

**MEDICAL STAFF
RULES AND REGULATIONS
OF THE
UNIVERSITY OF ILLINOIS HOSPITAL AND
HEALTH SCIENCES SYSTEM**

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ARTICLE I. ORGANIZATION OF THE MEDICAL STAFF

The Board of Trustees of the University of Illinois is responsible for ensuring that quality care is provided to patients at the University of Illinois Hospital and Clinics. As described in the Medical Staff Bylaws, it has delegated services provided at the University of Illinois Hospital and Clinics. A systematic and effective mechanism exists for communication between the governing board, the administration of the Hospital and Clinics, and the Medical Staff. The Medical Staff is accountable to the Board of Trustees of the University of Illinois.

The Medical Staff of the University of Illinois Hospital is organized under the Medical Staff Bylaws as a single organized entity. It has established an Executive Committee and standing Medical Staff and Hospital Committees to oversee the broad range of activities provided by its members. The purpose and charges of these committees are listed below.

A. STANDING COMMITTEES OF THE MEDICAL STAFF

1. Executive Committee of the Medical Staff

The Medical Staff Bylaws specifically describe the duties, composition, election of members, and meeting requirements of the Executive Committee. The committee acts on behalf of the Medical Staff in accordance with its responsibilities as described in the Medical Staff Bylaws. The committee receives and acts upon reports of all standing committees and clinical services.

2. Committee on Credentials

Purpose: The committee oversees the appointment and reappointment of the Medical Staff and reviews requests for clinical privileges. The committee sends its recommendations to the Executive Committee which makes the final recommendation. Members of the committee are given a copy of the purpose and charge of the committee and are thereby made aware of their responsibilities as members, and by virtue of participation agree to abide by the charge of the committee as outlined below.

Charge: 1. Review and act on all applications for *appointment* to the Medical Staff in accordance with the procedure described in the Medical Staff Bylaws.

2. Review and act on all applications for *reappointment* to the medical staff in accordance with the procedure described in the Medical Staff Bylaws.

3. Review and act on all requests for clinical privileges in accordance with the requirements and specifications listed in the Medical Staff Rules and Regulations. Review any instances of medical practice outside the scope of approved privileges.

4. Ensure that all recommendations for both initial appointment and reappointment are in compliance with the University of Illinois Non-Discrimination Statement and Affirmative Action Plan.

5. Evaluate and clearly document reasons for denial of all Applications for appointment/reappointment to demonstrate that decisions are made in a nondiscriminatory manner.

6. Evaluate carefully and completely any practitioner complaints alleging discrimination.

7. Complete a confidentiality statement agreement annually as part of the Medical Center Learning Management System mandatory educational requirement, to attest that all information related to the credentialing process, initial and reappointment, is kept confidential.

3. Committee on Committees

Purpose: The purpose of the Committee on Committees is to direct the committees structure by reviewing committee charges and appointments.

Charge: 1. Oversee the committee structure of the University of Illinois Hospital and Clinics by reviewing the charge and membership of committees and identifying obsolete committees and recommending new committees.

2. Nominate membership and the chair and co-chair of each committee.

4. Committee on Medical Staff Bylaws

Purpose: The committee reviews and revises the Medical Staff Bylaws and Rules and Regulations to ensure that they meet accepted standards and reflect current medical staff policy and practices.

Charge: 1. Review the Bylaws, Rules and Regulations every year to assure that they are in compliance with the Joint Commission and other applicable professional standards. Assure that these documents accurately reflect current medical staff policy and practice. Report any recommended revisions to the Executive Committee.

2. Review any other proposals for amendments of the Bylaws or change in the Rules and Regulations and forward these with comment to the Executive Committee.

5. Committee on Practitioners' Assistance

Purpose: The Committee acts as an advocate for practitioners at the University of Illinois Hospital who are stressed or impaired. The purpose of the process is assistance and rehabilitation, rather than discipline, to aid a practitioner in retaining or regaining optimal professional functioning, consistent with protection of patients.

Charge: 1. Promote awareness and educate the staff on the stressful situations experienced by house staff and other practitioners and serve in an advisory capacity on these matters in a process that is separate from the medical staff disciplinary function.

2. Assist in the identification of stressed and impaired practitioners. Encourage self-referral and referral by other organization staff. All complaints, allegations or concerns that are part of a referral by other organization staff will be evaluated for credibility.

3. Maintain confidentiality of the practitioner seeking referral or referred for assistance, except as limited by law, ethical obligation, or when the safety of a patient is threatened.

4. Assist in the process of intervention with impaired practitioners. Refer individual to the appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.

5. Assist in the development of treatment plans, and monitoring of compliance with them. Monitoring of the affected practitioner and the safety of patients until the rehabilitation process is complete. When a practitioner fails to complete a prescribed rehabilitation program, the reasons for their failure to do so are evaluated, progress in their current treatment plan and their current situation are also evaluated, and further recommendations for a revised treatment plan if needed or appropriate are made and agreed upon by the Committee as well as the practitioner.

6. Advise the Chief Medical Officer's office regarding the safety of a practitioner's continued practice. If at any time during the diagnosis, treatment, or rehabilitation phase of the process it is determined that a practitioner is unable to safely perform the privileges he/she has been granted the matter is forwarded to Medical Staff Leadership for appropriate corrective action that includes strict adherence to any state or federally mandated reporting requirements.

6. Medical Staff Review Board

Purpose: The Medical Staff Review Board plays a critical role in the evaluation and correction of significant adverse events and peer review cases.

Charge:

1. Reviews investigation of all significant and sentinel events:
 - Endorses or modifies action plans to be sent to line managers
 - Reports regularly and by exception to the Chief Medical Officer and the Executive Committee of the Medical Staff
2. Analyzes peer review issues identified by the Clinical Departments and the Risk and Quality Managers, and makes recommendations as necessary for correction to the Chief Medical Officer and the Executive Committee of the Medical Staff.
3. Reviews the trends in medical malpractice claims and potential compensable events and makes recommendations to the Chief Medical Officer and Executive Committee of the Medical Staff.

B. STANDING COMMITTEES OF THE HOSPITAL

1. Committee on the Operating Room

Purpose: The committee reviews all issues affecting the management and patient care in all inpatient and ambulatory surgical suites and recovery rooms.

Charge:

1. Review and revise standards, policies and procedures for the care of patients and the function of all operating rooms and recovery rooms. This may include review of surgical practice, anesthesia, nursing and other support services in both the ambulatory and inpatient surgical areas.

2. Evaluate the distribution of operating room time assignments by departments and the distribution and utilization of personnel so that the operating suite is managed efficiently.

3. Serve in an advisory capacity to hospital management on issues such as major equipment purchases or remodeling of physical facilities.

4. Review and advise on all issues affecting the function and services provided in the operating suite.

2. Committee on The Electronic Medical Record

Purpose: The committee monitors the quality of medical records and works with the Health Information Management Department to develop standards, policies and procedures that assure the availability of complete and organized medical records.

Charge:

1. Monitor the medical staff record review procedure. Each department must regularly review the quality of the medical record to assure that documentation of medical evaluation and treatment is clear and complete.

2. Review statistics on the timeliness of medical record completion and advise the Chief of Service of any deficiencies.

3. Assist with development of standards, policies and procedures to assure the availability of a complete medical record for each patient encounter.

4. Review and approve all new medical record forms. This includes review of any computer-generated forms or procedures that serve as medical record documentation.

5. Design and develop clinically and operationally based rules which support and improve patient safety and efficient operations.

6. Standardize documentation of the patient medical record driving towards a complete electronic medical record. This includes assessment across all services of informational needs.

3. Committee on Infection Control

Purpose: The committee reviews the infections within the hospital and clinics and monitors the overall hospital infection control program. This includes review of the management of infections and any epidemic potential within the hospital.

Authority: The committee shall have the authority, delegated by the Hospital Chief Medical Officer to institute appropriate control measures or studies whenever the committee determines the existence of a threat or danger to any patient or personnel.

Charge: 1. Determine the scope of the hospital infection control surveillance program that identifies all hospital infections including nosocomial infections.

2. Oversee the management of infections within the hospital and clinics, This includes, (a) reviewing data on nosocomial and community-acquired communicable infections; (b) ratifying recommendations of the infection control staff with respect to the preventions and control of infections; and (c) approval of hospital policies and procedures related to hospital infection control.

