- Trinity Health Physician Welcome Letter
- Trinity Health Background & Leadership
- Trinity Health Code of Conduct
- Business Courtesy and Medical Staff Incidental Benefits FAQ

Saint Joseph Health System – Leadership - [https://www.sjmed.com/](https://www.sjmed.com/)
- SJRMC – Medical Staff Mission Statement & Code of Conduct Policy
- Plymouth Medical Center - [https://www.sjmed.com/plymouth-medical-center](https://www.sjmed.com/plymouth-medical-center)
- SJRMC Medical Library Website - [https://www.sjmed.com/medical-library-website](https://www.sjmed.com/medical-library-website)
- SJHS Available Clinical Services - [https://www.sjmed.com/medical-services](https://www.sjmed.com/medical-services)
- Employee Relations Philosophy Policy
- On-Line Incident Reporting Policy
- Provision of Care Plan
- Serious Reportable Events, Sentinel Events & Indiana Medical Errors Policy
- State of Indiana – Indiana’s Prescription Drug Monitoring Program (“INSPECT”) Enrollment - [https://secure.in.gov/pla/inspect.htm](https://secure.in.gov/pla/inspect.htm)
- State of Indiana – Death Certificates Enrollment - [https://idrsthin.isdh.in.gov/](https://idrsthin.isdh.in.gov/)

Medical Staff: Health & Well Being of Physicians
- The Stress and Depression Questionnaire - [https://www.michianawellness.org/welcome.cfm](https://www.michianawellness.org/welcome.cfm)
- Impaired or Dysfunction Provider Policy
- Well Being Committee – Centralized Policy
- Pain Management Policy

Physician Peer Review
- Focused Professional Practice Evaluation (“FPPE”)
- Occurrence Monitoring & Peer Review (Medical Staff)
- Ongoing Professional Practice Evaluation (“OPPE”)
- Proctoring Policy & Procedure Medical Staff Peer Review
Dear Practitioner:

We are pleased to welcome you to the Trinity Health community. Thank you for allowing us to be a trusted partner in your patients’ care. As we work to build a People-Centered health system, we are focused on our relationship with you and all of our valued clinicians. We appreciate your compassion, competency and professionalism as together, we strive to deliver exceptional care to those we serve. We know that caring for patients and for our communities presents many challenges and opportunities. We understand that each day you experience the joy of helping others, while at times being asked to overcome obstacles yourself. As a physician, you hold the most important and primary connection to patients and their families as they navigate our health care system. You are not only a leader in health care; you are a leader in your community and in our delivery system.

You are joining a medical staff that is part of one of the largest not-for-profit health system in the United States. We have an enduring faith-based legacy and a steadfast mission to be a transforming and healing presence within the communities we serve. We are committed to being a people-centered health care system that enables better health, better care and lower costs. Our strategic plan outlines how we will become a People-Centered health system in the next several years. This includes redesigning our care models and collaborating effectively with engaged physicians and clinicians. As a partner of Trinity Health, you will experience:

- A culture based on shared mission, values and vision
- People-Centered care initiatives that focus on value and triple aim outcome
- Engaged colleagues who reflect the diversity of our communities
- Leadership on a national level
- A fiscally sound organization with a focus on quality metrics
- Physician leadership with integrity

Together, we will continue to strive for clinical excellence delivered with compassion and efficiency, providing an exceptional experience to our patients and their families.

With best wishes,

Barbara Walters, D.O., Chief Population Health Officer
Daniel J. Roth, M.D., Interim Chief Clinical Officer
Jeffry Komins, M.D., Interim Chief Medical Officer
Eric Hartz, M.D. Chief Medical Information Officer

Trinity Health Mission:
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Values:

- Reverence
- Commitment to Those Who are Poor
- Justice
- Stewardship
- Integrity
Welcome, Physicians!

*Our goal:* Be the best partner possible to physicians as we work towards better health, better care and lower costs.
Our Mission drives our Vision and strategy
We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

Our Core Values
• Reverence
• Commitment to Those Who are Poor
• Justice
• Stewardship
• Integrity
Our People-Centered 2020 Strategic Plan includes five focus areas to achieve our Vision.

- People-Centered Care
- Engaged Colleagues
- Operational Excellence
- Leadership Nationally
- Effective Stewardship

Physicians & Clinicians
Our 22-state diversified network

93 Hospitals* in 20 Regional Health Ministries**

47 Home Care & Hospice Locations Serving 116 Counties

1.75% Of all babies born in America

59 Continuing Care Facilities

15 PACE Center Locations

7.5k PNO Physicians & Clinicians

24k Affiliated Physicians

*Owned, managed or in JOAs or JVs.

**Operations are organized into Regional Health Ministries (“RHMs”), each an operating division which maintains a governing body with managerial oversight subject to authorities.

Trinity Health values our physician partners

We are committed to working closely with our physician partners to build a People-Centered health system to provide better care, better health and lower costs.

Our national ministry allows you access to:

• A culture based on shared mission, values and vision
• People-Centered care initiatives that focus on value and triple aim outcome
• Engaged colleagues who reflect the diversity of our communities
• Leadership on a national level
  - Phenomenal collective knowledge
  - Diverse clinical staffs across the country
  - Resources and the ability to leverage skills and scale
  - Advocacy at national, state and local levels
  - Access to large amounts of data
  - Payer contracting
  - Collaboratives that lead to establishment of national standards of practice
  - Trinity Health National Accrediting body – ACCME for CMEs
  - Teaching hospitals and international health programs
  - Physician Wellness Program and commitment to personal and professional health
  - Value-Based Purchasing focus – help with the latest regulations – MACRA, etc.
• A fiscally sound organization with a focus on quality metrics
• Physician leadership with integrity, with physician engagement prioritized
Trinity Health System Office is your partner and available to help

Physician Executives and Department Leadership

• Barbara Walters, D.O., EVP, Chief Population Health Officer  
  Barbara.Walters@trinity-health.org

• Daniel J. Roth, M.D., EVP, Interim Chief Clinical Officer  
  Daniel.Roth@trinity-health.org

• Jeffry Komins, M.D., Interim Chief Medical Officer  
  JKomins@trinity-health.org

• Eric Hartz, M.D., Chief Medical Information Officer  
  hartzce@trinity-health.org

• Gale Gartner, director, Physician Services  
  gartnerg@trinity-health.org

• Sandy Hess, Physician Engagement Manager  
  sandy.hess@trinity-health.org
This Code of Conduct is effective: March 1, 2018.
Code of Conduct – Supplement for Medical Staff

As a member of the medical staff of a Trinity Health hospital, you serve as a trusted partner in the delivery of health care services to our patients and community. The Trinity Health Mission Statement calls us to serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities. Guided by our Core Values, we are committed to the delivery of people-centered care that leads to better health care, improved health outcomes, and overall lower costs for our patients, residents, members and communities we serve.

Trinity Health has established a system-wide Integrity and Compliance Program to support all who work in our health care ministry in understanding and following the laws, regulations, professional standards, and ethical commitments that apply. The Trinity Health Code of Conduct describes behaviors and actions expected of all who work in Trinity Health – colleagues, physicians, suppliers, board members and others. This Supplement describes those areas of the Code of Conduct that have particular application to our relationship with you as a member of the hospital's medical staff. If you have any questions regarding this information, please contact your Medical Staff Office or the Integrity & Compliance Officer at your Ministry. The complete Code of Conduct is available online at http://www.trinity-health.org/documents/codeofconduct.pdf.

****

The following standards are expected of all clinical professionals who work in Trinity Health, including members the medical staff:

Professionalism

- Deliver people-centered, quality health care services with compassion, dignity and respect for each individual.
- Deliver services without regard to race, color, religion, gender, sexual orientation, marital status, national origin, citizenship, age, disability, genetic information, payer source, ability to pay, or any other characteristic protected by law.
- Maintain a positive and courteous customer service orientation.
- Demonstrate the highest levels of ethical and professional conduct at all times and under all circumstances.
- Speak professionally and respectfully to those with whom you work and whom you serve.
- Respond to requests for information or assistance in a timely and supportive manner.
- Behave in a manner that enhances a spirit of cooperation, mutual respect, a supportive team environment and trust among all members of the team.
• Deliver services in accordance with all professional standards that apply to your position.
• Create and maintain complete, timely and accurate medical records consistent with medical staff bylaws.
• Protect the privacy and confidentiality of all personal health information - electronic, paper or verbal - you may receive.
• Maintain appropriate licenses, certifications and other credentials required of your position.
• Abstain from inappropriate physical contact or inappropriate behavior with others.
• Report any harassment, intimidation or violence of any kind.
• Maintain a safe work environment by performing your duties and responsibilities free from the influence of drugs or alcohol.
• Protect the confidentiality of all peer review information.

Commitment to Providing Quality Care that is Safe and Medically Appropriate

• Commit to safety: every patient, every time.
• Speak up when you see a quality or safety issue and discuss mistakes you see with others so we can learn how to prevent future mistakes.
• Adhere to clinical guidelines and protocols that reflect evidence-based medicine.
• Actively engage and support efforts to improve quality of care, including organization-approved technology advancements.
• Actively participate in initiatives to improve care coordination between and among caregivers, community support agencies and other providers.
• Actively participate in initiatives to improve the health of the community as a whole.

Advocating for Our Patient's Needs

• Provide comfort for our patients, including prompt and effective response to their needs.
• Communicate clinical information to patients and their designees in a clear and timely manner.
• Discuss available treatment options openly with patients, or their designees, and involve them in decisions regarding their care.
• Provide care to all patients who arrive at your facility in an emergency, as defined by law, regardless of their ability to pay or source of payment.
• Clearly explain the outcome of any treatment or procedure to patients, or their designees, especially when outcomes differ significantly from expected results.
• Respect patient advance directives.
• Address ethical conflicts that may arise in patient care, including end-of-life issues, by consulting your organization’s medical ethics committee or Mission Officer.
• Provide care that is consistent with the Ethical and Religious Directives for Catholic Health Care Services.
Stewardship of Resources

- Properly use and protect all resources including materials and supplies, equipment, staff time and financial assets.
- Respect the environment and follow your organization’s policies for the handling and disposal of hazardous materials and infectious waste.

Corporate Citizenship

- Act with honesty and integrity in all activities.
- Actively participate in training programs offered by your organization.
- Follow your organization's policies requiring the disclosure of outside activities or relationships that could represent a conflict of interest with your medical staff membership or role and any other responsibilities.
- Follow all requirements of Medicare, Medicaid, other federal and state health care programs, as well as those of commercial insurance companies and other third-party payers. These requirements generally involve:
  - Delivering high-quality, medically necessary and appropriate services.
  - Creating and maintaining complete and accurate medical records.
  - Submitting complete and accurate claims for services provided.
  - Protecting the privacy and security of health information we collect.
- Conduct all medical research activities consistent with the highest standards of ethics and integrity and in accordance with all federal and state laws and regulations, and your organization's Institutional Review Board policies.
- Immediately notify your Medical Staff Office if notified you have been excluded or debarred from participation in federal or state health care programs.

Where to Find Help

If you have a question or concern about possible violations of law, regulation or the Code of Conduct, you are encouraged to seek answers by contacting one of the following resources:

- Your Chief Medical Officer or Medical Staff Office
- Another member of your organization's senior management team
- Your Ministry's Integrity & Compliance Officer
- The Trinity Health Integrity and Compliance Line at 1-866-477-4661 or you may file a written report online at www.mycompliancereport.com using access code "THO"
Thank You!
We appreciate your taking time to review this information and our commitment to carrying out our Mission with the highest standards of ethical behavior. Your dedication and support is critical to this important effort.
Business Courtesies and Medical Staff Incidental Benefits - FAQ

Q. What is a Business Courtesy?

A. For purposes of Trinity Health policy, a Business Courtesy is any items of value given to a physician (or their immediate family member) for free or at discounted cost by a Trinity Health Medicare enrolled provider organization.

Q. What are common examples of Business Courtesies?

A. The following are common examples of Business Courtesies:

   o Payment of meals and beverages held at off-campus locations
   o Payment of greens, entry fees or other activities related to a golf outing
   o Providing tickets to a sporting, concert or theatre event
   o Providing flowers, perishable items or other gifts in recognition of a birthday, anniversary or other special occasion
   o Payment of program costs for a continuing medical education program held at an off-campus location where CEUs are granted to participants
   o Payment of travel and lodging expenses

Q. Does the Business Courties policy apply to items of value given by a Trinity Health organization to physicians employed by a Trinity Health organization?

A. No. Items of value given to employed physicians are not considered business courtesies for purposes of this policy, but would be covered by employee benefit policies and should be addressed by the entity responsible for the physician's payroll, compensation and benefits.

Q. What about gifts or other items of value given to individuals or entities that are not physicians or their immediate family members?

A. These courtesies are governed by the Trinity Health Code of Conduct – refer to Relationships with Suppliers and Other Business Partners for more information.
Q. Why are physicians subject to stringent restrictions regarding the giving and receiving of Business Courtesies and other items of value?

A. There are federal and state laws and regulations intended to curb fraud and abuse in government funded health care programs, such as Medicare and Medicaid. One such law, the Physician Self-Referral Law or "Stark" law, as it is commonly referred, prohibits physicians from referring Medicare and Medicaid patients to hospitals for certain services if the physician (or an immediate family member) has a financial relationship unless an exception is met. Business Courtesies are considered financial relationships and the law places strict limits on the amount and form of such items.

Q. What is the dollar limit for Business Courtesies?

A. Business Courtesies are subject to an annual limit of $398, individually and in total, for each physician (including gifts to immediate family members). This limit is as of 2017 and is subject to periodic updates by the Centers for Medicare and Medicaid Services.

Q. Can Business Courtesies be given to encourage or reward patient referrals?

A. No. Business courtesies or any other gifts of value may never be given to reward or induce referrals of any items or services payable by a federal health care program. While in some industries it may acceptable to reward those who refer business to you, it is a crime in federal and state health care programs.

Q. May a gift certificate or gift card be given as a Business Courtesy?

A. No. Cash equivalents, such as gift cards and gift certificates, may never be provided as a Business Courtesy.

Q. What happens if the annual Business Courtesy limit is exceeded?

A. The consequences for exceeding the limit can be serious. A facility may lose their ability to bill Medicare for services ordered by the physician receiving the Business Courtesy. Or, at the very least, a physician may be asked to repay the overage. For these reasons, accurate tracking of Business Courtesies is very important. Any identified overages should be immediately reported to your organizations Integrity & Compliance Officer or Legal Counsel for appropriate follow-up and corrective action.
Q. How do I ensure my organization does not exceed the annual Business Courtesies limit?

A. Each Trinity Health facility that is subject to the Stark Law limits on Business Courtesies is required to establish a tracking system to ensure the annual limit for each physician is not exceeded. If you are not familiar with your organization's process, please contact your Integrity & Compliance Officer for more information.

Q. What are Medical Staff Incidental Benefits? Are these the same as Business Courtesies?

A. Medical Staff Incidental Benefits are not Business Courtesies. The Stark Law allows hospitals and other health care facilities to provide low dollar items of value to physicians who are appointed members of the facility's medical staff provided all of the following requirements are met:

   a. The value of each benefit may not exceed $33.00 per occurrence. This limit is as of 2017 and is adjusted periodically by the Centers for Medicare and Medicaid Services;
   b. May not be cash or cash equivalents such as gift certificates, gift cards, vouchers or checks;
   c. Are used by physicians while physically present on the campus of a Trinity Health facility;
   d. Are offered during periods when physicians are making rounds or performing other duties at Trinity Health facilities for the benefit of Trinity Health and its patients;
   e. The benefits are reasonably related to the delivery of medical services to Trinity Health patients;
   f. The benefits are offered to all medical staff members practicing in the same specialty;
   g. The benefits are consistent with the types of benefits offered to medical staff members in the community;
   h. The benefits are not determined and do not taken into account the volume or value of referrals or other business between the physicians and Trinity Health facilities.

Q. What are common examples of Medical Staff Incidental Benefits?

A. Common examples of Medical Staff Incidental Benefits include:

   a. Providing physicians a Continuing Medical Education program (e.g. "Ground Rounds") on-campus for benefit of hospital and patients
   b. Free parking provided to physicians in a Trinity Health parking facility
   c. Providing physicians with discounts while dining in the hospital cafeteria
   d. Modest food or beverages provided in connection with attendance at meetings held on a hospital campus
   e. Pagers for use while on the hospital campus
Q. My hospital has asked 3 medical staff members to participate in an off-site medical staff leadership development program. In order to ensure physician participation, the hospital is paying for the physician's travel and lodging as well as compensating the physicians for their time away from their practices. Is this a Business Courtesy that requires tracking?

A. The benefits described are definitely financial relationships subject to Stark Law requirements. However, the value of the benefits (travel, lodging and compensation) will far exceed the annual limit for Business Courtesies. The best option here is to work with your organization’s Legal Counsel to draft a personal services agreement describing the benefits and compensation to be paid to the physicians in exchange for their participation in the leadership development program. If using a personal services agreement, tracking under the Business Courtesies policy would not be required.

Q. My hospital sponsors monthly "Grand Rounds" educational programs for our medical staff. The programs are offered on the hospital's campus and are open to all members of the medical staff. The programs address topics such as quality, accreditation, patient experience of care and other subjects. Continuing Medical Education (CEUs) credits are granted to participants. Are these programs considered Business Courtesies or Medical Staff Incidental Benefits?

A. The Grand Rounds programs described are provided on campus to members of the facility's medical staff, are considered low value (less than $33 per occurrence) and are primarily for the benefit of the hospital and its patients. These programs would meet the Medical Staff Incidental Benefits requirements and would not be subject to an annual limit or tracking by individual physician.

Q. Similar facts as the prior question, but the educational programs are held at off-campus locations. Hospital personnel plan and coordinate the programs and participating physicians receive CEU credits. The hospital rents the conference facilities, provides meals and pays for the travel and compensation of guest speakers. Do these programs still qualify as Medical Staff Incidental Benefits?

A. Because the programs are not held on the hospital's campus, they do not meet the Medical Staff Incidental Benefits requirements. The value of the benefits provided to each attending physician must be tracked in accordance with the Business Courtesies policy and are subject to the annual limits. Alternatively, the hospital could seek funding for the cost of the programs from via medical staff fund contributions, payments by attendees or a combination of both.

Q. The hospital's intake coordinator schedules a lunch meeting with staff of an independent physician office to discuss opportunities to improve coordination and communication on patient admissions. The physician office is not located on campus. There are four (4) physicians and ten
(10) staff in the office. The intake coordinator brings sandwiches and drinks costing $80.00 to the meeting for all attendees. How would the cost be treated for tracking under the Business Courtesies policy?

A. Since the lunch was not provided on the hospital's campus, the value ($80) must be tracked under the Business Courtesies policy. The $80 is allocated to each of the physicians in the office (4), even if one or more of the physicians did not attend the meeting. The value allocated to each physician for tracking against the annual Business Courtesies limit would be $20.

Q. A hospital administrator gives a gift of an oil painting valued at $1,000 to a 4-physician practice in appreciation for the group's leadership of a hospital led quality initiative. Is the value of the gift attributed to each physician for tracking purposes $250 ($1,000/4)?

A. The annual Business Courtesy limit cannot be aggregated to provide a larger gift to a group of physicians. In this case, the oil painting is considered indivisible and would require tracking the entire amount ($1,000) amount as a Business Courtesy provided to each physician. Because this amount exceeds the annual limit ($398 in 2017), the gift is prohibited.

Q. Physicians on the medical staff at our hospital receive a 10% discount on meals in the hospital cafeteria, the same discount offered hospital colleagues. Is the hospital required to track the value of the 10% discount?

A. Provided the value does not exceed $33 per occurrence (which would require the value of the meal to exceed $330, very unlikely), the cafeteria discounts do not need to be tracked. This is an example of a Medical Staff Incidental Benefit provided on the hospital's campus to ensure the availability of medical staff members for the benefit of the hospital and its patients.

Q. An administrator at the hospital takes an independent physician out to a restaurant to discuss operations in the hospital's orthopedic department. The total cost of the dinner is $150. Is this considered a Business Courtesy since there was a valid business purpose for the meeting and dinner?

A. Yes the value of the dinner would still require tracking under the Business Courtesies policy. The dinner was not held on the hospital's campus and was not of low value. For tracking purposes, the total cost of the dinner ($150) can be divided among the two attendees. Thus, $75 would be attributed to the physician for tracking against the Business Courtesies annual limit.

Q. Same scenario as above, but the physician's spouse also attended the dinner and the total cost was $225. How would the allocation change?
A. The Business Courtesies policy applies to both physicians and their immediate family members. Therefore a total of $150 would be allocated against the physician's annual Business Courtesies limit representing the cost per person of $75 ($225/3) multiplied by 2 for both the physician and the spouse.

Q. The hospital's CEO invites two independent members of the medical staff to attend a local sporting event. The costs of the tickets are $65 each. The CEO personally pays for the tickets and the dinner attended by all 3 before the game. How would this scenario be handled?

A. Since hospital funds were not used for the tickets and the CEO did not seek reimbursement from the hospital for the expenses, there is no requirement to track the value of the tickets under the Business Courtesies policy.
MEDICAL STAFF MISSION STATEMENT
The Medical Staff of SJRMC, Mishawaka and SJRMC, Plymouth are organized to promote the health of our community. The Medical Staff is committed to excellent patient care and embraces the highest standards of the profession in its relationship with patients, SJRMC associates and our peers.

MEDICAL STAFF CODE OF CONDUCT
A. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all Medical Staff members and Allied Health Professionals practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

B. When a Medical Staff member or Allied Health Professional encounters circumstances suboptimal to the care of their patient it is their responsibility to document the occurrence by entering it into the Midas reporting system, or by reporting it to administrative personnel or by contacting the Medical Staff Office.

