MEDICAL STAFF

RULES AND REGULATIONS

PART A. CLINICAL

I. ADMISSION AND DISCHARGE OF PATIENTS

A. A patient's general medical condition is managed and coordinated by a physician (MD or DO) credentialed and privileged by the CVMC medical staff.

B. An inpatient may be admitted and attended only by a physician (MD or DO) credentialed and privileged by the CVMC medical staff. A patient who is placed in the clinical observation unit (outpatient) may be attended to by a privileged Allied Health Professional (NP or PA). ***Revised by MEC 06/14/16; BoT 06/27/16**

C. A provisional diagnosis is provided by the attending physician prior to the patient's admission, except in cases of emergency, in which case the diagnosis is given as soon as possible after admission. The AHP will provide a provisional diagnosis for patients placed in the clinical observation unit. ***Revised by MEC 06/14/16; BoT 06/27/16**

D. Admissions to and discharge from intensive care units, and to other special care areas, shall be in conformity with the specific policies developed for each unit.

E. The attending physicians' responsibilities include:

1. Management of the patient to include at a minimum a physician visit to evaluate the patient's progress daily while the patient is in a critical care unit (ICU or special care nursery), at least 3 days per week for the Inpatient Rehabilitation Facility and every other day for other units, unless otherwise required by federal or state law. ***Revised by MEC 06/09/15; BoT 06/22/15**

2. Prompt completion and accuracy of the patient's medical record;

3. Instructions to hospital personnel regarding the patient's care;

4. Providing reports of the condition of the patient for the patient's relatives and (if applicable) the referring practitioner; and

5. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility shall be entered on the order sheet of the patients' medical record.

F. The licensed independent practitioner (MD, DO, oral surgeon, dentist, or podiatrist) responsible for management of the patient is also responsible for providing information necessary to assure the protection of other patients and the hospital staff *(example: reporting communicable diseases)*, and to provide such information as may be necessary to assure the protection of the patient from harm to self or others. Revised 4/26/10

G. Each licensed independent practitioner (LIP {MD, DO, oral surgeon, dentist or podiatrist}) credentialed by the medical staff provides the name(s) of other LIP (MD, DO, oral surgeon, dentist, or podiatrist) members of the medical staff to be called in the attending physician's absence. For any physician in a group practice,

it will be assumed a physician associate who is also a member of the medical staff shall assume responsibility for his or her patients unless otherwise stated. Revised 4/26/10

H. Members of the medical staff cooperate with the utilization review function by being sure that the patient's medical record includes at least:

1. Reason for admission (*what is to be done for the patient as an inpatient that cannot be done as an outpatient?)*

2. Plans for post-hospital care, including early referral to discharge planning, when applicable

3. Written reasons for continued hospitalization beyond specific periods of stay identified as "review points" in the utilization review function.

I. Histories and physical examinations are required prior to any surgical or invasive procedure or within 24 hours of inpatient admission. Histories and physical examinations completed 30 days or less before an inpatient admission or any surgical or invasive procedure may be accepted from a physician licensed to practice in North Carolina who is not a member of the CVMC medical staff. However, updates to the history and physical examination required prior to any surgical or invasive procedure or within 24 hours of inpatient admission may only be performed by a privileged practitioner. Specific requirements for H&P content by level of service may be found in the History and Physical Documentation Requirements contained in Appendix 3 of the Medical Staff Bylaws. ***Revised by MEC 06/14/16; BoT 06/27/16**

1. Histories and physical examinations may be performed and documented by a dentist or a podiatrist for outpatient surgical procedures.

2. In the event the patient requires placement in observation or admission as an inpatient, a history and physical must be performed and documented by the provider responsible for the management of the patient's health status while receiving care. ***Revised by MEC 06/14/16; BoT 06/27/16**

J. Patients are discharged only on order of the licensed independent practitioner (MD, DO, oral surgeon, dentist, or podiatrist) or by an Allied Health Professional under the supervision of the physician responsible for the patient's care, unless the patient leaves the hospital against medical advice, in which case the Leaving Against Medical Advice form is to be completed. Revised 4/26/10

K. Patient transfers to and from other hospitals shall be in accordance with Administrative Policy CC-3.

L. If death occurs, the deceased patient is pronounced dead by the licensed independent practitioner (MD, DO, oral surgeon, dentist, or podiatrist) responsible for the patient's care or by an Allied Health Professional under the

supervision of the attending physician within a reasonable time. (See Administrative Policy PC-22). Revised 4/26/10

Release of deceased patients will be in accordance with legal requirements of the state.

It is the duty of members of the Medical Staff to secure meaningful autopsies whenever possible. The following represent circumstances in which an autopsy should be considered.

1. No diagnosis before death
2. Post-op death (within 10 days of surgery)
3. Unanticipated death
4. Death incident to pregnancy
5. Death after transfusion (if clinical indications for transfusion reaction were present)
6. Death brought on by a disease that is medically unusual
7. Death in the presence of a perplexing clinical problem
8. Death due to a genetic disease, for the purpose of genetic counseling

M. The County Medical Examiner shall be notified of any death that is defined by state law to be a reportable death. The attending physician is responsible for reporting to the hospital administration all deaths that might fall under the purview of the Medical Examiner, prior to seeking autopsy permission from the deceased patient's next of kin. The following types of deaths in North Carolina are to be reported to the Medical Examiner:

1. Homicide
2. Suicide
3. Accident
4. Trauma
5. Disaster
6. Violence
7. Unknown, unnatural or suspicious circumstances
8. Poisoning or suspicion of poisoning
9. Public health hazard *(such as acute contagious disease or epidemic)*
10. Death in any infant, child or young adult without significant medical history
11. Deaths during surgical or anesthetic procedure

12. Sudden unexpected deaths that are not reasonably related to known previous disease
13. Deaths without medical attention
14. Deaths of a prisoner while in custody (all causes of death)
15. Deaths of paraplegics, quadraplegics if neural deficit was due to an accident, traumatic wound or incident, or an act of war.

If an autopsy is deemed necessary, it is performed according to N.C. statute and does not require any prior family consent. Autopsies are performed at the discretion of the Medical Examiner and not all cases deemed to be "ME" cases are autopsied. If the Medical Examiner declines autopsy, then permission must be obtained from the legal next of kin if a medical autopsy is ordered. (See Administrative Policy PC-17):

II. ORDERS AND PRESCRIPTIONS

A. Requirements

1. All orders for medical treatment, drugs, and biologicals must be received from a practitioner credentialed by the CVMC Medical Staff and shall be in writing, signed, dated, and timed. Orders for diagnostic testing or rehabilitation services must be received from a practitioner licensed in the state of North Carolina. (See Administrative Policy PC-48).