3. Serve as a liaison to the Environment of Care Committee, and each clinical/ancillary department to promote and uphold the objectives of the Infection Control Program.

4. Laboratory Utilization and Practices Committee

Purpose: The committee reviews utilization of the clinical laboratory testing with the goal to improve the quality of patient care. This will be achieved by promoting interaction between care givers and the pathology laboratories, reviewing test ordering practices of health care providers and providing feedback, and seeking new and innovative interfaces between the clinical laboratories, health care providers and patients.

Charge: 1. Promote awareness and educate the staff on the best use of clinical laboratory testing.

2. Review clinical test ordering practices and advise/recommend changes that would improve patient care. This includes a) monitoring test utilization and providing feedback to care providers, b) evaluating requests for new laboratory tests, and c) identifying outdated tests and ensuring their removal from the test menu.

3. Serve in an advisory capacity on interdepartmental issues of appropriate laboratory testing for the patient population served by the hospital and its clinics.

4. Identify opportunities to improve online test ordering and reporting.

5. Identify new and innovative ways to provide guidance in test interpretation and reflexive test ordering practices.

6. Address any other projects assigned by the Chief Medical Officer.

5. Transfusion Practices Committee

Purpose: The Transfusion Practices Committee of the University of Illinois Medical Center at Chicago serves to provide a mechanism for oversight of transfusion practice, including utilization review, by peer analysis. Organizations such as The Joint Commission and professional societies such as the AABB have required monitoring of blood utilization in one form or another since 1961. The Transfusion Practices Committee works to assess, measure, and improve clinical processes related to blood transfusion at the University of Illinois Medical Center at Chicago.

When problems with any of the below categories are discovered, process improvement through corrective and preventive action must take place and be documented.

Charge: 1. To make certain that the University of Illinois Medical Center at Chicago is in compliance with all regulatory requirements related to collection, processing, storage and transfusion of blood components.

2. To evaluate the ordering practices and component usage of the Medical Staff to ensure that patient safety is maximized and component wastage is minimized.

3. To investigate instances where inappropriate patient identification or sample collection and labeling impacted patient safety.

4. To evaluate new components and products for usage by the University of Illinois Medical Center at Chicago and to make recommendations regarding supply within the blood bank.

5. To evaluate the recognition, reporting, assessment and treatment of infectious and non-infectious adverse events of transfusion

6. To make available to the Medical Staff the most recent peer-review recommendations regarding blood component usage and transfusion medicine.

7. To evaluate the ability of the hospital transfusion service to meet patient needs

6. Committee on Pharmacy and Therapeutics

Purpose: The Pharmacy & Therapeutics Committee provides leadership and oversight in drug therapy practice and utilization by reviewing and monitoring usage and control of medication.

Charge: 1. Formulary Management: The Committee supervises the selection and distribution of drugs and therapeutic agents by maintaining a hospital drug formulary. This includes managing drug availability, handling and administration of drugs, patient selection and use criteria, guidelines and standards, non-formulary usage, clinical outcomes, cost effectiveness and all other aspects of drug therapy.

- Hear and assess requests for introduction of new therapeutic agents into the hospital formulary. A majority vote of the committee is required for a favorable decision. Negative decisions may be appealed only by presentation of new evidence in support of the application or by formal appeal to the Executive Committee.
- Review the status of any therapeutic agent in current use, upon the committee's initiative or upon request by the Director of Hospital Pharmacy, any Chief of Service or the Chief Medical Officer.

2. Drug Usage Evaluation: Review the appropriateness of the use of drugs for patient care through analysis of patterns of drug practice and advise departments regarding the appropriateness of drugs used on their services.

3. Quality of Care Review: Monitor and evaluate issues related to quality and safety of patient care, including adverse drug reactions, medication errors and medication-related sentinel events.

- Authorizes the investigation and root cause analysis of all significant medication events by the Medication System Review Committee. Reviews Medication System Review Committee recommendations and endorses or modifies recommendations of that committee. Hospital-wide physician practice issues are forwarded to the Medical Staff Executive Committee. Provider specific performance issues are referred to the head of the appropriate department for peer review.

4. Education: Recommend programs designed to meet the informational needs of the professional staff on matters related to drugs and their appropriate therapeutic use in patients across the continuum of care.

5. Control the emergency ordering of drugs which are not customarily maintained on the hospital formulary.

6. Monitor the use of experimental drugs or drugs which have not been accepted for general use by the committee.

7. Committee on Perinatal Administration

Purpose: The committee reviews the quality of care of the mother, fetus and neonate. This includes reviews of standards, policy and procedure governing patient care in these areas and review of relevant research projects.

Charge: 1. Monitor the overall quality of patient care in the maternal, fetal and neonatal areas. Discuss and advise on any changes that would improve patient care. This includes review of any home care or outreach program.

2. Review and revise as needed standards, policies and procedures governing patient care.

3. Review research proposals and projects that involve patient care in these areas. All research projects must secure Institutional Review Board approval prior to implementation.

4. Review and develop guidelines for medical-ethical issues involving care.

5. Serve in an advisory capacity on any issues affecting patient care of the mother, fetus or neonate.

8. Emergency Management Committee

Purpose: The committee oversees the hospital disaster plan to assure that it is adequate for providing patient care during an internal disaster and to assure that proper resources and plans are available for providing emergency care during an external disaster.

Charge: 1. Review the hospital disaster plan annually to assure that it is adequate for providing patient care during an internal disaster and for providing emergency care during an external disaster. Assure that adequate resources, communications systems and trained personnel are available.

2. Review the hospital response to test disaster drills and to any naturally occurring disasters. Report any responses that were deficient and follow-up on departmental or hospital-wide corrective actions.

9. Committee on Emergency Cardiac Care

Purpose: The committee directs the hospital Cardiopulmonary Resuscitation (CPR) Program and evaluates the effectiveness of the hospital-wide CPR Program.

Charge: 1. Oversee the CPR educational program in basic life support and advanced cardiac life support for all appropriate UICMC personnel.

2. Direct and monitor the CPR teams. This includes reviewing all CPR responses and their documentation, status and adequacy of equipment, supplies, support services and personnel.

3. Review and revise as needed standards, policy and procedure related to CPR activities.

4. Evaluate outcomes of CPR and implement changes to improve morbidity and reduce mortality.

10. Committee on Medical Ethics

Purpose: This multidisciplinary committee serves as an advisory board, which reviews medical/surgical practice, organizational and professional issues, and patient care issues that relate to the discipline of clinical medical ethics. The committee is also responsible for activities regarding hospital policies related to these issues, including reviewing and revising existing policies as well as drafting new policies.

Charge: 1. Review, revise, and draft as needed, hospital policy and procedure regarding medical ethical topics such as withholding cardiopulmonary resuscitation, care of patients at end of life, and informed consent.

2. Serve as a discussion forum and advisory body on medical ethical issues.

3. Participate in direct medical ethics consultation and case review through the UIMC ethics consult service.

4. Participate in educational opportunities related to medical ethics for the UIMC campus and community.

11. Oncology Advisory Board

Purpose: The Oncology Advisory Board is a multidisciplinary, standing committee which serves as liaison group for interdepartmental oncology activities and seeks to promote and advance the patient care, research and educational programs in the field of oncology.

Composition: The committee members are representatives from surgical oncology, medical oncology, radiation oncology, diagnostic radiology, pathology, and gynecology. The American College of Surgeons cancer liaison physician is also a member of this committee. The committee may also include representatives from family practice, pharmacy practice, nursing, administration, quality assurance, and social services. The hospital tumor registrar serves as staff to the committee in the coordination of the cancer program. All physicians on the committee are board certified.

Charge: 1. Promote continuing education, patient care and research programs in oncology undertaken at the medical center. Plan and complete a minimum of two patient care evaluation (PCE) studies annually, one to include survival data and, if available, comparison data.

2. Review and make recommendations on any issues related to the Cancer Registry and other oncology reporting systems. Serve as registry physician-advisors.

3. Serve in an advisory capacity on any issues related to the broad field of oncology. Make certain that consultative services from all major disciplines are available to all patients.

4. Make certain that cancer conferences include major cancer sites yearly and are primarily patient oriented and prospective.