C. Medical Staff members and Allied Health Professionals will refrain from disruptive behavior as outlined in the policy statement below.

D. Medical Staff members and Allied Health Professionals will abide by the Bylaws, Rules and Regulation and Policy and Procedure manuals, which have been adopted by the Medical Staff.

E. Medical Staff members and Allied Health Professionals will follow mandated guidelines as defined by HIPAA, EMTALA and they shall refrain from conflicts of interest as defined by state and federal laws and regulations.

F. Medical Staff members and Allied Health Professionals will attend patients when called upon to do so without regard to ethnicity, gender or financial status as outlined in anti-discrimination law.

G. Medical Staff members and Allied Health Professionals will agree to provide consulting service within the practitioner’s defined area of expertise when called upon to do so without regard to ethnicity, gender or financial status according to Medical Staff Bylaws 2A3c.

H. Medical Staff members and Allied Health Professionals shall participate in peer review, quality improvement and assigned committees as requested by his/her department chairperson or other medical staff leaders.

I. Medical Staff members and Allied Health Professionals shall bring concerns regarding peer behavior to the attention of the medical staff leadership in order to promote timely investigation and when appropriate collegial intervention. The principle of confidentiality and patient safety are paramount concerns governing this reporting.

POLICY:
It is the policy of the Medical Staff, which includes physicians and allied health professionals (“Practitioner”) that all individuals within SJRMC facilities be treated with courtesy, respect, and dignity.
To that end, all Practitioners shall conduct themselves in a professional and cooperative manner in the hospital.

Expiration Date: 12/18/2021
If a Practitioner fails to conduct him or herself appropriately, the matter shall be addressed in accordance with the following policy.

1. Collaboration, communication, and collegiality are essential for the provision of safe and competent patient care. As such, all Practitioners practicing in the Hospital must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

2. A Practitioner, treating patients at SJRMC-Mishawaka and SJRMC-Plymouth, may encounter circumstances suboptimal to the care of their patient. This may occur from deficiencies in supplies or equipment or from deficiencies in hospital personnel working on their behalf. Hospital policies and procedures will require upgrades from time to time with changes in medical knowledge. The Practitioner is encouraged to document perceived substandard care and to work towards possible solutions. This should occur in a constructive manner. The SJRMC Midas reporting system allows for appropriate documentation of such events and a means by which they can be analyzed by hospital personnel. The system is intended to promote useful dialogue and a platform for problem solving, ultimately resulting in improved patient care. Documenting an occurrence can be accomplished by:

A. Document in writing the date, description, patient name, witnesses (if any) of any occurrence and submit this documentation to one of the following individuals. (See attached form)

   1) Medical Staff President - 335-2353
   2) VP Quality Improvement - 335-1035
   3) Medical Staff Office, Mishawaka – 335-2383
   4) Medical Staff Office, Plymouth – 948-5005

B. or, enter an occurrence directly into Midas:

   1) Go to Daily Dose
   2) Click on Favorites
   3) Go to SJRMC Websites and Click on Midas RDE
   4) Click on Risk
   5) Select the Appropriate Risk Form depending on occurrence
   6) Select the correct Facility – Mishawaka or Plymouth.
   7) Enter incident date
   8) Choose patient or non-patient incident and click Next (the next screens vary based on patient or non-patient)

9) Patient:
   a) Enter patients medical record number or name
   b) Choose incident type by clicking on the drop down arrow to the right
   c) Enter factors contributing to incidence by clicking on magnifying glass and select the factor(s) from the right side of the screen – then click OK
   d) Enter where the incident took place by clicking on the magnifying glass and select unit from the menu at the right side of the screen – then click OK
   e) Enter shift – Also enter time and room if information is available
   f) Enter your last name and hit tab – select your first name if multiple options

Expiration Date: 12/18/2021
Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

10) Non-Patient:
   a) Choose incident type by clicking on the drop down arrow to the right
   b) Enter factors contributing to incidence
   c) Enter where the incident took place
   d) Enter shift – also enter time and room if information is available
   e) Enter non-patient type by clicking on magnifying glass and select type from the right side of the screen
   f) Enter non-patient name
   g) Complete “entered by” by entering your last name and hit tab – select your first name if multiple options
   h) Enter narrative of incident
   i) Click Save

C. You can also document the above by calling the Physician Concern Line at 285-5899 (Mishawaka only) and leave the details including the date, description, patient name, witnesses (if any) of any occurrence and a Midas entry will be made on your behalf.

3. This Policy outlines collegial and educational efforts that can be used by the SJRMC-Mishawaka and SJRMC-Plymouth Medical Staff to address conduct that does not meet this standard. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve the concerns that have been raised, and thus avoid the necessity of proceeding through the disciplinary process in the Credentials Policy.

4. This Policy also addresses issue of alleged sexual harassment of employees, patients, other Practitioners of the Medical Staff, and others, which will not be tolerated.

5. In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment in which the highest ethical and professional standards are maintained.

6. All efforts undertaken pursuant to this Policy shall be part of the Hospital’s performance improvement and professional and peer review activities.

7. If there is a possibility of an impairment issue, the Medical Staff Impaired and Dysfunctional Physician Policy should be referenced and consideration of referring the physician/practitioner to the Medical Staff Well-Being Committee should take place.

8. Reports shall be kept in the peer review protected practitioner's confidential file. These confidential files are retained in the Medical Staff Office.

GUIDELINES

A. A single egregious incident or repeated incidents shall initiate an investigation. Summary suspension may be appropriate pending this process. If it is unclear whether the conduct was actually disruptive, the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth)
Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

or President of the Hospital (Plymouth) may seek the expert opinion of an impartial individual experienced in such matters.

1) Issues of employee conduct will be dealt with in accordance with the Hospital's Human Resources Policies. Issues of conduct by members of the Medical Staff or Allied Health Professionals will be addressed in accordance with this Policy.

2) Every effort will be made to coordinate the actions contemplated in this Policy with the provisions of the Credentials Policy. In the event of any apparent or actual conflict between this Policy and the Credentials Policy, the provisions of this Policy shall control.

3) This Policy outlines collegial steps (i.e., counseling, warnings, and meetings with a practitioner) that can be taken to address complaints about inappropriate conduct by practitioners. However, a single incident of inappropriate conduct or a pattern of inappropriate conduct as determined by an appropriate investigation may be so unacceptable that immediate disciplinary action is required. Therefore, nothing in this Policy precludes an immediate referral of a matter being addressed through this Policy to the Executive Committee or the elimination of any particular step in the Policy.

4) Except as otherwise may be determined by the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth), the practitioner’s counsel shall not attend any of the meetings described in this Policy.

5) The Medical Staff leadership and Hospital Administration shall make employees, Practitioners of the Medical Staff, and other personnel in the Hospital aware of this Policy and shall institute procedures to facilitate prompt reporting of inappropriate conduct and prompt action as appropriate under the circumstances.

B. Unacceptable disruptive conduct may include, but is not limited to, behavior such as:

1) attacks – verbal or physical – leveled at other appointees to the medical staff, hospital personnel, or patients, that are personal, irrelevant, or beyond the bounds of fair professional conduct.

2) degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;

3) profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;

4) inappropriate physical contact with another individual that is threatening or intimidating;

5) unfocused non-constructive derogatory comments about the quality of care being provided by the Hospital, another Practitioner, or any other individual outside of appropriate Medical Staff and/or administrative channels;

6) inappropriate medical record entries impugning the quality of care being provided by the Hospital, Medical Staff Practitioner or any other individual;

7) imposing onerous requirements on the nursing staff or other Hospital employees;

8) refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws, Credentials Policy, and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other Practitioners of the Medical and Hospital Staffs); and/or
9) "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:
   a) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or insulting sounds;
   b) Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
   c) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and
   d) Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.

**REPORTING OF INAPPROPRIATE CONDUCT**

A. Documentation of disruptive conduct is critical because it is ordinarily not one incident that leads to disciplinary action, but rather a pattern of inappropriate conduct. Such documentation shall include:

1) Practitioners, nurses and other Hospital employees who observe, or are subjected to, inappropriate conduct by another Practitioner shall:
   a) notify the practitioner about the incident or,
   b) notify their supervisor about the incident or, if their supervisor's behavior is at issue,
   c) shall notify the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth).

2) Any practitioner who observes such behavior by another practitioner is encouraged notify the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) directly.

3) The individual who reports an incident shall be requested to document it in writing. If he or she does not wish to do so, the supervisor or Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) may document it, after attempting to ascertain the individual’s reasons for declining and encouraging the individual to do so.

4) The documentation should include:
   a) the date and time of the incident;
   b) a factual description of the questionable behavior;
   c) the name of any patient or patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
   d) the circumstances which precipitated the incident;
   e) the names of other witnesses to the incident;
   f) consequences, if any, of the behavior as it relates to patient care, personnel, or Hospital operations;
   g) any action taken to intervene in, or remedy, the incident; and
   h) the name and signature of the individual reporting the matter.
Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

5) Any physician or employee may report potentially disruptive conduct. The report shall be submitted to the medical director or a facility administrator and then forwarded to the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) for further consideration and or investigation as indicated.

INVESTIGATION

A. All reports of questionable behavior are fully investigated by risk management and medical staff services on behalf of the medical staff who may meet with the individual who prepared it and/or any witnesses to the incident to ascertain the details of the incident prior to any discussion with physician/practitioner. Once an incident is confirmed, a report will be forwarded to the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth). Unconfirmed reports will be dismissed in which case the individual initiating such report will be apprised.

B. If there is a possibility of an impairment issue, the Medical Staff Impaired and Dysfunctional Physician Policy should be referenced and consideration of a self-referral or referral of the physician/practitioner to the Medical Staff Well Being Committee should take place.

C. If an incident of inappropriate conduct has likely occurred, then the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) is informed and investigation will be conducted by medical staff leadership. Medical staff leadership has several options available, including, but not limited to, the following:

1) notify the practitioner and Department Chairperson that a complaint has been received and invite the practitioner to meet with the Department Chairperson, the Medical Staff President and if necessary the Chief Medical Officer of the Hospital (Mishawaka & Plymouth) or President (Plymouth) to discuss it in a collegial manner;

2) send the practitioner a letter of guidance about the incident;

3) educate the practitioner about administrative channels that are available for registering complaints or concerns about quality or services, if the practitioner’s conduct suggests that such concerns led to the behavior. Other sources of support may also be identified for the practitioner, as appropriate;

4) send the practitioner a letter of warning or reprimand, particularly if there have been prior incidents and a pattern may be developing;

5) all meetings will take place within 30 days of the date the report was received and verified and will be documented with and a copy placed in the physician’s medical staff file;

D. During an investigation the identity of an individual reporting a complaint of inappropriate conduct will not be disclosed to the practitioner. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate referral to the Executive Committee pursuant to the Credentials Policy.

E. If the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) prepares any documentation for a practitioner's file regarding its efforts to address concerns with the practitioner, the practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the Chief Operating Officer of the Hospital and/or the President of the Medical Staff documentation.
Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

F. If additional complaints are received concerning a practitioner, the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) may continue to utilize the collegial and educational steps noted in this Section as long as it believes that there is still a reasonable likelihood that those efforts will resolve the concerns.

ACTION

A. A single confirmed incident warrants a discussion with the offending physician; the medical staff leadership designee shall initiate such a discussion and emphasize that such conduct is inappropriate and must cease. The initial approach should be collegial and helpful to the physician/practitioner and the hospital.

B. If it appears that a pattern of disruptive behavior is developing, the medical staff leadership and the Chief Medical Officer of the Hospital (Mishawaka & Plymouth) or President (Plymouth) or their designee shall discuss the matter with the physician/practitioner as outlined below:

1) Emphasize that if such repeated behavior continues, more formal action will be taken to stop it. The MEC and CEO will be notified.

2) All meetings will take place within 30 days of the date the report was received and verified and will be documented with a copy placed in the physician’s medical staff file;

3) A follow-up letter to the physician/practitioner shall state the nature of the problem and inform the individual that he or she is required to behave professionally and cooperatively within the hospital.

4) The involved physician/practitioner may submit a rebuttal to the charge. Such rebuttal will be maintained as a permanent part of the record.

C. The presence of an attorney for the practitioner or the Hospital is allowed only after an investigation has been fully reviewed and a determination has been made in which the practitioner is entitled to a Hearing. i.e. suspension of privileges for longer than 30 days, revocation of membership or privileges, etc.

Referral to the Executive Committee

A. At any point, the Chief Medical Officer of the hospital (Mishawaka & Plymouth) or President of the Hospital (Plymouth) and/or medical staff leadership may refer the matter to the Executive Committee for review and action. The Executive Committee shall be fully apprised of the actions taken by the Chief Medical Officer of the hospital and/or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth) or others to address the concerns.

B. If the Medical Executive Committee, after review of information provided, calls for an investigation then the matter is referred to the Credentials Committee, which becomes the investigative body of the medical staff. The Credentials Committee then issues a report to the Medical Executive Committee of its finding. The Medical Executive Committee may, based upon the facts and recommendations presented by the Credentials Committee, make recommendations for action including, but not limited to, the following:

1) require the practitioner to meet with the Board Chair;

2) require the practitioner to meet with the full Executive Committee;

3) issue a letter of warning or reprimand;

4) require the practitioner to obtain a psychiatric evaluation by a physician chosen by the Executive Committee;
Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

5) require the physician to complete a behavior modification course;
6) impose a “personal” code of conduct on the practitioner and make continued appointment and clinical privileges contingent on the practitioner’s adherence to it; and/or
7) suspend the practitioner’s clinical privileges for less than 30 days.

The imposition of any of these actions does not entitle the practitioner to a hearing or appeal.

C. At any point, the Medical Executive Committee may also make a recommendation regarding the practitioner’s continued appointment and clinical privileges including, but not limited to, revocation and/or suspension for greater than 30 days that does entitle the practitioner to a hearing as outlined in the Credentials Policy, or may refer the matter to the Board without a recommendation. If the matter is referred to the Board, any further action, including any hearing or appeal, shall be conducted under the direction of the Board.

Sexual Harassment Concerns

A. Because of the unique legal implications surrounding sexual harassment, a single confirmed incident requires the following actions:

1) A meeting shall be held with the Practitioner to discuss the incident. All meetings will take place within 30 days of the date the report was received and verified and will be documented with and a copy placed in the physician’s medical staff file. If the practitioner agrees to stop the conduct thought specifically to constitute sexual harassment, the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's quality file. This letter shall also set forth those additional actions, if any, which result from the meeting.

2) If the practitioner refuses to stop the conduct immediately, this refusal shall result in the matter being referred to the Executive Committee for review pursuant to the Credentials Policy.

3) Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the Chief Medical Officer of the hospital and/ or Medical Staff President (Mishawaka & Plymouth) or President of the Hospital (Plymouth), or designee(s). If the investigation results in a finding that further improper conduct took place, a formal investigation in accordance with the Credentials Policy shall be conducted. Should this investigation result in an action that entitles the individual to request a hearing under the Credentials Policy, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

This policy shall be the sole process for dealing with egregious incidents and disruptive behavior, and shall be interpreted and enforced by the Medical Staff.

Attachment: Documentation Form
Retaliation and Retribution Hospital Policy
### PRACTITIONER USE – DOCUMENTATION OF OCCURRENCE

<table>
<thead>
<tr>
<th>Date of Occurrence:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of this Report:</td>
<td></td>
</tr>
<tr>
<td>Patient Name/Medical Record Number: (if known)</td>
<td></td>
</tr>
<tr>
<td>Description of Occurrence:</td>
<td></td>
</tr>
<tr>
<td>Witnesses: (if any)</td>
<td></td>
</tr>
<tr>
<td>Name of Practitioner Making Report:</td>
<td></td>
</tr>
</tbody>
</table>

Submit this form to one of the following:

- Mishawaka
  - Medical Staff President-
  - Ph: 335-2353
  - Fax: 335-1001
- Medical Staff Office – Mishawaka Plymouth
  - Ph: 335-2383
  - Ph: 948-5005
  - Fax: 335-1053
  - Fax: 948-5478

### References/Standards:

- Policy Origin Date: May 1999
- Review Date: December 2009(M), December 2012 (M), December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date: August 2007 (M), January 2012 (P)
- Effective Date: December 1999 (M), December 1999 (P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 154
Title: MEDICAL STAFF MISSION STATEMENT AND CODE OF CONDUCT POLICY

TITLE: RETALIATION AND RETRIBUTION

POLICY:
1. All employees, supervisors, physicians and trustees have a responsibility to report in good faith, concerns about actual or potential wrongdoing and are not permitted to overlook such situations. We are firmly committed to a policy that encourages timely disclosure of such concerns and prohibits any action directed against an employee, physician, trustee or volunteer for making a good faith report of their concerns.

2. No one at any level of SJRMC is permitted to engage in retaliation or any form of harassment against an employee, physician, trustee or volunteer reporting a concern. Anyone who engages in such retribution is subject to discipline, up to and including dismissal on the first offense. All substantive instances of retaliation or harassment against anyone reporting through the Four-Step Process will be brought to the attention of the Organizational Integrity Officer.

3. This does not mean that employees or others will be shielded from the consequences of doing something wrong simply by reporting their actions or from the consequences of their actions under current employment policies. However, a prompt and forthright disclosure, even if the error was willful, may be considered a constructive action.

References/Standards:
- Policy Origin Date: June 1998
- Review Date: September 2005, December 2012 (M), December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date:
- Effective Date: April 2009
- Reviewed/Recommended By: Organizational Integrity Team
Welcome to the Saint Joseph Regional Health System
Plymouth Medical Staff!!

Resource Personnel
Hospital Administrator – Daniel Kunde  574-948-5009
President – Christopher Karam  574-948-5002 or 574-335-2344
CNO – Loretta Schmidt  574-948-5001 or 574-335-2343
Regional CMO – Genevieve Lankowicz, MD  574-335-2353
Risk Management – Jennifer Byall  574-948-5004
Physician Support (IT/Cerner)  574-335-5066
Medical Staff Services – Denise Duschek  574-948-5005

Communication
Communication between the Medical Staff Members is facilitated by the following means:
- The Full Medical Staff meets at least one a year
- Department meetings (frequency determined by department)

Service Chiefs
Surgery: James Dammon, MD & Brian Piazza, MD
Anesthesia: James Dammon, MD (interim)
Emergency: W. Kurt Reiss Jr., DO
Family Medicine: Laura Blackford, MD
Medicine (IM/Cardio): Chuck Nwakanma, MD
Obstetrics/GYN: Noreen Faulkner, MD
Pathology: James Dyer, MD
Pediatrics: Rushbah Shah, MD
Radiology: Tim Smith, MD

Medical Staff Leadership - 2010
- President – Noreen Faulkner, MD (OB/GYN)
- Vice President – Laura Blackford, MD (Family Medicine)
- At-Large – James Dammon, MD (Gen Surgery)
- At-Large – Rushbah Shah, MD (Pediatrics)
- At-Large – W Kurt Reiss Jr., DO (Emergency Medicine)

Practitioners on Staff
A physician roster is available upon request. Please contact Denise Duschek in the Medical Staff Office at 574-948-5005

Proctoring
If proctoring is required in order to meet specified privilege criteria, proctors should be obtained during this time. For additional information regarding this please contact the Medical Staff Office.

Health Information Management
It is imperative that medical records be completed in a timely manner. Our suggestion is for physicians to complete all outstanding records at least once a week. The actual Medical Records Completion policy is included in the Physician Orientation Manual and is available in the Medical Staff Office.
Welcome!

Welcome to the Saint Joseph Regional Medical Center Medical Staff Website

Thank you for being a member of the Saint Joseph Regional Medical Center medical staff. We want to make sure that you and your patients have an exceptional experience at SJRMC.

We hope that the resources available on this site are just one of the many ways that we can facilitate efficient communication between the hospital and our physicians. Our door is always open and we welcome any of your thoughts about how we can continue to improve our organization.

This website was developed with the intent to be used as a tool, be it for communications or for physician specific information. We hope you will come to rely on this site because of its many wonderful capabilities.
For Physicians

- Physician Online Verification
- Pay Medical Staff Application Fee & dues
- In-Peak Symposium
- Find a Physician
- Syllabus, Policies, and Rules and Regulations
- Medical Staff Policies and Procedures
- Hospital Services
- Links
- Contact Information
- Medical Library Website

Medical Library Website

This site is currently only available for users on-campus, or to those members of the Medical Staff who have EBox Access.

If you are a member of our Medical Staff and wish to get EBox Access, please contact Jennifer Hechman at 874-395-1012.
Our Services & Specialties

At Saint Joseph Health System we’re called to care for the health of the members of our community. Our commitment to you and your family's well-being means providing you access to healthcare and support throughout your medical journey. When you have an emergency, our Emergency Department locations make it easier for the local EMS to get you here fast. If you need diagnostic imaging services, our radiology experts will be there with answers to all of your questions. We believe in a seamless care experience and offer a full range of medical services, from health and wellness, to out-patient treatment and acute in-patient care.

Our medical services include:

- Asthma education
- Paqui and Brian Kelly Comprehensive Breast Center
- Diabetes support
- Emergency Department
- Gastroenterology
- Heart & vascular
- Home care
- Hospice program
- Imaging/radiology
- Laboratory services
- Mobile Medical Unit
- Neonatal intensive care
- Obstetrics
- Oncology
- Orthopedics
- Pediatrics
- Podiatry
- Radiology services
- Rehabilitation & therapy
- Robotic Services
- Sleep disorders
- Sports medicine
- Stroke care
- Surgical services
- Wound healing
Title: Employee Relations Philosophy

<table>
<thead>
<tr>
<th>Document Owner: Hofstra, Donna</th>
<th>PI Team: Leadership</th>
<th>Date Created: 03/90</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): LaFrancois, Mary</td>
<td>Date Approved: 06/27/11 06/19/2014</td>
<td></td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMC)</td>
<td>Department: Recruiting (14001_83015)</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Saint Joseph Regional Medical Center, Inc. and all Member Entities (SJRMC) takes sincere pride in its philosophy regarding all our employees. Our policy of treating employees with personal dignity includes supporting an employee's freedom and responsibility to discuss any suggestions or concerns that he or she has and to expect in return, a fair, unbiased answer or consideration.

