



METHODIST HEALTHCARE - MEMPHIS HOSPITALS and METHODIST HEALTHCARE – OLIVE BRANCH HOSPITAL

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FOREWORD

In accordance with the medical staff bylaws, each department of the medical staff formulates rules and regulations for the conduct of its affairs. Department policies must be consistent with the medical staff bylaws, the general rules and regulations of the medical staff and system policies. Information included about department functions, etc. is not repeated in this document. However, references to medical staff bylaws are made when appropriate.

DEPARTMENTS

The medical staff organization is divided into 4 core departments Medicine, Surgery, Pediatrics and Obstetrics & Gynecology. The current list of active medical staff departments are as follows:

Department
Anesthesiology
Cardiology
Cardiothoracic Surgery
Critical Care
Emergency Medicine
Gastroenterology
General and Plastic Surgery
Internal Medicine
Neurosurgery
Neurology
Obstetrics and Gynecology
Ophthalmology
Orthopaedics
Otolaryngology
Pathology
Pediatrics
Radiology
Urology

The medical staff bylaws define how medical staff members are assigned to departments as well as the functions of departments, and responsibilities of department chairs. This is not repeated in the department policies or committee policies. The medical staff bylaws also describe the process for establishing additional departments.

Clinical Departments shall be expected to meet quarterly; however, at the discretion of the Chair or Medical Executive Committee (MEC), any such meeting may be cancelled, postponed or scheduled more frequently as needed.

DEPARTMENT OF ANESTHESIOLOGY

Scope and Aspect of Anesthesia Care:

The Department of Anesthesiology's scope of care includes all patient care areas in which anesthesia services are required or requested. This includes, but is not limited to, Same Day Surgery and AM Admit, Preoperative Holding, Operating Rooms, Post Anesthesia Care Unit, Labor & Delivery, and (when requested) Cardiac Cath Lab, GI endoscopy suites, MRI, Invasive Radiology, other procedural areas.

SECTION 2: ORGANIZATION OF THE DEPARTMENT

The department chair is elected for a two year term, The Chair shall have been a member of the Active staff in good standing (no adverse recommendations concerning medical staff appointments/privileges, no DEA sanctions, no professional conduct or quality issues) for at least three (3) years and certified in the relevant specialty unless the latter requirement is waived by the Board.

The chair shall serve as Director of Anesthesia Services for the system. The chair may, at his/her discretion, appoint representatives from within the department to function as the director(s) of anesthesia services for individual facilities. The chair is responsible for:

- reviewing the description of the anesthesia services director role
- verifying that privileges for both anesthesia and sedation are granted in accordance to scope, including competencies, training and experience
- ensuring supervising anesthesiologists are immediately available to intervene ensuring safety measures are appropriate in areas where anesthesia/sedation are provided
- ensuring anesthesia/sedation evaluations and documentation are appropriate, including the pre-anesthesia evaluation, post anesthesia evaluation, and intra-operative anesthesia/sedation record

SECTION 3: DEPARTMENT DAYTIME, ON CALL AND EMERGENCY COVERAGE

The Department of Anesthesiology will work closely with each Facility Administration and Clinical OR Directors to establish a level of daytime service commensurate with the needs of the facilities elective schedule. These needs will be periodically evaluated and restructured to account for fluctuating case volumes, practice patterns, and facility efficiency.

The Department of Anesthesiology will structure and maintain an emergency call system.

The management of emergency cases that arise during "routine working hours" will be coordinated by anesthesiologist in charge of that days OR schedule in conjunction with the surgeon and the clinical lead for the operating room.

The Department of Anesthesiology will structure and maintain an emergency call schedule for night and weekend cases. This schedule will be provided to each facility.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Anesthesiology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Anesthesiology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

Use of data to identify improvement opportunities
Provide appropriate goal oriented feedback to physicians, nurses, and staff
Actively participate in peer review processes
Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review processes are implemented in conjunction with the guidelines established by the Peer Review Oversight Committee (PROC). The department chair will appoint a peer review panel comprising three anesthesiologists, each with a minimum of five years' experience on the active medical staff. This panel will convene on an "as needed" basis to review charts as determined by current department clinical triggers and/or referral from the PROC. Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services / Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

Patient Care

Physicians or CRNA/GRNAs acting under the direct and immediate supervision of a credentialed anesthesiologist will provide anesthesia services. In cases of life or limb emergencies it is acceptable for anesthesia to be initiated by the CRNA/GRNA while the anesthesiologist is in route.

Pre-Anesthesia/Sedation Responsibilities

Surgical and procedural patients will undergo evaluation (including interview and examination of the patient) by the attending/supervising anesthesiologist prior to the induction of anesthesia for elective (and where feasible – emergency) cases.

Documentation of this evaluation shall include the following:

- Pertinent medical history review
- Anesthesia/sedation history; drug and allergy history (within 48 hours of induction)
- Physical examination, to include at a minimum heart, lungs, and airway assessment; this must be performed within 48 hours of induction by those privileged to administer anesthesia/sedation
- Assessment of risk to the patient for receiving anesthesia/sedation (within 30 days/update within 48 hours)
- Physical condition of the patient prior to induction of anesthesia/sedation (within 48 hours of induction)

Patient consent for administration of anesthesia/sedation

An anesthetic care plan will be documented in the record.

Obstetrical patients requesting epidural analgesia will be evaluated by either the CRNA/GRNA or supervising anesthesiologist prior to placement.

Pre-induction

Prior to the induction of anesthesia the following elements should be confirmed

- The patient's identity
- The surgeon's availability
- The availability and serviceability of pertinent anesthesia equipment and medications

Intra-operative period

An intra-operative anesthesia/sedation record must be present for each patient who will receive general/regional/monitored anesthesia, or deep sedation.

For patients receiving moderate sedation, an intra-operative anesthesia record is not required because moderate sedation is not considered to be "anesthesia" and is not subject to this requirement.

Patients undergoing anesthesia/deep sedation will be monitored in accordance with the relevant guidelines endorsed by the American Society of Anesthesiologists. The conduct of the anesthetic will be documented on the patient's Anesthetic Record.