5. Oversee and implement policies and practices to insure that the institution meets the cancer program approval criteria of the American College of Surgeons Commission on Cancer.

12. Committee on Utilization Management

Purpose: The UM Committee oversees a Medical Center wide utilization management program, that assures that regulatory requirements are met for the various agencies (The Joint Commission, Medicare and Medicaid) and for the various contracted managed care plans. The Committee also makes recommendations to the Executive Committee of the Medical Staff and UIC Physician Group for changes in processes and procedures that will enhance utilization management.

Charge: 1. The Committee will collect and analyze trended data as a means to focus and direct UM efforts on areas identified as having a high rate of inappropriate utilization (in-patient, pharmacy, SNF/home health placements, ancillaries, etc.).

2. The Committee will develop educational programs with a focus on such areas as early discharge planning, efficient use of resources, and documentation.

3. The Committee will route identified UM issues to the appropriate place of resolution and monitor for corrective action.

4. The Committee will approve the screening criteria used by the UM department and oversee the compliance with time frames for Medical Center/Departmental compliance and inter-rater reliability testing.

5. The Committee will provide a forum to review denied and extended stay cases and to review appeals data for these denied cases.

6. The Committee will coordinate activities with the Quality Improvement Committee when appropriate, and when issues related to quality of care, or system of care, impacts on utilization or are identified as part of the UR process.

13. Committee on Nutrition

Purpose: The Committee will review issues and needs related to nutritional services to provide a consistent approach to the development of sound practice standards in order to direct the application of nutritional services at the UICMC.

Charge: 1. Identify existing nutritional services and processes that exist across the Medical Center, that support healthcare delivery.

2. Perform a Needs Assessment that accurately describes the scope of services required to meet the needs of our patients and address regulatory requirements.

3. Identify and prioritize the urgency with which to address changes in our current services.

4. Identify short term and long term solutions to the existing gaps.

Charges 3 and 4 will be developed bearing in mind that the ultimate goal is to provide high quality nutritional services in a cost-effective manner.

14. Medical Center Management Policy and Procedure Committee

Purpose: The purpose of the Medical Center Management Policy and Procedure (MCMPP) Committee is to provide oversight and coordination for the development and maintenance of organization-wide policies and procedures.

Charge: 1. Identify needed policies arising from existing and evolving, organizational, community and regulatory agency requirements.

2. Promote the development of compatible interdisciplinary policies and procedures that support important patient and organizational functions across both inpatient and ambulatory departmental structures.

3. Periodically review existing organizational wide policies and procedures to ensure that they remain current and consistent with internal and external expectations and requirements.

4. Advise Medical Center departments/units regarding best practice for creation of departmental level policies, as well as effective processes to integrate policies into operational and clinical practices and staff education.

15. Medical Center Safety Committee

Purpose: The purpose of the Medical Center Safety Committee is to improve patient safety by focusing on system issues which decrease the risk of medical errors using the quality improvement approach.

Appointing Authority: CEO, HealthCare System

Charge: 1. Proactive risk assessment of patient/employee safety issues across the organization, with prioritization of the most significant areas warranting organizational improvements.

2. Promote a culture of safety across the organization.

3. Analyze data on patient and staff perceptions and ideas on how patient safety can be improved, and incorporate into changes to improve performance and reduce risk of sentinel events.

4. Implement National Patient Safety Goals within the organization.

5. Conduct an annual redesign of a high risk process with the goal of proactively preventing adverse events.

6. Report safety recommendations and effectiveness of outcomes to leadership of governance, management, and medical staff.

16. Committee on Sedation and Analgesia

Purpose: The committee reviews all aspects of care related to the provision of moderate sedation for the purposes of diagnostic or therapeutic procedures by non-anesthesiologists.

Charge: 1. Review and revise all standards, policies and procedures on moderate sedation practices throughout the medical center to be in compliance with changing regulations and practice standards, as well as promote best practices in the literature/professional organizations to assure patient safety.

2. Provide competency training materials for both physicians and non-physician personnel involved in moderate sedation cases.

3. Standardize documentation of moderate sedation cases in the medical record compliant with the appropriate legal and regulatory regulations.

4. Implement a centralized compilation of all reported adverse outcomes associated with moderate sedation. Based on review and analysis of data, make appropriate recommendations to the Medical Staff Executive Committee, other appropriate medical center committees, and the clinical services for practice improvements and policy modifications.

ARTICLE II.
MEDICAL STAFF APPOINTMENT,
REAPPOINTMENT AND CLINICAL PRIVILEGES

A. MEDICAL STAFF APPOINTMENT AND RENEWAL OF APPOINTMENT

The Medical Staff Bylaws define the categories of membership and the qualifications of members of the Medical Staff. The general procedure for application and appeal is also described. The following section of the Rules and Regulations is meant to complement the Bylaws by providing a more detailed guide to the applicant on his or her responsibilities and to describe the process for evaluating each application.

B. CLINICAL PRIVILEGES

The Medical Staff through its Bylaws has developed a process for clinical privilege delineation that applies professional criteria to all applicants to assure that each applicant is fairly reviewed, has reasonable qualifications and practices within the scope of the privileges granted.

1. Type of Clinical Privileges

- a. Full clinical privileges for a clinical service are defined by the service and may be requested and granted based on specific criteria developed by each Chief of Service.
- b. Privileges granted are not only based on the clinical service and qualifications of the individual, but also on consideration of the procedures and types of care, treatment, and services that can be performed or provided within the proposed setting. They are setting specific in that they may be performed in the medical center, associated clinics and laboratories, operating rooms, and emergency department unless the setting is otherwise specified or restricted. Settings may be otherwise specified or restricted because they may require consideration of setting characteristics, such as adequate facilities, equipment, number, and type of qualified support personnel and resources.

2. Eligibility for Clinical Privileges

- a. Each applicant for clinical privileges must be a member of the Medical Staff or a Staff Affiliate within an appropriate clinical service.
- b. Each applicant must be reviewed and approved by the Chief of Service, who shall consider all of the following as minimal criteria of professional competence.
 - 1) Demonstrated clinical competence for the indicated privileges in the particular specialty;
 - 2) Adequate physical and mental health to perform the duties requested is evaluated as part of the initial credentialing application process required by the Health Care Professional Credentialing and Data Collection Act (410 ILCS 517), ongoing, and as part of the reappointment process.

- 3) Either of the following:
- i) Certification by an appropriate American Board specialty, including certification when appropriate;
 - or
 - ii) Other equivalent credentials, training and experience which are to be documented.

C. PROCEDURE FOR APPOINTMENT TO THE MEDICAL STAFF AND CLINICAL PRIVILEGES DELINEATION

1. Procedure for Initial Appointment and Clinical Privileges Delineation

a. General Procedure

- 1) Application for appointment to the Medical Staff must be submitted in writing on an official applicant form and shall require information concerning the applicant's professional qualifications and other pertinent questions of a personal and professional nature. (All information that is related to the credentialing process, initial and reappointment, is kept confidential. Medical Staff Office employees with access to this data have a documented confidentiality statement agreement. Maintaining confidentiality is also a part of such employee's annual evaluation.) This information includes but is not limited to:

- a) The applicant's degrees;
- b) Graduate medical experience;
- c) Illinois Professional Licensure;
- d) Health Status;
- e) Current competence;
- f) Involvement in professional liability action.