2. SJRMC has made the commitment to providing a Just Culture environment for all associates. Just Culture has an emphasis on patient safety. This type of environment refers to our efforts as an organization to be "just" – or fair – with all of our associates. The lessons of Just Culture are applicable to every walk of life. It is a set of ideas that influence how we respond to the fallibility of our fellow human beings. In a Just Culture model, we address three behaviors: Human Error, At-Risk Behavior, and Reckless Behavior.

3. The principles of our Employee Relations Program:
   A. Our goal is to create, nurture and preserve an environment where all employees can contribute according to their diverse skills and to their full potential.
   B. In our interactions with each other, our goal is to:
      1) listen to all ideas and not to react with biases and prejudices,
      2) value the unique background of all individuals, not to preserve sameness,
      3) move beyond stereotypes, not build walls around each other based on race, gender, disability, age, religion, color, creed, ethnic origin or veteran status.
   C. Our commitment is to trust-building and open communication.
   D. We encourage you to discuss any work problem with your supervisor. If something is bothering you, tell your supervisor.
   E. We encourage you to contact the Human Resources Representative on any problem or question. We are here to serve you.
   F. If you think a policy or procedure has not been followed, you have access to our formal and informal problem-solving process.
   G. We create special moments in time to recognize and honor you for your dedication, contributions and service to the organization and the communities in which we work.
   H. People are the only lasting assets in health care. Human beings, in all their many faces, form the basis of our future success or failure.
   I. Our organization believes that our ability to communicate directly with each other, without the intervention of an outside organization, is an important ingredient in our successful Employee Relations environment. It is our intention to preserve our program of open communication, involvement and participation. This means that you are free to work directly with any questions or problems you have and to exercise your legal rights.

Expiration Date: 06/05/2020
Title: Employee Relations Philosophy

References/Standards:
- Policy Reviewed: 06/11
- Policy Revised: 07/02

The Senior Management Team of SJRMC reserves the right to unilaterally change, modify, amend, add, delete, or rescind any or all policies, at any time, as it determines appropriate in its sole discretion. No employee or manager of SJRMC except the Chief Executive Officer or Chief Human Resources Officer has the authority to modify any Human Resources Policies or Procedures, and any such modification must be in writing.
Title: Online Incident Reporting

<table>
<thead>
<tr>
<th>Document Owner: Jennifer Byall</th>
<th>PI Team: PI Leadership Team</th>
<th>Date Created: March 1989</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): Jennifer Byall</td>
<td>Date Approved: July 6, 2011</td>
<td>10/18/2018</td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMC)</td>
<td>Department: Performance Improvement (14030_77400)</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Saint Joseph Regional Medical Center endorses a culture of safety and views incident reporting as a means of improving systems and processes in providing healthcare services to all patients. The Leadership team is committed to a learning environment that encourages reporting of errors and hazardous conditions. SJRMC conducts a systematic program of Occurrence reporting that identifies actual errors, injuries, or near misses or the potential for errors. It is assumed that associates are doing their best and that errors are not the result of incompetence or misconduct. Occurrence reporting is non-punitive and all associates are encouraged to report all patient and visitor occurrences. Refer to exceptional situations as outlined in the Non-Punitive Reporting Policy.

2. All Midas/VOICE Incident/Event Reports will be maintained by the Risk Management Department. Incident/Event reports are the privileged information of SJRMC.

3. Never document in patient's medical record "Incident/Event Report filed." Document in the medical record only the facts pertaining to the incident/event.

4. An Incident/Event Report is not a part of the medical record.

5. All Incident/Event Reports are confidential professional/peer review and quality improvement document of Saint Joseph Regional Medical Center and/or the Saint Joseph Physician Network and Trinity Health System. This document is protected from disclosure pursuant to Indiana Statute (I.C 34-30-15), and other state laws as well as the federal Patient Safety and Quality Improvement Act, 42 U.S.C. 299b-21-b-26 and other federal laws. Unauthorized disclosure or duplication is absolutely prohibited.

6. It shall be the responsibility of each associate to report all incidents/events at the time they are encountered.

PROCEDURE:

A. GUIDELINES/PROCEDURE: For Online Entry Of Incidents Incident / Event
   a) The associate or his/her supervisor shall complete the incident/event report on-line in MIDAS/VOICE, which will then be directly transmitted to Risk Management. The report should be completed objectively, accurately and without conclusions, criticisms, or blame placement. Events resulting in death or serious physical or psychological injury will be reported immediately to the Risk Manager.
Title: Online Incident Reporting

b) Enter into MIDAS all potential grievances.

c) PATIENT/CUSTOMER RELATIONS: Patient/customer relations may include the perception of the patient or family member as it relates to our facility and our environment and to the services and personal treatment they expect and receive before, during and after their experience at SJRMC. Sometimes we fail to meet a patient/family's expectations; sometimes we exceed the expectation. These types of situations should be documented in the MIDAS.

d) Positive incident/events: It is important that the incident/event analysis include positive occurrences. Positive occurrences include compliments from patients, families, physicians, etc.

e) Document the nature and facts surrounding the occurrence in the nurse's notes of the patient's medical record. Do NOT write "Incident/Event entry in MIDAS/VOICE".

f) When an actual or suspected injury has occurred and the patient is examined by a physician, an entry should be made on the progress notes by the physician.

2) MIDAS

a) Is to be utilized for all reporting of Physician/Provider issues. Responding to complaints from phone calls, walk ins and letters: See Complaint/Grievance Resolution Policy.

3) VOICE: Is to be used for reporting of all other incidents with exception of MD/Procedural issues and grievances, which are reported in MIDAS and associate injuries are reported in UAIR.

Related Documents:

- Non-Punitive Reporting
- Service Recovery
- Serious Reportable Events, Sentinel Events and Indiana Medical Errors Complaint/Grievance Resolution
- Responding Justly

Definitions:

- Incident/Event:
  o An incident/event is any event or situation which is inconsistent with Saint Joseph Regional Medical Center’s standards of care or routine, or which has significant positive or negative impact upon the safety, security, or satisfaction of a patient, family, visitor, associate, volunteer, physician or others.
  o Occurrences may be expressed verbally or in writing by patients, family, and visitors through direct approach, patient surveys, letters, telephone calls, or personal visits to the SJRMC.
PLAN FOR THE PROVISION OF PATIENT CARE

Fiscal Year 2020

Approval:

Chairman, Board of Directors

Date

President

Date

President, Medical Staff

Date

Chief Operating Officer/Chief Nursing Officer

Date
Saint Joseph Regional Medical Center-Plymouth

PLAN FOR THE PROVISION OF PATIENT CARE

ORGANIZATIONAL ADMINISTRATIVE COMPONENTS ............................................................. 1

I. SJRMC- PLYMOUTH MISSION STATEMENT ........................................................................... 1

II. PATIENT CARE SERVICES VISION STATEMENT ............................................................... 1-2

III. STANDARDS OF CARE............................................................................................................ 3

IV. PROVISION OF CARE, TREATMENT, AND SERVICES ........................................................ 3

V. ETHICS, RIGHTS, AND RESPONSIBILITIES........................................................................ 4-6

VI. DEFINITION OF PATIENT SERVICES, PATIENT CARE AND PATIENT SUPPORT ........ 7

VII. PATIENT CARE DEPARTMENTS ........................................................................................ 7-8

VIII. STAFFING ........................................................................................................................... 8-9

IX. PATIENT CARE ORGANIZATIONAL PERFORMANCE IMPROVEMENT ACTIVITIES .. 10-11

X. SUPPORT SERVICES ............................................................................................................. 11

XI. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES ....................................... 11

XII. DEPARTMENTS ................................................................................................................. 11-24

ADMINISTRATION ........................................................................................................... 11
RADIATION ONCOLOGY ............................................................................................ 11-12
CARDIOPULMONARY ..................................................................................................... 12
EDUCATIONAL SERVICES ...................................... 12-13
NUTRITIONAL SERVICES .......................................................................................... 13-14
PATHOLOGY AND CLINICAL LABORATORY ........................................................... 14-15
PHARMACY ................................................................................................................. 15-16
RADIOLOGY ................................................................................................................ 16-18
REHABILITATION SERVICES .................................................................................... 18-19
CASE MANAGEMENT ..................................................................................................... 19
SAINT JOSEPH HEALTH CENTER............................................................................ 19-20
INPATIENT & OUTPATIENT NURSING UNITS.................................................................... 20-24

Adverse Weather /Staffing Shortage Action ......................................................... 24
Master Staffing Plan .............................................................................................. 25
Floating .................................................................................................................. 26

XIII. PATIENT CARE LEADERSHIP TEAM MEETINGS ............................................................. 26

XIV. HOSPITAL/MEDICAL STAFF ............................................................................................... 26

XV. BUDGETING .......................................................................................................................... 27

XVI. STAFF EDUCATION ............................................................................................................ 27
XVII. CLINICAL EDUCATIONAL AFFILIATIONS

XVIII. COMMUNITY RELATIONSHIPS
ORGANIZATIONAL ADMINISTRATIVE COMPONENTS

Saint Joseph Regional Medical Center – Plymouth is a 58 bed, not-for-profit hospital. Services are planned based on the population, the Mission Statement and the identified needs of the patients, staff, and family. Patient care services are organized in response to patient needs as identified in the planning process and prioritized in the strategic plan.

The Plan for the Provision of Patient Care is a written document that provides the plan for providing patient care at Saint Joseph Regional Medical Center – Plymouth. This plan is based on the philosophies of the Sisters of the Holy Cross and the Sisters of Mercy, Saint Joseph Regional Medical Center – Plymouth and Patient Care Services.

This plan is evaluated annually. The Board of Directors, Medical Staff, President, Vice President, and Department Directors are involved. The review is done to assess the adequacy and accuracy of the plan and to determine whether the hospital is complying with its own plan to provide care. The following factors are considered:

1. Patient care requirements for care and the effectiveness to address these needs
2. Recruitment and retention data
3. Performance improvement data including risk management and utilization management
4. Consistent applications of Standards of Care and Standards of Practice throughout all departments
5. Information from surveys of patients, significant others, the community, physicians, other health care providers, and staff

I. MISSION STATEMENT

We, Trinity Health, serve together in the spirit of the Gospel as a compassionate and transforming healing presence within our communities.

PATIENT CARE SERVICES VISION STATEMENT

In conjunction with the Mission Statement of Trinity Health and Saint Joseph health System, we believe:

1. The patient and/or family will be our primary focus through a multi-disciplinary care process.
2. In building an atmosphere of mutual respect and trust that fosters teamwork.
3. In promoting and empowering all individuals to establish, pursue and achieve ongoing educational goals.
4. In effectively communicating information.
5. In being responsive to the needs of those we serve by providing quality services with a focus on patient safety.
6. In being vigilant in developing and directing our human and financial resources.

PATIENT CARE COUNCIL Mission Statement:

SJRMC-Plymouth serves to promote and facilitate a holistic approach to the delivery of
compassionate and competent patient-centered care in a preferred workplace culture. This preferred culture embodies the principles of shared governance and decision making, evidence-based practice, staff ownership, responsibility and accountability.

**PATIENT CARE COUNCIL Scope:**

**Scope:** The Patient Care Council scope includes the oversight for the following functions:
- Incorporation of Evidenced Based Standards of Practice- Determination and incorporation of “best practices”
- Quality and Outcomes Evaluation, Measurement and Improvements
- Nursing and Patient Care Peer Review
- Core Measure analysis and Improvements- Nursing and Patient Care focused/dependent measures
- The Joint Commission nursing/patient care standards compliance
- Nursing and Patient Care Risk and Patient Relations data analysis
- Patient Safety
- Nursing and Patient Care Strategic Plan Development and Implementation
- Promotion of a patient centered culture including building and enhancing healthy collegial working relationships and building the culture of nursing
- Patient Satisfaction
- Nursing and Patient Care Practice Standards Development
- Professional Development to include: Assessment of learning and educational needs for staff and patients; oversight of research activity Plan and develop teaching tools and strategies and implement and promote programming in order to promote professional staff development and optimize learning by staff and patients
- Assess, organize and develop a staff education/development plan annually
- Resource Management to include staffing, supplies, equipment, work processes, productivity value analysis
III. STANDARDS OF CARE

Standards are derived from the Joint Commission on Accreditation of Healthcare Organizations, Indiana State Department of Health, American Nurses Association, Nuclear Regulatory Commission, FDA, Board of Pharmacy, CLIA, as appropriate, and American Physical Therapy Association, American Speech and Hearing Association, American Occupational Therapy Association, American Association of Cardiovascular and Pulmonary Rehabilitation.

Standards within the following patient-focused functions that follow are adhered to by the following departments, as appropriate:

- Radiology
- Laboratory
- G.I. Lab
- Cardiopulmonary
- Outpatient Clinics
- Medical/Surgical
- Rehabilitation
- Performance Improvement
- Center for Spiritual Care
- Radiation Oncology
- Emergency
- Sterile Processing Department
- Hospitalist and Physician

IV. PROVISION OF CARE, TREATMENT, AND SERVICES

Care, treatment, and services are provided through the successful coordination and completion of a series of processes that include appropriate initial assessment of needs; development of a plan for care, treatment, and services; the provision of care, treatment, and services; ongoing assessment of whether the care, treatment, and services provided are meeting the patient’s needs; are either the successful discharge of the patient or referral or transfer of the patient for continuing care, treatment, and services. The provision of care, treatment, and services to patients is composed of core processes or elements, including the following activities:

- Assessing patient needs; Planning, providing, & coordinating care, treatment and services for all patients
- Providing access to the appropriate levels of care and/or disciplines for patients
- Providing interventions based on the plan of care, treatment, and services
- Teaching patients what they need to know about their care, treatment, and services
- Coordinating care, treatment, and services, if needed, when the patient is referred, transferred, or discharged

Within these core processes, care activities include the following:

1. Providing access to levels of care and/or disciplines necessary to meet the patients’ needs
2. Interventions based on the plan of care, including the education or instruction of patients regarding their care, treatment, and services
3. Coordinating care to promote continuity when patients are referred, discharged, or transferred

The activities are performed by a wide variety of staff and licensed independent practitioners. Therefore communication, collaboration, and coordination are among the most important elements that are adopted so that care, treatment, and services are provided at the highest level.

These elements are interrelated activities within the ongoing care process, and are integrated throughout the organization’s patient care departments highlighted in this plan.
V. ETHICS, RIGHTS, AND RESPONSIBILITIES

The goal of the ethics, rights and responsibilities function is to improve care, treatment, services, and outcomes by recognizing and respecting the rights of each patient and by conducting business in an ethical manner. Care, treatment, and services are provided in a way that respects and fosters dignity, autonomy, positive self regard, civil rights, and involvement of patients. Care, treatment, and services consider the patient's abilities and resources; the relevant demands of his or her environment; and the requirements and expectations of the providers and those they serve. The family is involved in care, treatment, and service decisions with the patient's approval. All persons will be treated with dignity and respect as referenced in the Patient's Rights & Responsibilities.

- Respect for the patient's right of privacy, confidentiality, dignity of person and right to receive/refuse proper medical care is reviewed with all staff members annually.
- Patients are provided with consultative services regarding Advance Directives.
- Informed consent is obtained.
- Patients/Families are involved in their plan of care.
- All departments operate under the established organizational code of ethics.

A. PATIENT’S RIGHTS TO CARE

The hospital maintains mechanisms to ensure that patients receive care appropriate to the patient's needs, whether physical, psychological or spiritual.

1) Physical and psychosocial needs are addressed through the skills of multi-disciplinary caregivers who assess, diagnose and treat patients. Competence of the caregivers is assessed through the hospital competency assessment process as well as the credentialing and privileging process of the medical staff.

2) Spiritual needs are identified by all caregivers. Pastoral care is provided through the Center for Spiritual Care. Community resources are also available. Religious and dietary requirements are met as requested by the individual.

3) The hospital actively supports the needs of the bereaved at the time of a patient’s death, and during the grieving process. The hospital participates in identifying community needs and developing support groups and community awareness.

4) Spiritual resources, educational materials and other supportive resources are age appropriate, with services, resources and education serving neonatal, pediatrics, adolescents, adults and geriatric patients.

5) Special populations are recognized.

6) Policies and procedures for identifying and reporting child abuse, sexual assault, domestic violence and endangered adults are in place and responded to in the Emergency Department and for inpatients. Education is provided for staff.

7) The hospital maintains access to individuals and communities that assist with translation, and responds to those with physical challenges (i.e., hearing impaired, visually impaired, communication impaired).

8) Staff and community resources are identified and made available for out of town patients/families with no local resources, for the visually and hearing impaired, for those with emotional or developmental challenges, and for various cultural and ethnic groups.

B. PATIENT’S RIGHTS IN DECISION MAKING

The patient participates in all decision-making processes, including informed consent, and the
chart documents legally designated representatives, family, and other emergency contact persons, to assist the patient when he/she is unable to communicate individually. Advance directive education is provided, and documented in the medical record. Patient/family has access to the Ethics Committee.

C. RESOLUTION OF CONFLICT IN DECISIONS

When conflict occurs regarding a decision, resolution of the conflict may be facilitated through the use of a number of mechanisms.

Ethical conflicts will be referred to the Ethics Committee. Employee conflicts will be referred to the Human Resources Department. Conflicts or concerns regarding other issues are referred to the appropriate manager, executive administrator, or medical staff for resolution.

D. DECISIONS TO FOREGO OR WITHDRAW LIFE-SUSTAINING TREATMENT

The patient has the right to refuse or forego life-sustaining treatment.

Saint Joseph Regional Medical Center – Plymouth will support the competent patient’s right to determine treatment options in accordance with Indiana and Federal laws.

E. FORMULATION OF ADVANCE DIRECTIVES

Saint Joseph Regional Medical Center – Plymouth provides education, information and opportunities for individuals to formulate advance directives, and/or designate a health-care representative in accordance with the Patient Self-Determination Act.

1) Patients (and/or their designated health care representative or legal guardian) participate in education and decision-making.

2) Advance directive status is inquired during the initial registration process for inpatients and outpatients and additional information is obtained during the assessment process for adult inpatients.

3) Social work services are available to patient/families to assist with advocacy, education and access to services.

F. DECISIONS TO WITHHOLD RESUSCITATIVE MEASURES

Saint Joseph Regional Medical Center – Plymouth respects the right of the patient to express his/her wishes regarding resuscitative measures. Consultation between physicians, family members, staff and the patient or his/her representative will occur in order to clarify, document and implement the patient’s wishes regarding resuscitative measures.

G. DECISIONS RELATIVE TO CARE AND TREATMENT AT THE END OF LIFE

Services are provided to patients who are terminally ill to assist in meeting the spiritual needs of the patient and their support persons. Standards for Care of the Dying as well as social services, pastoral care and referrals to appropriate programs, e.g., Hospice, are made.

H. CONFIDENTIALITY OF INFORMATION

Only those individuals involved in the care of the patient or those individuals with administrative responsibilities involving the services rendered to the patient will have access to patient information. Mechanisms for access to records, which safeguard the patient’s right to confidentiality, are in place.
I. PRIVACY AND SECURITY

The patient’s right of privacy will be met through the use of doors, cubicle curtains, and appropriate draping for procedures. Patients unable to express their need for privacy will be afforded the same respect as those who are able to verbalize their needs.

Safety needs are met through the use of appropriate safety/security devices, e.g., wheelchairs, walkers, side rails, etc.

Environmental security is provided by the Security Department, which maintains regular surveillance of the buildings and grounds and is available to provide additional assistance for events requiring their expertise.

Security of valuables and personal belongings is provided. Closets in patient rooms provide storage. There is also a safe in the Emergency Department. It is encouraged that valuables be left at home.

J. COMMUNICATION

Patients requiring the services of a translator, or those who have a hearing impairment and communicate through the use of American Sign Language, will be assisted with communication by individuals fluent in the patient’s language. Use of the Cyracom line is available. References of individuals and organizations available for translation service are available to all staff.

Adaptive devices, i.e., communication boards, etc. are available for patients who require them. Special telephone adapters are available to meet the needs of the hearing impaired.

K. RESOLUTION OF COMPLAINTS

Patients or their family members/significant others who have a complaint or concern regarding their care, services provided or billing will be offered resolution through a number of mechanisms. All members of the management and administrative staff will be available to assist in the prompt resolution of complaints.

L. ORGAN DONATION

Saint Joseph Regional Medical Center – Plymouth, in collaboration with the medical staff, has implemented a policy and mechanism for the procurement and donation of organs and other tissues. Indiana Donation Alliance, which consists of The Indiana Organ Procurement Organization (IOPO), Red Cross Tissue, & Lion’s Eye Bank, provides services and education to potential donors/families and to staff members.

M. RESEARCH, EXPERIMENTATION, CLINICAL TRIALS

No research, experimental and/or clinical trials will occur without the approval from the governing board, administration, medical executive staff and involved patient.

