RULES AND REGULATIONS
OF THE
MEDICAL STAFF

St. Luke's Hospital - Anderson
St. Luke's Hospital - Allentown Bethlehem
St. Luke's Hospital – Miners
St. Luke's Hospital - Monroe
St. Luke's Hospital-Quakertown
St. Luke's Hospital – Warren

Amendments through:
October 14, 2016

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RULES AND REGULATIONS

OF THE MEDICAL STAFF OF ST. LUKE'S HOSPITALS Anderson,

Allentown & Bethlehem, Miners and Quakertown

A. ADMISSION AND DISCHARGE OF PATIENTS

1. All patients must be admitted to the hospital by a member of the active or designated credentialed member of the allied Professional Staff (Physician Assistant, Nurse Practitioner, Nurse Midwife, aka Advanced Practitioner). Advanced practitioners have admitting authority on behalf of the designated attending physician. Admissions should have verbal or written orders within two hours of the time of admission.

2. A member of the Medical Staff who has admitting privileges will be designated in the patient's medical record as the attending. The practitioner, or his designated alternate, will be available at all times to respond to the needs that arise in the treatment of the patient. The attending may delegate in writing on the chart a specific aspect of the patient's care to another practitioner. The attending, however, maintains ultimate responsibility for the patient's care.

3. When a patient undergoes surgery, the service attending will remain the same unless otherwise designated.

4. A provisional diagnosis or valid reason for admission must be stated at the time of admission to the hospital.

5. A patient to be evaluated on an emergency basis who does not have a physician may request any practitioner in the applicable department to attend to/consult on him/her. If the requested physician is not on call and chooses not to accept the patient, then the on call physician for the applicable department will be assigned to the patient. All members of the medical staff are responsible for participation in the schedule of emergency coverage, and the chief of each department shall provide to the emergency department a schedule for such assignments, subject to any applicable hospital policies and medical staff bylaws. Any disputes in regard to the call schedule may be taken to the Medical Executive Committee ("MEC"). All practitioners shall provide care for patients regardless of their ability to pay.

6. As appropriate to the hospital, each section of a department is required to fulfill its obligations to staff hospital clinics in its specialty area. All medical staff members, as per their signed application, are required to fulfill their St. Luke's Hospital & Health Network ("SLHHN") clinic obligations if requested as according to the Bylaws. An individual may be excused from clinic duty at the discretion of the department chief. Any disputes may

be taken to the MEC by either the departmental chief or the individual active staff physician.

7. Each member of the staff who does not reside within a reasonable distance (approximately 30 minutes, subject to exceptions granted by the MEC) of the hospital, shall name a member of the medical staff who resides within this distance who may be called to attend his patients in an emergency, or until he arrives.

8. The Patient Access Center will process patients on the basis of the following order of priorities:

    (a) Emergency Admissions – Within 24 hours following admission, the attending practitioner shall write an admitting note explaining the need for this admission.

    (b) Routine Admissions - This will include elective admissions involving all services.

9. No patient will be transferred out of the critical care units without notification of the responsible practitioner.

10. The admitting physician is responsible for alerting fellow hospital caregivers as to the unstable or violent nature of his patient when appropriate so as to prevent potential harm to others as well as to prevent self-induced patient injury.

11. Should a question arise as to the appropriateness of an admission or discharge from a special care unit or cardiac unit, the decision shall be made by the Unit medical director and the attending physician. If a disagreement arises, the respective department chief will make the final decision.

12. The attending practitioner is required to document the need for continued hospitalization and plans for post hospital care.

13. Patients shall be discharged only on order of the attending practitioner. Should a patient leave without the attending physician's discharge order or against the practitioner's advice, a notation will be made in the patient's medical record by the attending practitioner.

14. Doctors, podiatrists and dentists may admit or discharge their own patients. If applicable, a consultant shall be responsible for the care of any medical problems that may be present, or arise, during the hospitalization and shall be responsible for that medical portion of the patient's record. The medical record of oral surgery patients shall document a detailed description of the dental problems by the responsible oral surgeon and pertinent instructions given to the patient and/or family at the time of discharge. When

appropriately trained and privileged, Oral Surgeons may perform a History & Physical on their surgery patients.

15. Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry.

B. MEDICAL RECORDS

1. The attending practitioner shall be responsible for the preparation of the medical record and shall provide sufficient information to identify the patient, support the diagnosis, justify treatment, document the course and results accurately and facilitate the continuity of care

   All providers are required to use the Hospital Information System (HIS) for documenting in-patient records, and other needs as determined by SLUHN (Added.7/15).

   All medical providers will be required to receive training and demonstrate competence in the use of the HIS as determined by SLUHN. No provider will be permitted to schedule or treat patients without demonstrating competence in the use of the HIS (Added.7/15)..

2. History and Physical

   a. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

   b. The St Luke's University Hospital Network requires that qualified personnel perform medical screening exams. The Network defines qualified personnel as a Licensed Independent Practitioner (MD, DO) or an advanced practitioner (PA, CRNP). Emergency Medical Treatment and Active Labor Act (EMTALA) required regulation 12/12/12.

   c. EMTALA physician on call lists are available 24/7 through the hospital operator at the Bethlehem, Allentown and Anderson Hospitals. Miners, Warren and Quakertown Hospital operators can be contacted independently for on call lists.

3. Pertinent progress notes shall be recorded at the time of observation. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least once a day. Progress notes should be of a quality sufficient to permit continuity and transfer of care.

4. Permanent operative reports shall include the name of the licensed independent practitioner and assistants; procedure(s) performed and description of the procedure; findings; estimated blood loss, specimens removed; type of anesthesia, complication(s), and postoperative diagnosis. A comprehensive operative/procedure progress note shall be written in the medical record immediately after surgery. The permanent operative report should be dictated within 24 hours after surgery. Failure to dictate operative reports within 24 hours will result in the report being considered delinquent.

5. Consultations

   a. Consultants shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.

   b. Consults should be obtained when: the attending physician would like an additional opinion or expertise to determine a diagnosis or a course of treatment. Attempts will be made to honor consultations requested by patients/families when they are medically appropriate and can be reasonably accommodated after discussion with the attending physician; or when requested by the department chief.

   c. Urgent consults should be seen within 6 hours unless another timeframe is agreed upon by both the attending and consulting medical staff members. It is required that the requesting physician communicate directly with the consultant.

   d. Routine consults should be seen within 72 hours unless another timeframe is agreed upon by both the attending and consulting medical staff members, subject to specialty exceptions as appropriate.

   e. The consultant can write orders unless the attending physician does not want the consultant to do so. The attending physician should designate the specific problem or area that he desires the consultant to address. If it is necessary that the consultant re-evaluate the patient, this request should also be ordered by the attending physician or his designee.

6. All clinical entries in the patient's medical record shall be dated, timed and signed.

7. Symbols and abbreviations may be used only when they have been approved by the medical executive committee. An official record of approved abbreviations shall be kept on file in the Medical Record Department.

8. The primary diagnosis shall be recorded by the attending physician, without the use of symbols or abbreviations, dated, timed and signed by the responsible practitioner at the time of discharge of all patients.

9. A discharge summary shall be written or dictated on all medical records of patients hospitalized over 48 hours. For patients staying 48 hours or less, a final progress note is required to include the following: reason for hospitalization, significant findings, procedures performed and care, treatment and services provided, and condition at discharge. Written discharge instructions must be given to each patient.

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

11. Access to all medical records of all patients shall be afforded to members of the medical staff for study and research when approved by the St. Luke's Hospital & Health Network Institutional Review Board (IRB) before records can be studied.

12. Subject to the discretion of the chief executive officer, former members of the medical staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

13. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the medical records committee.

14. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee and an entry shall be made in the chart within a reasonable time.

    a. Pennsylvania state licensure regulations permit CRNPs to complete the patient's death certificate.
    b. At St Luke's Quakertown and Miners, RNs can pronounce under certain circumstances as outlined in administrative policy "Care of the Deceased".
    c. New Jersey state law does not permit RNs or Advanced Practitioners to pronounce in the hospital.

15. It shall be the responsibility of all staff members to secure autopsies whenever possible. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 24 hours and the complete protocol should be made part of the record within 3 months. Autopsy reports will be completed within the following time frames: Gross = 15 days; Microbiology = 30 days; and Toxicology = 6 months.
    a. Autopsies are performed at St. Luke's Bethlehem only.

16. All medical records should be completed in all required details on the patient's discharge date (rev.7/15)..

a. Those Medical Staff members whose charts are still incomplete as of fifteen (15) days after discharge shall be notified by the Medical Records Department of their chart deficiencies. If the chart deficiencies have not been rectified within five (5) days from notification, the admitting privileges of the Medical Staff Member will be automatically

administratively relinquished, as described below, until the delinquent, warning and pending relinquishment status chart deficiencies are completed. The Medical Records Department will check charts at its discretion for compliance but will regularly check for deficiencies on Mondays and Wednesdays. (The timing for OR and Cardiac Catheterization Lab report completion, as described in item 4, supersedes the medical record timing in order to determine whether documentation is complete or not.).

b. Automatic relinquishment of admitting privileges will continue until all delinquent, warning, and pending relinquishment status chart deficiencies are completed, and medical records is notified (during normal medical record's business hours) to change the status. Automatic relinquishment will result in: a) the practitioner will not be allowed to schedule or perform elective procedures, perform consults, round (be on-call) if a part of a group practice or coverage group, admit or assign patients to observation, or accept transfer of a case unless authorized by the Vice President of Medical Affairs (VPMA) or designee; b) all current cases under the care of the involved practitioner who are in the hospital will not be affected by this automatic relinquishment. The automatic relinquishment will remain in effect until all delinquent, warning and pending relinquishment medical records are completed. The physician must notify Medical Records, during normal medical record business hours, when all charts have been completed. Upon suspension the physician needs to notify their affected patients.

c. When a physician reaches his/her third relinquishment within a 12-month period or is on relinquishment for more than 1 month, a letter will be sent to the physician notifying him/her of pending presentation to the MEC. The MEC will consider whether the staff member should be considered to have resigned appointment and clinical privileges based on their medical record delinquency record.

17. A medical record, authenticated by the practitioner responsible for its clinical accuracy, shall be generated for each patient who visits the Emergency Department.

C. GENERAL CONDUCT OF CARE

1. A general consent form signed by or on behalf of every patient admitted to the hospital, should be obtained at the time of admission.

2. Surgical consent should be obtained prior to surgery according to the hospital's Informed Consent Policy except in those situations in which the patient's life is in jeopardy and consent cannot be obtained because of the patient's clinical condition. In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from parents, guardian or next of kin, the circumstances should be fully documented on the patient's medical record.

3. Every hospital patient shall be on the service of a member of the medical staff, and shall be visited at least once daily by the attending practitioner or by his designee.

4. All DNR orders will be reviewed with the patient/patient representative prior to performance of a surgical procedure or initial renal dialysis. A note of the content of the discussion and decision regarding the DNR order will be made by the physician in the Progress Notes.

5. All orders shall be in writing unless there is an emergency situation requiring rapid patient interventions. Verbal/telephone orders should be signed/countersigned, dated and timed by the attending/consulting physician within seven (7) days (Rev. 12/13). For verbal orders, or for the reporting of critical test results over the telephone, the order or test result will be verified by having the person receiving the information record and "read back" the complete order or test result. The following shall govern the role of advanced practitioners:

   a. Physician Assistant

      • May practice medicine with physician supervision and according to the written agreement between the supervising (substitute) physician(s) and the PA (rev. 12/13)

      • May function within their defined scope of practice denoted by specific privileging and State licensure (rev. 12/13)

      • May arrange consults for, social service, other providers and physicians (

      • May order rehabilitation services (added 11/12).