In addition, three letters of reference are required from professional peers familiar with the applicant's clinical competence and ethics (**UIC residents being credentialed require only one letter of reference from their residency program director**). Letters of reference requests are generated by the Medical Staff Office (MSO) and are sent to the individuals named on the application by the applicants as peer recommendation references. The letters will include a picture ID as described in #4 below. The letters will also include the following elements to ensure these elements are addressed consistently on all applicants:

- Technical and Clinical Skills
- Clinical Judgment
- Interpersonal Skills
- Communication Skills
- Professionalism
- Systems Based Practice

- 2) Each applicant must sign the application and acknowledge his or her obligation for the following duties:
- a) To provide continuous care and supervision to all patients within the University of Illinois Hospital and Clinics for whom he or she is responsible;

- b) To provide full and accurate information on the application form;
 - c) To access and read a copy of the Medical Staff Bylaws and Rules and Regulations as well as the Hospital Policies and Guidelines and abide by them.
- 3) Each applicant shall sign a statement which:
 - a) Authorizes the hospital to contact other health care institutions with which the applicant has been associated and with others who may have information bearing on his or her competence, character and ethical qualifications;
 - b) Releases from any liability, to the fullest extent permitted under the law, the hospital and the medical staff for acts performed in evaluating the applicant and his or her credentials.
- 4) Each applicant to the Medical Staff must be assigned to a specific clinical service. Each applicant shall be reviewed by the Chief of Service of the specialty of the applicant. The review shall include evaluation of the applicant's education, training, experience, demonstrated competence and judgment. Upon application, the clinical service will verify that the practitioner requesting approval is the same practitioner identified in the documents by viewing an acceptable and valid picture ID. A valid picture ID issued by a state, federal, or regulatory agency is required. Acceptable identification includes, but is not limited to, a current picture Hospital ID Card, a valid picture State or Federal ID such as a passport or a driver's license, or a birth certificate.
- 5) Each applicant to the Medical Staff must have his or her clinical privileges delineated. Each applicant must complete a clinical application for each service in which privileges are requested. The Chiefs of Service for those services shall review each request for clinical privileges, taking into account the applicant's training, experience, demonstrated competence and judgment, as well as morbidity and mortality data as appropriate.
- 6) As described in the Bylaws, the Chief(s) of Service(s) involved shall forward a recommendation for Medical Staff appointment and clinical privileges delineation for each applicant to the Chief Medical Officer. The Chief Medical Officer or designee will transmit the application and supporting documents to the Credentials Committee. This Committee will review each application and make a recommendation. The recommendation to grant, deny, revise, or revoke privileges is made by the Credentials Committee. This recommendation will be forwarded to the Medical Staff Executive Committee (MSEC). After MSEC review, a recommendation will be forwarded to the GB, or a designated Committee of the GB, for final approval. Practitioners, the clinical department, and chief of service are notified of the credentialing decision in writing within

10 business days of the GB decision according to the process and procedure defined and approved by the organized medical staff. For privileges being revised, revoked, or denied, the reason for this action is communicated in a letter sent certified return receipt mail with a description of the Fair Hearing (denial/appeal) Process defined in the Medical Staff Bylaws. Mandatory reporting to all regulatory agencies is completed as applicable and appropriate as approved by the organized medical staff. The membership process, including all primary source verification (PSV) and granting of privileges, is completed within 180 calendar days of receipt of a completed application by the MSO. The MSO notifies hospital departments as appropriate of new and resigned medical staff members. Privileges can be viewed on the MSO Privileging module on the hospital web page. Practitioners, upon request, will be informed of the status of their *credentialing* application.

The practitioner has an obligation to access and read a copy of the Medical Staff Bylaws and Rules and Regulations and the Hospital Policies and Guidelines to abide by them. The Rules and Regulations informs the practitioner of their right, upon request as stated above, to review information obtained during the initial and reappointment credentialing process that is not peer review protected or subject to other contractual or disclosure restrictions, and to be informed of the status of their application.

b. Documentation

Each application will be considered complete when all of the following information is received and complete:

- 1) Official Application for Appointment to the Medical Staff;
- 2) Copy of:
 - (a) Current Illinois License information and Illinois Controlled Substance License (if applicable) *both to be verified via the Joint Commission approved IDFPR web site*;
 - (b) Current Federal Drug Enforcement Agency (DEA) license (if applicable) with home or hospital Illinois address, unless a waiver has been approved by Chief Medical Officer;
 - (c) Board Certificate (if applicable);
 - (d) Insurance Certificate (if applicable);
 - (e) Payment of Medical Staff Dues (if applicable).
- 3) Application for Clinical Privileges for each clinical service in which privileges are requested;

- 4) Three names of peer recommendation references.

2. Procedure for Approval of the Provisional Appointment

- a. Policy

- 1) Except as otherwise provided herein, the first year (twelve months) of the initial two year appointment to any class of membership of the Medical Staff is considered to be provisional. At the end of that time period, a focused Professional Practice Evaluation will be completed for all initially requested privileges to assess current clinical competence, practice behavior, and ability to continue to perform the privileges that were granted at the time of initial appointment. If privileges continue beyond the one year provisional appointment, this period is considered part of the initial two year appointment, and subject to reappointment at the completion of the two year period as per article IV, Section 7, Page 1 of 1 of the Medical Staff Bylaws. (Reference to procedure for Reappointment and Reaffirmation of Clinical Privileges).

3. Procedure for Reappointment and Renewal of Clinical Privileges

- a. Policy and Procedure

- 1) The GB or designee has final authority for granting, reviewing, renewing, or denying privileges. Each appointment to the medical staff is a two-year appointment. Data related to clinical activity is evaluated as part of the reappointment process. The practitioner should have sufficient patient contact to maintain clinical privileges. Determination of sufficient contact shall be at the discretion of the Chief of Service. Inability to demonstrate a minimal level of clinical activity may result in denial of reappointment.
- 2) Prior to the expiration of the appointment, each appointee shall complete an application for reappointment to the medical staff and an application for renewal of clinical privileges. The appointee is required to submit any reasonable evidence of current ability to perform privileges if it is requested.
- 3) The Chief of Service shall evaluate each application and make a recommendation regarding reappointment and renewal of clinical privileges.
- 4) The Chief of Service shall consider the following factors including but not limited to:
 - a) Professional ethics, clinical competence and judgment in treatment of patients, diagnosis of patients seen and procedures performed;
 - b) Current licensure;

- c) The physical and mental capacity of the applicant to treat patients;
 - d) Compliance with Medical Staff Bylaws and Rules and Regulations and hospital policies and procedures;
 - e) Attendance and participation in departmental and hospital meetings, committees, and activities;
 - f) Cooperation and relations with hospital personnel, medical staff and trainees; general attitude toward patients, the hospital and the public;
 - g) Results of quality assurance/risk management activities if available. For “0” activity the practitioner is responsible for obtaining a quality profile from the facility that is their primary place of employment if requested to do so;
 - h) Continuing medical education activities if requested;
 - i) Current or previous successful challenges to licensure or registration or voluntary/involuntary relinquishment or loss of membership and/or privileges at another hospital;
 - j) Involvement in professional liability actions;
 - k) Peer and clinical service recommendations.
- 5) As described in the Bylaws, the Chief of Service shall forward a recommendation regarding reappointment and renewal of clinical privileges to the Chief Medical Officer who will send it to the Committee on Credentials.

This recommendation will include his/her review of the quality profile generated by MSO if data is available. The quality profile is only one component of the evaluation. The evaluation and recommendation is also based on personal observation and/or peer recommendations, and of the results of monitoring and evaluation activities which may include but are not limited to surgical and other invasive procedures as applicable, outcomes, blood usage, medical records completion, clinical pertinence review, utilization review, meeting attendance, risk management, patient complaints, current licensure, relevant training and experience, current competence, professional performance within the level/scope of privileges, judgment, evaluation of health status to perform the privileges requested, and any other quality improvement activities as available including evidence-based criteria and information from other sources where the practitioner is more active.

Peer recommendations may be obtained and evaluated when insufficient practitioner-specific data are available. Peer recommendations are

obtained from a practitioner in the same professional discipline as the applicant with personal knowledge of the applicant's ability to practice and should include information on relevant training and experience, current competence, and any effects of health status on privileges being requested.

After Credentials Committee action, a recommendation will be forwarded to the Medical Staff Executive Committee (MSEC). After MSEC action, a recommendation will be forwarded to the GB for final approval. Practitioners are notified of the recredentialing decision in writing within 10 business days of the GB decision. Practitioners, upon request, will be informed of the status of their *recredentialing* application.

The practitioner has an obligation to access and read a copy of the Medical Staff Bylaws and Rules and Regulations and to abide by them and the Hospital Policies and Guidelines. The Rules and Regulations informs the practitioner of their right, upon request as stated above, to review information obtained during the initial and reappointment credentialing process that is not peer review protected or subject to other contractual or disclosure restrictions, and to be informed of the status of their application.

a) Documentation

Each application for reappointment to the Medical Staff shall include the following documentation:

- 1) Official Application for Reappointment to the Medical Staff;
- 2) Application for Renewal of Clinical Privileges for each clinical service in which clinical privileges are requested;
- 3) Copy of:
 - (a) Current Illinois License to Practice information & Controlled Substance License (both verified via IDFPR web site);
 - (b) Current Federal Drug Enforcement Agency (DEA) license, (if applicable), unless a waiver has been approved by the Chief Medical Officer;
 - (c) Board Certificate, if acquired or renewed since appointment or last reappointment (if applicable); and
 - (d) Proof of professional liability insurance coverage (if applicable).