Patients and patient representatives are educated regarding patient rights, responsibilities and advance directives along with how to report concerns upon admission to the hospital. The information provided contains detailed explanations regarding:
1. Patient rights
2. Obtaining Information about your treatment and health care team
3. Making decisions about your care (involvement and participation in care)
4. Comfort and safety practices
5. Privacy and Confidentiality of all communications
6. Advance Directives
7. Responsibilities as a patient

VI. DEFINITION OF PATIENT SERVICES, PATIENT CARE, AND PATIENT SUPPORT

Patient services at Saint Joseph Regional Medical Center – Plymouth occur through an organized and systematic process designed to ensure the delivery of safe, effective and timely care and treatment. Providing patient services and the delivery of patient care requires specialized knowledge, judgment and skill derived from the principles of biological, physical, behavioral, psychosocial and medical sciences. As such, patient services will be planned, coordinated, provided, delegated and supervised by professional health care providers who recognize the unique physical, emotional and spiritual needs of each person. Patient care encompasses the recognition of both disease and health, patient teaching, patient advocacy, spirituality and research. Under the auspices of Saint Joseph Regional Medical Center – Plymouth, medical staff, registered nurses and allied health care professionals function collaboratively as part of a multi-disciplinary team to achieve positive patient outcomes.

In the strictest sense, patient services are limited to those departments that have direct contact with patients. The full scope of patient care is provided only by those professionals who are also charged with the additional functions of patient assessment and planning patient care based on findings from the assessment. Patient services and patient care are provided primarily by licensed staff. Patient support is provided by a variety of individuals and departments, which may not have direct contact with patients, but who support the care provided by the hands-on care providers.

VII. PATIENT CARE DEPARTMENTS

Patient care departments are those inpatient and outpatient departments that provide patient services and/or patient care and where services and/or care are rendered by the types of staff described above.

Inpatient Care Units
- Medical/Surgical
- Critical Care Unit
- New Beginnings Birthplace (LDR and Post Partum)

Patient Services Departments
- Emergency Department
- GI Laboratory
- Pharmacy*
- Laboratory
- Radiology
- Nuclear Medicine
- Rehabilitation Services
  - Speech and Audiology
  - Physical Therapy
  - Occupational Therapy
  - Cardiac Rehabilitation
- Outpatient Care Unit
- Center for Spiritual Care*
- Post Anesthesia Care Unit
- Operating Room/Surgery
- Nutritional Services*
- Cardiopulmonary Services
- Radiation Oncology
VIII. STAFFING

Hours Of Care

Hours of care are defined as the hours, on **average**, that a patient will receive patient care per day. Because this is an average, some patients may receive more or less hours of care depending on each patient’s particular needs or acuity.

Hours of care are formulated from the historical evaluation of the Medical Surgical and Critical Care patient population. Professional organizations also have recommendations for hours of care.

The Medical Surgical and Critical Care Departments have divided the hours of care required by each shift. Then, utilizing the ANA principles of staffing, the following factors are evaluated to determine appropriate staffing. 1) Patient Care/Unit related considerations 2) Staff related considerations 3) Institution/ Organization related considerations 4) Historical evaluation and recommendations.

In consideration of these aforementioned factors, there may be occasions when a unit may be over or under in hours of care. This evaluation takes place multiple times a day and as often as appropriate.

Each year during budget development, these four factors, plus the hours of care are evaluated. If it is noted that a particular unit is frequently under or over in its utilization of hours of care, and in the absence of quality or staff related indicators (i.e. turnover, long vacancies, etc.) the hours of care may be adjusted accordingly.

**Staffing plans** for patient care service departments are developed based on the level and scope of care that needs to be provided, the frequency of the care to be provided, and a determination of the level of staff that can most appropriately provide the type of care needed.

Each department has a staffing plan, which is reviewed each fall as part of the budgeting process, and is based on the following criteria:

- utilization management
- employee turnover
- performance improvement activities
- changes in customer needs/expectations

A. Establishing Adequate Staffing Patterns and Measuring Staff Effectiveness

Saint Joseph Regional Medical Center-Plymouth utilizes several factors when establishing an adequate staffing pattern for all of its departments.

- The nursing departments utilize the ANA principles for Nurse Staffing along with their respective professional organizations.
- Registered Nurses are utilized in all nursing units (No LPN’s)
- Non nursing areas utilize their professional organization’s standards and or the respective history that, through outcomes, has proven to be an effective model.
- A quarterly report card demonstrating organizational outcomes is utilized to measure the effectiveness of the staffing model
Feedback from medical staff and other relevant stakeholders

B. Evidence to support the establishment of staffing levels

The areas that are reviewed when establishing a staffing pattern are broken down into three areas. Those areas are 1) Patient Care Unit Related, 2) Staff Related and 3) Institution/Organization Related. Professional organization standards are considered & utilized, as appropriate.

PATIENT CARE UNIT RELATED

The following are the critical factors that must be considered in the determination of appropriate staffing levels.

- **Patients** - The patient characteristics and number of patients for whom care is being provided
- **Intensity of unit and care** - Individual patient intensity across the unit intensity, variability of care, admissions, discharges and transfers, volume.
- **Context** - Architecture (geographic dispersion of patients, size and layout of individual patient rooms, arrangement of entire patient care unit(s)) technology (beepers, cell phones, computers), same unit or cluster of patients.
- **Expertise** - Learning curve for individuals and groups of nurses, staff consistency, continuity and cohesion, cross training; control of practice; involvement in performance improvement activities; professional expectations; preparation and experience.
- **Patient Specific Considerations** - Age and functional ability, communication skills, cultural and linguistic diversities, severity and urgency of admitting condition, scheduled procedures, availability of social supports, other specific needs identified by patient or healthcare provider.
- **Unit Functions** - Unit governance, involvement in performance improvement activities, use of evidence based care protocols, and evaluation of practice outcomes

STAFF RELATED

Staff role responsibilities and competencies of each nursing or healthcare team member should be well articulated and defined. The following characteristics should be taken into account when determining staffing;

- Experience with the population being served
- Level of experience
- Education and preparation, including certification
- Language capabilities
- Tenure on the unit
- Level of control of practice environment
- Degree of involvement in Performance Improvement
- Measure of immersion in activities such as nursing research which add to the body of nursing knowledge
- Measure of involvement in interdisciplinary and collaborative activities regarding patient needs in which the nurse or other healthcare team member takes part
- The number and competencies of clinical and non-clinical support staff the RN must collaborate with and supervise
INSTITUTION/ORGANIZATION RELATED

The organizational policies should recognize the needs of both patients and nursing staff and provide the following:

- Effective and efficient support services
- Access to timely, accurate, relevant information provided by communication technology that links clinical, administrative and outcome data
- Sufficient orientation and preparation including nurse preceptors and nurse experts to ensure RN and other Healthcare teams members competency
- Preparation specific to technology used in providing patient care
- Necessary time to collaborate with and supervise other staff
- Support in ethical decision making
- Sufficient opportunity for care coordination and arranging for continuity of care and patient and/or family education
- The right for staff to report unsafe conditions or inappropriate staffing without personal consequences and;
- A logical method for determining staffing levels and skill mix

PROFESSIONAL ORGANIZATIONAL STANDARDS

When available, the respective professional organization and other health-related organizations staffing standards will be utilized.

C. Measures of the effectiveness of staffing

Saint Joseph Regional Medical Center-Plymouth utilizes data to identify staffing needs and to assess staffing effectiveness. The following clinical/service (C/S) & human resource (HR) screening indicators are monitored on an ongoing basis to determine staffing effectiveness.

- Overtime (HR)
- Family Complaints (C/S)
- Patient Complaints (C/S)
- Staff vacancy rate (HR)
- Staff satisfaction (HR)
- Patient falls (C/S)
- Adverse drug events (C/S)
- Staff turnover rate (HR)
- Nursing care hours per patient day (HR)
- Staff injuries on the job (HR)
- Injuries to patients (C/S)
- Skin breakdown (C/S)
- Hospital acquired pneumonia (C/S)
- Postoperative infections (C/S)
- Urinary tract infections (C/S)
- Cardiac arrest and Rapid Response events (C/S)
- Length of stay (C/S)
- Case Mix Index
- Utilization of Patient Care Sitters
- Patient Care Population characteristics and demographics

IX. PATIENT CARE ORGANIZATIONAL PERFORMANCE IMPROVEMENT ACTIVITIES
All departments are responsible for following the organization’s plan for Improving Organizational Performance.

X. SUPPORT SERVICES

Other hospital services are available and provided to ensure that direct patient care and services are maintained in an uninterrupted and continuous manner, by coordinating identified organizational functions such as: leadership/management, information systems, human resources, environment of care, infection control, and organizational performance improvement. These services support the comfort and safety of the patient and the efficiency of services available. These support services are fully integrated with the patient services departments of the hospital.

XI. INTEGRATION OF PATIENT CARE AND SUPPORT SERVICES

The importance of a collaborative multi-disciplinary team approach, which takes into account the unique knowledge, judgment and skills of a variety of disciplines in achieving desired patient outcomes, serves as a foundation for integration. Open lines of communication exist between all departments providing patient care, patient services and support services in the hospital and, as appropriate, with community agencies to ensure efficient, effective and continuous patient care. Nursing and patient care support services participate as appropriate in multidisciplinary and keystone rounding for coordination of care purposes.

XII. DEPARTMENTS

A. ADMINISTRATION

A Board of Directors, composed of community leaders and physicians, governs Saint Joseph Regional Medical Center – Plymouth. The Board guides strategic planning and the management of the organization. The administrative staff includes the President, Chief Nurse Officer, Hospital Administrator, Risk and Patient Safety Representative, and the Performance Improvement Representative. (See Organizational Chart for department responsibility.)

The Chief Nurse Officer, President and Hospital Administrator, along with the Administrative Ops team, is appropriately integrated with the medical staff and the support staff resources in the hospital. This is accomplished not only by organizational relationships, but by structure, council, and various team memberships and relationships.

B. RADIATION ONCOLOGY

Scope: The Radiation Oncology Center treats patients that have been diagnosed with cancer by administering ionizing radiation. The radiation is delivered externally via x-rays or electrons from a linear accelerator. Treatments are performed more commonly on an outpatient basis but occasionally on an inpatient basis, as needed.

Staffing Plan: Radiation Oncology services are provided Monday thru Friday from 8:00 AM to 4:00 PM with certain holidays excluded. Occasionally, heavy patient volume or other events may dictate that patient care activities take place prior to or after listed hours. Staffing for the department is based on patient acuity, volume, & the intensity of the treatments being provided. Daily staffing for 25 patients or less requires 2 Radiation Therapists, a Registered Nurse, a Dosimetrist, and a Receptionist. If daily treatment volume exceeds 25, it will be necessary to consider the addition of another Radiation Therapist and to extend treatment hours. Physics support is provided by a contractual
relationship. The Center contracts with Michiana Hematology Oncology to provide physician support Monday – Friday, with after hour care available with the Radiation Oncologist on call for Michiana Hematology Oncology. The Department offers an Oncology Patient Navigator to meet with newly diagnosed patients across the health system on an as needed basis.

**Organizational Relationships:** Radiation Oncology is integrated and works collaboratively with other departments within the organization as needed.

**C. CARDIOPULMONARY**

**Scope of Practice:** The Cardiopulmonary Department provides complex services to all ages of patients with acute and chronic illness and is defined as an allied health care specialty with medical direction in the treatment, management, control, diagnostic evaluation, and care of patients with deficiencies and abnormalities with the cardiopulmonary system. Additional activities include: diagnostic assessment, therapy, education of the patient and family and continuum of care. Diagnostic assessment methods include; Respiratory care assessment and protocol indicators, cardiac monitoring, cardiac sonography, cardiac stress testing, pain management procedures, electro diagnostic, and neurologic testing. Therapy includes the application and monitoring of medical gases (excluding anesthetic gases) and environmental control systems, mechanical ventilator support, artificial airway care, bronchopulmonary hygiene, pharmacological agents related to respiratory care procedures and coordinating patient discharge through appropriate home care agencies.

**Staffing Plan:** The Cardiopulmonary Department is staffed with licensed Respiratory Care Practitioners, registered or registry eligible cardiovascular and diagnostic sonographers along with PRN registered radiologic Nuclear Medicine technologists. Respiratory Care services are provided 24 hours a day, 7 days a week. Cardiac, pain management, electro diagnostic, and neurology services are provided Monday-Friday with on-call services for emergency services. Cardiopulmonary is staffed Monday-Friday with at least one Respiratory Therapist. Three days per week there is an additional therapist that provides PFT procedures, as well as, assistance during high volume respiratory needs. Midnight and Weekend coverage is provided with one therapist working 12-hour day/afternoon shifts and one therapist working a 12-hour afternoon/midnight shift. Workloads that exceed normal staffing levels, are met with scheduled overtime and staff adjustment. Respiratory workload equivalents, exceeding normal staffing levels, are the total number of scheduled procedures, per shift, requiring twenty minutes or more to perform. One additional therapist will be added to day and afternoon shifts when workload procedures exceed 64 and one additional therapist as procedures increase by 12. One therapist will be added to the midnight shift when procedures exceed 48 and one additionally as procedures increase by 12. An additional staff person, which is ACLS certified works Monday through Friday to provide cardiac support during procedures, holter/event hook-ups/reading, EKG’s and monitors department needs throughout the day. Our Echo Department is staffed by registered Echo Sonographers, 10 hours/day, Monday – Friday from 7:00 a.m. – 5:00 p.m. and on-call weekends from 7:00 a.m. – 7:00 p.m. Holidays are treated like weekends.

**Organizational Relationships:** Cardiopulmonary is fully integrated with all other departments.

**D. CLINICAL EDUCATIONAL SERVICES**

Educational Services are coordinated by a full-time Mastered prepared, Certified RN-Clinical Education Specialist.

**Scope:** Educational Services provides support for staff educational activities through
classroom facilities, on-line programming and attendance documentation. Clinical education provides proactive strategies, which result in excellence in clinical practice. Educational presentations and initiatives are provided by an Evidenced Based, multi-modal systematic approach. Assessment of RN learning needs will be done in conjunction with the Clinical Education Specialist bedside colleagues and, Managers of the Nursing Units. Educational services also assists in competencies for licensed and unlicensed personnel throughout the facility. Assistance is also given for community health educational events, and space provided and coordinated for community support groups.

**Organizational Relationships:** Educational Services are integrated throughout the facility. The department has membership in Performance Improvement teams and Shared Leadership in order to implement changes that occur through education and utilizes staff expertise to aid in disseminating and teaching within all clinical departments.

F. EMERGENCY DEPARTMENT

**Scope:** It is the role of the Emergency Department to minimize danger to the emergency patient and promote safe and timely health care in accordance with standards set by the Consolidated Omnibus Reconciliation Acts of 1985. All patients presenting to the Emergency Department will be provided with a Medical Screening Examination by a physician to determine whether the patient is suffering from an emergency medical condition. A screening exam includes services in the emergency department as well as services offered by intra-hospital departments with specialized equipment. The Emergency Department staff will serve the community by rendering prompt and adequate treatment of emergency health conditions through medical and nursing care; to meet the physical, emotional and spiritual needs of all persons presenting themselves for treatment; and to provide appropriate health care education through discharge planning. Everyone who seeks care in the Emergency Department is cared for regardless of the complaint and/or financial status. The Emergency Department provides appropriate care based on the intensity and complexity of each individual patient’s presenting illness/injury. The Emergency Department emphasizes the human as well as the technological aspects of medicine, and strives to promote the psychological and physical well-being and comfort of our patients.

**Staffing Plan:** The Emergency Department is well-organized, properly managed and staffed according to the nature and extent of the health care needs. Emergency care is provided by qualified individuals and appropriate services are provided through a well-defined plan based on the community needs and the defined capability of the hospital. The Emergency Department offers emergency care 24 hours a day, with at least one physician and Registered Nurses experienced in emergency care on duty in the emergency care area, and with specialty consultations available within 30 minutes by members of the Medical Staff. All nursing staff is ACLS and PALS certified within 1 year of hire date. The staffing ratios are consistent with ENA standards and assures triage on a 24/7 and 365 day basis. Nurse Practitioners and Physician Assistants provide support to the Emergency Department physicians during peak volume periods. On an annual basis, Administration reviews the patient census, quality outcomes, staff perception of safety and engagement, acuity and FTE reports. Based on this data, FTEs are determined to meet best practice standards. On a biweekly basis, the Director reviews the FTE report and Labor Distribution report to explain variances. On a daily shift to shift basis, the Director and the Administrative Supervisor reviews the staffing needs and calls for additional staffing as needed. Scheduled staff will never be reduced due to the unpredictability of Emergency Department patient census and acuity.

**Organizational Relationships:** The Emergency Department is fully integrated with all departments to ensure appropriate and timely completion of diagnostic procedures and to address special needs in the holistic delivery of care.
F. NUTRITIONAL SERVICES

Nutritional Services provides daily patient meal trays and nourishments along with a full spectrum of nutrition support, counseling, instruction, and consultations to patients and employees, as needed. These services are provided in cooperation with the patient, family, and the multidisciplinary health care team.

The Registered Dietitian is available in person three days per week, 8:00 a.m. – 4:30 p.m., three days a week. The Registered Dietitian is available on-call during off hours via Doc Halo – SJ Dietician On Call and telephone for consults, instructions and support. In the event that the on-campus Registered Dietitian is not available, alternative coverage will be provided by a PRN Registered Dietitian from the Mishawaka Campus.

The Department Supervisor of Food and Nutrition Services, is available Monday through Friday, 6:30 a.m. to 3:00 p.m.

G. PATHOLOGY AND CLINICAL LABORATORY

Scope: The Laboratory provides a wide variety of diagnostic and therapeutic clinical laboratory testing for patients of all ages and diagnostic complexities. Laboratory policies and procedures follow the regulations established under the Clinical Laboratory Improvement Act of 1988.

Hours of Operation: The laboratory operates 24 hours a day, seven days a week for inpatients, emergency room patients and urgent outpatient testing. It operates from 7:00 AM to 6:00 PM Monday through Friday and 7:30 to 11:00 AM on Saturday for routine outpatient testing.

Services: Laboratory tests performed in the laboratory are based on patient care needs as recommended by licensed independent practitioners. Additional esoteric testing performed is based on volume. Pathologists oversee the clinical and anatomical operation of the laboratory. The pathologists provide professional services including tissue, cytology and bone marrow examination. Transfusion services include the preparation and transfusion of blood and blood products and therapeutic phlebotomies. The departments within the laboratory include:

1. Chemistry/Immunochemistry/Coagulation
2. Hematology/Urinalysis/Body Fluids
3. Immunohematology/Serology
4. Microbiology/Parasitology/Virology
5. Histology/Cytology
6. Point of Care Testing

Tests not performed are processed and sent to reference laboratories approved by the medical staff.

Staffing Plan: Staffing is based on a full-serviced department. Technologists, phlebotomists and support-staff are scheduled according to projected influx of procedures. A pathologist is available seven days a week. Minimum staffing will be as follows:

Monday-Friday
- Six General Technologists (Day Shift)
- One Microbiology Technologist
- Three 3-11 General Technologists
- One 11-7 General Technologist
- Three Phlebotomists (Day Shift)
- Two Phlebotomist (Evening Shift)
- Two Support Staff
**Saturday**
One Microbiology Technologist  
One General Technologist  
Two Phlebotomist (Day Shift)  
Two 3-11 General Technologist  
Two 11-7 General Technologist  
One Support Staff  
One Phlebotomist (11p-7a)

**Sunday**
One Microbiology Technologist  
One General Technologist Day Shift  
One Phlebotomist  
Two 3-11 Technologist  
Two 11-7 Technologist  
One Phlebotomist (11p-7a)

**Patient Education:** The Laboratory is involved with educating patients and staff on the proper collection of specimens.

**Organizational Relationships:** The Laboratory is fully integrated with all departments of the hospital and works closely with the nursing units and physician offices. Members of the Laboratory are active participants on Performance Improvement Functional Teams. The laboratory is in constant communication with the medical staff regarding new and updated procedures and other patient care needs.

**H. PHARMACY**

**Scope:** The scope of service includes preparation and dispensing of medication pursuant to federal and state regulations, formulary review and maintenance, drug and drug interaction information, and medication usage evaluation. Scope also includes medication event monitoring, adverse drug reaction monitoring & reporting, pharmacokinetic dosing, nutritional support, monitoring of renal function/Creatinine clearance, education of hospital staff, and community-wide education. Pharmacy will also monitor/document their interventions and medication errors, including physician related prescribing errors. Pharmacy will provide counseling and education to patient/caregiver if/when appropriate; All ages & complexities of patients are served by the Pharmacy Department.

**Staffing Plan:** Pharmacy services are provided seven days a week. Pharmacy hours are Monday through Friday, 6:30 a.m. to 6:00 p.m.; Saturday, Sunday, 8:30 a.m. to 2:30 p.m.

Staffing is based on a full serviced department and fluctuates with the expected daily schedule. Minimum staffing as follows:

**Monday-Friday**

Technicians: 1 from 0630-1800, and 1 from 0930-1800  
Pharmacists: 1 from 0630-1500, 1 from 0730-1600 (staffed approximately 75% of the time), and 1 from 0930-1800.

**Saturday & Sunday (and Holidays)**

1 Pharmacist & 1 Technician during operating hours

During increased volumes, Pharmacy Manager will assist when not already staffing. Additional staff will be called in when necessary. Electronic orders are validated by Saint Joseph Regional Medical Center-Mishawaka when Plymouth pharmacy is closed. If an issue cannot
be reconciled by Mishawaka Pharmacy staff they have the option to contact the Plymouth Pharmacy Manager. After the pharmacy manager, the hospital admin on call can be utilized if needed.