The intra-operative anesthesia/sedation record should be legible and complete with respect to the following:

- Patient's name/hospital identification number
- Names of practitioners administering the anesthesia/sedation, and as applicable, name(s) of supervising anesthesiologist,
- Time-based documentation of vital signs, oxygenation and ventilation parameters
- Fluids administered, including name and amount,
- Medications and anesthesia/sedation agents (including name, dosage, route and administration time)
- Blood or blood products, if applicable (may be documented by nursing)
- Techniques used and patient position(s), including insertion of any intravascular or airway devices
- Significant intraoperative events,(such as any complications, adverse reactions, or problems occurring during anesthesia/sedation)including time and description of symptoms, vital signs, treatments rendered and patient's response to treatment.

Additionally, all orders entered by a CRNA/GRNA shall be reviewed and co-signed by a supervising anesthesiologist prior to the patient's transfer from the perioperative area.

Post Anesthesia/Sedation Care

At the conclusion of surgery the patient may be transferred to the PACU, ICU, or another recovery area. At the time of transfer the receiving RN will be given a verbal report. The patient's vital signs will be documented in the anesthesia record at the time of transfer. Prior to discharge from any recovery area, the patient must meet the facility's established criteria. In cases limited to sedation the patient may, at the anesthesiologist's discretion, bypass PACU or another recovery area for direct transfer to Same Day Surgery.

Post Anesthesia/sedation evaluation (followup report)

A post anesthesia/sedation evaluation for proper anesthesia recovery shall be completed and documented within 48 hours for each patient who has received general/ regional/monitored anesthesia care or deep sedation by the individual who administered the anesthesia or by any individual qualified to administer anesthesia/deep sedation.

The Post-Anesthesia/sedation evaluation shall include the following elements:

- Vital signs: Heart rate, blood pressure, temperature
- Respiratory function including respiratory rate, airway patency, and oxygen saturation
- Level of consciousness & mental status
- Cardiopulmonary status
- Pain
- Nausea & vomiting
- Post operative/post procedural hydration
- Any complications occurring during post-anesthesia/sedation recovery
- Any follow – up care needed and/or observations
 - Any patient instructions given

Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

General Care and Safety Guidelines

The Department of Anesthesiology, in conjunction with BioMedical and Facilities Management will work together to ensure the anesthetic monitors, anesthesia machines, and ancillary equipment are kept in optimal working order.

Anesthesiologists working within the MH-MH or MHOBH will work to promote all relevant hospital safety and performance initiatives to include (but not limited to):

- Infection Control
- Antibiotic Dosing
- Glucose Control
- Fire Safety
- Operating Room Time Out Procedures
- Resident Supervision Policies

Members of the Department of Anesthesiology, as part of the general credentialing process, agree to abide by the MH-MH and MHOBH Physician Code of Conduct. Furthermore, we acknowledge it is our obligation to promote and maintain a professional work environment for the associate staff and our patients.

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF CARDIOLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Cardiology and Chief for each hospital will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

All active physicians must take ED call. It is possible to extend this to courtesy staff on a department basis with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Cardiology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Cardiology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: The Department of Cardiology shall consistently conduct peer review by a multi-member committee of cardiologists (at least one must be an EP physician) and other ad hoc specialties as needed. Peer review must be performed in accordance to the Medical Staff Governance Documents.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for the Department of Cardiology

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF CARDIOTHORACIC SURGERY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Cardiothoracic Surgery will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

All active physicians take call on a rotating basis.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT QAPI

The Department of Cardiothoracic Surgery will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Cardiothoracic Surgery are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer review: The Cardiothoracic Surgery Department shall conduct peer review by a multi-member committee of CT surgeons, a cardiologist, an anesthesiologist and other ad hoc specialties as needed. Peer Review must be performed in accordance to the Medical Staff Governance Documents.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department.

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF CRITICAL CARE

SECTION 2: ORGANIZATION OF THE DEPARTMENT

The Pulmonary Critical Care department chair is elected for a two-year term. The Chair shall have been member of the Active staff in good standing (no adverse recommendations concerning medical staff appointments/privileges, no DEA sanctions, no professional conduct or quality issues) for at least three (3) years and certified in the relevant specialty unless the latter requirement is waived by the Board

The Pulmonary Critical Care chair shall serve as the medical director of respiratory services and is responsible for oversight of respiratory services.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

Critical Care Department members do not take ED call.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Critical Care will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Critical Care are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review processes are implemented in conjunction with the guidelines established by the PROC charter. The department chair appoints the peer review panel. This panel will convene on an “as needed” basis to review charts as determined by current department clinical triggers and/or referrals.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for the Department of Critical Care.

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF EMERGENCY MEDICINE

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Term: The Department Chair of Emergency Medicine will serve a two year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. It is possible to extend that to courtesy staff on a department basis with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Emergency Medicine will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review:

Cases identified as appropriate for peer review are submitted for review.

1. The Department of Emergency Medicine has a separate committee that meets monthly at the discretion of the chair to review cases.
2. Designated Emergency Medicine physicians are assigned to be on the peer review committee. The meeting is open to all Emergency Medicine members.
3. The physician does not review his/her own cases.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

Admitting to Inpatient Services:

An Emergency Medicine physician will not admit patients in his/her own name for inpatient services and will treat inpatients of other physicians only when unusual circumstances require it, including a specific request from the patient's attending physician to do so in an emergency.

Advance Directives in the ED:

Resuscitation will not be withheld from any patient unless appropriate documentation is available, unless the treating physician deems resuscitation medically inappropriate.

Evaluation and Treatment

All patients presenting to the emergency department for care will receive a medical screening examination. If additional assessment and/or treatment is needed, the patient will be seen by an emergency department physician, on-call physician, the patient's private physician, dentist (if appropriate), other qualified provider (nurse practitioner or physician assistant), or registered nurse for Labor and Delivery area.