2. Preprinted Order Sets
When preprinted order sets are used, each page of a preprinted order set must be signed or initialed at the bottom of the page. Each page of an approved preprinted order set will be numbered with the last page noting the total number of pages included in the set. Each place in the preprinted order set where changes, such as additions, deletions or strike-outs of components that do not apply have been made must be initialed. The last page of the order set must be signed (no initials), dated and timed. ****Added: Board of Trustees 9/27/10***

3. Orders that are illegible, improperly written, are unclear, or contain prohibited abbreviations will not be carried out by the staff until clarified and rewritten. Orders for medications or treatments involving medications will not be accepted without a valid signature by the credentialed practitioner. The use of signature stamps or copies of original signatures are not acceptable for these orders.

4. Documentation submitted with orders for outpatient services should be sufficient to provide evidence of medical necessity for diagnostic or therapeutic services or for routine screening pursuant to Title XVIII of the Social Security Act and all related rules and regulations which govern Medicare payments for services deemed medically necessary and reasonable. Orders for outpatient services are good for a period of one year from the date ordered. If the care is to be continued, the provider must rewrite the order every 365 days.

B. Drugs and medications to be administered to patients shall be those listed in the hospital formulary. Non-formulary selection or substitution will be implemented at the discretion of the pharmacist.

C. Drugs for bona fide clinical investigations may be exceptions to Section B, above. These shall be used in full accordance with the statement of principles involved in the use of investigational drugs in hospitals and all regulations of the Federal Drug Administration. See Administrative Policy RI-8.

D. Medication Renewal:

Medications not specifically prescribed as to time (for example, "24 hours") or number of doses (for example, "times 3 doses") must be reviewed by the prescriber for renewal or discontinuation no more than 14 days after initially prescribed or renewed. * **Revised by MEC 09/08/15 Approved Board of Trustees 09/28/15**

E. When a patient goes to surgery, delivers, or is transferred to another inpatient unit (exclusive of inpatient rehabilitation and psychiatry), previous orders are not canceled unless the physician writes, "Cancel previous orders." New orders written post-operatively, post delivery or following an internal transfer will be added to any previously written orders.

F. A verbal order or telephone order is appropriate, if:

1. It is dictated to an authorized professional functioning within his/her scope of practice.

2. It is signed, dated and timed by the responsible practitioner or a member of the practitioner's medical practice group no later than 30 days after the patient's discharge date. Practitioners who are not a member of a medical practice group may sign for another practitioner for whom coverage is being provided as long as all parties have signed a statement of agreement that is on file in the Health Information Management Department. **Revised by MEC on03/12/13; Approved by BoT on 03/25/13.**

3. Verbal communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible.

4. When a verbal order is given authorizing the application of restraints or seclusion for behavioral health reasons, the verbal order must be signed within one hour. When a verbal order is given authorizing the application of restraints to directly promote medical healing, the order must be signed with 24 hours. If the verbal orders are given by a physician other than the physician responsible for the management and care of the patient, that physician must be notified as soon as possible. (See Administrative Policy PC-14).

5. Staff receiving verbal or telephone orders are required to write down the complete order and then read it back to the ordering practitioner to eliminate the possibility of miscommunication.

6. Physicians receiving critical test values or results verbally or by telephone are also expected to read back the results to assure accurate and complete communication.

G. Respiratory Care Orders:

Respiratory services are provided on the orders of a doctor of medicine or osteopathy, oral surgeon, dentist, podiatrist or an allied health provider who is practicing within their scope of practice. **Revised by MEC on 9/11/12; Approved by BoT on 9/24/12.**

H. Clinical practice guidelines must be approved by the Board of Trustees upon recommendation of the Medical Executive Committee prior to implementation. Examples of approved clinical practice guidelines include clinical protocols, clinical practice guidelines, and outcome management plans. Upon authentication by the ordering practitioner of the clinical practice guideline, documentation of individual orders carried out as part of the clinical practice guideline do not require subsequent authentication.

III. THE PATIENT'S MEDICAL RECORD

A. The patient's medical record, like the patient, is the overall responsibility of the attending licensed independent practitioner (MD, DO, oral surgeon, dentist, or podiatrist).

B. All members of the Medical Staff and other practitioners credentialed by the Medical Staff are responsible for safeguarding patient confidentiality. Prior to using Catawba Valley Medical Center computer systems, each practitioner credentialed by the Medical Staff will have on file a Signature Identification and Verification and a Confidentiality Agreement For Use of Information and Electronic Signatures.

C. GENERAL DOCUMENTATION GUIDELINES

1. Documentation in the medical record should be specific, objective, and complete regarding services rendered, observations, and the patient's response to services/treatment clearly, concisely, and objectively documented.

2. All notations shall be recorded legibly in black ink. Pencils, light or colored inks or felt-tip pens should not be used.

3. Legibility is essential. Credentialed practitioners who have difficulty writing legibly should print all entries. Given the critical importance of legibility, consistent issues in this regard will be referred to the department chairman for assessment and follow-up. Intervention may include, but not

be limited to, referral to the appropriate Medical Staff Committee or department. Revised 4/26/10

4. All entries in the medical record should be dated, timed and signed/authenticated as outlined in the Medical Record Documentation Requirements attached to this document. Initials should only be used when the complete signature of the individual recording by way of initials is clearly documented within the record with a cross-reference to the recorded initials. Electronic signatures via ChartMaxx are password protected and each practitioner credentialed by the Medical Staff signs a statement agreeing to comply with policies related to privacy and security of patient information. Revised 4/26/10

5. Final diagnoses and procedures should be recorded in full, without abbreviations or symbols. Abbreviations should be avoided when recording medications on physician orders and should not be used in the record if included on the organization's list of prohibited abbreviations. (See Administrative Policy IM-25)

6. Personal criticisms or any statements that would unnecessarily incriminate another staff member or employee of Catawba Valley Medical Center should not be recorded in the patients' medical record. Statements which indicate a bias against the patient should not be recorded in the medical record.

7. Terms such as "negative" and "normal" should not be overused. Use measurable terms and clearly describe findings.

8. Blank lines should not be left between entries for subsequent recording of data.

9. The attending licensed independent practitioner (MD, DO, oral surgeon, dentist, or podiatrist) is responsible for recording the principal diagnosis and procedure for each admission. The definition of principal diagnosis is, "the diagnosis established after study to be chiefly responsible for occasioning the admission to the hospital." The attending licensed independent practitioner is also ultimately responsible for documenting co-morbidities and complications that co-exist at the time of admission, or develop subsequently, and which have an effect on the treatment received or the length of stay. Revised 4/26/10

10. The discharging practitioner is responsible for recording the condition of the patient on discharge in specific, measurable terms avoiding the use of vague terminology such as "improved." Written instruction and related education provided to the patient or significant others at discharge should be documented in the medical record.

    a. An MD or DO responsible for the patient during the patient stay must co-sign the Discharge Summary to verify its content.