Organizational Relationships: The Pharmacy Department is fully integrated with the rest of the hospital. Members of the Pharmacy staff sit on various hospital teams.

i. RADIOLOGY

Scope: The primary purpose of radiology services is to provide a study of the anatomical process of the human body by acquiring diagnostic images. Radiographic diagnostic procedures are performed on outpatients and inpatients of all ages and complexity. Along with providing plain and fluoroscopic radiographic images the department provides, Diagnostic Ultrasonography, Nuclear Medicine, Mammography and Breast Localizations, Bone Density and Computerized Tomography. The department provides support to the Emergency Department, CCU, Surgery, Obstetrics, Medical Surgical Unit and portable services to all patient care areas as ordered by a licensed independent practitioner and approved or reviewed by a radiologist.

Staffing Plan: Radiologic technologists cover Plain Radiology, Fluoroscopic Radiology, CT, Mammography, and Bone Density, Monday through Friday 7a-5p. Plain Radiology and CT are covered seven days a week, 24 hours a day. Weekends are covered with one Radiologic Technologists along with an additional Radiologic Technologist on call for help/back up. Nuclear Medicine, Diagnostic Ultrasound and Mammography are staffed with registered or credentialed technologists in the prospective field of their expertise. These services are available Monday through Friday 7a-5p. Nuclear Medicine and Diagnostic Ultrasonography procedures can also be done on an urgent or emergency basis during the evenings and weekends. Staffing is based on a full service department and fluctuates with the daily schedule and projected influx of procedures due to other department schedules. The radiology manager is available to help as volumes increase. Part time and PRN staff is available for extreme circumstances. Depending on the acuity of the patient, a nurse or other support staff may accompany the patient to the radiology department. A radiologist is on duty within the department 5 days a week (M-F) from 8 AM until 4:30PM. A Radiologist is available at the Mishawaka facility until 10pm on weekdays and 8 pm on weekends. All other hours are covered by Night Shift for Radiology interpretations. Holidays are treated like weekends.

Full Service Staffing Plan:
Minimum staff is one technologist for the following modalities every weekday:
Computerized Tomography
Nuclear Medicine
Mammography
Ultrasound
Plain x-ray film – main department
Diagnostic Room in the Emergency Center
*** Additional staff is added as volumes increase.

Full Schedule:
Computerized Tomography – 2
Nuclear Medicine – 2
Mammography – 2
Ultrasound – 2
Plain x-ray film – main department – 2
Diagnostic Room in the Emergency Center - 1

All radiologic technologists are registered by the American Society of Radiologic Technologists (ASRT) and certified by the Indiana State Board of Health. Many of our technologist have
additional registrations in other modalities, such as CT, Mammography, and Nuclear Medicine.

Organizational Relationships: The Radiology Department is fully integrated with all other departments. Members of the Radiology Department sit on various teams and task forces.

J. DIAGNOSTIC SERVICES - CARDIOVASCULAR/SPECIAL PROCEDURES SECTION

Hours of Operation - 8 am to 4:30 p.m Monday, Wednesday and Friday.

Scope of Service

Patient care is provided to adolescent, adult and geriatric patients undergoing evaluation and care for cardiovascular diseases.

The special procedures lab provides diagnostic and interventional procedures involving major organ malady.

The goal is to restore the patient to optimum health.

Cardiac Services:
- Elective cardiac catheterization
- intra-aortic balloon pump placement
- permanent and temporary pacemaker implantation
- transesophageal echocardiography
- cardioversion
- pericardiocentesis
- tilt table studies
- peripheral vascular angiography and angioplasty

Interventional Radiology Services
- peripheral vascular angiography and angioplasty
- vascular embolizations
- uterine artery fibroid embolization
- venous angiography and intervention
- inferior vena cava filters
- Picc lines
- central lines
- port-a-caths
- vertebroplasty
- organ and lesion biopsies
- organ drainage
- abscess drainage
- thoracentesis
- paracentesis
- chest tubes

Staffing Plan

Clinical Supervisor- 1, RN – 2, RT-1

Staffing adjusted to meet patient needs.

Competencies

Radiologic Technologist – State licensure, ARRT Registry (CEUs necessary to maintain), competency skills checklist, annual performance valuation, mandatory inservices, ACLS certification (optional)

Registered Nurse - State licensure, American Heart Association certification, competency
J. Cath/IR

Scope: Outpatient Department consists of one procedure room and one holding room. The department is open on Wednesdays from 8:00 a.m. until 4:00 p.m. Types of procedures are multiple types of CT guided biopsies as well as ultrasound guided biopsies, Paracentesis, thoracentesis, PICC line placements, abscess drain placements check/changes, tilt table studies, TEE, and Cardioversions.

Staffing: We staff according to volumes, usually 2 RN's and 1 Radiology Technologist. We have one Interventional Radiologist in the department.

K. REHABILITATION SERVICES

Scope: The primary purpose of Rehabilitation Services is to provide patients of all age groups with comprehensive services in the Inpatient Acute and Outpatient Therapy areas. This includes but is not limited to an initial assessment/evaluation, re-evaluation, development of a treatment plan, documentation of care, consultation, education, discharge planning and the use of appropriate treatment techniques specific to the patients needs. The treatment program/protocol recognizes the individual's personal goals and these are incorporated into those of the referral source and the therapist providing treatment.

Staffing Plan: Rehabilitation Services (Occupational Therapy, Physical Therapy, and Speech Therapy, and Cardiac Rehabilitation) are routinely provided Monday - Friday from 0715 to 1900 on prescribed medical referral that is consistent with the Indiana Practice Act for each discipline. Each professional of Physical, Occupational, and Speech Therapy shall provide, on average, 6.5 billable hours. Exception to this standard may occur if individual patients with a specific diagnosis require services from a professional that is certified in that particular treatment area. Cardiac rehabilitation will provide hours consistent with patient care needs. These will be assessed by the overseeing physician. Ancillary staff consisting of senior and junior Physical Therapy aides shall be scheduled Monday through Friday from 0715 to 1900 based on volumes and patient acuity. This is determined weekly according to scheduled patients. Hours for ancillary staff including Physical Therapy Assistants and Certified Occupational Therapy Assistants shall flex up or down during this time to meet the patient's needs. Minimum staffing for the Inpatient and Outpatient Adult therapy setting for Speech Therapy and Occupational Therapy is allowed since there is only one Speech Therapist and one Occupational Therapist that covers both areas.

Weekends, after hours, and Holiday services are driven by volumes and are accommodated on a PRN basis with all professional Rehabilitation Services staff scheduled to be on call. Anticipated average in Physical Therapy during off hours is 2.5 billable hours. The professional shall flex up or down during this time to meet the patient's needs. Should Occupational or Speech Therapy receive orders for patient care during off hours, the Physical Therapist scheduled to cover given holiday or weekend shall contact the Occupational or Speech Therapist. Baseline staffing of aides and Physical Therapy Assistants in Physical Therapy will be available on weekends, after hours, and holidays for support of the Physical Therapist. These staff members attendance is based on volume and patient acuity and shall be determined on an as needed basis weekly.

The Rehabilitation Services staff consists of physical therapists, physical therapy assistants, speech pathologist, occupational therapists, occupational therapy assistant, rehabilitation aides, rehabilitation service technician, and nursing staff or exercise physiologists with cardiac specialization and the cardiac rehabilitation physician/medical director. Additional staff is recruited as specific needs are identified and patient treatment hours exceed national standards that are defined by each of the Rehabilitation Services disciplines. Staffing hours
are adjusted for variances in caseload. Staff is not required to work overtime but may do so in times of high patient census, scheduled hours and volume of service.

**Organizational Relationships:** Rehabilitation Services Department is fully integrated with the rest of the facility. Members of the Rehabilitation Services staff sit on various teams and task forces. There is a high level of open communication between all departments of the facility and Rehabilitation Services.

**L. CASE MANAGEMENT**

**Scope:** Case managers coordinate the admission process and provide consultative discharge planning, community referrals, patient/family conferences, multi-disciplinary collaboration, patient advocacy, planning for daily living, education, transfers to rehab facilities, home health care arrangements, and nursing home placement. Also provide psychosocial intervention/counseling, assist with adoptions, and make referrals to financial counselors, when appropriate. All types, ages, & complexity of patients are served. Social Work is available for referrals as indicated by screening criteria.

**Staffing Plan:** Case Management Services are available Monday through Friday, 8:00 a.m. to 4:30 p.m. by 3 full-time RN Case Managers, 1 full-time Social Worker, and 1 PRM RN Case Manager. There is a full time RN Case Manager available by phone every weekend from 9:00 a.m. – 9:00 p.m. Referral to a social worker is available for consults, when patient needs are identified. The case managers would also be available in an emergency situation to assist in the provision of patient care. Case Managers are available for all departments of the hospital.

**Organizational Relationships:** Case Management is fully integrated with all other departments. Staff participate on hospital teams.

**M. SAINT JOSEPH HEALTH CENTER**

**Scope:** Saint Joseph Health Center Outreach Services provides care to the Uninsured and Insured of the community. SJHC works closely with the Emergency Department and Case Management by providing follow up care after being seen in the ED or after being discharged from the hospital as a 24 hour observation patient or inpatient. SJHC educates and supports patients in their understanding and the navigation process of becoming insured. SJHC, provide financial applications for all uninsured and underinsured patients to complete to determine if they qualify for hospital financial charity. Services provided to patients are primary and routine care. Services include: health education, health screening, preventative services, and management of acute and chronic illnesses. A medication room is maintained with a medication window open on Tuesdays from 1:30 – 4:30 p.m., Wednesdays 9:00 a.m. – 5:00 p.m. and Fridays from 9:00 a.m. – 12:00 noon. Food pantry services are available the hours the clinic is open. Patients in need of food assistance are provided 1-2 bags of food within a 30-day window. An automated telephone system greets all callers to the SJHC and provides quick access to medication refills, access to "how to become a SJHC patient", how to make an appointment, and to afterhours care 24/7.

**Staffing Plan:**
- 3 Full Time Family Nurse Practitioners
- 1 – Volunteer Medical Director
- 3 Full Time Certified Medical Assistants
- 1 Full Time RN
- 1 Full Time Manager/MSW
- 1 Part Time Certified Medical Assistant
- 1 PRN Certified Medical Assistant
- 3 Full Time Medical Receptionists
Volunteers support the following areas within the SJHC: front desk greeters, Food Pantry Support, Medication Room Window Greeters, and general volunteer support as needed.

1 Volunteer Physicians who visit 1 time a month for 2-3 hours

**Hours of Operation:**
Saint Joseph Health Center is open Monday, Wednesdays, Thursdays from 8:15 am – 5pm, Tuesdays from 8:15 am – 7pm, and Friday from 9am – 12 noon.

**Organization Relationships**
SJHC is fully integrated with all other departments along with the Saint Joseph Physician Network, Health Insurance Services, Mishawaka Campus Outreach Services. SJHC staff participates on a variety of hospital teams. SJHC participates with and is a member/receiving agency of the United Way of Marshall County and participates with numerous Outreach Activities. The SJHC is located in the Community Resource Center (CRC) and closely networks with the other social/medical services agencies located within the building such as Real Services, Health Insurance Services, Visiting Nurses, Cardinal Services, Township Trustee, SNAP and Medicaid.

N. **INPATIENT NURSING UNITS**

1) **Critical Care Unit (CCU)**

**Scope:** The Critical Care Unit provides care for both medical and surgical patients 18 years and older with diagnosis of status epilepticus, renal failure, drug intoxication, major surgical cases, acute and R/O MI’s, multi-system failure, shock, hemorrhage, acute respiratory failure or distress and severe hypertension. These patients may be placed in CCU due to their need of cardiac or hemodynamic monitoring, cardioversion, close observation of vital signs and condition, ventilatory support, or drug titration.

Patients requiring diagnostics such as cardiac catheterization, TEE, and some kinds of interventional radiology may need to be transferred to a facility providing this testing. Those needing renal dialysis, ICP or close neurologic monitoring due to trauma will also be transported to a facility offering those services.

**Staffing Plan:** CCU is a 7-bed inpatient unit that provides nursing care 24 hours a day, 7 days a week. It consists of an all RN staff, with secretarial assistance 20 hours per week. Staffing takes into account hours of care, patient acuity, and the skills needed for the care of the patients present. If the Unit is empty and there are no telemetries there is at least 1 CCU RN in the building and a second RN on call. If the unit is empty and there are telemetries, there is at least one RN in the unit to watch the telemetry and one RN on call. Maximum staffing is 3 RN’s on the day and evening shift and two RN’s on the night shift, however, another RN or assistant may be added if the acuity is such that it is needed.

2) **Medical-Surgical Unit**

**Scope:** The Medical-Surgical Unit provides patient care to a minimal to moderate complexity of patients from pediatric to geriatric, 24 hours a day, seven days a week. The Medical Surgical Unit provides care to patients with a variety of diagnoses to include but not limited to orthopedic, oncologic, cardiac and respiratory disorders and general surgery. Patients requiring diagnostics such as cardiac catheterization, ERCP and other types of interventional radiology may need to be transferred for procedures.

**Staffing Plan:** The Medical Surgical Unit is a 30 bed unit that provides nursing care 24
hours a day, 7 days a week. The staff consists of registered nurses, nursing assistants and unit secretaries. Staffing is based on hours of care, patient acuity, skill level needed to provide care required and the level of experience of the staff assigned. The staffing for each shift is determined by an ongoing reassessment of the needs of the unit at least every 8 hours.

Additional staffing is obtained through use of PRN Staff, staff working extra hours, or the Supervisor may be called in to assist in staffing.

3) Obstetrics:

Scope: The Plymouth Obstetrics provides nursing care to the obstetric patient and infant, as well as overflow of clean surgical cases (i.e. gynecology and cholecystectomy patients) 24 hours a day, seven days a week. This includes but is not limited to pregnancy and pregnancy related diagnoses, antepartum patients with complications, post-operative gynecology patients and post-operative cholecystectomy patients. Services provided to mothers and infants includes: induction, amniotomy, amnioinfusion, non-stress tests (NST), nitrous oxide, cesarean sections, venipuncture, epidural and spinal anesthesia, infant oxygen therapy, circumcision, and treatment for hyperbilirubinemia. Outpatients are seen to evaluate labor symptoms, NSTs, pregnancy induced hypertension (PIH), injections/infusions, and fetal surveillance.

Obstetrics Admission Criteria: Plymouth Obstetrics will accept all pregnant patients greater than or equal to 20 weeks gestation for admission. In the even the pregnant patient requires a higher level of care the Obstetrician in collaboration with a physician at a higher level of care facility will arrange for transport.

Nursery Admission Criteria: The New Beginnings Birthplace will admit all newborns born at this facility to the newborn nursery. An exception to this admission is if the NICU team from a higher level of care facility is on site for delivery. In this case the newborn will be admitted per the guidelines of that facility. If a newborn requires a higher level of care after admission transport arrangements will be made by the newborn’s attending physician in collaboration with a neonatologist at a facility with a NICU. Newborns less than 35 weeks gestation will be transferred to a NICU facility.

Staffing Plan: The New Beginnings Birthplace operates 24 hours/day 7 days/week. The staff consists of RNs, OB technicians, an OB Educator/Supervisor, and a Director of Maternal Child Services.

Mon –Friday day shift (7a – 7p): 3 RNs, OB Educator/Supervisor, Maternal Child Services Director

Staffing can be reduced to 2 RNs when there is a low patient census

Mon-Friday night shift (7a-7p): 2 RNs - minimum

Saturday & Sunday day/night shift: 2 RNs - minimum

OB Technicians are available and/or required by census.

When there is a high volume of patients anticipated OB RNs will cover up to 2 additional shifts in a six week schedule. The Administrative Supervisor will help in an emergency until additional staff arrives. Two Float Nurses are trained to staff Labor and Delivery in the event of high volume.

Staffing ratios are based on AWHONN standards. A copy of the standards is available in the Plymouth Obstetrics department as well as on AWHONN.org.
O. **OUTPATIENT NURSING UNITS**

a. **Surgical Services**

**Scope:** The Surgical Services Department provides patient care seven days, 24 hours a day to both inpatients and outpatients through all phases of the surgical experience, intra-operative care and Post Anesthesia Care Phase I. The patient population varies from pediatric to geriatric. Complexity of patient care includes minor surgical procedures to major surgical cases. Services provided includes, but is not limited to, urology, obstetrics, gynecology, general, orthopedic, ophthalmology, ENT and vascular. Anesthesia provided to include general, spinal, regional, deep sedation, and pain management post-procedure.

**Staffing Plan:** Minimum staffing requirements are based on AORN standards for a registered nurse who assumes the circulating role and a registered nurse/CST at the operative field. Additional staffing based on patient/procedure acuity, skill mix/competencies of staff, physician needs, patient census/workflow, number of OR rooms scheduled, data, etc. The clinical director provides staffing as warranted by any change in the caseload or staffing variability. The unit operates four days a week, Monday through Thursday. When the department is closed there are four staff members on call, one of which is always an RN competent in surgery and one competent in Post Anesthesia care. Two on-call staff, one of which is always an RN to circulate and a scrub personnel will be within the 30 minute response requirement. Minimum staffing for PACU will be two RN’s.

b. **GI Laboratory**

**Scope:** The GI Lab serves both inpatients and outpatients. Registered nurses/CST assist the physician with the procedure. Registered Nurses are responsible for initial assessment, preparing and monitoring the patient receiving moderate sedation and the recovery and discharge of patients post-procedure. Great Lakes Anesthesia provides anesthesia services.

Procedures include but are not limited to: colonoscopy, gastroscopy, sigmoidoscopy, and PEG placement. Clinical Team is trained in the care of the scopes and disinfection process.

**Staffing Plan:** The GI Lab is staffed with registered nurses/CST. Procedures are scheduled five days a week Monday through Friday through Surgery scheduling. Emergency procedures are done as necessary. Minimum staffing consists of the following when procedures are scheduled:

- **Pre/Post:** 2 RNs
- **Procedure:** RN, Circulatory, CST/RN to Assist during procedure.

The Supervisor provides staffing as needed. Float nurses have been oriented to assist in the GI Lab as needed.

c. **Outpatient Care Unit:**

**Scope:** The Outpatient Care Unit provides patient care 12 hours a day, Monday – Thursday, Friday from 7a – 3p. The patient population varies from pediatric to geriatric. Care provided includes, but is not limited to, pre and postoperative care, cardiac and interventional radiology procedures observation, pre-surgical testing, medical treatments, pain management, and blood transfusions. Complexity of care is limited to minor to moderate procedures. Overflow of patients will be placed on IP units as
needed with coordination from the Administrative Supervisors.

**Staffing Plan:** Minimum staffing consists of 2 RNs. Staffing may be adjusted based on census, acuity, and workflow. Additional staffing is provided by the clinical director, float nurse pool & surgical staff, as needed.

**Nursing Scope Of Care:** The practice of nursing shall include but is not limited to:

- Assessing human responses to actual health conditions
- Identifying problems and/or special needs that reflect the status of an individual, family or group
- Executing a nursing treatment regimen
- Teaching health care practices
- Collaborating with other health care personnel to promote the provision of health care
- Evaluating a patient’s response to interventions
- Executing diagnostic and therapeutic regimens prescribed by medically privileged practitioners
- Administering, supervising, delegating and evaluating nursing activities.

**Staffing and Scheduling:** A registered nurse is responsible for assigning nursing staff members to provide nursing care to patients. The following guidelines shall be considered:

1) Level of care (acuity, treatments, meds, etc.)
2) Potential for infection
3) Emotional needs
4) Educational needs
5) Level of functioning
6) Unit design
7) Safety
8) Frequency of required monitoring
9) Staff competence, skills/abilities
10) Staff mix

**Organizational Relationships:** All Nursing Units are fully integrated with all other departments.

D. **Wound Care**

**Scope:**

The Wound Care Center provides outpatient wound care services Monday through Friday and inpatient wound care services 7 days a week. Both inpatient and outpatient services are physician driven using providers from the following disciplines: Surgery, Interventional Radiology; Family Medicine; Internal Medicine; and Podiatry with one Nurse Practitioner providing collaborative support.

Advance wound services include debridement, advanced dressing application, negative pressure therapy, gold standard offloading with the use of Total Contact Cast, application of skin substitutes/biological products and hyperbaric oxygen therapy.

Wound etiology of both acute and chronic wounds include, but are not limited to burns, diabetic foot ulcer, pressure ulcer, venous stasis ulcers, and peripheral arterial ulcers. The acuity of patient care varies based on individual comorbidities with the most common being the increasing number of obese and diabetic patients.

**Staffing:**
Wound Care Clinic:

1 Case Manager (RN) per Physician clinic supported by 1 intake nurse and 1 discharge nurse. (intake and discharge nurse can be mixed skill including RN or LPN)

HBO:

Minimum staffing requires 2 specialty trained HBO staff one of which must be an RN. A specialty trained HBO physician must be on campus and accessible for the entire HBO treatment.

Inpatient Wound Care:

A trained Wound Care Physician is on call 7 days a week. Nursing coverage Monday through Friday is provided by a Wound Care Center RN. Weekend and holiday coverage is provided by a trained inpatient staff nurse, supported by an outpatient RN rotation.

ADVERSE WEATHER /STAFFING SHORTAGE ACTION

In the event of adverse weather or severe illness of several staff members (flu) the following options will be explored.

1. Ask staff currently on duty to stay over, and have the following staff come in early.

2. Call Security/Maintenance or Law Enforcement Agencies to go get staff and bring in to work if weather is adverse (i.e., snow).

3. Pull nurses from units that are not as busy and have them assist in basic nursing and patient care.

4. As a last resort, which requires executive level approval, call in agency help.

MASTER STAFFING PLAN

Unit Specific Staff Plan

♦ Hours of Care Formula

Number of FTE’s x 8 hr/shift ÷ Average Daily Census (ADC) = Hours of Care

The following information is used to calculate Nursing Hours of Care for each nursing unit:

- Historical trends including patient intensity, census and specific patient care issues
- Other area hospital budgeted hours of care
- National organization’s recommendations (such as AWOHNN, etc.)