ARTICLE III.

CONDUCT OF PATIENT CARE

This Article describes principles for the organized delivery of patient care at the University of Illinois Hospital and Clinics. The hospital and clinics provide a complete range of health services to patients. The attending physician, who is ultimately responsible for the planning and direction of patient care, shall be guided by these principles.

A. PHYSICIAN RESPONSIBILITIES

1. Attending Physician

Every patient admitted to the hospital or clinics shall have an attending physician who is known to the patient and who is responsible for the patient's care. The attending physician shall provide for the continuous care of his or her patients. The attending physician may include the resident physician in certain aspects of patient care responsibilities (See House Staff Manual). However, the attending physician must be responsible for and must monitor the quality of patient care provided by the resident house staff. Communication among all practitioners involved in a patient's care, as well as with the patient, family, and other staff as appropriate, is necessary to ensure continuity of care. This communication is evidenced by documentation in the medical record.

2. Medical Direction of the Ambulatory Services

Responsibility for the quality of patient care provided in the ambulatory services rests with the Chief of Service responsible for each clinical area. The Chief of Service may delegate certain responsibilities for medical direction to a member of the attending staff. Each patient seen in the ambulatory area shall have an identified physician directing his or her care, either an attending physician or a resident physician acting under the supervision of an attending physician.

3. Resident Physician

All patient care activity provided by the house staff is under the supervision of attending physicians. The level of responsibility of each resident is determined by the RRC Approved Program Guidelines and the program director's designation of an individual resident level of responsibility as determined by evaluations. A licensed house staff may write orders within the scope of their licensure. Responsibilities of the resident physician are described in the University of Illinois House Staff Manual.

4. Consultative Services

Requests for consultative services are the responsibility of the attending physician. The attending physician shall provide for the continuous care of his or her patients. The Medical Staff through its Bylaws and Rules and Regulations, has developed a clinical privilege delineation that applies professional criteria to each Licensed Independent Practitioner (LIP) to assure that each is fairly reviewed, has reasonable qualifications and practices within the scope of the privileges granted. When the patient requires care that is not within the scope of privileges granted to the attending physician, or the diagnosis and/or course of treatment cannot be clearly determined, a consultation may be requested to corroborate findings. The consultant should respond in a timely manner, discuss the case with the referring physician, and write a consultation note in the

patient's medical record as per policy and procedure. Confirmation of corroboration is evidenced by appropriate documentation in the medical record.

5. Communication with Referring Physicians

All referring physicians should be kept abreast of the progress of their patients. A letter shall be sent to the referring physician whenever a referred patient is discharged from the hospital. In addition, a referral letter shall be sent for patients followed in the ambulatory service whenever there are significant changes in condition or treatment plan.

6. Maintaining Current Licensure

It is the practitioner's responsibility to maintain current licensure to include not only their license to practice, but also Federal DEA and State Controlled Substance licenses as applicable, from the relevant governmental body.

The practitioner is required to notify the Chief Medical Officer immediately if his/her license to practice in any jurisdiction has ever been denied, restricted, limited, suspended, revoked, canceled and/or subject to reprimand or probation either voluntarily or involuntarily, or if application for a license has ever been withdrawn. Clinical privileges will be suspended immediately upon notification of any of the above related to license to practice.

The medical staff office must also be informed if the practitioner has been notified in writing that he/she is being investigated as the possible subject of a criminal or disciplinary action for any reason, especially with respect to their DEA or controlled substance registration.

7. Disciplinary Action

It is the practitioner's responsibility to notify the medical staff office of any disciplinary action filed against them by State or Federal regulatory agents, or of any reports to the National Practitioner Data Bank (NPDB).

B. PATIENT RIGHTS AND OBLIGATIONS

1. Patient Rights

The patient has the right to:

- a. Considerate and respectful care at all times;
- b. Knowledge of the identity of all health providers, hospital staff and visitors;
- c. Informed participation in decisions involving his or her health care, including provisions for continuity of care;
- d. Complete and current information concerning diagnosis, treatment, prognosis, risk, and alternative treatments as evidenced by documentation in the medical record;
- e. Personal, information, visual, and auditory privacy;
- f. Confidentiality of his or her medical record and health care information;
- g. Safe hospital practice, including environmental safety and freedom from disturbing behavior or habits of other patients, visitors and staff;
- h. Present complaints regarding their care, and receive a response addressing the complaint, (MCMPP #RI 1.01 addresses this procedure). To provide oversight in the process of analyzing and improving patient satisfaction, a report of patient satisfaction and complaints, including Medical Staff Review Board physician specific complaints, will be periodically included on the agenda for the MSEC and data will be presented to the MSEC.
- i. In the event of an unanticipated outcome, patients have a right to expect disclosure of the unanticipated outcome. These are defined as those that differ significantly from what was anticipated to be the result of a treatment or procedure. An unanticipated outcome may or may not include error. A known complication or side effect is not an unanticipated outcome, but information about such outcomes may also be provided out of respect for the patient.

The patient's attending physician is responsible for assuring that explanations are provided to the patient, and when appropriate, to the family, whenever an outcome differs significantly from that which was anticipated. The responsible Licensed Independent Practitioner (LIP) or his/her designee should assure that information regarding outcomes of care is available to the patient and when appropriate, the patient's family. At a minimum this includes outcomes of care that the patient (or family) must be knowledgeable about in order to participate in current and future decisions affecting the patient's care. It also includes unanticipated outcomes of care that relate to sentinel events considered reviewable by The Joint Commission.

2. Patient Obligations

The obligations of the patient include:

- a. Provision of complete and accurate history;
- b. Communication of his or her own comprehension of contemplated care;
- c. Reasonable compliance with instructions and appointments for treatment;
- d. Acceptance of the consequences of his or her action when refusing care or failing to observe instruction;
- e. Observation of hospital rules, including smoking limitations and noise control;
- f. Respect for other patients, hospital staff and property.

C. THE CONTINUITY OF PATIENT CARE

The Medical Staff shall assist with the planning and execution of patient care so that appropriate coordination of services and follow-up care occurs.

1. Ambulatory Care

A full range of health care services is provided in the Ambulatory Service Department of the hospital. The same standards for patient safety, quality of care, and monitoring of care that are found in the inpatient setting are applied in the ambulatory area. This includes integration of services between the hospital and ambulatory areas. Medical staff coverage and availability for primary care and consultative services are provided in the ambulatory care areas during routine working hours and through the emergency room after hours and on weekends.

2. Surgicenter

The Surgicenter has the facilities and staff to provide care to outpatients undergoing surgery, diagnostic procedures and post-operative recovery.

3. Emergency Room

Emergency medical evaluation and comprehensive treatment is available 24 hours a day. Upon presentation to the Emergency Room by an individual for examination or treatment for a medical condition a licensed physician will conduct a medical screening examination, including routine ancillary services to determine if an individual has an emergency medical condition. This will be done regardless of the individual's insurance status.

Emergency services are organized under the direction of a qualified member of the Medical Staff. The emergency department is staffed and equipped to handle all levels of medical and trauma emergencies. The Emergency Service Department is a participant in the community-based emergency referral plan. The Department is fully integrated with the hospital inpatient and ambulatory care areas. A medical record is maintained on every patient treated in the Emergency Service Department; this record is maintained as part of the patient's permanent medical record. At the time of discharge from the emergency room, each patient is given written discharge instructions including a plan for follow-up care.

4. Hospital Pre-Admission

Each patient scheduled for elective hospital admission is to be referred by the admitting physician to the Pre-Admission Department for scheduling of any pre-admission tests or consultations, review of the insurance coverage and anticipated financial obligation, and pre-admission certification for those patients with certain third party coverage requirements for pre-admission review.