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF GASTROENTEROLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Gastroenterology will serve a two-year term. The physicians can vote at two facilities if they have had at least 25 patients per year at those facilities

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

All active physicians must take call. It is possible to extend this to courtesy staff on a department basis with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Gastroenterology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Gastroenterology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review:

Peer Review is conducted by a panel of reviewers according to the Medical Staff Governance Documents. The group meets on a regular basis to review cases. Physicians do not review their own cases.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for the Department of Gastroenterology

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF GENERAL AND PLASTIC SURGERY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of General and Plastic Surgery will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. It is possible to extend that to courtesy staff on a department basis with the approval of the MEC. Exception: The Plastic Surgery call schedule shall include all plastic surgery physicians, courtesy through active (except Senior Active physicians), who practice at MH-MH or MHOBH.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of General and Plastic Surgery will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of General and Plastic Surgery are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: The Department of Surgery will have a list of Active Staff Surgeons with two physician reviewing each peer review case. Physician reviewers will not review peers within their group or themselves.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF INTERNAL MEDICINE

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Term: The Department Chair of Internal Medicine will serve a two year term; Limited to 2 consecutive terms.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call.

Emergency Room Call Schedule Policy:

A sub-specialist from the Internal Medicine Department may take ED call provided they meet the following provisions:

- The sub-specialist must obtain approval from the Internal Medicine Department chair to be added to the ED call schedule.
- The sub-specialist must agree to remain on the call schedule for at least 90 days.
- No member of the Internal Medicine Department will be allowed to take call at more than two facilities.
- The admitting Internal Medicine physician must agree to manage the patients themselves and avoid consulting a General Internist.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Internal Medicine will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Internal Medicine are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

Use of data to identify improvement opportunities
Provide appropriate goal oriented feedback to physicians, nurses, and staff
Actively participate in peer review processes
Coordination and oversight of Focused Professional Practice Evaluation

Peer Review:

The Internal Medicine Peer Review Committee will meet monthly. The peer review committee will include six Internal Medicine Physicians appointed by the IM Chair. The committee members will be determined as follows: two Internal Medicine physicians from MUH, and one Internal Medicine physician from each of the other four adult hospitals. In the case that an Internal Medicine representative cannot be obtained for each hospital the Department Chair will appoint a suitable alternative. The Internal Medicine Chair will also appoint a similar number of alternate physicians. Alternate physicians will be notified one month in advance if they will be required to review cases and vote at peer review. The term for committee members is 2 years with a maximum of 3 consecutive terms. Each member or approved alternate shall be required to attend 50% of meetings annually. Failure to attend 50% of meetings may result in immediate dismissal of the member from committee service and selection of an alternate member by the department chair.

If a committee member has a conflict of interest relating to an item on the agenda, Medical Staff policy requires the member to excuse him/herself from vote and/or discussion: and, if appropriate, leave the room during the discussion.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

All unassigned internal medicine patients presenting to the ED within 7 days of discharge shall be readmitted by the discharging physician. For all unassigned patients who present to the ED after 7 days of discharge, the last internist who has previously admitted the unassigned patient shall have the option to readmit that patient if he/she chooses. Otherwise, the ED physician shall call the IOC (Internist on Call).

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF NEUROSURGERY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Neurosurgery Surgery will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. *Specific details of call schedule are to be determined by department chair with input from department members.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Neurosurgery will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Neurosurgery are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review is conducted by a panel of reviewers. Physician reviewers do not review peers within their group nor themselves. A panel of three physicians is appointed for three years. If one of the three is involved in the case, then the other two reviewers will complete the process. After three years, the department chair will appoint a new peer review panel.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF NEUROLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Neurology will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. *Specific details of call schedule are to be determined by department chair with input from department members.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Neurology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Neurology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer review: Peer Review will be conducted by a panel of reviewers. Physician reviewers do not review peers within their group nor themselves. Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department.

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Obstetrics and Gynecology will serve a two-year term.

Meeting Attendance: Members of Obstetrics and Gynecology are required to attend > 50% of the scheduled department meetings at their primary Methodist hospital.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. It is possible to extend that to courtesy staff on a department basis with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Obstetrics and Gynecology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Obstetrics and Gynecology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review is conducted by a panel of reviewers representing all facilities. The group meets on a regular basis to review cases. Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

ACOG

Physicians with Obstetrical privileges are encouraged to comply with the recommendations of their specialty's professional organization, The American College of Obstetrics and Gynecology (ACOG), when evaluating the "decision to incision" time of Cesarean sections. The recommendations are to serve only as guidelines. When assessing the relationship of decision to incision time and patient outcome, the final determination will be made through the peer review process.

C-SECTIONS

Elective, repeat Cesarean sections and elective inductions should not be performed prior to 39 weeks gestation. Variances will be subject to peer review.

When a patient of a physician or physician group presents to a Methodist Hospital for care but the **physician or physician group does not provide services** at that facility the procedure is as follows:

1. The physician will get a status report from the nurse.
2. The physician will give orders if the patient can be treated as an outpatient or discharged with follow-up instructions
3. If the patient requires hospital admission, the physician may refer the patient to the OB physician taking ER call. The physician may ask the nurse to notify the OB ER call physician of his/her decision.

Violations of this policy/procedure will be subject to peer review.

Documentation of Cesarean sections requires the same elements of any operative procedure as outlined in the medical staff rules and regulations.

