then receive another notification in their EPIC inbox from the Medical Staff Executive Committee (MSEC) when the record becomes delinquent at 15 days.

   a. If a physician identifies a medical record deficiency that was inaccurately assigned, the physician will be prompted to send notice to HIM for reassignment of the record.

   b. Any record that is delinquent 30 days or more will prompt a certified letter to the physician from the MSEC requesting that all delinquencies be completed, and informing of the process to follow.
7. A physician with a record 45 days old will experience automatic relinquishment of all clinical privileges, and receive notification thereof.
   
a. The physician will have 15 days from the notice of the 45 day old record, to resolve all medical record delinquencies. Automatic Resignation from the medical staff will occur if the delinquencies are not completed within 15 days.

b. As outlined in the bylaws, no procedural hearing rights will be provided. After Automatic Resignation, the physician will be required to complete the initial application process, pay all associated applications fees and meet all threshold eligibility criteria in order to be considered for appointment to the medical staff.

MEDICARE ACKNOWLEDGEMENT SIGNATURE
Approval/Review Date(s): 5/26/99

I. STATEMENT OF POLICY:

Under Medicare’s prospective payment system, Federal regulations require that the hospital have on file a signed acknowledgement that attending physicians have received the following notice required for Medicare reimbursement.

“We acknowledge that Medicare payment to hospitals is based in part on each patient’s principal and secondary diagnoses and the major procedures performed on the patient, as attested to by the patient’s attending physician by virtue of his or her signature in the medical record. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds, may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.”

II. PURPOSE

Sparrow Health Systems will obtain and file a signed Acknowledgement of Medicare Reimbursement Form.

III. PROCEDURE

A. The Acknowledgement of Medicare Reimbursement Form will be sent to each physician at the time of initial credentialing. The physician will receive the following:

1. Mid-Michigan Uniform Credentialing Application
2. Department Privilege list
3. Conscious Sedation Privilege List and Test
4. Pharmacy Card
5. Acknowledgement of Medicare Reimbursement Form
6. Department Rules and Regulations
7. Medical Staff Bylaws

B. Upon the return of the initial application the Medical Staff Coordinator will verify the return of all the following forms:

1. Mid-Michigan Uniform Credentialing Application
2. Department Privilege List
3. Conscious Sedation Privilege List and Test
4. Pharmacy Card
5. Acknowledgement of Medicare Reimbursement Form

C. If the Acknowledgement of Medicare Reimbursement Form is not returned with the initial application, the Medical Staff Coordinator will notify the physician, by letter, requesting the return of the signed form.

D. The Acknowledgement of Medicare Reimbursement Form will be filed in a book in alpha order, located in the Medical Staff Office.

E. If the physician resigns from staff, the Acknowledgement of Medicare Reimbursement Form will be voided.

F. If the physician returns, (s)he will be sent another Acknowledgement of Medicare Reimbursement Form.

G. If a physician is on staff, but an Acknowledgement of Medicare Reimbursement Form is not on file, the physician will be sent an Acknowledgement of Medicare Reimbursement Form to sign and return.