      • May pronounce death and sign death certificates (rev.7/15).

      • The supervising physician shall countersign the patient record within 10 days

   b. Nurse Practitioner

      • Works in collaboration with a physician licensed to practice medicine in the respective state of the practice. (rev. 12/15)

      • May function within their defined scope of practice denoted by specific privileging and State licensure

      • May arrange consults for social service, other providers and physicians.

      • May order rehabilitation services. (added 11/12)

      • May pronounce death and sign death certificates in Pennsylvania but not New Jersey. (rev.7/15).

   c. Imaging technologists may accept verbal orders only in their area of expertise.

Pharmacists may transcribe verbal orders pertaining to medications. Respiratory therapists may transcribe oral orders pertaining to respiratory treatments. The ordering practitioner should countersign, date and time the verbal order within 24 hours. Other disciplines that are permitted by the State Licensure Board to accept verbal orders are RN, LPN, GN, PT, OT, and Speech Pathologists.

d. Dietitians (RD/LDN)

May modify or change an admission/initial or subsequent diet order written by the Physician/LIP in order to meet the nutrition goals for the patient, in accordance with hospital policy as indicated in the exception from the Pennsylvania State Department of Health.

6. The practitioner's orders must be legible and complete in order to be executed.

7. When patients go to surgery, all previous orders are cancelled.

8. When a patient is transferred in or out of a special care unit, all previous orders are rewritten or reconciled. Transfer orders are to be written by the physician or the patients present orders can be reviewed by the nurse and a verbal order obtained for transfer. Transfer of service should not be considered complete until there is a written or verbal telephone order from the receiving physician acknowledging patient acceptance by the receiving physician.

9. Orders for narcotics and controlled substances must be dated, timed and signed by the practitioner on the physician's order sheet. The practitioner's D.E.A. number is on file with the VPMA of the hospital, the St. Luke's University Health Network medical staff office and the hospital pharmacy. If a change in the status of the practitioner's DEA number occurs, the VPMA of the hospital or his designee should be notified immediately.

    - For the Automatic Stop Order Policy refer to the Pharmacy and Therapeutics Committee Manual.

10. Any elective surgical admission to the hospital preferably should have pre-admission testing. If this is not possible, orders for laboratory testing and imaging studies must be available in the Admitting Department at the time of admission.

11. Reports from laboratories outside the hospital are acceptable in lieu of tests performed in the hospital if the work is done in an accredited laboratory and if the test is recent enough to be pertinent to the individual case. All laboratory reports, including outside lab reports, are made part of the medical record.

12. Except in life threatening emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be cancelled. In any emergency the practitioner shall make at

least a comprehensive progress note regarding the patient's condition prior to induction of anesthesia and start of the surgery.

13. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic assessment and follow-up of the patient's condition.

14. All tissues removed at the operation, other than those exempted, shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record. The list of exempted tissues will be kept in the Network Department of Medical Affairs.

15. Surgical infections of clean surgical cases shall be reported to the infection control committee.

16. Specific regulations have been adopted in connection with the operation of specific care units such as the recovery room, and critical care unit, etc. Practitioners managing patients in these areas shall familiarize themselves with these regulations and conform to them. At the Allentown, Anderson and Bethlehem campuses, patients requiring admission to a critical care unit will be placed on the service of either the hospitalists, medical critical care, surgical critical care, cardiology or cardiothoracic surgery. All new orders and changes in a patient's care management plan will be discussed with the critical care team to assure continuity of care.

17. Surgery and cancer therapy treatment of patients at St. Luke's University Network Hospitals shall not be started prior to the review of the pertinent pathology slides read elsewhere, except when the life and/or safety of the patient would be imperiled by a delay in such slide review.

18. As applicable to the hospital setting, any patient admitted to a teaching service is to be regarded as the responsibility of the attending physician. Attending physicians must be notified by residents of admissions and significant changes in the course of any patient's hospitalization on that teaching service. Residents on teaching services will work only under the supervision of their attending physicians.