11. See the Medical Record Documentation Requirements grid, Appendix 1, for specific requirements by patient type.

12. Substantive changes to medical records forms may be made only with the approval of the Medical Executive Committee.

D. RESIDENTS AND ALLIED HEALTH PROFESSIONALS

1. All patients being admitted as an inpatient or undergoing an outpatient surgical procedure must have the name of a designated Catawba Valley Medical Center medical staff member entered on the medical record as the attending physician. Patients placed in the Clinical Observation Unit will be cared for, following approved protocols, by a privileged AHP.

2. Residents and/or nurse practitioners should indicate who the designated Catawba Valley Medical Center medical staff member is at the time of dictation. Co-signatures by the designated Catawba Valley Medical Center medical staff member are required on the following:

Nurse Practitioner (1st 6 Months)	Resident
History and Physical	History and Physical
Orders	Discharge Summary
Progress Notes	Consultation Note
	Operative Reports

The resident, physician assistant, nurse midwife, CRNA, or nurse practitioner may write patient care Orders and Progress Notes. These Orders and Progress Notes need not be co-signed by the attending physician.

3. The resident, physician assistant, nurse midwife, CRNA, or nurse practitioner is notified of incomplete medical records just as are members of the Catawba Valley Medical Center medical staff.

4. Any record remaining incomplete after the departure of a resident will be forwarded to the Resident Liaison Physician for appropriate action.

5. Final responsibility for any record remaining incomplete after the departure of a physician assistant, nurse midwife, CRNA or nurse practitioner will fall to the supervising physician of record.

E. LATE ENTRIES, AMENDMENTS AND/OR CORRECTIONS

Documentation in the patient's medical record should occur at or near the time of the events being recorded. All entries in the record should be permanent. A modification to medical record documentation is discouraged and should only be done after consultation with the Director of Health Information Services.

1. CORRECTIONS:

   a. A single line should be drawn through the incorrect entry with "error" printed beside it and the signature of the individual correcting the information and the date along with the reason for change.

   b. Erasures, correction fluid, or obliteration of documentation are unacceptable.

   c. Rebuttals – care providers should not correct entries recorded by other clinicians. If an incorrect entry is identified, the individual who recorded the information should make the amendment. If clarifying documentation is required, a new entry should be made which objectively documents clarifying facts.

   d. Corrections >72 Hours from the recorded events – consultation should be made with the Director of Health Information Services and the Director of Risk Management before making any amendments or corrections.

F. COMPLETION OF MEDICAL RECORDS

1. Medical records will be available via the organization's electronic medical record system, after discharge and must be completed by the practitioner within fifteen (15) days after discharge or the record will be considered delinquent. Revised by MEC 09/08/15 Approved Board of Trustees 09/28/15

2. Every Tuesday, incomplete medical records are counted. Practitioners are notified by fax of all medical records that are at least fifteen (15) days old.

3. If any record remains incomplete the next Tuesday by 21 days or more after discharge, the practitioner's admitting privileges and ability to post surgical/invasive procedure cases is suspended by the Director of Health Information Services or his/her designee. Revised by MEC 09/08/15 Approved Board of Trustees 09/28/15. If the suspended physician has a previously posted outpatient surgical case, it may be performed to ensure the patient is not inconvenienced. Should this previously posted outpatient surgical patient then require emergency admission, the suspended physician may admit that patient on an emergent basis. All registration areas, the Emergency Department, Catawba Valley Medical Center Administration, the Chief of Staff, the Medical Staff Coordinator, the appropriate Department Chairman and the administrators/ directors of the Surgical Suite, Cardiac Cath Lab, and other practice sites, as appropriate, will be notified of suspensions. Revised 4/26/10

4. The practitioner shall remain suspended until the delinquent records are completed. During this time, the practitioner may attend patients already in-house and/or posted for inpatient or outpatient surgical/invasive procedure services. No previously scheduled case may be rescheduled.

Upon completion of the delinquent medical records, the practitioner shall receive a Reinstatement Notice. This notice is also sent to all recipients of the suspension notice. Revised 4/26/10

5. Should the practitioner fail to respond within a ten (10) day period, all patient care activity shall be suspended and the practitioner referred to the Medical Executive Committee for action.

6. Any practitioner who is suspended three (3) times in one calendar year is referred to the Medical Executive Committee and reported to the North Carolina Medical Board.

7. The delinquency rate will be reported quarterly to the Medical Staff and this information will be available at the time of each practitioner's renewal of privileges.

G. SECURITY OF THE MEDICAL RECORD

1. Written consent of the patient or his legal representative is required for release of medical information to persons not otherwise authorized to receive this information.

2. Medical records (either paper or digital) may be removed from the hospital only in accordance with a court order, subpoena or statute. Unauthorized removal of patient records from the hospital by a practitioner is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee. Revised 4/26/10

3. Access to patient medical records shall be afforded to members of the Medical Staff for bona fide study and research consistent with Administrative Policy IM-1. The Medical Executive Committee shall approve all such projects before records may be studied. Subject to the discretion of the Director of Health Information Services, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the hospital.

4. Medical record reports are not to be dictated on cellular telephones due to the risk of patient confidentiality being breached by the high probability of eavesdropping on cell phones as well as the frequent degradation of the signal.

H. SPECIFIC DOCUMENTATION REQUIREMENTS

A more detailed explanation of documentation requirements is provided in the table below. Requirements are divided by Inpatient, Day Surgery, Non-operative Invasive Procedures, Observation, Outpatient, Emergency Department, Hospice, Obstetrical and Newborn patient classifications. (See Appendix 1).

IV. CONSULTATIONS

A. Consultations are required in the following situations:

1. In instances where the patient has attempted suicide or exhibits ongoing suicidal ideations and is not attended by a psychiatrist.

2. In instances where the patient requires acute dialysis and is not attended by a nephrologist.

3. In instances where the patient has remained on a ventilator for greater than 72 hours and is not attended by a pulmonary specialist.

4. When the patient or family requests a consultation

B. Consultants are expected to respond in a timely fashion, generally within 24 hours unless deemed an emergency by the requesting physician.

C. The physician assigned emergency call coverage for his/her specialty is required to respond to any consult requests to the satisfaction of the requesting physician.

D. In the event that the Emergency Department physician and the specialist on-call do not agree on the need for an emergency consult in the ED, the opinion of the Emergency Department physician will be determinative. See Article VII.C for required response time.

V. SEQUENCE OF RESPONSIBILITY or CHAIN OF COMMAND (See also Administrative Policy A-23) Revised 4/26/10

A. In the event of a change in the patient's status and the nurse is unable to locate either the patient's physician or the physician on call, assistance sought from the following, in the stated order:

- The physician's associates
- Chief of the Medical Department involved
- Vice-Chief of the Medical Department involved
- Chief of Staff
- Vice-Chief of Staff
- Secretary of the Medical Staff

B. In the event a physician's order is questioned; the registered nurse or clinical department member will attempt to clarify with the physician who wrote the order. If the employee still has doubt about the order, they may seek assistance from other members of the Medical Staff in the following order after informing the ordering physicians that the Chief of the Department will be contacted to discuss the order:

- Physician's associates or physician on-call for the ordering physician
- Chief of the Medical Staff Department involved
- Vice-Chief of the Medical Staff Department involved

- Chief of Staff
- Vice-Chief of Staff
- Secretary of the Medical Staff

C. For problems relating to specific committee functions, e.g. infection control, utilization review, and critical care, the committee chairman will be notified. In his absence a medical staff member of the committee or Chief of Staff will be called.