Documentation of vaginal delivery or Cesarean section

A delivery note should be documented immediately following delivery and include the following elements:

Delivery:	SVD:	LF	VAC	VTX
	Breech:	Frank	Footling	Other _____
Infant:	M	F	Sing/Multi	
	APGARS	_____/_____/_____		
	Weight:	____ lbs.	____ oz.	Grams: _____
	Fluid:	CL	MEC (thick, light)	DELEE: Y N
	ABNORMALITIES:			
Placenta:	Spontaneous	Manual		
	Vessels	2	3	
Episiotomy:	None	Median	Mediolateral	
	1	2	3	4
	Suture: _____			Repair: Y N
Laceration:	None	Cervical	Vaginal	
	Periurethral	Perineal	1	2
	Repair:	Y	N	3
	Suture:	_____		
EBL:	_____			
Anesthesia:	None	Local	Pudendal	
	Epidural	Spinal	General	

Complications:**Comments:****SUCROSE ADMINISTRATION FOR ANALGESIA DURING NEONATAL CIRCUMCISION****Procedure:**

1. Prior to preparation of the operative field, nursing will assess pain level using appropriate pain scale
2. During preparation of the operative field, nursing will administer sucrose solution by repeatedly dipping pacifier in 24% sucrose solution or by oral syringe 2 minutes before the procedure. The dosage by oral syringe is 1 ml for infants less than 3000 grams and 2 ml for infants greater than or equal to 3000 grams. A small pacifier dipped once holds approximately 0.1 ml.
3. Monitor pain response during and after procedure.
4. Repeat the oral syringe dose every 2 minutes as needed, with a total of 3 doses per procedure.

Equipment: 24% sucrose solution, pacifier, oral syringe.

Documentation: Nursing will document time, dose, and response with each administration.

Normal and Abnormal Qualifications

Only Board eligible obstetricians granted full obstetrical privileges by Methodist Healthcare – Memphis Hospitals and/or Olive Branch Hospital may do major operations and pathological obstetrics such as cesareans, breech delivery, version and extraction, Dührssen's incision, mid or high forceps, forceps rotations, malposition, uterine inertia, hemorrhage, toxemia, and multiple pregnancy.

All other physicians granted obstetrical privileges may do normal obstetrics such as spontaneous and low forceps deliveries with episiotomy, and give general supportive care. They must obtain a consultation on all abnormal obstetrics such as listed above.

Consultation

The consultant must be a board-certified obstetrician; he/she must record the consultation in the patient's chart and sign it.

The attending physician, if not a board-certified obstetrician, should follow the recommendation of the consultant. However, he/she may request the opinion of another qualified consultant if he/she desires.

In cases of abnormal obstetrics when the attending physician is not a board-certified obstetrician, the consultant should assume responsibility for the patient's care. The consultant should not assume this responsibility, except with the consent of the attending physician and the patient, or her husband, or a responsible member of the family, except in an emergency.

MEDICALLY INDICATED TERMINATION

1. Medically indicated termination is a surgical procedure. For its performance, adequate facilities, equipment, and personnel are required to assure the highest standards of patient care.
2. No indicated termination may be performed at the MH-MH or MHOBH except under the document recommendation of the primary physician and at least one (1) consultant, both of which must be documented on the chart prior to the procedure being performed. The consulting physician is not required to physically assess the patient to provide a recommendation.

The additional consultant must be a member of the Active or Senior Obstetrical Staff (as defined in the medical staff bylaws) of the MH-MH or MHOBH; and is not required to be outside of the primary physician's primary practice group; and further, that under no circumstances can an indicated termination be done unless it is for the purpose of preserving life or health of the mother, including psychological reasons.

3. The usual informed consent, including operative permit, should be obtained. No physician should be required to perform, nor should any patient be forced to accept an a medically indicated termination.
4. Medically indicated termination should be performed only by physicians who are qualified to identify and manage complications that may arise from the procedure.
5. A nurse may begin the procedure if all of the following criteria are met:
 - Both physicians have documented in the medical record their recommendations for the performance of the procedure
 - The primary physician has entered the order in the medical record for the medication to start the procedure. No phone or verbal orders will be entered for this purpose.
 - The patient is in the labor and delivery unit
6. In the situation of an emergent condition, a physician consultation is required but documentation of the consulting physician's concurrence with the primary physician's plan of care is not required prior to initiation of the procedure, but must be completed within 12 hours of conversation with the primary physician.

STERILIZATION

1. Sterilization is available to anyone 18 years of age or over on request of the patient.
2. The only qualification for a patient 18 years or older will be a sterilization form properly signed and witnessed.
3. To require without reservation a court order on any sterilization involving mentally incompetent patients and documented consent and request for sterilization with copies to be maintained in the Medical Record of the patient for voluntary sterilization on mentally competent patients.

DELIVERY ROOM REGULATIONS

1. Infected cases cannot be done in the delivery room unless appropriate precautions are taken to prevent spread of infection.
2. Episiotomy repairs (lacerations) on mothers, who have delivered at home or delivered prior to arrival in the labor and delivery suite, may be done in the delivery room.
3. Non-infected surgical complications in maternity patients can be done in the Delivery Room. These include:
 - ☐ Ectopic Pregnancy
 - ☐ Ovarian Torsion
 - ☐ Abortions, incomplete, missed and therapeutic
 - ☐ Incompetent cervix
 - ☐ Post-partum hematoma

- ☐ Removal of hydatidiform moles
- ☐ Cesarean Sections
- ☐ Post-partum sterilization
- ☐ Appendectomy
- ☐ Surgical treatment of post-partum hemorrhage to include hysterectomy
- ☐ Hemorrhoidectomy

RECOVERY ROOM

Following surgical procedures, patients will be transferred to the recovery room to remain until reacted from anesthesia.

Admission Policies - Room Assignments

No patient having therapeutic radioactive implantation shall be assigned a room in the area assigned to the maternity patients.

Fetal Age of Perinatal Childbirth

Twenty- (20) weeks gestation is recognized as the criterion for determining whether a delivery is an abortion or a stillborn. This is in order to determine whether or not a still birth certificate is to be filled out. The twenty-week gestation period is to be determined only by the attending physician.

PREPARED CHILDBIRTH

1. At the discretion of the attending physician, the support person is permitted to stay with the mother during labor. If the mother is sedated, the support person is to wait in the father's waiting room.
2. At the discretion of the attending physician, the support person is allowed to go to the delivery room with the mother during labor for prepared childbirth.

UNATTENDED DELIVERIES

Unattended deliveries are those in which the physician is absent at the time of the delivery and circumstances reveal, after appropriate peer review, that the physician could, or should have been present at the time of the delivery. The physician is defined as the physician responsible for the patients care, prearranged call coverage physician or another physician who has been asked in advance by the attending/on call physician to care for the patient.