Annual Evaluation

Annually, as part of the budget process, each nursing unit’s hours of care are evaluated based on the following criteria.

1. Scope
   - Patient volume compared to previous years
   - Patient type
- Area of operation
- Operating hours
- Changes or implementation of Protocols or Special Procedures
- Bed utilization
- Fluctuations in patient volume

2. Qualifications
   - Staff requirements compared to patient needs
   - New technology, procedures requiring education time
   - State and Federal regulations requiring education time
   - Performance improvement/risk management issues requiring education time

3. Staffing
   - Changes in care delivery
   - Shift to shift evaluation
   - Performance improvement/risk management issues requiring changes in staffing
   - Performance Improvement / Patient Outcomes
   - Patient Satisfaction Survey

4. Assignments
   - Evaluation of methods used to make assignments
   - Review of staffing variances
   - Staffing mix
   - Performance Improvement / Patient Outcomes
   - Patient Satisfaction Survey

5. Overtime/Additional FTE Usage
   - Evaluation of trends noted when reviewing overtime and FTE usage

**Daily Ongoing Evaluation**

A minimum of every eight hours the staffing needs of each unit is evaluated. The evaluation process is completed by or in collaboration with the Staffing Coordinator, Administrative Supervisor, Unit Charge Nurse or Department Director.

Each inpatient unit is staffed in accordance with their nursing care hours. In addition, patient intensity/need is discussed with the charge nurse and appropriate personnel assignments are made.

**FLOATING**

The Department Director or Administrative Supervisor is responsible for making the decision of who is to be floated. A competent Registered Nurse must be available to act as direct supervisor if a staff member has not been fully cross-trained. Nurses providing care in another department will provide basic nursing care and function within the scope of their competency and skill set in their home department.

**XIII. ADMINISTRATIVE OPS TEAM MEETINGS**

The Administration Operations Team meets every month to discuss common issues and goals, receive organizational updates and to discuss and action plan regarding patient care issues. The meeting is directed by the President, Hospital Administrator or Designee, or Chief Nurse Officer. Members of the Administrative Ops Team are as follows:
MEDICAL STAFF

i. The Medical Staff is organized, is accountable to the Board of Directors, and has responsibility for the quality of all medical care to patients and for the ethical conduct and professional practice of its members.

Membership on the Medical Staff of the Health System is a privilege, which shall be extended only to professionally competent Physicians who continuously meet qualifications, standards, and requirements set forth by Bylaws. This membership also includes physicians and podiatrists who are members of the Medical Staff on the date of the adoption of the Bylaws.

The Medical Executive Committee of the Medical Staff shall be responsible for:

1. Ensuring that activities of Medical Staff members result in patient care quality, and stewardship of resources.
2. Identifying problems or potential problems related to the delivery of overall medical care by the Medical Staff.
3. Serving as a resource to ensure that quality improvement activities incorporate effective action and appropriate follow-up.
4. Identifying continuing medical education needs of the Medical Staff through problem identification and recommended actions.
5. Ensuring that the Medical Staff meets the Standards of the Joint Commission on Accreditation for Healthcare Organizations.
Within the Medical Staff there are several departments. Each department has a Chairperson. The Chairperson of the department ensures the department is carrying out the responsibilities listed in the Medical Staff Bylaws. The departments are:

1. Anesthesiology
2. Emergency Medicine
3. Family Medicine/Internal Medicine/Pediatrics
4. Obstetrics/Gynecology
5. Pathology
6. Radiation Oncology
7. Radiology
8. Surgery

The clinical departments shall each determine the frequency of their own meetings.

Competency of the Medical Staff and provision of quality of care is measured and analyzed on an ongoing basis as a component of credentialing and privileging. Quality care is further strengthened through the establishment of multidisciplinary, service line peer review committees. The Credentials Committee of the Medical Staff is responsible for conducting, coordinating and reviewing credentials and qualification of all new and current members of the Medical Staff. The Medical Staff participates in organization-wide performance improvement activities to enhance and improve quality of the care and services provided.

XV. BUDGETING

Definition

On an ongoing basis, Directors are expected to manage their units within budget and in keeping with quality standards of patient care and personnel management.

Variances to budget are expected to be identified, documented, and justified.

Analysis

1. Daily
   - Assess patient intensity and needs
   - Assess number and skill of staff needed
   - Supervise efficiency of work performed
   - Monitor appropriate usage of supplies
   - Counsel problem employees
   - Approve, monitor overtime
   - Review hours of care

2. Weekly/Biweekly
   - Review staffing levels
   - Review overtime
   - Review hours of care
   - Analyze non-productive full time employees

3. Monthly
- Repeat weekly process, focusing on monthly and YTD data
- Look for trends, emerging problems, special situations
- Plan and implement interventions to correct variances

XVI. STAFF EDUCATION

The Clinical Education Department assures orientation and continuing educational programs which are based on documented needs of the staff. These needs are identified through analysis of data and by various other means, including results of monitoring and evaluating activities, analyzing feedback from program participants and obtaining annual input from nursing and all hospital staff for perceived educational needs. In addition, departmental educational offerings are planned and implemented each year and are presented on an annual calendar.

XVII. CLINICAL EDUCATIONAL AFFILIATIONS

Saint Joseph Regional Medical Center – Plymouth has agreements with schools of nursing, physical therapy, physical therapy assistants, occupational therapy, occupational therapy assistants, and speech language pathologists for clinical education. The Chief Nurse Officer and/or Director of Clinical Education meets periodically with multiple schools to review the needs of the organizations.

XVIII. COMMUNITY RELATIONSHIPS

The Chief Nursing Officer provides for nursing services representation to health care agencies and nursing continuing education groups for the purpose of communication, cooperative planning for new programs and/or for problem solving.
Title: Serious Reportable Events, Sentinel Events & Indiana Medical Errors

<table>
<thead>
<tr>
<th>Document Owner: Jennifer Byall</th>
<th>PI Team: PI Leadership</th>
<th>Date Created: 03/02/2017 May 1998</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): Christopher Karam, LeAnn Springman, Loretta Schmidt, Stephen Anderson, Tammy Awald</td>
<td>Date Approved with no Changes: 03/02/2017</td>
<td>Date Approved: 03/02/2017; July 6 2011</td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMC)</td>
<td>Department: Performance Improvement (14030 77400)</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:
1. Saint Joseph Regional Medical Center (SJRMC) is committed to providing quality care to all patients and preventing undesired patient outcomes or occurrences.
2. As part of the SJRMC's commitment to quality care and patient safety, appropriate steps will be taken to prevent the occurrence of these events. The purpose of this policy is to provide a procedure to identity, investigate and manage Serious Reportable Events as reportable to Trinity Health (SRE), Sentinel Events as defined by The Joint Commission and Indiana Medical Error Reporting System (Indiana State Department of Health), as well as near misses and unexpected outcomes. This policy provides the procedure in place for the management of these events.
3. Attention will be focused on understanding the factors that contributed to the event as well as changing the hospital’s culture, systems and processes to reduce the probability of such an event in the future.

PROCEDURE:
A. All parties involved in the identification and reporting processes and activities will exercise confidentiality.
B. When a SJRMC associate or Medical Staff member becomes aware of an event, they will notify the Department Director or Supervisor. If Department Director /Supervisor are unavailable, a voicemail may be left and the Administrative Supervisor must be notified.
C. When an reportable event occurs the following should happen:
   1) Take action to protect patients and to prevent similar events from occurring
   2) Sequester any medical equipment or records necessary to conduct an investigation
   3) Notify the Department Director/Supervisor or Administrative Supervisor (if not already aware)
   4) The Administrative Supervisor will Notify the Administrator On-Call
   5) The Administrator On-Call will determine if the COO/CMO/CNO and the Risk Manager/Patient Safety Officer or others need to be notified
   6) A VOICE incident report or MIDAS incident report must be completed.
D. Within 24 hours the Department Director and Senior Leadership will conduct an initial investigation to determine if the event meets the definition of a Reportable Event. this team may include:
   1) Risk Manager/Patient Safety Officer
   2) Department Director/Manager
   3) Director of Performance Improvement
Title: Serious Reportable Events, Sentinel Events & Indiana Medical Errors

4) The designee of any of the above.
5) If necessary, other people with relevant functional expertise, i.e. Pharmacy, Lab or Radiology
6) President of Medical Staff
7) General Counsel

E. Trinity Health Reportable Events

1) Serious Reportable Events:
   a) The Risk Manager or designee will submit a report to the Trinity Home Office within five (5) business days of discovery thru STARS. Events that result in death or permanent harm should be reported in STARS immediately but no later than one (1) business day after the discovery of the event.
   b) When a RHM reports a SRE to Trinity Home Office that results in death or permanent harm the RHM CEO will call either the Executive Vice-President Chief Clinical Officer, or the Senior Vice President Chief Quality and Patient Safety or the Senior Vice President System Chief Nursing Officer no later than one (1) business day after discovery of the Event. When the CEO is unavailable to place the call, the executive next in line shall make the call. The CEO/RHM executive will be expected to discuss the facts of the event, investigation conducted to date, status of the Root Cause Analysis (RCA), risk manager involvement, status of disclosure to patient and/or family, staff support provided, 3rd party inquiry (i.e. press, local government authorities) and any response or needs the RHM may have related to the event. Questions about whether an event should be called to the EVP or SVP can be directed to a Loss Control Director in Insurance and Risk Management Services.

2) Adverse Clinical Events:
   a) It is an unexpected adverse clinical event that does not meet the definition of a Serious Reportable Event. The RHM CEO will call either the Executive Vice President Chief Clinical Officer, or the Senior Vice President Chief Quality and Patient Safety, or the Senior Vice President System Chief Nursing Officer no later than one (1) business day after discovery of an adverse clinical event when that event,
      (1) Results in death or permanent harm or
      (2) Could reasonably be expected to lead to reputational harm or
      (3) Could reasonably be expected to result in a review by a licensing or accrediting agency or
      (4) Requires securing non Trinity Health resources for advice, or consultation during the investigation state.
      (5) Could reasonably affect multiple patients
   b) When the CEO is unavailable to place the call, the RHM executive next in line shall make the call. The CEO/RHM executive will be expected to discuss the facts of the event, investigation conducted to date, status of the RCA, risk manager involvement, status to patient and/or family, staff support provided, 3rd party inquiry (i.e. press, local government authorities), and any response, could reasonably affect multiple patients, and any needs the RHM may have related to the event.
Title: Serious Reportable Events, Sentinel Events & Indiana Medical Errors

F. ISDH procedure for reporting a reportable event is as follows:
   1) The report shall:
      a) Be made to the Indiana State Department of Health
      b) Be submitted not later than 15 working days after the reportable event is determined to have occurred by the hospital
      c) Be submitted not later than 4 months after the potential reportable event is brought to the hospital's attention; and
      d) Identify the reportable event, the quarter of the occurrence, and the hospital, but shall not include any identifying information for any patient, for any licensed individual or any hospital employee involved, or any other information.
   2) A potential reportable event may be identified by a hospital that:
      a) Receives a patient as a transfer, or
      b) Admits a patient subsequent to discharge, from another health care facility subject to a reportable requirement. In the event that a hospital identifies a potential reportable event originating from another health care facility subject to a reportable event requirement, the identifying hospital shall notify the originating health care facility as soon as they determine an event has potentially occurred for consideration by the originating health care facility.
   3) The report, and any documents permitted under this section to accompany the report, shall be submitted electronically to the Indiana State Department of Health.

G. The Joint Commission requirements for reporting:
   1) Self-reporting of a sentinel event to the Joint Commission is not required. However, the expectation is to identify and respond appropriately to all sentinel events. A thorough and credible comprehensive systematic analysis and action plan is to be completed within 45 business days of the event or of becoming aware of the event. This includes a timely, thorough, and credible root cause analysis; developing an action plan to implement improvement to reduce risk; implementing the improvements; and monitoring the effectiveness of those improvements. Under the direction of Trinity Health, we do not report to TJC.

H. Root Cause Analysis (RCA) will be conducted for each SRE, SE and Indiana Medical Error as required.
   1) An RCA team, including SJRMC associates and/or medical staff members involved in the event will be organized by the Risk Management/PI department to investigate identified events. The team will include associates at all levels closest to the issue and also those with decision-making authority. The team will clearly define the issues and be responsible for finding an opportunity for improvement.
   2) If the event is a fall, a fall huddle form may replace the RCA unless the fall results in death or permanent loss of function as a direct result of the injuries sustained.
   3) The RHM will complete a Root Cause Analysis (RCA) within three (3) weeks of discovery as required by Trinity Health. RCA for events that result in death or permanent harm should commence immediately or within 3 business days after discovery.
Title: Serious Reportable Events, Sentinel Events & Indiana Medical Errors

4) All Hospital acquired Stage 3, 4 and unstageable pressure ulcers require an intensive review. Discussions about the need for an RCA should be done in collaboration with the wound care specialist and the Risk Manager. The intensive review or RCA will be reported to the System Office within (3) weeks of discovery.

5) The RCA team will develop a corrective action plan which includes; action to be taken, implementation of the action plan and development of education to implement the action plan.

REALTED DOCUMENTS/INFORMATION:
• List of Serious Reportable Events (attached above)

Definitions:
• Sentinel Event: A patient safety event(not primarily related to the natural course of the patient's illness or underlying condition) that reaches the patient and results in any of the following:
  o Death, permanent harm or severe temporary harm. A listing of TJC Sentinel Events are in attachment A
• TJC - An adverse event is a patient safety event that resulted in harm to a patient
• TJC - A no-harm event is a patient safety event that reaches the patient but does not cause harm
• TJC - A close call ( or "near miss" or "good catch") is a patient safety event that did not reach the patient
• TJC - A hazardous (or "unsafe") condition(s) is a circumstance ( other than a patient's own disease process or condition) that increases the probability of an adverse event.
• SRE’s (see attachment A link at top of document (paperclip)
• Root Cause Analysis (RCA): A process for identifying the most basic or causal factors that underlies variation in performance including the occurrence of a reportable event or near miss. The root cause analysis identifies potential improvements that could be made in systems and processes that would improve the level of performance and reduce further risk.
• Permanent Harm: A serious reportable event resulting in harm with no expected change in clinical condition; includes events resulting in permanent loss of organ, limb, physiologic or neurologic function
• Severe Temporary Harm: Critical potentially life-threatening harm lasting for a limited time with no permanent residual, but requires transfer to a higher level of care/monitoring for a prolonged period of time, transfer to a higher level of care for a life-threatening condition, or additional major surgery, procedure, or treatment to resolve the condition.
• Adverse Clinical Event is defined and listed as an event that would require a call to a System Office Senior Leader
  o Results in death or permanent harm or
  o Could reasonably be expected to lead to reputational harm or
  o Could reasonably be expected to result in a review by a licensing or accrediting agency or
Title: Serious Reportable Events, Sentinel Events & Indiana Medical Errors

- Requires securing non Trinity Health resources for advice, or consultation during the investigation
- Could reasonably affect multiple patients

References:

- Indiana Medical Error Reporting System
- The Joint Commission Sentinel Events Chapter
- Trinity SRE
Welcome

The Indiana Prescription Monitoring Program (POMP) has moved. To register for the POMP and to perform patient look-up requests please use the following link: https://indiana.prescribers.net/appe

Prescription data submissions now being submitted through the Apathis Clearinghouse. Please use the following link: https://apathisclearinghouse.net

If you had an account on the original Indiana Prescription Monitoring Program system please check your email for information regarding access to the new website.

If you are unable to locate the email or if you require technical assistance please contact support at 844-446-0767 or submit your request to inspect@taek.com and someone will assist with account updates and password resets within 24 hours.

The following information will be required to process your request:

First Name:
Last Name:
DOB:
Individual email address (only the practitioner has access to):
DEPA:
Professional License #:
**IMPORTANT NOTICE**

With the most recent update of Google Chrome, the IDRS will no longer run on that browser. Please use Internet Explorer for this system until we find a fix or workaround. Thank you for your patience.

For Fetal Death password resets, please contact the Electronic Registrar Helpdesk at 317-233-7989.

---

**WELCOME TO IDRS**

**About Us**

Our goal is to provide you with the technological tools that increase the accuracy of processing death certificates at the same time reducing costs. To assist you in understanding how the Indiana Death Registration System works, we have developed some common Frequently Asked Questions.

**Diagram:**

- **1. Medical Certifier**
- **2. Funeral Director**
- **3. Local health Dept.**
- **4. Local health Dept.**
- **5. IFDH**

Under Indiana law, the funeral director is responsible for “initiating” or starting the death record. Once the funeral director completes the information for which they are responsible, the record is “released” to the medical certifier. That could be a coroner, local health officer or physician. The IDRS sends an email notification to the medical certifier and up to three additional individuals “cc” (as designated by the medical certifier) that a record is waiting for them in the IDRS. The medical certifier logs into the IDRS, enters the data for which they are responsible or reviews the data that one of their support staff has entered. Support or administrative staff of funeral homes and physicians’ offices are able to access the IDRS if they complete a User Agreement. That allows them to add or edit the information that their funeral directors or medical certifiers reviewed it. If the information is correct they enter their 4 digit PIN. It is then sent to the state.

Once the death record is signed by the funeral director and medical certifier, it is electronically submitted to the local health department as required by law. The local health department reviews it and if complete, sends it sending it on to the Indiana State Department of Health. Once ISDH accepts it, the death record is fully final and ready for issuance by the local health department and the ISDH. The same process flow of the paper records but the IDRS is a more secure and efficient system.

To have access to the IDRS, a User Agreement must be completed and submitted to ISDH. A username, password and PIN, if applicable, is then emailed to the user. Information on the IDRS and the User Agreement forms are on the IDRS Services tab.

---

https://idrsthin.isdh.in.gov/
Dear Colleagues,

Each year, across the United States, a significant number of physicians die by suicide. As physicians, we care for a large number of patients, yet often we do not seek the care we need. It’s difficult to seek help when we become overwhelmed, burned out, or experience mental distress.

During National Suicide Prevention Awareness Month we encourage physicians and colleagues to learn more about how to prevent suicide.

1. Learn the signs of suicide which may include:
   - Hopelessness
   - Rage, uncontrolled anger, seeking revenge
   - Increased drug or alcohol use
   - Withdrawing from friends, family and society
   - Anxiety, agitation, unable to sleep or sleeping all the time
   - Dramatic mood changes
2. Do your part to raise awareness and prevent suicide
   - Listen and talk about mental and emotional health, show support
   - Help them get help
3. Practice self-care and make it a priority
   - Practice emotional hygiene
   - Make time for friends and family – and for yourself

Saint Joseph Health System is committed to the health and well-being of our physicians. Please take a few moments to visit www.michianawellness.org, which offers a brief questionnaire (The Stress and Depression Questionnaire) that requires approximately five minutes. This is our regional anonymous online screening tool to assess your level of burnout or distress. We provide this service in partnership with the National Association for Suicide Prevention and Oaklawn as well as other health facilities in our local area. If you or someone you know is having suicidal thoughts, please call the National Suicide Prevention Lifeline at 1-800-273-TALK (8255).

Have a restful weekend and be sure to make time for yourself and the people or activities restoring balance for you.
Jen Lankowicz

Genevieve Lankowicz, MD, MBA, CPE
Regional Chief Medical Officer
Saint Joseph Health System
5215 Holy Cross Parkway
Mishawaka, Indiana 46545
p: 574.335.2353
Genevieve.Lankowicz@sjrmc.com

Confidentiality Statement: This message (including any attachments) is intended only for the use of the addressee and may contain information that is privileged and confidential. If you are the intended recipient, further disclosures are prohibited without proper authorization. If you are not the intended recipient or an authorized representative of the intended recipient, the use, dissemination or reproduction of this communication is prohibited and may be a violation of federal or state law and regulations. If you have received this transmission in error please destroy all copies of the message and its attachments and notify the sender immediately.
Title: Impaired or Dysfunctional Provider

Background:
The problem of impairment is complex, and the peer review investigation and hearing process may not be appropriate in this situation. The American Medical Association defines the impaired provider as “one who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process or loss of motor skill, or excessive use or abuse of drugs, including alcohol.” This policy is intended to provide some overall guidance and direction on how to proceed when confronted with a potentially impaired provider.

Because of the independent nature of most providers’ practices and the serious implications of any disability, impairment is often difficult to identify early and is always difficult for the impaired provider to acknowledge. It is hard to face the problem with a provider. For all these reasons, the problem often goes unaddressed for too long. Nevertheless, it is the obligation of the hospital and medical staff leadership to address it. The following policy provides the framework within which to do it.

Because the term “impaired provider” includes a variety of problems, from age to substance abuse to physical or mental illness, the steps provided below will not be suitable in every circumstance. There can be no one policy to cover all situations. Specific needs and varying circumstances preclude a single inflexible mechanism for dealing with all impaired providers. The number and seriousness of incidents involving a provider, for example, may dictate the appropriate response by the hospital. If the “investigation” suggested in the policy is carried out, the individuals conducting the investigation will vary from hospital to hospital, depending upon personalities, circumstances, and the structure of the medical staff. Whatever mechanism a hospital chooses, the risk of patient harm must be of paramount concern. Immediate action may be necessary.

One exception to this policy is impairment due to age and irreversible medical illness or other factors not subject to rehabilitation. In such cases, the sections of the policy dealing with rehabilitation and reinstatement of the provider are not applicable.

Key factors to keep in mind while dealing with any issue relating to a provider’s illness or disabilities are state reporting statutes and the application of the Americans with Disabilities Act. These policies should, under any interpretation of the law, be legally appropriate, as with all matters with significant legal implications. Legal counsel should be consulted.