19. Physician orders for physical restraint and/or seclusion will be governed by the St. Luke's Hospital "Physical Restraint Policy" as outlined in the St. Luke's Nursing Procedure Manual.

20. Any member of the Medical Staff who has reason to suspect drug diversion (theft for purposes of self-administration, selling or other use) from the hospital by an employee or member of the Medical Staff is required to report such information immediately to his or her chief of service or VPMA.

21. The chief of service will then notify the VPMA, Network Director of the Department of Pharmacy Services, who will assist in follow-up of the incident including advising as to the

appropriate agencies and/or departments to be notified.

22. Physician Orders for Life-Sustaining Treatment (POLST) is a process approved by the State Department of Health ("DOH") for patients to express their end of life treatment expectations and is countersigned by their physician. The DOH considers the signed POLST to be a medical order. The DOH, the St. Luke's Medical Staff By-laws and its Rules & Regulations require that only authorized medical staff members be permitted to prescribe and give medical orders in the St. Luke's Hospital University Health Network (SLUHN) facilities. SLUHN recognizes the value of POLST as a means to facilitate the patient's directions through this medical order. Accordingly, SLUHN facilities will recognize and implement the POLST orders of physicians who are not on the St. Luke's Hospital Medical Staff so long as an authorized SLUHN representative first confirms that the physician who signed the POLST has a current, unrestricted state medical license.

23. a. General Policy

(i) for purposes of this Policy, the term "outpatient services" means outpatient diagnostic radiology, nuclear medicine, rehabilitation, respiratory care, infusion services or laboratory tests.

(ii) orders for outpatient services shall only be accepted from:

(aa) members of the Medical Staff of the Hospital or any other St. Luke's University Health Network Medical Staff;

(bb) members of the Allied Professional Staff of the Hospital who have been granted appropriate clinical privileges by the Hospital, to the extent permitted by their licenses; or any other St. Luke's University Health Network Medical Staff;

(cc) other practitioners who have been granted permission to order such outpatient services by the Sr. Vice President for Medical & Academic Affairs (Sr. VPMAA) or designee pursuant to this Policy.

b. General Requirements

(i) to be eligible to order outpatient services, a practitioner who is not a member of the Medial Staff or Allied Professional Staff must:

(aa) have a current, unrestricted license to practice his or her profession;

(bb) be authorized by his or her license to order the service in question;

(cc) order services for outpatients only; and

(dd) not have been excluded from or sanctioned by any federal or state governmental health care program.

(ii) hospital personnel will treat orders for outpatient services issued pursuant to this Policy in the same manner as they treat orders issued by Medical Staff members and Allied Professional Staff.

(iii) the hospital will include outpatient services ordered by non-Medical Staff members in its quality review and performance improvement processes.

c. Processing Requests from Non-Affiliated Individuals to Order Outpatient Services

(i) to order outpatient services from the Hospital pursuant to this Policy, the non-St. Luke's Medical Staff practitioner must submit a request for the outpatient service on the practitioner's prescription pad or letterhead.

(ii) The request shall be submitted to the Medical Staff Office.

(iii) the Medical Staff Office shall:

(aa) verify that the individual's license is current and not subject to any restrictions, or conditions; and

(bb) review the Office of Inspector General's List of Excluded Providers to verify that the individual has not been excluded from any federal health care program.

(iv) the VPMAA or designee will determine whether the individual will be granted permission to order outpatient services.

d. Interpretation

This Policy is intended to promote convenience for patients who may be traveling to communities served by the Hospital and other appropriate circumstances. The Sr. VPMAA reserves the right to decide to continue to accept orders from practitioners who are located in the communities served by the Hospital who seek to order outpatient services on a regular basis who could order such services as a member of the medical staff of another hospital.

D. MISCELLANEOUS

1. As applicable to the respective hospital, medical staff shall participate in the instruction of medical students, interns, residents, fellows, nurses and para-medical personnel.