5. Hospital Admission

Each hospital admission is planned by the admitting physician so that inpatient services may be used efficiently. Patients are not to be admitted for services that can be provided in the ambulatory setting, unless their medical condition so dictates. An Authorization for

Admission form must be completed for each admission. The admitting physician shall discuss each patient's planned admission with the inpatient attending or resident physician prior to admission to assure that continuous and coordinated care is provided.

6. Performance of the History and Physical

A patient's medical history and physical examination (H&P) are performed by a licensed independent practitioner, or which can be delegated to a "resident" physician, or another member of the medical staff such as an advanced practice nurse (APN). *(For additional information please refer to the Medical Staff Bylaws Article III Section 1 Page 1- 2).*

7. Discharge Planning and Referral for Home Health Care Service

Each hospitalized patient shall be evaluated for any continuing care needs after hospitalization. Arrangements should be made for all required services, educational materials and equipment well in advance of discharge. This includes referral to appropriate ambulatory clinics, the Visiting Nurse Association or other appropriate home health service agency. The discharge planning procedure is described in MCMPP CC 2.06, Discharge Planning and Process.

8. Hospital Transfers and Referrals to Other Inpatient Care Facilities

All transfers or referrals from the hospital to other health care facilities should be planned carefully so that there is adequate continuity of care and transfer of information. This procedure is described in MCMPP CC 3.02, Transfer of Medical Center Patients to Other Facilities.

D. DOCUMENTATION AND PROCEDURES RELATING TO PATIENT CARE

1. General Policies for Medical Record Documentation

- a. A medical record shall be maintained for every patient who is evaluated or treated as an inpatient, ambulatory care patient, or emergency patient. This record serves as a basis for documenting the patient's medical evaluation, treatment, and change in condition during the period under observation. The record may be used for other purposes such as billing, legal review, and audit by outside quality improvement and utilization management agencies.
- b. The medical record is the property of the medical center and is maintained for the benefit of the patient, the medical staff and the medical center. The medical center is responsible for safeguarding both the record and its informational content against loss, defacement, tampering, and from use by unauthorized individuals. The medical record may be removed from the medical center jurisdiction only in accordance with the court order, subpoena or statute.
- c. General policies applicable to all documentation:
 - 1) Each note, order or authenticated report shall be signed.
 - a) An authorized computer signature is considered to be a valid signature.
 - b) All practitioners who use a computer user code or computer signature to authenticate entries must sign a confidentiality agreement consistent with MCMPP IM 3.02, *Confidentiality Agreement and Security Awareness*.
 - 2) All written notes must be written in black or blue ink and be legible to persons other than the writer.
 - 3) Only approved abbreviations and symbols may be used.
 - 4) Attending and resident physicians should not comment in the record on the quality of the notes of medical students.
 - 5) Each inpatient medical record should include a note signed by the physician.
 - 6) The medical record must be sufficiently documented to reflect attending physician participation in the supervision of patient care.
 - a) Attending notes are required:
 - Within 24 hours of admission to the service
 - Within 24 hours upon transfer from another inpatient service
 - Within 24 hours of transfer to/from a separate ICU service

- When there is a significant change in patient status or plan without a change in service
- Within 24 hours of an inpatient consultation.

- 7) Any corrections or amendments to the medical record must be clearly and correctly dated and signed.

d. Release and Confidentiality of Medical Record Information

- 1) The medical record is maintained as a confidential document by all users. Written consent of the patient or his legally qualified representative is required for the release of medical information to persons not otherwise authorized to receive the information. Release of information requests should be sent to the Health Information Management Department for processing.
- 2) The medical record may be used for the following purposes without written consent:
 - a) Automated data processing of designated information;
 - b) Quality Assessment and Utilization Management activities;
 - c) Official surveys for hospital compliance with accreditation, regulatory, and licensing standards;
 - d) Educational purposes and research programs;
 - e) Departmental review of work performance.
- 3) Computer Access passwords must be kept confidential at all times and must never be shared.
- 4) Suspend screen or logoff procedures must be followed to prevent unauthorized viewing of electronic medical record information.

2. Medical Record

a. Admission Procedure

A current thorough history and physical examination should be performed and documented within 24 hours after admission or prior to the performance of surgery. For surgical patients, a history and physical can be done up to 30 days prior to surgery, provided that an update is made and documented within 24 hours of the inpatient admission. A copy must be in the medical record along with copies of diagnostic tests and preoperative diagnosis prior to surgery. Medical record data and information is analyzed in a timely manner. In emergency surgical situations a brief note including pre-operative diagnosis is recorded before surgery. A statement of the conclusions or impressions drawn from the admission history and physical examination should be documented. There should be a periodic review of the planned course of action, as appropriate. A preliminary diagnosis and treatment or diagnostic plan should be recorded.

For Pediatric and Adolescent Patients, the Following Should Be Included in the Admission Note as appropriate:

- 1) An evaluation of the patient's development including age, length or height, head circumference, weight.
- 2) Consideration of educational needs and daily activities;
- 3) Patient's immunization status;
- 4) Family's and/or guardian's expectation for involvement in the care of the patient.

b. Progress Notes

Pertinent progress notes shall be recorded at the time of observation and will be sufficiently informative to describe the patient's course, any changes in condition, and results of treatment. Progress notes shall be written at least daily on critically ill patients and where there is difficulty in the diagnosis or management of the clinical problem. All diagnostic and therapeutic procedures should be recorded in the progress notes.

c. Medical Orders

- 1) A legible handwritten signature or an authorized computer signature must immediately follow each order or set of orders. Each order written or entered into the computer must record the date and time.
- 2) Ordinarily, orders are written only by the service responsible for the patient. All orders written by a medical student must be reviewed and countersigned by a resident or attending physician responsible for the patient prior to the order being enforced.

- 3) Verbal orders and phone orders may be taken by the following health care staff:
 - a) Patient care and medication orders (with the exception of Do Not Resuscitate orders) may be taken by a registered nurse.
 - b) Respiratory therapy orders may be taken by a certified or registered respiratory therapist.
 - c) Medication orders and tests for therapeutic effect may be taken by a registered pharmacist.
 - d) Dietary orders may be taken by a registered dietitian.
 - e) Dialysis orders may be taken by a hemodialysis technologist.

Verbal orders must be countersigned by a medical staff member within the timeframes stated in MCMPP TX 5.02. All unsigned verbal orders must be signed prior to writing the discharge order. This “Discharge Co-Sign Rule” will apply to APNs as well as physicians.

- 4) Allied Health Professionals may write orders under protocols approved by Clinical Department Heads. These orders must be countersigned by a licensed physician within 48 hours. Advanced Practice Nurses may write orders under their scope of practice and privileges as defined by the collaborative agreement.
 - a) An APN may write an order to admit to a particular service and attending, not to themselves, and this order does not need to be co-signed.
 - b) An APN may write a discharge order, and this order does not need to be co-signed.
- 5) All orders are reviewed in the following situations:
 - a) At transfer into or out of an intensive care unit
 - b) At transfer from one clinical service to another
 - c) At transfer to the operating room
 - d) At transfer from the recovery room to the clinical unit

NOTE: Temporarily housing a patient of one medical specialty on the clinical unit of an unrelated specialty is not a medical transfer.

- 6) Medication orders must include:

- a) Generic or brand name of the medication (the generic equivalent from the formulary may be substituted);
 - b) Dosage in metric system, except for those medications traditionally ordered in units;
 - c) Route of administration;
 - d) Frequency of administration;
 - e) Duration of order, where appropriate.
- 7) Controlled substance orders (narcotics, stimulants, hypnotics, etc.):
- a) Must conform to above standards for medication orders;
 - b) Are valid for 72 hours only and then shall be rewritten;
 - c) Are written by a physician or dentist with a federal Drug Enforcement Agency (DEA) number or a hospital assigned number. Orders for controlled substances by physicians or dentists who do not have these numbers must be countersigned within 24 hours by a physician or dentist who has one of these numbers.
- 8) Treatment orders must include:
- a) Type of treatment;
 - b) Time interval (if administered more than one time);
 - c) Additional instructions necessary to assure patient safety.
- 9) Orders for diagnostic procedures must be signed by a physician.
- 10) Orders for restraint or seclusion:
- Refer to MCMPP #TX 1.07.
- 11) Orders for electroconvulsive or other convulsive therapy for psychiatric patients:
- Prior to initiating electroconvulsive therapy, a psychiatrist who is not involved with the care of the patient must evaluate the patient, consult with the psychiatrist responsible for the patient, and document in the medical record his or her concurrence with the decision to administer such therapy.

d. Medical Consultation Notes and Radiation Therapy Consultation Notes

Consultation notes shall evidence review of the patient's history, laboratory data, pertinent findings and examination on a case by case basis as appropriate, and the consultant's opinion and recommendations. Follow-up consultation notes should be placed in the progress notes of the record.