D. For problems that may disrupt the operation of the hospital, the Administrator on Duty or VP on-call should be notified. Assistance will be sought from the following, in order:

- Chief of Staff
- Vice-Chief of Staff
- Secretary of the Medical Staff

VI. GENERAL RULES REGARDING SURGICAL CARE

A. PURPOSE: Utilization of the Surgical Suite at CVMC for operative and invasive procedures is a high priority for surgeons and the hospital alike. Utilization of the block schedule has been designed with the following goals in mind:

- Provide surgeons with the appropriate amount of block time, as well as optimal access to that block in order to accommodate typical surgical volume.
- Maximize schedule flexibility to allow for add-on, urgent, and emergent cases.
- Maximize O.R. utilization
- Provide surgeons with appropriate block release time to meet specific practice demands.

Added by MEC on 9/13/11; Approved by BoT on 9/26/11.

B. DEFINITIONS:

1. **Block Time**: The time on the Surgical Suite schedule between 7:30 and 15:00 (Monday-Friday) designated for specific surgeons, groups of surgeons, or services to schedule procedures.
   - Individual block: a block of time designated for one surgeon.
   - Group Block: a block of time designated for all surgeons within a particular group or practice.
   - Service Block: a block of time designated for all surgeons within a particular service.
2. **Block Utilization**: Block utilization is calculated based on actual "in room" minutes plus average service specific turnover time, divided by the block time designated.

$$\text{Block Utilization} = \frac{\text{Total "In Room" Minutes Used + Average Service-Specific Turnover Time}}{\text{Total Block Time Designated}}$$

Note: Total "In Room" Minutes Used is calculated from "Wheels In to Wheels Out"

3. **Start Time**: The hospital recognizes and tracks two start times:

- "Wheels In" Time: The time the patient is wheeled into the procedure room.
- "Cut" Time: The time the surgeon begins the procedure (makes an incision, inserts an endoscope or begins an exam)

4. **Posted Time**: The posted time listed on the Surgical Suite Schedule will be the "Wheels In" time.
5. **Emergency/Emergent**: a medical condition requiring immediate surgery to prevent loss of life, limb, sight, hearing, organ or vital body function.
6. **Urgent**: a medical condition requiring surgical treatment within a limited amount of time to avoid probable increased risk of loss of life, limb, sight, hearing, organ, vital body function, morbid infection, or permanent disability.
7. **Administratively Urgent**: In-house patient needing surgery to avoid extended length of stay (LOS). (Example: Post-Partum Tubal Ligation, Wound Vac Change, I & D)
8. **Elective/Non-Urgent**: procedures in which delays will not result in further deterioration in the patient's condition.
   Added by MEC on 9/13/11; Approved by BoT on 9/26/11.

C. Scheduling Surgical and Endoscopy Procedures:

1. LIPs (MD, DO, oral surgeon, dentist or podiatrist) having privileges to perform surgical or invasive procedures may schedule procedures in the Surgical Suite (Operating Rooms and Endoscopy Procedures Rooms).
2. The LIP (MD, DO, oral surgeon, dentist or podiatrist) performing the procedure must have been approved (been officially privileged) to perform a specific procedure before requesting the case to be added to the schedule.
3. Procedures are scheduled based on the block schedule. Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.
4. Staffing is based on the number of cases scheduled each day and is specific for each case's complexity and the needs of the patient. Each room is staffed with a minimum of one registered nurse.
5. Normal operating hours for elective procedures performed in the Surgical Suite are Monday – Friday from 07:30 – 15:00 for thirteen (13) procedure rooms.
6. After 15:00, the following rooms may be utilized:

Time	Number of Rooms	Designation
15:00 – 17:00	2	Elective
	1	Urgent
	1	Emergency
17:00 – 19:00	1	Elective
	1	Urgent
	1	Emergency
19:00 – 07:30	1	Urgent
	1	Emergency

7. For Weekends, the following rooms may be utilized:

Time	Number of Rooms	Designation
07:30 – 15:00	1	Elective
	1	Urgent
	1	Emergency
15:00 – 07:30	1	Urgent
	1	Emergency

8. For Holidays, the following rooms may be utilized:

Time	Number of Rooms	Designation
07:30 – 07:30	1	Emergency
	1	Urgent

9. The hospital observes the following holidays: New Year's Day, Easter Friday, Independence Day, Labor Day, Thanksgiving, and Christmas Day.

10. One room of urgent, in-house inpatient/observation patient cases (including post-partum tubal ligations) may be scheduled on the above mentioned holidays.

11. The patient must already be "in-house" – not scheduled to come in through the ED or Day Surgery for a planned procedure. Added by MEC on 9/13/11; Approved by BoT on 9/26/11.

12. These urgent cases may not be scheduled until after 17:00 the day before the holiday.

13. Holidays that fall on Saturday will normally be observed on Friday and Saturday. Holidays that fall on Sunday will normally be observed on Sunday and Monday.

14. In the event the hospital is experiencing a utility failure, only emergency cases will be performed.

15. Start time is the time the patient is taken into the procedure room or "wheels in" time – not the incision or "cut" time. Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.

16. When a case is schedule, a start time or wheels in time is estimated. Revised by MEC on 9/13/11; Approved BoT on 9/26/11.

D. Block Scheduling Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.

The Surgical Services Joint Governance Council functions to provide equitable distribution of priority time in the Surgical Suite. The Committee will serve as forum for the review and analysis of utilization issues, and to provide a formal mechanism for the appropriate allocation of time to each surgical section. See the

Surgical Services Joint Governance Council Rules and Regulations for additional information.

1. The only guaranteed start times are 07:00, 0715 and 07:30 (*the time the patient is taken into the procedure room (Wheels In), not the incision time (Cut Time)).* Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.

2. Time requests will be honored, if possible, recognizing that schedule times are approximate.

3. Scheduling will be done on a Priority/Block Scheduling basis until 12:00 the day before. Cut-off time for the Monday schedule is 16:00 on Friday.

4. Cases that require equipment that may be limited (i.e. laser) will be scheduled on a first come, first served basis.

5. Emergency cases (including non-elective C-sections) take precedence over elective and urgent cases, and will be performed in the first available room. The physician must document on a pre-printed form in the medical record that the case is an emergency, stating the threat to life, limb or body organ and/or any other evidence that the case is a medical emergency. The form may be reviewed by the Department for appropriateness.