Policy: Medical Staff policy regarding impaired providers

1. Report and investigation:
   A. If any individual working in the hospital has a reasonable suspicion that a provider appointed to the medical staff is impaired, the following steps should be taken:
      1) The individual who suspects the provider of being impaired must give an oral or, preferably, written report to the Chief Medical Officer or the Medical Staff Office for presentation to the President of the Hospital or the Medical Staff President (or the Well-Being Committee). The report must be factual and shall include a description of the incident(s) that led to the belief that the provider might be impaired. The individual making the report does not need to have proof of the impairment, but must state the facts that led to the suspicions.
Title: Impaired or Dysfunctional Provider

2) If, after discussing the incident(s) with the individual who filed the report, the President of the Hospital or the Medical Staff President believes there is enough information to warrant an investigation, the President of the Hospital and/ or Medical Staff President shall request that an investigation be conducted by the Centralized Well Being Committee which requires Drug and Alcohol testing of the individual per the Substance Abuse Drug Free Workplace Policy. A report of the test results and investigation findings will be rendered to the Centralized Well Being Committee and the Medical Staff President.

3) If the investigation produces sufficient evidence that the provider may be impaired, a member of the Well-Being Committee shall meet personally with that provider or designate another appropriate individual to do so. The provider shall be told that the results of an investigation indicate that the provider may suffer from an impairment that affects his or her practice. The provider should not be told who filed the report, and does not need to be told the specific incidents contained in the report.

4) Depending upon the severity of the problem and the nature of the impairment, the Well-Being Committee has the following options:
   a) if the Physician provider Well-Being Committee believes that the physician provider can continue to treat patients without risk to the well-being of such patients, then the Well-Being Committee shall require the provider to undertake a rehabilitation program as a condition of continued appointment and clinical privileges; or
   b) if the Well-Being Committee believes that the provider cannot treat patients without risk to the well-being of such patients, the Well-Being Committee shall seek voluntary relinquishment of such privileges and require the provider to undertake a rehabilitation program; or
   c) recommend corrective action pursuant to Section 8.4 of the Medical Staff Bylaws.

5) The hospital shall seek the advice of hospital counsel to determine whether any conduct must be reported to law enforcement authorities or other government agencies, and what further steps must be taken.

6) The Well-Being Committee shall inform the individual who filed the report that follow-up action was taken.

7) Throughout this process, all parties shall avoid speculation, conclusions, gossip, and any discussions of this matter with anyone outside those described in this policy.

8) In the event there is an apparent or actual conflict between this policy and other policies of the Medical Staff—the provisions of this policy shall supersede such policies.

Rehabilitation
1. If rehabilitation is possible, hospital and medical staff leadership shall assist the provider in locating a suitable rehabilitation program. The Medical Staff shall not reinstate a provider, if such provider’s privileges have been reduced, suspended or revoked, until it is established, to the Medical Staff’s satisfaction, that the provider has successfully completed a rehabilitation program in which the Medical Staff has confidence.

Credentialed Provider as a Patient
1. Credentialed practitioners cannot provide patient care while currently receiving direct medical care or under the influence of medication altering their cognitive function.

2. To protect our patients, below are circumstance where a credentialed provider or allied health practitioner are not allowed to provide medical care for any patient:
   A. If a practitioner is currently an inpatient
   B. If a practitioner is receiving direct medical care as an outpatient that renders him/her unable to respond to an urgent medical situation
Title: Impaired or Dysfunctional Provider

C. If the practitioner is under the influence of any medications or substance that adversely affects cognitive function.

3. When a practitioner is under direct medical care, he/she is to transfer their patients as soon as possible to call coverage practitioners or to the SJRMC hospitalist adult or pediatric services, if applicable.

4. Hospital staff is not to accept any patient care orders of a practitioner known to be directly receiving medical care or under the influence of any medication or substance that adversely affects cognitive function.

5. A practitioner who is directly receiving medical care shall not;
   A. round on their patients
   B. access the medical records for any decision making
   C. order any labs or tests
   D. provide any orders for treatment

6. A request for an exception to this policy can be made to the President of the Medical Staff who may consult the practitioner's attending provider for consideration.

References/Standards:

- EDUCATION REFERENCE:
  A. Medical Staff Orientation Binder
  B. Employee Orientation Material

- RESOURCE REFERENCE
  A. Indiana State Medical Association Physician Assistance Program

- Policy Origin Date: May 1999 (M)
- Review Date: December 2009, December 2012, December 2015 (M)
- Revised Date: December 2014 (M), June 2016 (M)
- Effective Date: August 1999 (M), March 2016 (P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 72
Title: Well Being Committee-Centralized

<table>
<thead>
<tr>
<th>Document Owner</th>
<th>PI Team</th>
<th>Date Created</th>
<th>Date Approved</th>
</tr>
</thead>
<tbody>
<tr>
<td>Teresa Onken</td>
<td>N/A</td>
<td>01/01/2014</td>
<td>02/25/2014</td>
</tr>
</tbody>
</table>

Location: Saint Joseph Regional Medical Center (SJRMC)

Department: Medical Staff Office, Plymouth-Medical Staff Affairs, SJPN - Staffing Services

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Centralized Well Being Committee is a joint Committee between Saint Joseph Regional Medical Center – Mishawaka, Saint Joseph Regional Medical Center – Plymouth, and Saint Joseph Physician Network to form a Centralized Well Being Committee to serve as the Well Being committee for each entity.

2. Composition:
   A. The composition of the Centralized Well Being Committee shall include at least one member from each entity for a minimum total of 6 members. Ad hoc members will include at least one Administrator in addition to the SJPN Executive Medical Director.
   B. The appointment and removal of Centralized Well Being Committee members shall be governed by the respective Medical Staff Bylaws.

PROCEDURE:

A. The above entities agree to use their individual and collective resources to improve the wellness of the provider credentialed by the individual medical staffs and, specifically, to achieve a higher degree of advocacy to serve all providers without humiliation and rejection with the goal of having successful, healthy careers and personal lives.

B. This Committee is an advocacy committee and is not a disciplinary committee. If a provider does not work cooperatively with the Committee, the Committee would provide a report to the appropriate President of the Medical Staff where that provider has membership and/or privileges for their respective Medical Executive Committee or SJPN Executive Committee to act according to their own individual Medical Staff Bylaws as it relates to collegial and investigative procedures as well as report ability.

C. Each entity may withdraw from the Centralized Well Being Committee at any time with 30 days prior notice. New entities may be added to the Centralized Well Being Committee upon unanimous approval of all currently participating entities.

   D. This Committee will operate to the full extent provided by law and the individual Medical Staff Bylaws. This Committee is required to maintain all information in strict confidence in accordance with applicable Indiana law, including but not limited to, Indiana Code 34-30-15-1 et. seq. or the corresponding provisions of any subsequent state or federal statute providing protection to peer review or related activities.

Expiration Date: 12/31/2021
Title: Well Being Committee-Centralized

References/Standards:
- Policy Origin Date: January 2014 (M), March 2014 (P)
- Review Date: December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date:
- Effective Date: February 2014 (M), March 2014 (P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 204

Expiration Date: 12/31/2021
Title: Pain Management

<table>
<thead>
<tr>
<th>Document Owner: Michael Poulsen</th>
<th>PI Team: POC</th>
<th>Date Created: 07/01/08</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): Loretta Schmidt</td>
<td>Date Approved with no Changes: 01/22/2018</td>
<td>Date Approved: 01/22/2018</td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMC)</td>
<td>Department: Faculty Practice (14030_86035), Family Medicine Center (14030_86030), Nursing Admin (14030_10005), Sports Medicine Fellowship (14030_23910)</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. Patients in all settings will be assessed/screened for presence, absence and history of pain.

2. Assessment of pain (Pain Scales):
   A. Patient’s self-report is the primary indicator of pain reporting:
      1) Verbal (0 – 10) Pain Scale with 0 being no pain and 10 being worst pain.
         a) Adults and Children who can understand number concept
      2) Faces Scale: Children (age 3 and older) and Adults
      3) Other self-reporting methods may be used when the patient is unable to use the verbal (0–10) scale or the Faces Scale. Examples: Visual Analog Scale (VAS); Categorical Scales: patient rates pain using verbal or visual descriptor (mild, unbearable, crushing, etc.

3. Assessment of Pain in Patients with Barriers to Communication
   A. Infants and children
   B. Individuals with advanced age (e.g. older than 85 years)
   C. Adults with emotional or cognitive disturbances
   D. Patients with cultural, educational, or language barriers to communication
   E. Intubated patients
   F. Patients who are seriously ill

4. General Approach to Pain Assessment of Patients with Barriers to Communication
   A. Allow sufficient time for the assessment
   B. Allow opportunity to use a rating scale or other tool appropriate for that population (i.e. intubated patient may nod, point to a number on a scale, etc)
   C. Use of Hierarchy of Pain Assessment:
      1) Self-report whenever possible
      2) Search for Potential Causes of Pain –Pathologic Conditions (e.g. surgery, wound care, rehab activities, positioning/turning, blood draws, heel sticks, history of persistent or chronic pain)
      3) Observe Patient Behaviors that may indicate pain such as grimacing, crying, agitation.

Expiration Date: 01/22/2021
Title: Pain Management

4) Use of behavioral pain assessment scales
   a) FLACC (non-verbal pain scale based on five sub-scores of face, legs, activity, cry, consolability) Scale for Pediatrics (2 months to 7 years of age),
   b) CRIES is the pain assessment tool for neonates
   c) CPOT (Critical Care Pain Observation Tool)
   d) Checklist of Nonverbal Pain Indicators (tested is adults in acute and long term care settings for acute and chronic pain)
   e) Pain intensity using objective judgment may not be an accurate reflection of the severity of pain in these patients. A multifaceted approach is recommended (observation, family/caregiver and evaluation of response to treatment).

5) Surrogate Reporting (family members, parents, caregivers)
6) Attempt an Analgesic Trial based on estimated pain intensity (mild, moderate, severe), patient’s pathology and analgesic history.

5. Initial patient history will include: Screening question about pain based on patient self-report.

6. When self-report is not obtainable the nurse will utilize Hierarchy of Pain Assessment as above. A positive finding for pain on admission will initiate further questioning, which includes, but is not limited to the following:
   A. Description
   B. Intensity
   C. Location
   D. Aggravating and alleviating factors
   E. Associated signs and symptoms
   F. Impact on functional ability
   G. Methods of pain management (current and past regimens and effectiveness)
   H. Patient’s personal goal for pain relief
   I. Physical exam/observation of the pain site

7. Initial assessment of learning includes pain management and becomes a part of the plan of care.

8. Pain assessment (intensity and/or pain relief) will be assessed/screened and documented at a minimum:
   A. On admission/presentation to Emergency Department
   B. Routine: based on unit standards, physician orders, and patients’ status.
   C. After any known pain producing event
   D. With each new report or behavioral indication of pain
   E. After each pain intervention once sufficient time has lapsed for the treatment to reach peak effect (pharmacologic and nonpharmacologic).
      1) Within 30 Minutes for IV Medications
      2) Within 60 Minutes for PO Medications or other Non-Pharmacologic interventions
Title: Pain Management

3) Intensity (reported verbal pain level 0-10 or corresponding pain level if objective pain scale utilized) of pain should be document at time of Intervention and post intervention as above.
   a) If verbal rating scale utilized and patient resting or cannot rate intensity of pain at minimum document the following
      (1) Pain relieved with Medication? Yes or No (If unable to determine – i.e. patient sleeping then complete is pain level acceptable?
      (2) Is pain level acceptable? Yes, No, Unable to Determine, or Other. If Unable to determine or other (add comment – i.e. sleeping).

9. Parents/legal guardians will be involved in pain management decisions regarding their child
10. Methods to decrease pain in neonates, infants, and children include but are not limited to:
    A. Providing information and preparing the parent and child.
    B. Involving the parent.
    C. Maintaining a quiet, calm environment.
    D. Allowing comfort items such as favorite stuffed animals or blankets.
    E. Giving the child choices to increase the perception of control.
    F. Planning ahead and drawing all blood samples at once if possible.
    G. Sucrose Pacifier
11. All terminally ill patients will be kept as comfortable as possible to allow them to die comfortably and with dignity. It is understood that medications may be given to the dying patient, even if this therapy may indirectly shorten patient’s life, as long as the intent is not to hasten death.

PROCEDURE:

Pain Assessment
A. Admitting nurse questions patient for current pain and a history of pain. If patient complains of pain or behavioral indicators are present, appropriate approved scale should be used for intensity and the remainder of comfort section completed.
B. Process of interventions should be initiated and documented with modifications based on patient self-report and ongoing assessments. Patient preferences for pain management strategies (pharmacologic and/or nonpharmacologic) should be utilized when possible. Personal, cultural, spiritual, and/or ethnic beliefs will be considered in decisions regarding pain management.
C. Prescribed analgesics should be administered in a timely, logical, and coordinated manner.
D. There are certain circumstances when an LIP may write PRN medication orders that allow variation in administration based on patient preference.
   1) A patient may request to receive a medication ordered for a lesser pain scale. It is NEVER acceptable to administer a medication intended for a higher pain scale based on patient preference.
Title: Pain Management

a) For example, if a patient has on their profile Tylenol 650 mg every 4-6 hours PRN for Mild Pain and Norco-5 1 tablet every 4-6 hours PRN for Moderate pain then:
   1. If the patient reports their pain is Mild, they can receive the Tylenol because it is indicated for Mild Pain
   2. If the patient reports their pain as Moderate, they can receive the Norco for Moderate pain or the Tylenol because it is ordered for a lesser pain scale
   3. If the patient reports their pain as Mild, they can NEVER receive the Norco, as it is intended for a higher pain scale

2) The medical record must accurately reflect that the medication used for a lesser pain scale was based on patient preference.

E. As an adjunct to analgesia, nonpharmacologic approaches may be utilized (e.g. distraction therapy, positioning).

F. If a patient continues to complain of unrelieved pain following interventions, the physician should be contacted. Additionally, new pain, change in location, quality or intensity, and side effects should be documented and reported.

G. Patient and family education should include rights and responsibilities, information to allay fears and correct misconceptions about pain medications, pain treatment, and expected response.

H. A proactive approach should be utilized re: anticipated pain-producing events, e.g. exercise, wound care, diagnostic/therapeutic procedures.

I. Pain management should be included in the discharge planning process.

J. Staff education regarding pain management should be provided, and staff competency should be evaluated during orientation and on an on-going basis.

K. Pain management issues will be included in topics for discussions during interdisciplinary care planning/conferences.

L. Patient’s preference for pain rating scale will be determined at first report of pain, and will be utilized for subsequent pain assessments. Change in the patients’ condition may require utilization of a different pain scale or method.

Related Documents/Information:
- See Range Order policy for medication administration requirements based on patient pain rating (mild, moderate, severe) and rules regarding patient preference when requesting medication ordered for lower rating.
Title: Pain Management

References/Standards:

- Gelinas C., Fillion L., Puntillo K., et al: Validation of the Critical Care Pain Observation Tool (CPOT) in adult patients, Presented at the IASP 11th World Congress on Pain, Sydney Australia, August 12, 2005
Title: Focused Professional Practice Evaluation (FPPE)

<table>
<thead>
<tr>
<th>Document Owner: Chris Stefaniak</th>
<th>PI Team: N/A</th>
<th>Date Created: 02/01/2008</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): Denise Dushek, Karyn Delgado, Teresa Onken</td>
<td>Date Approved with no Changes: 03/19/2019</td>
<td>Date Approved: 03/19/2019 02/01/2009</td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMc)</td>
<td>Department: Medical Staff Office, Plymouth-Archive Administration</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

**POLICY:**

1. The organized medical staff has defined the circumstances requiring monitoring and evaluation of a practitioner’s professional performance that does not have documented evidence of competency performing the privilege(s) at our hospital. This process is also used when a question arises regarding a currently privileged practitioner’s ability to provide safe, high quality patient care. The FPPE process is time-limited.

2. Evaluation of professional practice will be completed in the following specific circumstances:
   A. A period of focused professional practice evaluation is implemented for all initially requested privileges. This includes:
      1) All new practitioners
      2) All new privileges for existing practitioners
   B. Clearly delineated criteria as defined by the medical staff will be used for evaluation of the performance of practitioners when issues affecting the provision of safe, high quality patient care are identified (“triggered”) i.e. A.5.
   C. The FPPE process is delineated as follows:
      1) criteria for conducting performance evaluation
      2) method for establishing the monitoring plan specific to the requested privileges
      3) method to determine the duration of performance monitoring
      4) circumstances under which monitoring by an external source is required
   D. The FPPE process will be implemented consistently.
   E. The decision to assign a period of performance monitoring to further assess current competency is based on evaluation of a practitioner’s current clinical competency, practice behavior, and ability to perform the requested privilege. The type of monitoring will be determined by predefined criteria.

**PROCEDURE/GUIDELINES:**

A. Initially Requested Privileges:

1) Criteria for Conducting Performance Monitoring:
   a) FPPE for practitioners identified below will be evaluated at least the first three months.
      1) All new practitioners;
      2) All new privileges for existing practitioners
Title: Focused Professional Practice Evaluation (FPPE)

2) The monitoring plan will be specific to the requested privileges or group of privileges and may include proctoring, as applicable. Review for each practitioner will include review of the following data reports and information by the department/specialty representative.

a) Midas Statit Reports – These reports include inpatient and outpatient data for both the individual physician and comparison with the aggregate of the physicians in that specialty:

(1) Admission Activity
(2) Length of Stay Data (actual and expected)
(3) Mortality Data (actual and expected)
(4) Procedures by ICD
(5) All Risk related occurrences
(6) All Quality Indicator related occurrences

b) Proctoring requirements are delineated and developed according to the Medical Staff Proctoring policy.

c) Chart reviews-The department chair or representative will complete Five retrospective chart reviews including one sedation case if sedation privileges are granted.

(1) The APNs and PAs will be asked for patient lists for their initial three (3) months for review.

3) Department Chair or Representative will document pertinent findings and recommendations to include:

a) Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety.

b) Request for additional review for an individual practitioner based on an identified issue. Information gathered for review may include, but not be limited to:

(1) Drill down reports
(2) Additional performance of a specific procedure
(3) Additional Monthly Review
(4) Direct Observation
(5) Concurrent Monitoring
(6) Retrospective Chart Review
(7) Discussion with other individuals involved in the care of the practitioner’s patients including consulting physicians, assistants at surgery, nursing and administrative personnel.

c) The information gathered will be presented to the Department Chair or Representative to complete.

4) Method for determining the duration of performance monitoring:

a) The above process will continue for at least the first three months of each practitioner’s FPPE. The practitioner will then be reviewed for termination of FPPE. Continuation, limitation, or revocation of any existing privileges will then be considered. This will provide a minimum of a three month evaluation period.
Title: Focused Professional Practice Evaluation (FPPE)

b) If no activity at the 3 month FPPE review, the practitioner will remain on FPPE and will continue to be monitored monthly. The sponsoring physician will be notified when an APN or PA does not have needed volumes.

(1) If a physician does not have any activity in their first 12 months, they will automatically move to Affiliate Medical Staff Status for administrative purposes. Physicians will be notified one month prior to staff status change. This administrative action does not entitle the physician to appeals.

(2) If an APN or PA does not have any activity in their first 12 months, their privileges and affiliation will automatically expire for administrative purposes. Practitioners and their sponsoring physician will be notified one month prior to staff status change. This administrative action does not entitle the practitioner to appeals.

c) The department chair or representative may request immediate action according to the Medical Staff Bylaws be taken at any time during the FPPE process, which may include, but not be limited to, forwarding concerns to the following committees:

(1) Credentials Committee for review and/or
(2) Physician Well Being Committee for review, as applicable
(3) Medical Executive Committee

d) Extension of evaluation period will continue until the Department Chair or Representative is either:

(1) Satisfied with the information received and reviewed, or
(2) Recommendations are made to the Credentials Committee or Physician Well Being Committee, as applicable, for review and recommendation to the Medical Executive Committee for action including, but not limited to, the initiation of the Collegial Investigation per the Medical Staff Bylaws Credentials Policy Manual.

5) Criteria for conducting FPPE for those practitioners who need evaluation of their performance as a result of an issue affecting the provision of safe, high quality patient care.

a) Evaluation will take place as soon as a “trigger” is identified. Triggers can be single incidents or evidence of a clinical practice trend.

b) Review will continue, at a minimum, on a monthly basis for the first three months. Triggers will be consistently identified and implemented.

(1) Triggers may include, but are not limited to, data obtained from quality indicators, risk indicators, utilization indicators, unexpected deaths, medical leave of absence, Hospital and Medical Staff Bylaws, Rules & Regulations or policy violations. See Attachment from the Occurrence Monitoring and Peer Review Medical Staff Policy.

(2) FPPE may also be triggered during the OPPE review.

6) Data elements and supporting documentation will be reviewed by the department chair or representative of each practitioner under FPPE whose review was initiated (triggered) by practice indicators.

7) Administration review, department chair or representative review and the duration of monitoring will be conducted as outlined in Procedure 1.
Title: Focused Professional Practice Evaluation (FPPE)

8) Circumstances under which monitoring by an external source is required:
   a) Need for specialty review, when there are a limited number or no medical staff members within the required specialty on the medical staff.
   b) The peer review / Credentials Committee is unable to make a determination and requests an external opinion.

9) If behavior is identified as a possible issue at the time of initial appointment of a new applicant or if a behavior occurrence triggers a FPPE, the Medical Staff Code of Conduct Policy will be followed.

10) Upon completion of the above review, evaluation results and recommendation will be presented to the Credentials Committee.