Radiation therapy consultation notes should include documentation of any radiotherapy treatments ordered and given.

e. Transfer Note

A transfer note shall be recorded for each patient upon transfer to another service or upon transfer into or out of an intensive care unit. This note should summarize the patient's hospitalization up to the time of transfer.

f. Discharge Note

A discharge note should be recorded at the time of discharge for each patient. It should include a final diagnosis, discussion of any complications, a statement of the patient's condition, instructions given to the patient and/or family as pertinent. Consideration is given to instructions relative to physical activity, medication, diet, and follow-up care. Completion of the electronic documentation form also fulfills this requirement.

g. Discharge Summary

A dictated discharge summary is required for all patients except uncomplicated obstetrical deliveries, normal newborn infants, and patients with problems of a minor nature who required hospitalization for less than 48 hours. A short stay written discharge summary shall be completed for these cases.

The discharge summary shall include at a minimum the reason for hospitalization, the significant findings, procedures performed, treatment rendered, complications, the principal and additional diagnoses, the condition of the patient at discharge, and follow-up instructions. The discharge summary should be dictated within 24 hours of discharge and signed promptly. Discharge summaries may be dictated by a resident or Advanced Practice Nurse, but must be co-signed by the responsible attending physician.

h. Operative Notes and Reports

- 1) A preoperative note, including a preoperative diagnosis, must be recorded prior to surgery.
- 2) For all operative or high risk invasive procedures, a post-procedure note must be documented in the medical record immediately after the procedure, and before the patient is transferred to the next level of care. This note should be documented on either an approved Medical Center form, or electronic medical record template. The immediate post-procedure note must minimally contain the following required elements-
 - 1) indication/diagnosis for the procedure,
 - 2) procedure performed,
 - 3)

practitioner(s) performing the procedure, 4) significant findings, including specimens removed (if any), 5) post-procedure diagnosis (if known), 6) unanticipated events/complications, 7) estimated blood loss.

- 3) The completion of an immediate post-procedure note does not preclude the need for a more detailed dictated or typed operative/procedure report for all procedures performed in the Main Operating Room, Surgicenter, Interventional Diagnostic areas, or Obstetrical Unit (excluding normal deliveries). The full report should be dictated by the next day following the operation/procedure, and should be incorporated into the medical record within 48 hours from the date/time of the procedure. Operative/Procedure reports must be co-signed by the responsible attending physician.

i. Anesthesia and Pre-Anesthesia Notes

A pre-anesthesia evaluation by the anesthesiologist is required to determine the capacity of the patient to undergo anesthesia and to formulate an anesthesia plan. It shall include at a minimum a record of the patient's previous drug history, prior anesthesia experiences, any potential anesthetic problems, review of the patient's physical status, pertinent information relative to the choice of anesthesia and the surgical procedure anticipated. Immediately before the induction of anesthesia, the patient needs to be reevaluated.

The Anesthesia Record should record all pertinent events that took place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs administered, type and amount of all fluids administered, including blood, techniques used, unusual events, and the status of the patient at the conclusion of anesthesia.

There should be at least one post-anesthetic visit with a timed note describing the presence or absence of any anesthesia-related complication and the management of such. In addition, documentation includes vital signs and level of consciousness, IV fluids administered including blood, drugs administered. The anesthesia attending or resident physician will document the findings of a post-anesthesia visit for all hospitalizations involving anesthesia provided in the operating room, with the exception of stays less than 48 hours.

j. Surgical Pathology Report

The pathologist is responsible for preparation of a dictated descriptive report of each gross specimen with the pathologic diagnosis based on the specimen. Authenticated and dated surgical pathology reports shall be filed on the record. Tissue specimens need to be transmitted for pathological diagnoses in their entirety. Portions of tissue may be removed after review by Pathology.

k. Radiology and Nuclear Medicine Reports

An authenticated report of each examination, with an interpretation, should be dictated and available within forty-eight hours after the examination.

l. Other Laboratory Reports

All final laboratory reports become a part of the patient's medical record.

m. Death Note

All patient expirations should have a note describing the reason for admission, hospital course, and the circumstances of the death including any cardiopulmonary resuscitation efforts, and a record of the notification of the family.

n. Autopsy (Necropsy) Report

The gross and microscopic necropsy report becomes a part of the patient's completed medical record. The provisional anatomic diagnosis should be recorded in the medical record within two days. The complete autopsy protocol should be completed and recorded within sixty days, barring any special studies as defined in MCMPP # IM 2.01.

3. Ambulatory Care Record

- a. A medical record is maintained for every patient who receives care in an ambulatory service.
- b. A summary listing of significant medical information is recorded in each patient's record. Included at a minimum is the following information:
 - 1) Current and past significant diagnoses, problems or conditions;
 - 2) Prior surgical procedures including invasive procedures;
 - 3) Immunization record;
 - 4) Known adverse and allergic reactions to drugs;
 - 5) Medications known to be prescribed for and used by the patient.
- c. The following information is documented in each patient's medical record:
 - 1) Patient Identification;
 - 2) Relevant history of illness and physical findings;
 - 3) Diagnostic and therapeutic orders;
 - 4) Clinical observations, including results of treatment;
 - 5) Reports of procedures, tests ordered and their results;
 - 6) A diagnostic impression;
 - 7) Medical Decision Making;
 - 8) Patient disposition and any instructions given to the patient and/or family for follow-up care;
 - 9) Referral information to and from outside health agencies;
 - 10) Growth charts for pediatric patients;
 - 11) An accurate and complete description of the techniques and findings of all operative procedures performed which is dictated or written immediately following surgery;
 - 12) A summary of the patient's psychosocial needs when indicated;
 - 13) Evidence of appropriate informed consent.

4. Emergency Services

- a. A medical record is maintained for every patient who receives emergency care.
- b. Each time a patient visits the Emergency Room, the following information is recorded:
 - 1) Pertinent history of the illness or injury and physical findings including vital signs;
 - 2) Emergency care provided prior to arrival;
 - 3) Diagnostic and therapeutic orders;
 - 4) Clinical observations, including results of treatment;
 - 5) A diagnostic impression;
 - 6) Patient disposition and any instructions given to the patient and/or family for follow-up care;
 - 7) A patient's leaving against medical advice.

5. Rehabilitation Unit

Documentation in the medical record will include at a minimum the following information:

- a. Referral reason;
- b. A summary of the patient's clinical condition, functional strengths and limitations, indications and contraindications for rehabilitation services and prognosis;
- c. Goals of treatment and treatment plan;
- d. Ongoing assessments as required by the patient's condition including the perception of the patient and family;
- e. Assessment of achievement and further rehabilitation on at least a monthly basis.

6. Radiation Therapy

All requests and referrals for radiation therapy must include the clinical indications. Unless otherwise justified, the medical record of each patient receiving radiation therapy reflects a histologically substantiated diagnosis.

7. Computerized Record

Valid and authenticated entries into the computerized record become part of the permanent patient medical record. The same care with handling and confidentiality should be maintained for the computerized medical record as with the written medical record.