6. Physicians cannot schedule two 07:30 cases on the same day, nor can they schedule a 07:00 and a 07:30 case on the same day.

7. Physicians in the Active and Associate categories only may utilize block time. The Surgical Services Joint Governance Council is responsible for notifying new members of their assigned days. Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.

8. When a room is being used by two physicians, one in the a.m. and one the p.m., the a.m. physician's schedule must permit him to be finished in time for the p.m. physician to start his case at 12:30.

9. Decisions concerning scheduling shall be at the discretion of the Scheduling Coordinator, under the supervision of the Surgical Services Administrator and shall be final.

10. Pediatric patients (age up to 5 years) should have priority over adult surgery for the early a.m. schedule times. The surgeon desiring to replace an adult case shall call the surgeon involved and gain permission to exchange scheduled times.

11. Specific policies regarding block allocation, reuests for changes in block time, and block release are located in the Administrative Policy PC-106 – Surgical Suite Scheduling & Block Utilization Policy. Added by MEC on 9/13/11; BoT on 9/26/11.

E. Loss of Priority

1. Physicians should be on the premises of CVMC prior to the patient entering the operating room and the induction of anesthesia.

2. Surgical Suite staff will monitor compliance with posted start times for the first case of the day by physician.

3. Any physician with two or more start times in excess of fifteen minutes beyond the case's posted start time occurring within any given month will be referred to the appropriate medical staff department for disciplinary action.

4. Disciplinary action for physicians with more than two first case delays of 15 minutes or greater after the posted start time in any one-month period will lose the privilege of scheduling in block time for a period of one month from the date of notification. Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.

F. Emergency/Urgent Surgery

1. Emergency is defined as a medical condition requiring immediate surgery to prevent loss of life, limb, sight, hearing, organ or vital body function.

2. An urgent case is defined as a medical condition requiring surgical treatment within a limited amount of time to avoid probable increased risk of loss of life, limb, sight, hearing, organ, vital body function, morbid infection, or permanent disability.

3. Elective cases are defined as those procedures in which delays will not result in further deterioration in the patient's condition.

4. Emergency cases will take precedence over elective cases.

5. During normal working hours, the surgeon will notify the Scheduling Coordinator, or designee, of the emergency and the urgency necessary in procedure performance. The procedure will be performed in the first available room.

6. After normal working hours, the surgeon may have the OR staff paged or call the Administrator on Duty to schedule the case and notify the call team that the case can be carried out as soon as the patient is properly prepped.

7. The following steps will be used to determine the order in which cases should be bumped for an emergency:
   a. First available room to come open
   b. When multiple rooms are open and available at the same time
      (i) A partner's case
      (ii) A case in the same section

8. A surgeon requesting an add-on emergency or urgent case (that would cause the delay of another surgeon's posted emergency, urgent, or elective case) must call the surgeon who would be delayed for approval to proceed. If the two surgeons are unable to reach an agreement, the Chief of Surgery/Chief of OB/GYN (or the appropriate Vice Chief or the Medical Staff Chain of Command, as appropriate) will be contacted to resolve the conflict.

9. The emergency team may be utilized for urgent and elective cases as long as anesthesia personnel, one RN, and one surgical tech are available for emergency procedures. Revised by MEC on 9/13/11; Approved by BoT on 9/26/11.

G. Information Required to Schedule a Procedure

At the given time of scheduling a procedure, the following information must be given:

1. Name of the patient
2. Type of procedure
3. Type of anesthesia
4. Name of operating surgeon
5. Birth date of patient
6. Length of time anticipated to complete the procedure
7. Patient location: Inpatient, Inpatient AM Admit, Day Surgery
8. 3rd party payer prior approval number, when available
9. Date and approximate time requested
10. Special equipment, instruments, procedures, and/or staff needed

H. Cancellation of Scheduled Procedure

Cancellation shall be communicated as soon as possible to the OR staff, or Administrator on Duty when the OR staff are unavailable. The Scheduling Coordinator will arrange the cases following in such a way as to most efficiently utilize the staff and rooms. The vacated space should first be offered to the physicians following that case, in that room.

I. Consent for Operation

1. The physician/surgeon must document the informed consent of the patient prior to the operative procedure. Once obtained, this must be written, signed and placed in the medical record prior to beginning the procedure. In emergency situations, where the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient (*e.g. unconscious)*, the circumstances shall be documented in the record and the physician may then proceed. Should the emergency involve a minor and consent cannot be immediately obtained from the parents, guardian or next of kin, the circumstances shall be fully explained in the medical record. If

time permits, a consultation in such instances may be desirable before the emergency procedure is undertaken.

2. The consent must be witnessed by someone other than the operating surgeon.

3 If written consent cannot be obtained, a witnessed telephone consent is acceptable. In the event a verbal or telephone consent is obtained, two individuals must witness the consent, one of which may be the operating surgeon.

4. Before any procedure is performed which may render a patient sterile, a signed form must be obtained, except in an emergent situation where consent cannot be obtained, in which case, the circumstances must be documented in the medical record. *(Reference: NC G.S.90-271 and 90-272).*

5. Should more than one operation be required during the patient's stay in the hospital, each additional procedure requires a specific consent before it is undertaken.

6. If two or more specific procedures are to be carried out at the same time by the same surgeon, and this is known in advance, all procedures may be described on the same form. If different physicians are performing two or more different procedures, separate forms are to be completed, fully describing each procedure.

J. Requirements Prior to Induction of Anesthesia

1. Proper identification of the patient shall be made prior to induction of anesthesia.

2. Consent for anesthesia must be obtained by the anesthesia provider prior to the induction of anesthesia and documented in the medical record.

3. Except in emergencies, the pre-operative diagnosis, a complete history and physical examination, and any indicated or required laboratory or other diagnostic tests must be recorded on the patient's medical record prior to any surgical or invasive procedure. If not recorded, no pre-op medications shall be given, and the procedure shall be delayed until the medical record is complete and all abnormal findings are addressed. Histories and physicals performed within thirty (days) of the surgical/invasive procedure must be updated if the History and Physical is older than 24 hours, even if there is no change in the patient condition. Laboratory work-ups must have been performed within a reasonable amount of time prior to surgery, based on the opinion of the anesthesiologist. In an emergency, the physician shall make at least a note including a tentative diagnosis and pertinent findings on the progress sheet prior to induction of anesthesia and start of surgery.

4. Lab work and EKGs done outside the hospital will be accepted if a copy of the tracing and report are submitted.

5. General and spinal anesthesia may be induced upon notification by the surgeon via phone of his imminent availability, unless a specific request to the contrary is received from the patient. Induction, positioning, prepping, and draping will then commence. The surgeon will be expected to begin surgery immediately following the aforementioned preparations. Should a delay in the start of surgery result due to the surgeon's lack of readiness or availability, this will be documented and future acceptance of such notification will not be accepted. Other forms of regional anesthesia shall be initiated at the discretion of the Anesthesia Department.