OB ADMISSION HISTORY & PHYSICAL

Documentation of the History & Physical of Obstetrical patients admitted to MH hospitals: Germantown, Olive Branch and South will be done electronically on the PowerNote titled OB Admission H&P,

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF OPHTHALMOLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Ophthalmology will serve a two-year term.

Frequency of meetings: Department meetings are held monthly.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

All active and courtesy physicians take call on a rotating basis.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Ophthalmology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Ophthalmology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review is done monthly in the department meetings. Physician reviewers do not review peers within their group nor themselves.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF ORTHOPAEDIC SURGERY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Orthopaedic Surgery will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

1. The Department of Orthopaedics call schedule includes all orthopedic physicians, courtesy through active less than 60 years of age, who practice at MH-MH or MHOBH.
2. If the patient is an ED patient (not an inpatient) the on-call surgeon should be contacted unless the patient has an established relationship (within 90 days perioperatively) with a specified orthopaedic surgeon. In order to call a specified orthopaedic surgeon, the chief complaint/reason for the ED visit must be related to the perioperative disease process or condition.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Orthopaedic Surgery will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Orthopaedic Surgery are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review:

Peer Review is conducted by a panel of reviewers. Physician reviewers do not review peers within their group nor themselves.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
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SECTION 5: PATIENT CARE POLICIES

CONSULTS

If a consult for an inpatient is specified for a physician or group, that physician or group will be responsible for seeing the patient within 24 hours if the physician or group practices at that hospital.

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF OTOLARYNGOLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Otolaryngology will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The Department of Otolaryngology call schedule includes all otolaryngology physicians, courtesy through active excluding Sr. Active Physicians, Otolologists, and Neuro-Otolologists (with practice comprised of 90% otology) who practice at MH-MH or MHOBH. If Otolaryngology service isn't offered at the physician's primary location, then the physician could potentially take call at their secondary facility.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Otolaryngology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Otolaryngology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review is conducted by a panel of reviewers on an as needed basis. . Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF PATHOLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Pathology will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

Not applicable to this department.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Pathology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Pathology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review is conducted on a regular basis by the peer review committee. Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

Handling of Specimens Removed during Surgical/Invasive Procedures

POLICY: All specimens removed during an invasive procedure should be sent to the pathologist for evaluation except for exempt specimens, as determined by the Medical Staff.

PURPOSE: To safely collect, identify, handle, store, and transport specimens.

GENERAL INFORMATION: Specimens can be blood, body fluids, tissue or other specimen types removed from the patient including implants, and culture and sensitivity studies. Specimens, which are exempt from the requirement to be examined by a pathologist, include the following:

- Specimens that by their nature or condition do not permit fruitful examination, i.e., cataracts, orthopedic appliances or other surgical hardware, liposuction specimens, abdominal panniculus.
- Therapeutic radioactive sources. The removal and disposal of these are guided by radiation safety policies.
- Foreign bodies given directly into the custody of law enforcement officials, i.e., bullets.
- Grossly normal placentas for which examination is not specifically requested by the attending physician.

Specimens for which gross only examination is acceptable are:

1. Tonsils and adenoids, patient under age 18
2. Teeth or tooth fragments
3. Scar tissue if excised for plastic repair
4. Bone fragments (first ribs, bunions, AC joint tissue, etc.)
5. Umbilical hernia, patient under age 18
6. Appendix testis
7. Supernumerary or traumatically amputated digits
8. Ventricular peritoneal shunt tubing
9. Foreign bodies, although these should be described with detail
10. Foreskin under age 10
11. Organs harvested and determined unusable

Examining pathologist may elect to perform microscopic evaluation on these tissues if gross examination or patient history warrants, or at surgeon's request.

Autopsy Service

Autopsy services are provided by the Pathology Department for patients who expire after admission to MH-MH or MHOBH. The autopsy is considered a medical consultation between the patient's attending physician and pathologist. Its performance is of value to medical professionals and the public as an educational tool as well as a tool to assess the quality of patient care, to evaluate diagnostic accuracy, or to monitor the effectiveness of new technologies or efficacies of therapeutic regimens. The information obtained is a source of clinical information in the quality assessment and improvement programs of MH-MH and MHOBH.

The following are general criteria for autopsy:

1. Unanticipated death
2. Death occurring while patient is being treated under a new therapeutic trial regimen
3. Unexpected intra-operative or intra-procedure death
4. Unexpected death occurring within 48 hours after surgery or an invasive diagnostic procedure

5. Death incident to pregnancy
6. Death when the cause is sufficiently obscure to delay completion of death certificate
7. Death in infants or children with a congenital malformation

Autopsies may be performed upon request by the attending physician and consent by the patient's legal next of kin.

The responsible pathologist has the ultimate authority for determining whether or not the autopsy will be performed. Certain cases may be deemed inappropriate and thereby deferred. These may include but are not necessarily limited to:

- Cases falling under the jurisdiction of the medical examiner or coroner. All such cases should be referred to the County Coroner and/or the State Medical Examiner's office, as appropriate. Reportable situations are deaths under suspicious, unusual, or unnatural circumstances, and any death in the Emergency Department.
- In cases in which the request for an autopsy is from the family of the deceased or a MH-MH or MHOBH Associate:
 - the request should be evaluated by the Chief Medical Officer (CMO) and the attending pathologist to determine if the death meets the general criteria listed above.
 - If the CMO and attending pathologist agree that an autopsy is warranted, the attending physician should be notified of the pending examination.
- Cases that may be deemed an unacceptable biohazard. These may include, but are not necessarily limited to, cases of HIV, prion or slow virus encephalopathies, or other viral illness such as hepatitis. It is necessary that pathologists and assistants practice in a safe medical environment and available facilities may not be properly equipped to protect from certain of these hazards.
- Cases in which the autopsy permit is not properly filled out and signed by the legally responsible next of kin or in which there is disagreement between individuals of the same order of kinship (i.e. two children, etc.).