2. Surgeons shall be in the operating room and ready to commence operation at the time scheduled.

3. Duties or responsibilities of a chief of service shall be performed or exercised in his absence by his designated agent unless otherwise specified.

4. Medical staff dues shall be as determined from time to time by the medical staff. Dues shall be paid by active, affiliate and active associate staff members of the staff. Dues for each respective campus that the provider is a member of will need to paid in order to receive a reappointment application for each. Notice of dues shall be e-mailed to all members approximately 90 days before their reappointment month. A second follow-up email will be sent to those physicians whose dues has not been received by the last day of the month. If no response within 5 days, it shall be interpreted as a voluntary resignation from the staff. Reinstatement of members shall be made on application, the procedure being the same as in the case of original appointment.

5. Disaster Assignments:

(a) All practitioners who are members of the active, active associate medical staffs shall respond to a call to participate in the care of patients whenever the disaster plan is implemented. Each practitioner shall perform such duties as are assigned to him by the chairman of the disaster committee or his designate. All practitioners specifically agree to relinquish direction of the professional care of their patients, service or private, to members of the medical staff appointed by the director of the

emergency operation and to permit transfer or discharge of their patients in preparation for admission of disaster casualties.

(b) Policies concerning patient care will be a joint responsibility of the chairman of the disaster committee and the chief executive officer of the hospital.

E. GENERAL PRINCIPLES OF PATIENT, PRACTITIONER AND HOSPITAL RELATIONSHIPS

St. Luke's Hospital, its Medical Staff, and its Employees will give considerate and respectful care to all patients without discrimination as to race, color, sex, sexual preference, religion, national origin, or ability of payment.

F. CODE OF CONDUCT GUIDELINES

Disruptive conduct by a Medical Staff member or Allied Health Professional (AHP) is behavior which adversely impacts on the quality and safety of patient care and includes, but is not limited to: verbal and/or physical abuse of colleagues, hospital personnel or patients, sexual harassment, and threatening or intimidating behavior exhibited during interactions with colleagues or hospital personnel, or patients. Examples of disruptive conduct are set forth in applicable Network policy.

1. Any medical staff member, AHP, employee or agent of the hospital, or patient may file a report regarding disruptive conduct.

2. Reports should be submitted to the VPMA or department chief wherein the physician holds privileges. If reports are submitted directly to the hospital President, he/she will notify the VPMA.

3. Notification of significant or repetitive reports involving members of the medical staff or AHP including employed physicians, will be made to the VPMA or the President of the Medical Staff**.** At the discretion of the VPMA, the Physician Health Committee may be consulted.

4. Reports must be in writing and should include documentation of the conduct, in as much detail as possible:

    a. the date and time of the behavior in question;

    b. the circumstances which precipitated the situation;

    c. whether the behavior involved a patient and, if so, the patient's name;

    d. a description of the behavior limited to factual, objective and observed acts as much as possible;

e. the consequences, if any, of the behavior as it relates to patient care and/or hospital operations;

f. a record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening; and

g. corroboration by another individual if possible.

5. The VPMA or designee, in collaboration with the chief of the department wherein the physician holds privileges, will conduct a review, which will include, but not be limited to, an interview with the involved physician.

6. Single minor incidents of disruptive conduct, warranting a discussion with the involved practitioner, will be handled by the VPMA or Sr. VPMA or Department Chief. A single copy of the incident and relevant follow-up documentation may be kept and placed in the practitioner's confidential file. The practitioner will have an opportunity to present a written response that will be placed in that practitioner's file. The practitioner will be entitled to review his or her file periodically.

7. The President of the Medical Staff will be made aware of any situations regarding disruptive behavior by a member of the medical staff, the nature and outcome of any counseling sessions by the VPMA or Department Chief and the contents of any reports that are put into a staff member's personal file regarding such incidents and counseling. Additionally, the President of the Medical Staff will be made aware of any pattern of disruptive behavior by a staff member and may be present for any counseling sessions by the VPMA and/or the Department Chief that may ensue.