F. Anesthesia Record:

The anesthetist and anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, choice of anesthesia (general, regional, spinal, or local), and post-anesthetic follow-up of the patient's pre-induction assessment.

L. Physician's Brief Procedure Note

A post-procedure progress note is entered into the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient. The Physician's Brief Procedure Note shall include:

1. Pre-Procedure (Operative) Diagnosis
2. Post-Procedure (Operative) Diagnosis/Findings
3. Procedure(s) Description
4. Specimens, yes or no and list if yes
5. Primary Surgeon/Assistants
6. Anesthesia
7. Estimated blood loss
8. Complications
9. Comments

Revised by MEC on 9/13/11; Approved by BoT on 9/26/11

M. Transferring Patients from the Operating Room

1. The surgeon and/or anesthesia personnel determine the patient's disposition after receiving anesthesia based on individual patient assessment and receiving unit capabilities. Discharge criteria approved by the medical staff may be utilized to facilitate the patient's disposition.

2. At the conclusion of surgery/anesthesia and at the discretion of the anesthesiologist, if the patient already meets the PACU discharge scoring criteria (Aldrete >8), the patient may be sent directly to the originating unit.

3. Surgeon or Anesthesiologist may decide to bypass the PACU and transfer the patient directly to CCU when appropriate.

N. Surgical Pathology

1. Specimen is defined as the pathologic or abnormal tissue that is excised during a surgical procedure.

2. Specimens removed during a surgical procedure shall be sent to the pathologist for evaluation. Such specimens shall be properly labeled, packaged in preservative as designated, and identified as to patient and anatomic site. Labeling occurs at the time the specimen is handed from the surgeon to the Surgical Suite staff. Label content is repeated back to the performing surgeon to insure proper identification. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and post-operative diagnoses. Receipt by the lab personnel shall be documented (including the time the specimen was received in the lab), and the identity of the specimens/patients shall be assured throughout the processing and storage.

3. A pathologist shall examine every specimen sent to the laboratory. The determination of which categories of specimens require only a gross description and diagnosis may be made conjointly by the pathologist and the medical staff, and documented in writing. Any decision to rely only on gross diagnosis requires considerable pathologic judgment and should be made sparingly. All final specimen handling decisions are the sole purview of the pathologist.

4. The following categories of specimens may be exempted from the requirement to be examined by a pathologist unless specified by the surgeon:

- cataracts
- fatty tissue
- eyelids
- bone fragments (** see below)
- bone fragments from knees
- hair
- PE tubes
- stones
- orthopaedic hardware
- implants
- placentae
- eye muscle
- knee and nasal cartilage
- skin and fat from facelift procedures
- urinary calculi
- gallstones
- teeth
- hardware
- foreskins
- toenails
- excess skin, fat, tendon, muscle, bone and soft tissues excised in the course of tissue rearrangement or grafting.
- traumatized soft tissues and bone excised during the course of surgical debridement of a traumatic wound.

** Does not include resections of pathologic bone and cartilage (femur heads replaced with orthopaedic hardware are not considered exempt tissue). Revised MEC 05/10/2016; BoT 05/23/2016

5. Body parts *(i.e. limbs)* should be sent to Pathology for release to a morgue if requested.

6. Any additions to or deletions from this list must be approved by the department involved and by the Medical Executive Committee.

7. Specimens from procedures utilizing surgically placed localizing clip, localizing needle, or microcalcifications will be sent first to Radiology for confirmatory films and an interpretation by a radiologist. The film and its interpretation will then be sent to Pathology with the specimen.

8. Bullets and fragments will be sent directly to a representative of law enforcement with proper chain of custody documentation.

9. Removal of therapeutic radioactive sources shall be guided by Radiation Safety monitoring requirements.

O. Utilization of the Call Teams

1. The emergency team may be utilized for urgent and elective cases as long as anesthesia personnel, one RN, and one surgical technologist are available for emergency procedures. Added by MEC on 9/13/11; Approved by BoT on 9/26/11.

2. Should a physician need a third scrub, every attempt will be made to accommodate the request.

3. The call team will be called only at the request of the operating physicians and not at the request of the Emergency Department physician.

4. The physician should call the team in after assessing the patient or when circumstances appear likely to dictate immediate surgical intervention.

P. Damaged Instruments

Damaged instruments, due to improper use of handling by physician or staff members, will be brought to the attention of the Surgical Services Administrator.

Q. Products and Equipment

The hospital has established a Surgical Services Value Analysis Committee in an effort to reduce cost, standardize and improve products used, and evaluate current products for quality and cost effectiveness. All products/equipment requested for use in the hospital must be approved by this committee, who has the authority to approve or reject products requested.

Surgeons will be notified by the Surgical Services Administrator or his or her designee when a product is deleted from stock or when policy changes are made that affect product selection or use.

Hospital policy disallows the use of human tissue provided by vendors not approved by the American Association of Tissue Banks (AATB) in conformance with recommendations by the Centers for Disease Control (CDC), unless an exemption is approved by the Medical Executive Committee. See Administrative Policy PC-63.

Requests for new instruments requiring budget consideration should be submitted to the Surgical Services Administrator.

VII. MEDICAL SCREENING EXAMINATIONS

A. Qualified Individuals

In addition to credentialed members of the Medical Staff, the following individuals have been designated as qualified to perform an initial emergency medical screening examination on behalf of the organization. Those individuals are delineated by hospital location below. See also Administrative Policy PE-7.

1. In the Emergency Department, medical screening examinations may be performed by physician assistants or nurse practitioners granted privileges in the Department of Emergency Medicine by the Board of Trustees to provide emergency medical services at Catawba Valley Medical Center.

2. Obstetrical patients requiring medical screening examinations may be evaluated in the Emergency Department or may be referred to the Birthing Center for evaluation. In the latter case, the initial assessment will be performed by certified nurse midwives or specially trained registered nurses of the Birthing Center and will include a physical assessment, prenatal medical history review, and labs as indicated. Birthing Center registered nurse staff will contact the responsible care provider for orders regarding disposition of the patient (i.e., admit, discharge or remain in observation).

3. Newborns from high-risk deliveries and other newborns determined to be "compromised" at the time of delivery will have initial medical screening examinations performed by a neonatal nurse practitioner.

4. Outpatients in the Clinical Observation Unit will have a medical screening completed by the Emergency Department provider, determined to be in stable condition and have no emergency medical condition prior to placement in the Clinical Observation Unit. ***Revised by MEC 06/14/16; BoT 06/27/16**

5. Patients presenting to any of the CVMC-owned physician practices during normal business hours will have an initial medical screening examination conducted either by a MD or DO who is a member of the CVMC medical staff or by a physician assistant or nurse practitioner privileged to conduct initial medical screening examinations by the CVMC medical staff. Revised 4/26/10

6. In all other satellite locations in which CVMC provides patient services but where no MD, DO or allied health professional privileged to provide emergency medical screenings are normally located, staff should immediately contact 911 for emergency medical assistance. The same procedure will also be followed for any location on the hospital campus other than the main hospital building.