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF PEDIATRICS

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections:

1. The Chair of Pediatric Medicine will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state all active staff members must take ED call. *Specific details of call schedule are to be determined by department chair with input from department members and with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI) PROGRAM

The Department of Pediatrics will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Pediatrics are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review:

Cases identified as appropriate for peer review and the results will go on record as part of the confidential peer review processes.

1. Pediatric Peer Review is conducted by separate committees that meet monthly to review cases. Peer review is conducted by a multidisciplinary panel of reviewers.
2. Peer review is screened by the Pediatric Morbidity and Mortality (M&M) Review Committee, the Pediatric Trauma Morbidity & Mortality Review Committee, the Pediatric Operative and Invasive Procedure Case Morbidity & Mortality Committee (OIPCR M &M), and associated sub-committees for process and physician issues. Process issues are referred to LBCH's Safety Operations Council and/or Perioperative Operations Committee and/or the LBCH Trauma Operations Committee. Physician issues are referred to the PROC who then refers cases requiring peer review to the Department of Pediatrics Peer Review Committee and/or the Trauma Peer Review Committee and/or Operative & Invasive Peer Review
3. The M&M Committee is a multidisciplinary screening committee for process, quality and patient safety issues identified from the Department of Pediatric Medicine. The M&M Committee chair is appointed by the LBCH Chief Medical Officer in consultation with LBCH's Medical Director or his/her designee for at least but not limited to a two (2) year term and shall consist of the following representative(s): Pediatric Critical Care Medicine (LBCH ED, PICU, and from the NICU), Pediatric Surgery and from the Department of Pediatric Medicine. In addition, the LBCH Vice President of Nursing or his/her designee and a representative from LBCH Administration shall serve as ex officio members. Only medical staff members will determine which cases will be referred for Peer Review. This committee meets monthly or a minimum of 10 times a year.

4. The Trauma M & M Committee is a multidisciplinary screening committee for process, quality and patient safety issues identified from Pediatric Trauma. The Trauma M & M Committee is chaired by the Trauma Medical Director and shall consist of the following representative(s): ED Attending, Orthopedic Surgeon, Anesthesiologist, Neurosurgeon, General Surgeons on Trauma Call Panel, and Critical Care Medicine. Other members shall consist of LBCH ED fellow(s), and Pediatric Surgery fellow(s). In addition, other representative(s) from the Trauma Team (APNs, Trauma Program Manager, Trauma Coordinator), will serve as members. In addition, representative(s) from LBCH Administration shall serve as ex officio members. Only medical staff members will participate in discussion regarding and determine which cases will be referred for Peer Review. This committee meets monthly or a minimum of 10 times a year.

5. OIPCR M & M is a multidisciplinary committee for patient safety and performance improvement (PIPS) designed to identify process, quality and patient safety issues that occur in surgical patients. The chair of OIPCR will either be the Surgeon-in-Chief or his/her designee. Members of OIPCR shall consist of the Chairman of Pediatric Surgery, the Medical Director of LBCH Operating Room and the Medical Director of LBCH Anesthesia. It shall also consist of the following representative(s): ED Attending, Orthopedic Surgeon, Anesthesiologist, Neurosurgeon, Pediatric Surgeons, Neonatologist, Radiologists, other children's surgical specialties, medical proceduralists, Pediatric Intensivists, hospital administration and nursing. Other members may include fellows in training from these disciplines. In addition, other representative(s) for the National Surgical Quality Improvement Team (NSQIP) (APNs, Surgical Program Manager, Surgical Program Coordinator), may serve as members. Representative(s) from LBCH Administration shall serve as ex officio members. Only medical staff members will participate in discussion regarding and determining which cases will be referred for Peer Review. This committee meets monthly or a minimum of 10 times a year

6. PROC sends referred cases for the Department of Pediatrics to the LBCH Peer Review Committee. The Peer Review Committee is a multidisciplinary committee appointed by the LBCH Associate Chief of Staff in consultation with LBCH CMO for a two year term. The committee consists of physicians representing the Department of Pediatric Medicine and the Department Surgery who have pediatric privileges. The committee is responsible for ensuring that PROC receives monthly reports on the scope and results of peer review activities conducted in their department. The Peer Review Committee is chaired by the Chair of Pediatric Medicine. The Peer Review Committee meets monthly or on an as needed basis.

7. A Physician does not review his/her own cases.

Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for the Department of Pediatrics

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF RADIOLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Term : The Department Chair of Radiology will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. It is possible to extend that to courtesy staff on a department basis with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Radiology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Radiology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer review: Peer review is conducted by the Department Chair or designee and a panel of reviewers selected by the Chair. . The group meets on an as needed basis to review cases. Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
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SECTION 5: PATIENT CARE POLICIES

INTERRATER RELIABILITY POLICY

The purpose of an interrater reliability program in for the Department of Radiology is to provide a retrospective review of randomly selected studies, representing the five modalities. The overall results of the interrater reliability program will be used to determine educational opportunities for all staff or an individual medical staff member. Data will be trended by specific medical staff member and compiled with other report card information.

- All medical staff members of the Department of Radiology will be expected to provide an “overread” of 10 charts per month per person using RADPEER. Trending information of overall outcomes will be presented to

the Peer Review Oversight Committee on a quarterly basis. Any MD specific information will be eliminated prior to presentation.

- Trending information of overall outcomes will be presented to the Peer Review Oversight Committee on a quarterly basis. Any MD specific information will be eliminated prior to presentation.
- Data on individual physicians will be compared to peer and benchmark data. In the event there appears to be a trend outside of peer/benchmark data with an individual physician, the Department Chair will be notified and will discuss with the physician.