8. If the behavior in question suggests impairment (medical, psychological, or substance abuse problem), the medical staff president or the VPMA or the Department Chief will contact the Medical Staff Health Committee. The Medical Staff Physician Health Committee may arrange for the practitioner to be evaluated by a professional with appropriate expertise.

9. If the practitioner refuses to be evaluated and the Medical Staff Physician Health Committee has reason to believe there is significant evidence of impairment, the Medical Staff Health Committee should report its findings to the VPMA and the President of the Medical Staff for appropriate action.

10. If the involved practitioner is determined not to be impaired, the VPMA and the Department Chief along with the President of the Medical Staff will meet with the practitioner to discuss the inappropriate behavior, emphasizing that if the behavior continues, more formal action may be taken (including referral to the MEC). This meeting will be documented and a follow-up letter to the practitioner, which will be part of the practitioner's permanent record, will emphasize that the practitioner is expected to behave professionally and cooperatively. One copy only of the letter to the practitioner will be kept and placed in the practitioner's confidential credentials file.

11. The VPMA, and or the Department Chief and or along with the President of the Medical Staff may use collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address concerns about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct may be so unacceptable that immediate disciplinary action is required.

12. Additional incidents within two years may be referred to the MEC. When patient and/or staff safety is in jeopardy, precautionary suspension procedures, as outlined in the Medical Staff Bylaws, may be indicated pending this process. The MEC may take additional steps to address the concerns including, but not limited to, the following:

- require the practitioner to meet with the full MEC or a designated subgroup;

- issue a letter of warning or reprimand; require the physician to complete a behavior modification course; impose a "personal" code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner's adherence to it and/or suspend the practitioner's clinical privileges.

G. Long Term Care Guidelines, St. Luke's Hospital - Miners

1. Every member of the medical staff with Rehabilitation and Nursing Center residents shall perform a face to face contact with the resident at least every 30 days for the first 90 days after admission and then every 60 days or as clinically indicated and document in the medical record. The Medical Director of Rehabilitation and Nursing Center shall be authorized to examine any resident and document progress in the medical record if the attending physician does not fulfill the thirty day requirement after due notification to the attending physician. After the initial physician visit an advanced practitioner may make every other required visit to the resident.

2. Verbal medication orders for residents of the Rehabilitation and Nursing Center must be countersigned, dated, and timed within 48 hours, care and treatment orders must be countersigned, dated and timed within 7 days. All verbal orders for residents of the Rehabilitation and Nursing Center must be signed in the designated timeframe by the ordering physician or fellow licensed independent practitioner authorized by the attending physician, permitting the licensed independent practitioner is knowledgeable of the resident's condition.

3. History and physical examinations for the Rehabilitation and Nursing Center facility residents must be recorded and placed in the resident's record within 72 hours.

4. Incomplete medical record: All medical records must be completed within thirty days of the resident's discharge from the Rehabilitation and Nursing Center. It is the responsibility of each member of the Medical staff to complete their portion of the

medical record. Records not completed within this 30 day period will be reported as delinquent.

5. All physicians and advanced practitioners will be notified of their incomplete medical records weekly. Any physician or advanced practitioner with more than three delinquencies on the monthly Medical Record Delinquency report will be reported to the Medical Executive committee for consideration of disciplinary action which can include suspension.

6. Any physician or advanced practitioner with more than 25 delinquent records on the monthly medical record delinquency report for two consecutive months will be reported directly to the medical director for consideration of immediate disciplinary action which may include suspension. Report will follow to the Medical Executive Committee.

H. Meeting Attendance

Failure to comply with the attendance requirements stated in the Medical Staff By-laws may result in administrative suspension until compliance as required is attained.

Approved: St. Luke's University Hospital Medical Staff March 21, 2013
Approved: St. Luke's University Health Network Board of Trustees April 22, 2013

Amendments included to: October 14, 2016