B. Procedure

1. All emergency medical screenings must be conducted in a manner that is reasonably calculated to exclude the presence of an emergency medical condition. This may include the utilization of necessary tests, ancillary services, and/or on-call specialists when necessary. Examinations will be based on the patient's chief complaint and their medical condition, regardless of age, race, sex, ability to pay, citizenship status, mental condition, or any other factor.

2. No medical screening examination will be delayed to obtain authorization for payment or for any other reason. Patients will be triaged, then examined and treated in the order determined by their medical acuity. Once it is determined the patient has an emergency condition; further treatment for that condition will not be delayed while obtaining financial information regarding further care, admission, or transfer, as appropriate to the needs of the patient.

3. Should a patient refuse a medical screening examination (i.e. decided to leave before being seen for the initial screening examination), treatment or transfer, hospital staff will take all reasonable steps to obtain informed written consent from the patient for refusing the examination, treatment or transfer. Staff will explain to the patient the hospital's legal obligations, the risks and benefits of refusing the examination, determine if the patient is competent to refuse, and then obtain the patient's signature. The individual conducting the medical screening exam must be involved in this process. Should a patient refuse to sign the consent form, a hospital representative will sign the statement indicating that the patient was offered but refused the examination and consent for same.

C. On-Call Physician Requirement

1. All members of the medical staff must participate in such emergency service coverage or consultation panels as may be determined by the Medical Executive Committee (MEC). On-call physicians must also respond to the Emergency Department in a reasonable timeframe, determined by the MEC to be thirty minutes under usual conditions, to all cases within the generally accepted scope of his or her practice specialty. In the event that a physician is unable or unwilling to respond appropriately to the Emergency Department, Emergency Department staff will inform the physician that his or her actions will be reported to the appropriate Department Chair and may affect the scope of privileges granted by the practitioner by Catawba Valley Medical Center. Should it

become necessary to transfer a patient because the on-call physician refused or failed to come to the ED, hospital staff will provide the name and address of the on-call physician on the transfer documents forwarded to the accepting facility. If the on-call physician is occupied with an emergency situation at either hospital for which he has call obligations and cannot respond within a time frame requested by the ED physician (this situation is not considered a failure), then the transfer protocol will be initiated if no other physician in that specialty is able to provide care to that patient. Revised 11/23/09.

2. If physician/physician practice has not provided care to a patient within the last three years and the patient requests that physician/physician practice provide care to them in the Emergency Department when they are not assigned as on-call for the Emergency Department, that physician/physician practice does not have to respond to that request. The physician on-call for the Emergency Department must then respond to the needs of the Emergency Department patient either on site or in the office for necessary follow-up care. Revised 11/23/09.

D. Specialty On-Call

Emergency Department Specialty On-Call coverage will follow Administrative Policy PC-37, "Emergency Department Specialty On-Call." Revised 11/23/09.

Last revised: May 23, 2005
September 27, 2005
November 27, 2007
January 28, 2008
November 23, 2009
April 26, 2010
September 27, 2010
September 26, 2011
September 24, 2012
January 28, 2013
March 25, 2013
January 26, 2015
June 22, 2015
September 28, 2015
June 27, 2016

MEDICAL STAFF

RULES AND REGULATIONS

PART B. ORGANIZATIONAL

I. GENERAL INFORMATION

A. The medical staff year begins January 1.

B. There will be an annual Meeting of the medical staff.*Revised by MEC 07/08/14 Approved by BoT 07/28/14

II. AGENDA FOR GENERAL STAFF MEETINGS

A. ORDER OF BUSINESS

1. Call to Order

2. Review and approval of minutes of the last regular and/or intervening special meetings

3. Old Business

4. Communications and Reports

5. Clinical Agenda

a. Reports related to the work of the clinical departments and the Medical Executive Committee in clinical review activities, reappointments, etc.

b. Discussion of and recommendations for improvements of professional activities in the hospital

B. REPORT OF THE MEDICAL EXECUTIVE COMMITTEE

C. REPORT OF THE CREDENTIALS COMMITTEE

D. REPORT OF THE HOSPITAL PRESIDENT

E. CLINICAL EDUCATION PROGRAM

F. ANNOUNCEMENT OF THE DATE AND LOCATION OF THE NEXT MEETING

G. ANY OTHER BUSINESS

H. ADJOURN

III. STAFF DUES

The Medical Executive Committee will from time to time determine appropriate amounts for the initial processing of applications and for reappointment. Revised 9/23/13

IV. NOMINATING COMMITTEE

A. Members of the Nominating Committee are appointed annually by the Chief of Staff. See Article VI of the Medical Staff Bylaws for additional detail.

B. The Nominating Committee slates one nominee for each office.

C. The Nominating Committee, or its representative, contacts each potential nominee. The potential nominee is advised of the tasks and obligations of the office for which the individual is to be nominated.

D. Agreement of the nominee to serve if elected is obtained.

E. The report of the Nominating Committee is given at the Annual Meeting by the chairman of the Nominating Committee.

V. MEDICAL EDUCATION COMMITTEE

A. Composition

The Committee will be composed of at least four members in good standing of the Active Medical Staff appointed by the Chief of Staff, one of whom shall serve as chair. The other physician members will include Activity Directors of the various recurring Continuing Medical Education (CME) activities. Additional members will consist of the CME Liaison, a Medical Librarian, a representative of Hospital Administration, and other appropriate representatives at the discretion of the Chair. Revised 09/08/15 Approved 09/28/15

B. Duties

The duties of the committee are:

1. To evaluate the educational needs of the medical staff, and as appropriate, other members of the medical community through needs assessment.

2. To plan formal group CME activities by offering opportunities for physicians and other medical practitioners to maintain and enhance their medical knowledge, clinical skills, professional development, and to improve patient outcomes. Revised 09/08/15 Approved 09/28/15

3. To ensure availability and documentation of CME credit in compliance with the guidelines established by the Accreditation Council for Continuing Medical Education (ACCME).

4. To evaluate the effectiveness of the continuing medical education program (including formal group activities, library and other activities).

5. To serve as liaison for student and resident rotations that occur in conjunction with other institutions. Revised 09/08/15 Approved 09/28/15

6. To plan for adequate funding for CME activities and advise on joint activities in accordance with the AMA Code of Ethics and ACCME requirements, where applicable. Revised 09/08/15 Approved 09/28/15

7. To serve as liaison between Catawba Valley Medical Center and other institutions, as appropriate. Revised 09/08/15 Approved 09/28/15

8. To provide periodic reports to the Medical Executive Committee and Board of Trustees as needed. Revised 09/08/15 Approved 09/28/15

C. Meetings

The committee (or subcommittees thereof) will meet as often as required, on call of the Chair. Revised 09/08/15 Approved 09/28/15

VI. SURGICAL SERVICES JOINT GOVERNANCE COUNCIL

A. Composition

The purpose of the Surgical Services Joint Governance Council is to serve as the leadership body that directs interdisciplinary Surgical Services initiatives related to Patient Safety, Customer Satisfaction, Regulatory Compliance, Productivity Based Block Utilization and Allocation, and Surgical Services Productivity.