Process:

1. On each business day, Monday through Friday, studies will be selected from the current days' studies that have old films of the same type.
2. QA specialist (or designee) will ensure a previous study of the same type exists in PACS.
3. Cross Facility overreads will occur, with the exception of Le Bonheur.
4. The radiologist will review the study in PACS, and note the appropriate agreement using the RADPEER program;
 - in agreement
 - complex diagnosis, not usually expected to be made
 - questionable interpretation
 - Disagree with interpretation
 - No report present on prior study
4. In the event a Radiologist did the initial read, he/she will not complete the overread
5. The Department Chair, Medical Director or the QA specialist (or designee) will be allowed access to the reports which will provide:
 - Summary statistics and comparisons for each participating physician by modality
 - Summary data for the group by modality
 - Data summed across all RADPEER™ participants

CONTRAST ADMINISTRATION

Radiology Technologists may administer IV and oral contrast according to the protocols developed by the Department of Radiology and approved by the medical staff under the following conditions:

1. The procedure order has been reviewed and verified by the technologist to fall within the parameters of an approved protocol.
2. A review of the patient's relevant medical history, laboratory results and current medications by the technologists reveals no abnormal or positive findings of the components listed on the "Contrast Assessment Flow" document or "Oral Contrast Assessment" review.

Any positive or abnormal findings of the above assessment will require consultation and approval of the responsible physician before the administration of contrast.

VAS CATHS CALL COVERAGE AT ADULT HOSPITALS

Vas Caths are non-tunneled percutaneous large bore venous access catheters placed for temporary hemodialysis access. Interventional Radiologists are trained in the placement of these devices utilizing image guidance for venipuncture and fluoroscopy to confirm catheter position.

1. Interventional Radiology (IR) physicians provide after hours and weekend call coverage for emergency services at all adult facilities.
2. When emergent hemodialysis is required, the IR physician on call will be available for Vas Cath placement.

- The emergency IR consult should be effected via a physician to physician conversation.
3. All Vas Cath placements by IR will be performed in the Radiology angiography suite.
 4. Timing of the procedure will be determined by the requesting and IR physicians based on hemodialysis schedule and current IR case demands

SECTION 1: DEPARTMENT NAME AND SCOPE OF CARE

DEPARTMENT OF UROLOGY

SECTION 2: ORGANIZATION OF THE DEPARTMENT

Elections: The Department Chair of Urology will serve a two-year term.

SECTION 3: DEPARTMENT EMERGENCY DEPARTMENT CALL INFORMATION

The bylaws state that all active staff members must take ED call. It is possible to extend that to courtesy staff on a department basis with the approval of the MEC.

SECTION 4: PEER REVIEW AND QUALITY ASSESSMENT PERFORMANCE IMPROVEMENT (QAPI)

The Department of Urology will perform peer review, quality assessment and performance improvement activities under the auspices, recommendations, and requirements established by the medical staff and governing body. The department chair is ultimately responsible for ensuring that appropriate peer review and quality assessment processes are in place and functioning within the department. All members of the Department of Urology are involved in the monitoring and evaluation activities that address the quality and appropriateness of care (Quality Assessment). These include:

- Use of data to identify improvement opportunities
- Provide appropriate goal oriented feedback to physicians, nurses, and staff
- Actively participate in peer review processes
- Coordination and oversight of Focused Professional Practice Evaluation

Peer Review: Peer review is conducted by a panel of reviewers according to Medical Staff Governance Documents. The group meets on a regular basis to review cases. Variations from standards of care and/or deviations in care will be trended. Opportunities for Performance and Process Improvement will be identified based on these trends and on significant safety events that are delineated from this Quality Assessment process.

Provider Services Quality Improvement Department

- Works with chair or designee to customize and oversee QAPI program
- Assures data integrity for improvement efforts
- Recommends data sources for analysis and trending
- Provides expertise and resources for data management and corresponding implementation efforts
- Shares best practices from external sources and/or other departments for review and consideration

SECTION 5: PATIENT CARE POLICIES

None specific for this Department

MH-MH & MHOBH Department Policies - Amendments

Revision #	Document	Reference	Subject of Revision	Board Approved
Original	Department R&R		Reformatted / streamlined	January 24, 2007
1	Department R&R, Radiology	Radiology, Section 6, Patient Care policies	Addition of Contrast Administration	March, 2007
2	Department R&R Orthopaedics	Orthopaedics, Section 3, #3	Addition regarding emergency room call information.	December 14, 2007
3	Department R&R	Revisions	Change Mortality and Morbidity process to coordination and oversight of focused professional practice evaluation Replaced QM with PROC	General maintenance
4	GI	Addition	Addition of gastroenterology Departmental R&R	February 29, 2008
5	Anesthesia	Revise Peer Review	Peer review: will be a 3 member committee. Members of the committee will serve annually and will be selected at the January Qtrly Mt.	February 29, 2008
6	Pathology	Section 3 & 6	Removed verbiage and added "not applicable to this department"	February 29, 2008
7	Departments and Divisions	Table	Added the Department of Gastroenterology	General maintenance
8	Department of General & Plastic Surgery	Section 3	Revision requiring all plastic surgeons except sr. active to take call	March 27, 2008
9	Cardiology	Section 4	Revision of the current language regarding peer review	May 28, 2008
10	Internal Medicine	Section 6	Addition clarifying all unassigned patients from the ED.	May 28, 2008
11	Internal Medicine	Section 4	Revision of the current language regarding peer review.	May 28, 2008
12	Urology	Section 4	Typo – replaced Internal Medicine with Urology	n/a
13	Anesthesiology	Section 6 #4	Revision clarifying that a post anesthetic followup note is required within 48 hours following surgery	November 2008
14	Cardiothoracic	Section 4	Revision to peer review: the cardiothoracic surgery department shall consistently conduct peer review by a multi-member committee of CT surgeons	January 2009
15	Emergency Medicine	Section 6	Revision to the description of defining Boards for department membership/privileges. Also defines that physicians in training may only work as double coverage physicians when in their final year of training and fully compliant with all other requirements; physicians in training will NOT be appointed to medical staff membership	January 2009
16	OB/GYN	Section 5	OB/GYN endorses Team One Training and implementation For all L&D areas.	January 2009
17	Maintenance		Miscellaneous errors/typo	March 2009
18	Cardiothoracic	Section 4	Changes to Peer Review: "must be performed in accordance of the MS R&R. Members of the department will participate on a rotating basis as determined by the chair	March 26, 2009
19	OB/GYN	Section 6 – Prepared Childbirth	Deleted the words; "if he/she has attended the required classes" in paragraph 1 & 2	April 30, 2009
20	Pathology	Section 6 – Patient Care Policies	Addition to R&R to meet TJC requirement that this policy be approved by the medical staff.	May 28, 2009
21	Emergency Medicine	Section 6 – Patient Care Policies	Addition to clarify advance directives in the ED.	May 28, 2009