8. Special Patient Care Documentation

a. Informed Consent

The member of the medical staff, resident or staff affiliate responsible for the patient's care obtains informed consent prior to performance of invasive procedures, operations, blood transfusion, experimental therapy, sterilization procedures and any other treatments where appropriate. Obtaining informed consent is a process; it is not merely the signing of a document. Informed consent is outlined in MCMPP TX 4.02.

b. Emergency Situations

If an emergency exists, i.e., imminent threat to life or limb, and consent cannot be obtained, the health care professional shall render appropriate emergency treatment. Subsequent documentation in the medical record shall reflect the clinical nature of the emergency and what reasonable attempts were made to contact the patient's legally-authorized representative to obtain consent.

c. Consent for Competent Adult Patients

- 1) The discussion by the member of the medical staff, resident or staff affiliate, should include at least the following points in a manner understandable to the patient:
 - i) Explanation of the procedure or the treatment and the reasons the treatment is indicated;
 - ii) Description of the expected benefits;
 - iii) Description of the possible discomforts, risks and adverse outcomes;
 - iv) Disclosure of any alternative treatments and their risks and benefits;
 - v) Description of possible outcomes if the treatment or procedure is not performed;
 - vi) Offer to answer any questions concerning the procedure or treatment;

- vii) Instructions that the patient is free to withdraw consent and to discontinue participation in the treatment or procedure at any time.
 - 2) The patient may grant consent and shall document this by signing a consent document.
 - 3) The physician should note in the patient's record the procedure followed, and information provided in informing the patient and obtaining the consent and the patient's understanding.
- d. Consent Procedure for Minors
- If a patient is a minor, his or her legally-authorized representative shall grant or withhold consent for any treatment or procedure involving that patient, except as provided by state or federal law. State and federal law allow minors to consent on their own behalf in some very specific instances and these are discussed in the Hospital Policy and Procedure on Informed Consent (MCMPP TX 4.02).
- e. Consent for Organ Donation for Transplantation
- Refer to MCMPP RI 4.06.
- f. Refusal to Authorize Examination or Treatment
- If a physician recommends a specific examination or treatment and the patient refuses such treatment, then the procedure for informed consent should be followed with the following modifications. The physician should write on the consent form that the patient refuses the recommended examination or treatment. The physician should note in the patient's medical record the circumstances of the explanation and the patient's reason for refusal. If possible, an individual who observed the physician's explanation and the patient's refusal should witness the physician's notation and the signature.
- g. Refusal to Authorize Life-Sustaining Treatment by a Competent Non-Terminally Ill Patient
- A competent patient may refuse life-sustaining treatment.
- h. Refusal to Authorize Treatment by a Terminally Ill Patient
- A terminally-ill patient who is competent may refuse treatment. The hospital policy on Do Not Resuscitate (MCMPP RI 4.03 for Adult Patients and RI 4.04 for Pediatric Patients) describes the procedure for discussing this situation with the patient and family, the appropriate medical record documentation of these discussions, and the writing of a Do Not Resuscitate order.

9. Completion of Medical Records

The medical records of discharged patients must be completed within 30 days following discharge. The Health Information Management Department prepares a delinquent and incomplete chart count which is submitted to the Chief Medical Officer twice a month and presented to the Executive Committee as scheduled. Any medical record not completed within 30 days is considered delinquent and reported as such. MCMPP IM 2.03 Timeliness of Medical Record Completion defines the actions of those individuals charged with initiating such actions should medical record deficiencies or delinquencies exist.

E. ASSESSMENT OF THE QUALITY OF PATIENT CARE

The Medical Staff participates in the hospital-wide multidisciplinary performance improvement process. National Quality Initiatives and Performance Improvement Reports are presented quarterly to the MSEC and to the GB.

Annually, the Graduate Medical Education Committee (GMEC) presents a report to both the MSEC and the GB that includes but is not limited to data and information related to the following program status and activities:

- Safety and quality of patient care
- Education and supervisory needs of residents
- Program evaluation by local participating hospitals
- Status of review of committee citations
- Service Chiefs report on their oversight of resident responsibility and progressive independence in patient care.

F. PUBLIC HEALTH RESPONSIBILITIES OF PHYSICIANS

1. Communicable Disease Reporting

The University of Illinois Hospital and Clinics complies with the laws of the State of Illinois and the Chicago Board of Health by reporting any cases of reportable diseases or conditions. Responsibility for reporting these diseases rests with the Attending Physician caring for the patient. The Hospital Infection Control Staff assist the Medical Staff by completing the required reports and maintaining records on all reportable communicable diseases. MCMPP IC 2.03, Communicable Disease Reports to the Health Departments, list diseases requiring formal reporting.

2. Vital Statistic Reporting

The University of Illinois Hospital and Clinics complies with the State of Illinois requirements for reporting the following vital statistics and completing the official reporting forms. Hospital staff will complete the demographic section of each report. The attending physician is responsible for completing the clinical portion and the certification signature. This responsibility may be delegated to a resident acting under the supervision of the attending physician.

a. Certificate of Live Birth

This official Certificate of Live Birth should be completed for each live birth at the University of Illinois Hospital.

b. Certificate of Fetal Death

The official Certificate of Fetal Death should be completed for each death at the University of Illinois Hospital and Clinics. The World Health Organization guidelines for death certificate completion should be followed.

3. Suspected Child Abuse and Neglect Reporting

The University of Illinois Hospital and Clinics complies with the Illinois Abused and Neglected Child Reporting Act that requires that hospitals and medical personnel report all suspected cases of child abuse or neglect to the Illinois Department of Children and Family Services (IDCFS). (Reference MCMPP TX 1.05, Child Abuse and Neglect). A telephone report must be made without delay at the time the child is seen and the diagnosis is suspected. The IDCFS Child Abuse Hotline number is 1-800-252-2873. An official Written Confirmation of Suspected Child Abuse/Neglect Report must be completed within forty-eight hours.

Any physician or health provider must report such suspected cases. The Medical Social Worker or the Hospital Administrator-on-Call may be contacted for assistance.

G. PHYSICIAN RESPONSIBILITIES TO PRIVATE OR GOVERNMENT HEALTH INSURANCE PROVIDERS AND UTILIZATION REVIEW AGENCIES

1. Health Maintenance Organizations

The University of Illinois Hospital and Clinics has contracted with several private Health Maintenance Organizations (HMOs) as a participating hospital. Members of the Medical Staff may elect to serve as primary care or consulting physicians with these organizations. Each attending physician who elects to participate in an HMO is expected to comply with the terms of the contract or agreement governing the provision of care.

Patients with health insurance through other HMOs may on occasion be treated at the University of Illinois Hospital and Clinics. It is the attending physician's responsibility to facilitate the communication of information to these organizations and to assist the University of Illinois Hospital with any requirements to assure appropriate reimbursement.

2. Other Health Insurance Provider Requirements

a. Medicare

This federal Medicare health insurance program requires that each hospital follow specific requirements defined by the contracting Peer Review Organization (PRO) in order to receive reimbursement for services. The attending physician is expected to comply with these requirements. This includes, among other requirements, adequate documentation in the medical record, appropriate use of hospital services, and cooperation with the PRO review and the hospital Utilization Management department.

b. Medicaid

The State of Illinois Medicaid health insurance program requires that each hospital treating Medicaid patients follow specific requirements in order to receive reimbursement for services.

c. Private Health Insurance Providers

Private health insurance providers are developing increasingly complicated review requirements for the hospital and physicians providing services to their subscribers. The attending physician is expected to comply with these review requirements, e.g., providing adequate pre-admission and hospital medical record documentation, transmitting required information.

3. Private Utilization Review Agencies

Certain private health insurance providers and self-insured groups have employed the services of private utilization review agencies to review the services received and costs incurred by their subscribers. The hospital Utilization Management Department assists the hospital with these external reviews in order to protect the interests of the Medical Staff and patients and to assure appropriate reimbursement to the hospital and physicians. The attending physician is expected to assist with this process.

H. PROFESSIONAL LIABILITY ISSUES

The University of Illinois maintains a self-insurance program that provides professional liability coverage to physicians practicing in its patient care areas. Physicians with medical practice outside of the University Hospital or its satellites should obtain their own private professional liability insurance coverage for those practices.

The Hospital has a Safety and Risk Management Office and the University Claims Management Office which both should be advised of any serious patient complaint or occurrence that may lead to a malpractice complaint.

All members of the Medical Staff are required to report in writing to both the Chief Medical Officer and the Chief of Service, any involvement in a professional liability action involving practice at the University of Illinois Hospital or other hospital at which the members is affiliated. At a minimum all final judgments or settlements are to be reported.

Any physician receiving a subpoena or court summons is expected to fulfill any legal obligation to respond or appear. Any physician who knows of or has received notice of a potential professional liability claim related to practice at the University of Illinois Hospital and Clinics is expected to notify the Office of Legal Counsel in writing within forty-eight hours.