The Committee is empowered and governed by the Medical Executive Committee to develop and enforce interdisciplinary Surgical Services policies.

Composition

1. Department of Surgery Member (1) / Chair, Department of Surgery
2. Department of Surgery Member (2) / Chief, Anesthesiology Section
3. Department of Surgery Member (3)
4. Department of Surgery Member (4)
5. Department of Surgery Member (5)
6. Department of Surgery Member (6)
7. Department of OB/GYN Member
8. Vice President, Operations
9. Administrator, Surgical Services

The Membership terms and requirements will be determined by the Surgical Services Joint Governance Council but shall remain consistent with the structure approved by the Medical Executive Committee in establishing the council.

B. Duties

The Surgical Services Joint Governance Council shall have the authority to:

a. Implement appropriate patient safety initiatives such as the National Patient Safety Goals and the Universal Protocol
b. Review customer satisfaction data
c. Implement changes in process as appropriate
d. Assure that Surgical Services is compliant with regulatory bodies such as CMS and Joint Commission
e. Review utilization information on a continuous basis
f. Allocate/adjust block time based on utilization data and thresholds
g. Respond to requests for changes in block time from current physicians
h. Respond to requests for block time from new physician
i. Communicate changes in the block time schedule to the appropriate Medical Staff
j. Track performance metrics for on-time starts, turnover time, and chart completion
k. Monitor physician compliance with appropriate referral to Medical Staff Peer Review as indicated. Revised 4/26/10

C. Meetings

The Surgical Services Joint Governance Council will meet as necessary but no less than bimonthly.

VII. CANCER COMMITTEE

A. Composition

The Cancer Committee is a multi-disciplinary committee that provides leadership to plan, initiate, stimulate, and assess all cancer-related activities of Catawba Valley Medical Center. Membership consists of at least one board certified physician representative from surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, cancer liaison physician and specialty practices as needed. Revised by MEC on 9/13/11; Approved BoT on 9/26/11

Non-physician members include administration, nursing, radiation therapy, dietetics, clinical resource management, cancer registry, medical records, and performance improvement. Additional physician or non-physician members include: hospice/ palliative care, clinical research, nutrition, pharmacy, pastoral care, American Cancer Society and public member of the community served. Revised by MEC on 9/13/11; Approved BoT on 9/26/11

The Cancer Committee Chair is a physician who may also fulfill the role of one of the required physician specialties. The Cancer Liaison Physician must be a member of the Cancer Committee and fulfill the role of one of the required physician specialties.

Coordinator assignments are required for each of the four areas of cancer committee activity; cancer conference, quality control of cancer registry data, quality improvement and community outreach. Selection of coordinator assignments is left to the discretion of the Cancer Committee. Added by MEC 9/13/11; Approved by BoT on 9/26/11.

B. Duties

The Cancer Committee shall:

1. Develop and evaluate the annual goals and objectives for the clinical, educational, and program activities related to cancer
2. Responsible for all program activities at Catawba Valley Medical Center Added by MEC 9/13/11; Approved by BoT on 9/26/11.
3. Promote a coordinated, multidisciplinary approach to patient management
4. Designate one coordinator for each of the four areas of cancer committee activity; cancer conference, quality control of cancer registry data, quality improvement and community outreach Added by MEC 9/13/11; Approved by BoT on 9/26/11.
5. Monitor and evaluate the Cancer Committee and cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis Added by MEC 9/13/11; ApprovedBoT on 9/26/11.
6. Ensure that educational and consultative cancer conferences cover all major sites and relates issues. Offer one cancer-related educational activity each year. Revised by MEC 9/13/11; Approved BoT on 9/26/11.
7. Ensure that an active supportive care system is in place for patients, families and staff
8. Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes
9. Implement two improvements that directly affect patient care Revised by MEC 9/13/11; Approved BoT on 9/26/11.
10. Promote clinical research. Provide a formal mechanism to educate patients about cancer-related clinical trials. Review the percentage of cases accrued to cancer-related clinical trials each year. Revised by MEC 9/13/11; Approved by BoT on 9/26/11.
11. Supervise the cancer registry and ensures accurate and timely abstracting, staging, and follow-up reporting
12. Review and document required studies measuring quality and outcomes. Review of CP3R results Revised by MEC 9/13/11; Approved by BoT on 9/26/11.
13. Perform quality control of registry data. Review 10% of analytic caseload to ensure that AJCC staging is assigned by the managing physician and recorded in the medical record on at least 90% of eligible analytic cases. Review 10% of the analytic caseload to ensure that 90% of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols. Revised by MEC 9/13/11; Approved by BoT on 9/26/11.
14. Encourage data usage and regular reporting
15. Ensure content of the annual report meets requirements
16. Publish the annual report by November 1 of the following year. Complete site-specific analysis that includes comparison and outcome data and disseminate results in annual report Revised by MEC 9/13/11; Approved by BoT on 9/26/11.
17. Monitor community outreach activities on an annual basis Revised by MEC 9/13/11; Approved by BoT on 9/26/11.
18. Uphold medical ethical standards
19. Establish subcommittees or workgroups as needed to fulfill cancer program goals Added by MEC 9/13/11; Approved by BoT on 9/26/11.

C. Meetings

The Cancer Committee shall meet at least quarterly, preferably every other month.
Revised by MEC 9/13/11; Approved by BoT on 9/26/11.

VIII. INSTITUTIONAL REVIEW BOARD

A. Composition

The Institutional Review Board is a multidisciplinary committee that reviews and approves clinical research projects involving human subjects in the Catawba Valley. Representatives are selected from both Catawba Valley Medical Center and Frye Regional Medical Center's administration, medical staff and service community. Membership is composed of a representative of each hospitals' Administration, a representative from at least one institution's Quality and/or Risk Management Department, a representative from at least one institution's Pastoral Care Department, a minimum of two (2), members of the medical staff, a minimum of two (2) pharmacists and a minimum of two (2) members of the community. Revised 4/26/10

B. Duties

The duties of the Institutional Review Board are as follows:

1. to review and approve/not approve clinical research proposals, investigations and trials, Revised 4/26/10

2. to monitor clinical research proposals, investigations, and trials.

C. Meetings

The Institutional Review Board will meet quarterly and as needed.

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September 27, 2005
November 27, 2007
January 28, 2008
November 23, 2009
April 26, 2010
September 26, 2011
September 23, 2013
July 28, 2014
September 28, 2015
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