22	Pathology	Section 6 - Patient Care Policy	Autopsy service – Description of Autopsy service and process.	June 25, 2009
23	Anesthesia	Revision of P&P	Department of Anesthesia revised the Policy and Procedures	June 25, 2009
24	Anesthesia	Section 6: Patient Care Policies; Intraoperative	Changes reflect the current supervisory levels provided by anesthesiologists	December 10, 2009
25	Maintenance		Made corrections of typos etc.	July 13, 2010
26	Cardiology	Peer Review	Revision to the Cardiology PR committee	September 15, 2010
27	Maintenance		Changed Plan to Policies	November 18, 2010
28	OB/GYN	Section 6	Verbiage change from “shall” comply to “encourage to” comply	September 14, 2011
29	Pathology	Section 6 Procedure /Process	Removed the procedure/process section from Section 6 This section addressed specimen handling and is more appropriately addressed in the hospital’s lab procedure manual	November 16, 2011
30	Renaming document		Departmental Rules and Regulation will be renamed Departmental Policies to more appropriately reflect their content.	November 16, 2011
31	Department of Surgery	Section 4	Revision to the peer review section stating that the department will have a rotating committee of Active Staff Surgeons for the purpose of conducting peer review.	February 15, 2012
32	Department of OB/GYN	Section 6	Revised write, written, writing with document documented, documenting to align with the electronic environment	June 20, 2012
33	Department of Critical Care	Addition	Addition of new Department – Critical Care	March 28, 2013
34	Department list review	Revision	Updated verbiage to align with the bylaws.	April 25, 2013
35	All Departments	Revision	All Department Peer Review and Quality Assessment Performance Improvement were updated to reflect current practices. Eligibility and Privileging removed as these requirements are in DOPs and Bylaws.	November 13, 2013
36	Department of Psychiatry	REMOVED	The Department of Psychiatry was dissolved as it did not have enough active members.	January 15, 2014
Unification Revisions	Peer Review Policies – Throughout the document		Added: MHOBH when MHMH is referenced. Methodist Healthcare – Memphis Hospitals (MHMH), <u>Methodist Healthcare – Olive Branch Hospital (MHOBH)</u> .	November 19, 2014
Unification Revisions	Department of Internal Medicine Peer Review Section		The committee members will be determined as follows: two Internal Medicine physicians from MUH, and one from the other adult facilities. To allow MHOBH to be represented in the Internal Medicine Peer Review.	November 19, 2014
37	Department of Otolaryngology	Revision	Revision to the ER call Section	October 21, 2015
38	Department of Radiology	Section 5.0 Addition	Addition of Vas Cath Call Coverage for adult hospitals	June 16, 2016
39	Department of Emergency Medicine	Section 2.0 Removal Section 4.0 Section 4.0 Peer Review	Removed Frequency of Meetings Corrected a typo Modified Peer Review meetings from Bi-monthly to monthly	October 19, 2016
40	Department of OB/GYN	Section 2.0 Section 5.0 (Normal and Abnormal Qualifications Section 5.0 - Addition	Added: Meeting attendance requirement Removed duplicate “Methodist Healthcare” Added OB Admission H&P	October 19, 2016
41	Department of Pediatrics	Section 4 Revision	Added Chief Medical Officer and Surgeon in	October 19, 2016

			Chief in place of “Medical Director”	
42	Department of Radiology	Section 2.0 Revision Section 4.0	Revised the word “Election” with “Term” Revised Peer Review change word change verbiage about department chair or designee conducting peer review to PROC representative. Remove the word regular add as needed.	October 19, 2016
43	Department of Anesthesiology	Section 2.0	This addition to the Anesthesiology Department Policies addresses the qualifications of the Chair and/or Medical Director.	December 21, 2016
44	Department of Pulmonary Critical Care	Section 2.0	This addition to the Pulmonary Critical Care Department Policies addresses qualifications of the Chair, who also serves as Medical Director of Respiratory Therapy Services.	December 21, 2016
45	Department of Anesthesiology	Section 5.0	These revisions to Anesthesia Department policies specify documentation requirements for Pre Anesthesia/Sedation responsibilities, Intra-operative period, and Post Anesthesia/Sedation Care. Standardized electronic (PowerChart) documentation will be implemented and required.	February 15, 2017
46	Department of Pediatrics	Section 4.0	These revisions to the Department of Pediatrics Policies meet the requirements of the Children’s Surgical Care Level 1 Accreditation guidelines.	February 15, 2017
47	Departments of General Surgery, Internal Medicine, and Radiology	Section 4 - Peer Review Section	Updated Peer Review sections to reflect current practice	October 18, 2017
48	Department Emergency Medicine	Section 5- Patient Care Policies	Addition to meet EMTALA guidelines for evaluation and treatment, All patients presenting to the emergency department for care will receive a Medical Screening Exam.	September 20, 2018
49	Department of IM	Section 2&4	The Department of Internal Medicine approved revisions to their department policies at their October meeting. The revisions reflect a change in the number of terms a department chair can serve from 3 to 2 to align with the Bylaws and to mandate 50% attendance by IM Peer Review Committee members.	December 19, 2018
50	Department of OB/GYN	Section 5.0	Updated the Abortion Policy, which is being, renamed “Medical Induced Termination Policy”	November 18, 2020
51	Entire Document	Update pronouns	Revised he/she and his/hers	Administrative revisions. No approval required.