References/Standards:
- Joint Commission Hospital Accreditation Standards (HAS) 2010
- Proctoring And Current Competency Requirements List
- Policy Origin Date: February 2008 (M), February 2008 (P)
- Review Date: December 2009 (M), December 2012 (M), December 2009 (P), December 2012 (P), December 2015 (M), February 2016 (P), December 2017 (M&P), January 2019 (M & P)
- Revised Date: August 2008 (M), September 2010 (M), August 2008 (P), September 2010 (P), December 2017 (M&P), February 2019 (P), March 2019 (M)
- Effective Date: February 2009 (M), February 2009 (P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 158
POLICY:
1. It is the policy of SJRMC to conduct review of Medical Staff indicators, appropriateness of care, complication and/or mortality rates, and resource utilization in a consistent and timely manner. To establish a uniform and consistent method of review, evaluation, and documentation of physician occurrences and peer review for the purpose of performance improvement, risk reduction, patient safety, appropriate utilization, and reduction of morbidity and mortality. Behavior issues will follow a separate review process according to the Medical Staff Code of Conduct Policy and will also be protected under peer review.

PROCEDURE:
A. Physician Performance Weekly Reviews - Triggered by Midas Reports, Chart Review and/or verbal notification.
   1) Members Include:
      a) Chief Medical Officer
      b) Clinical Risk Manager, Clinical Operations Improvement
      c) Peer Review Coordinator, Clinical Operations Improvement
      d) Manager, Medical Staff Services
   2) Issues Include:
      a) Quality –Review the summary of quality indicators identified and analyze for trends.
      b) Risk –Review the summary of risk indicators identified and analyze for trends.
      c) Bylaws/Rules and Regulations/ Medical Staff Policies -Review the summary of Bylaws/Rules and Regulations/Medical Staff Policy violations identified and analyze for trends.
      d) Utilization –Review the summary of utilization issues and analyze for trends.
B. Reports and / or data collected shall be maintained in a confidential manner in accordance with Indiana Law. Medical staff occurrences are entered into the MIDAS+ database for trending.
C. All occurrences are summarized by occurrence type and physician for review at the weekly Physician Performance Review meeting. From there, cases or trends can be referred to Department Chairs, an integrated performance improvement committee, a special peer review committee, and/or directly to Credentials or the Medical Executive Committee.
D. Participation in the peer review process by the practitioner whose performance is under review:
   1) The individual whose case or trend is under review shall have the opportunity to present his or her information regarding case management to the committee performing peer review. The
Title: Occurrence Monitoring & Peer Review (Medical Staff)

individual whose case is under review has the right to sit on the peer review committee during the time the case is reviewed and discussed, to provide additional information to the individual(s) performing peer review as necessary.

E. All individuals whose cases are referred for committee peer review shall be notified of the medical record number and date of admission of the case to be reviewed, in addition to the reason for review, at least two weeks prior to the scheduled peer review meeting date. In cases of immediate referral to committee, as determined by the Department Chair, the Department Chair shall notify the individual whose case is under review, regarding the reason for review and the scheduled date of review, as soon as the Department Chair makes the determination that the case must be referred for formal peer review.

F. Clinical Operations Improvement staff shall take the issue forward for review to the weekly physician review meeting. If issues or questions are identified, the medical staff Department Chair or designee is notified. The peer physician will assign the appropriate level of significance (Level 1 - 5) to each occurrence.

NOTE: If the level of significance is not determined, the Credentials Committee Chair shall assist in the final determination.

G. Peer review activity time frames:

1) Cases forwarded to medical staff departments or peer review committees from the weekly physician review meeting are to be reviewed within one month of referral or the next committee meeting.

2) Issues believed to be of such severity or urgency that immediate action is warranted, the Director, Clinical Outcomes Improvement and/or the Manager, Medical Staff Affairs shall, upon the receipt of the report, immediately notify the Medical Staff President and/ or Officers and the involved physician.

3) Time frames are adhered to in a reasonable fashion. All cases referred for peer review shall be reviewed within the time frames as listed above. In those instances where peer review falls out of the required time frames (medical record incomplete, practitioner under review is unavailable, reviewing committee rescheduling, etc.) the reasons for the delay will be documented. All efforts will be made to complete the peer review process as soon as practicable within the confines of the delay.

H. Action:

1) Level 1 issues will not require action. Recurrence or a pattern shall constitute a higher level of significance, thus requiring handling in a manner consistent with the level 2 or 3.

2) Level 2 – 5 issues require contact with the physician by the Department Chair or Vice Chair, with a written plan of action as applicable.

I. File Access:

1) Access by the physician will occur only during an investigation and with the appropriate approval and access granted by the person or committee involved in the investigation. (Indiana Code, Sec. 34-30-15-4). These are retained in the Medical Staff Office. Arrangements will be made for a review location on a case-by-case basis.

2) A Department Chair, Service Medical Director, and section chief may access the files of its members only for performance of the responsibilities of the position.
Title: Occurrence Monitoring & Peer Review (Medical Staff)

3) The President of the Medical Staff may have access to all Medical Staff Members’ files in performance of the responsibilities of the position.

4) The Chief Executive Officer, President of the Hospital, the Director of Outcomes Management or the Chief Medical Officer, Manager of Medical Staff Affairs, the Clinical Operations Improvement Clinical Risk Manager or Peer Review Coordinators may access all professional staff members’ files in performance of their responsibilities.

J. Performance Improvement

1) All cases undergoing peer review beyond the weekly physician review meeting will have a worksheet completed that lists the rationale for conclusion made by the peer reviewer(s).

2) All opinions regarding medical management, including minority opinions, will be considered in the ultimate determination of a case. This includes information and opinions from the individual whose case is under review.

3) Results of peer review are utilized at time of medical staff reappointment and to improve the organization’s performance in individual situations, and, as a whole.

4) Results of peer review activities are aggregated and reported ongoing and at time of medical staff reappointment to provide for practitioner specific appraisal of competency and renewal of clinical privileges.

5) Aggregated and trended results of peer review activities are utilized in the hospital-wide performance improvement program, via quarterly reporting to the Credentials Committee, to allow for organizational improvement as necessary.

6) Peer review conclusions, outcomes and actions resulting from peer review are monitored for effectiveness. Results of follow-up effectiveness monitoring are reported to the Medical Executive Committee.

DEFINITIONS:

1. Occurrence: An incident that is inconsistent with SJRMC procedures or routine patient care or results in serious physical or psychological injury or death.

2. Peer Review Component Definitions: Definitions of circumstances requiring peer review are listed below. Clinical Operations Improvement or the Credentials Committee may suggest revision to the lists, with final approval granted by the Medical Executive Committee. Circumstances requiring peer review include:

   A. Medical Staff Indicators (see annual Indicator list)
   B. Appropriate use of blood and components, medications, tests, procedures, level of care, etc.
   C. Deviation from external benchmarks identified for comparisons in screening for opportunities for improvement in management and outcomes.
   D. Risk occurrences (see annual Indicator list)

3. Peer review participants:

   A. A peer reviewer shall be defined as a member of the medical staff in good standing. In instances for occurrences involving clinical decision-making the opinions of a physician licensed in the same medical specialty as the individuals whose case is under review should be obtained.
Title: Occurrence Monitoring & Peer Review (Medical Staff)

B. A peer review committee is either the medical staff department to which the physician is assigned or the physician component of an integrated performance improvement committee where the members are considered experts in the function being monitored.

C. An individual functioning as a peer reviewer will not have performed any medical management on the patient whose case is under review. However, opinions and information may be obtained from participants involved in the patient’s care.

D. A practitioner-focused review is defined as when a process becomes more practitioner specific and requires more in-depth review involving monitoring, analyzing and understanding individual practitioner performance.

4. External Peer Review
   A. Circumstances that require external peer review include, but may not be limited to:
      1) Need for specialty review, when there are a limited number or no medical staff members of the institution with the identified specialty within the organization.
      2) The peer review committee is unable to make a determination and requests an external review.

5. Levels of Significance:
   A. Level 1: Occurrence that did not directly put patient care at risk. The case is managed and documented appropriately.
   B. Level 2: Occurrence that may impact patient safety or well-being or hospital operations. The case is managed appropriately, but documentation is not adequate.
   C. Level 3: Occurrence or medical/ surgical case management is questionable with no potential for significant adverse effect on the patient or hospital operations.
   D. Level 4: Occurrence or medical/ surgical case management is questionable with high potential for significant adverse effect on the patient or hospital operations.
   E. Level 5: Occurrence or medical/ surgical case management with significant, adverse effects on the patient and / or is direct violation of any legal/ medical staff Bylaws/ Rules requirement.

References/Standards:
- Policy Origin Date: September 2001
- Review Date: December 2009, December 2012, December 2015, December 2018
- Revised Date: January 2008
- Effective Date: October 2001
- Reviewed/Recommended By: Medical Executive Committee
- Policy 94
Title: Occurrence Monitoring & Peer Review (Medical Staff)

INDICATORS

<table>
<thead>
<tr>
<th>Quality Indicators – Medical Executive Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality concern (reviewed)</td>
</tr>
<tr>
<td>DVT / PE acquired after admission (trended)</td>
</tr>
<tr>
<td>Readmission for complication within 30 days (trended)</td>
</tr>
<tr>
<td>Unexpected death (see criteria below) (reviewed)</td>
</tr>
<tr>
<td>Iatrogenic disorder (adverse condition induced by effects of treatment) or iatrogenic complication (reviewed)</td>
</tr>
<tr>
<td>Sentinel events (reviewed)</td>
</tr>
</tbody>
</table>

**Pathology Review:**
- Appropriate Protocol deviation

**Risk Indicators**
- Behavior
- Confidentiality
- Privacy / Dignity
- Verbal Communication

**Documentation / Documentation not meeting Bylaws/Inappropriate documentation**
- Failure to diagnose, missed diagnosis or misdiagnosis

**Utilization Indicators**
- Timeliness
- Discharge issues
- Utilization issue

**Bylaws Violations**
- No response to page
- Failure to provide adequate coverage
- Failure to see patient in a 24 hour period
- Bylaws issue

**Unexpected Death Criteria**
- Unexplained death occurring in the hospitalized patient
- Death in outpatient setting, excluding the ED
- Deaths during *elective* surgical/invasive procedures
- Deaths within 72 hours of *elective* surgery/invasive procedure
- All pediatric deaths
- Death thought secondary to:
  - Medication reaction
  - Blood transfusion (hemolytic reaction)
  - Inpatient accident (e.g., fall)
  - Potential nosocomial infection as cause of death

*All indicators will be trended by physician and department.*
**Title:** Occurrence Monitoring & Peer Review (Medical Staff)

### PEER REVIEW PROCESS

**High Level Flow Chart**

<table>
<thead>
<tr>
<th>Decision Point</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reviewer screens that occurrence type selected is correct. Change if indicated.</td>
<td></td>
</tr>
<tr>
<td><strong>↓</strong> Trend</td>
<td></td>
</tr>
<tr>
<td>Summary of all occurrences are reviewed weekly for analysis of trends or need for Peer Review</td>
<td>No further review needed by case. No trends ID’d (Stop)</td>
</tr>
<tr>
<td><strong>↓</strong> Questioned case(s) or trend(s) ID’d</td>
<td></td>
</tr>
<tr>
<td>Peer Review Committee Review. May request additional information from involved practitioner</td>
<td>Acceptable (Stop)</td>
</tr>
<tr>
<td><strong>↓</strong> Questioned</td>
<td></td>
</tr>
<tr>
<td>Review performed by Medical Staff Professional Practice Council</td>
<td></td>
</tr>
<tr>
<td>Action(s): letter, review of additional similar cases, monitor of the following admissions for a defined timeframe, etc.</td>
<td>Resolved (Stop)</td>
</tr>
<tr>
<td><strong>↓</strong> Not resolved</td>
<td></td>
</tr>
<tr>
<td>MEC and/or Board</td>
<td>Resolved (Report resolution to MEC)</td>
</tr>
<tr>
<td><strong>↓</strong> Not resolved</td>
<td></td>
</tr>
<tr>
<td>Credentials Committee May request a peer review panel Or External Peer Review</td>
<td></td>
</tr>
<tr>
<td><strong>↓</strong></td>
<td></td>
</tr>
<tr>
<td>Report to National Practitioner</td>
<td>MEC and/or Board Final Decision</td>
</tr>
<tr>
<td></td>
<td>Resolved</td>
</tr>
</tbody>
</table>
Title: Occurrence Monitoring & Peer Review (Medical Staff)

Data Bank if indicated

Medical Staff Peer Review Worksheet

<table>
<thead>
<tr>
<th>MR#</th>
<th>Date of occurrence:</th>
<th>Indicator:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Abstract: See attached sheet

Peer Review Committee Comments:

P R C  Level of Significance finding:
- Level 1 – Patient Care not directly at risk. Managed and documented appropriately
- Level 2 – Patient safety, well being or hospital operations may have been impacted. Managed appropriately, but documentation is not adequate.
- Level 3 – Case management is questionable with no potential for significant adverse effect of the patient or hospital operations.
- Level 4 – Case management is questionable with high potential for significant adverse effect of the patient or hospital operations.
- Level 5 – Case management results in significant adverse effect of the patient and/or is direct violation of any legal/Medical Staff Bylaws / Rules requirement.

Problem Identification:
- None identified
- Issue in diagnosis
- Issue in judgement
- Patient non-compliance
- Natural progress of disease
- Issue with behavior

- Issue in documentation
- Issue in technique
- System and/or process problem
- Policy and procedure
- Other (specify):
- Communication issue

Iatrogenic Complication:
- Grade 1 – Non-life threatening, no residual disability, no added LOS, no invasive procedure treatment required.
- Grade 2 – Potentially life threatening, no residual disability, no invasive procedure treatment required.
- Grade 3 – Potentially life threatening, no residual disability, invasive procedure treatment was required.
- Grade 4 – Complication with residual or persistence of life threatening conditions
- Grade 5 – Death due to complication(s)

Disposition:
- Trend
- Closed

- Education
- Counseling
- FPPE

- Letter of Concern
- Letter of Inquiry

- External Review
- To Committee (specify):
- Violates Standard of Code of Conduct

PRC Chair/Designee ____________________________  (date)/(time)

This review is confidential and protected peer review material pursuant to Indiana Statute (I.C. §34-30-15).
Title: ONGOING PROFESSIONAL PRACTICE EVALUATION

<table>
<thead>
<tr>
<th>Document Owner: Chris Stefaniak</th>
<th>PI Team: N/A</th>
<th>Date Created: 10/01/2007</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): Denise Duschek, Karyn Delgado, Teresa Onken</td>
<td>Date Approved with no Changes: 12/19/2018</td>
<td>Date Approved: 12/19/2018 12/01/2007</td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMHC)</td>
<td>Department: Medical Staff Office</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. The OPPE requires that the medical staff conduct an ongoing evaluation of each practitioner’s professional performance. This process allows any potential problems with a practitioner’s performance or trends that impact quality of care and patient safety to be identified and resolved in a timely manner. The OPPE also fosters an efficient, evidence-based privilege renewal process. The information resulting from the ongoing professional practice evaluation is used to determine whether to continue, limit, or revoke any existing privileges(s).

PROCEDURE:

A. The respective department chair(s) are responsible to coordinate the Ongoing Professional Practice Evaluation (OPPE) review. The OPPE will be performed on all practitioners every eight months allowing an additional 60 day review period if necessary.

B. The type of information and the process for evaluation of each practitioner’s ongoing professional practice has been approved by the departments through the Medical Executive Committee. The defined process is below.

C. At each eight month review, every practitioner will be reviewed by the department/specialty Chair or representative. This review will be factored into the decision to maintain existing privileges(s), to revise existing privilege(s) or to revoke an existing privilege prior to or at the time of renewal. The fact that a practitioner doesn’t fall out on screening criteria does not meet the requirement for performance data review although zero data is in fact data and can be evidence of good performance, e.g. no returns to the OR, no complaints, etc. Review of privileges are evaluated at reappointment and consideration of the reason for zero or low volumes is taken into consideration, e.g. no longer performing the procedure, taking patients elsewhere for the procedure or privilege is typically a low volume procedure, etc.

D. Data reports and information that are included in the OPPE include, as applicable:

1) Midas Statit Specialty Profiles – These reports include inpatient and outpatient data for both the individual physician and comparison with the aggregate of the physicians in that specialty:

2) Midas Occurrence Report – Midas is a tool for collecting clinical practice concerns as well as patient and family concerns and compliments. The Occurrence Monitoring and Peer Review policy defines the process for collecting, investigating and addressing these concerns. This report includes individual and aggregated physician information on:

   a) Risk related occurrences

   b) Quality Indicators & Quality Indicator related occurrences
Title: ONGOING PROFESSIONAL PRACTICE EVALUATION

3) No/Low Volume Practitioner –
   a) Attestation of Clinical Competence
   b) Peer Reference, as needed

E. The department chair or representative will document pertinent findings and recommendations in the Midas Statit database to include:

1) Confirmation that the practitioner has been reviewed and there are no potential problems with performance or trends that would impact the quality of care and patient safety. The individual practitioner will then be reviewed again at their next eighth month OPPE.

2) Request for additional review for an individual practitioner based on an identified issue. Information gathered for review may include, but not be limited to:
   a) Drill down reports
   b) Additional performance of a specific procedure
   c) Additional Monthly Review
   d) Direct Observation
   e) Concurrent Monitoring
   f) Retrospective Chart Review
   g) Discussion with other individuals involved in the care of the practitioner’s patients including consulting physicians, assistants at surgery, nursing and administrative personnel

3) This review process will continue until the Department Chair or Representative is either:
   a) Satisfied with the information received and reviewed, or
   b) Recommendations are made to the Credentials Committee or Physician Well Being Committee, as applicable, for review and recommendation to the Medical Executive Committee for action including, but not limited to the initiation of the Collegial Investigation per the Medical Staff Bylaws Credentials Policy Manual.

4) Request for immediate action according to the Medical Staff Bylaws can be taken at any time during the OPPE process, which may include, but not limited to, forwarding concerns to the following committees:
   a) Credentials Committee for review
   b) Physician Well Being Committee for review (SJRMC-Mishawaka)
   c) Medical Executive Committee

F. The information gained by the review of the above information will be filed and incorporated into the two-year reappointment process. A summary report will also be forwarded to medical staff leaders. Single incidents or trending of quality and safety issues that impact the safety of patients will require immediate action by the medical staff.

G. “Trigger” - There may be circumstances where a single incident or evidence of a clinical practice trend may be identified through the OPPE process. If so, this will trigger a Focused Professional Practice Evaluation, which will be conducted according to Medical Staff Policy.

1) Triggers may include, but are not limited to, data obtained from quality indicators, risk indicators, utilization indicators, unexpected deaths, medical leave of absence, Hospital and Medical Staff Bylaws, Rules & Regulations or policy violations.
Title: ONGOING PROFESSIONAL PRACTICE EVALUATION

H. If behavior is identified as a possible issue, the Medical Staff Code of Conduct Policy will be followed as a component of the OPPE.

I. Relevant information obtained from the OPPE will be forwarded for inclusion into the performance improvement activities maintaining confidentiality.

References/Standards:
- Joint Commission Hospital Accreditation Standards (HAS) 2010
- Reappointment Cycle with OPPE Table
- Policy Origin Date: October 2007 (M), October 2007 (P)
- Review Date: December 2009 (M), December 2012 (M), December 2009 (P), August 2010 (P), December 2012 (P), December 2015 (M), February 2016 (P), December 2018 (M)
- Revised Date: August 2008 (M), September 2010 (M), December 2013 (M), August 2008 (P), September 2010 (P), September 2013 (P), September 2017 (M)
- Effective Date: December 2007(M), December 2007(P)
- Reviewed/Recommended By: Medical Executive Committee
- Policy 157

Expiration Date: 12/19/2021
Title: Proctoring Policy and Procedure

<table>
<thead>
<tr>
<th>Document Owner: Chris Stefaniak</th>
<th>PI Team: N/A</th>
<th>Date Created: 05/01/2000</th>
</tr>
</thead>
<tbody>
<tr>
<td>Approver(s): Karyn Delgado, Teresa Onken</td>
<td>Date Approved with no Changes: 12/19/2018</td>
<td>Date Approved: 12/19/2018 06/01/2000</td>
</tr>
<tr>
<td>Location: Saint Joseph Regional Medical Center (SJRMC)</td>
<td>Department: Medical Staff Office</td>
<td></td>
</tr>
</tbody>
</table>

Printed copies are for reference only. Please refer to the electronic copy for the latest version.

POLICY:

1. This policy assists the Medical Staff in determining the competency of:
   A. New practitioners who seek non-core privileges, and
   B. Practitioners who seek privileges to perform new or rarely performed procedures.

PROCEDURE:

A. The appropriate department shall recommend the terms of proctoring, including the number of cases required.

B. The Credentials Committee shall approve the terms of proctoring and authorize acceptable non-credentialed proctors.

C. Proctoring may require one or any combination of the following:
   1) Retrospective chart review within one month of discharge;
   2) Concurrent chart review within 24 hours (or earlier, if specified) of admission or the procedure in question;
   3) Availability on campus for immediate consultation and concurrent chart review within 24 hours of admission or the procedure in question; and/or
   4) The proctor’s presence during that portion of a procedure for which the Medical Staff requires proctoring. (A proctor is permitted - but not required - to intervene at any time during the observation to assist the proctored physician if he/she believe that such intervention is in the patient’s best interest. The proctor is not deemed the primary physician unless the proctoring program requires it; however, a proctoring physician is permitted to become the primary physician at any time during the case that he or she proctors.)

D. If proctoring is required for a procedure, it is mandated that at least one (1) case be performed at SJRMC-Mishawaka campus.

E. Proctoring reports are acceptable from the following locations:
   1) St. Joseph, Elkhart and Marshall county facilities, and
   2) Any Trinity Health / CHE facility, and
   3) Company Proctors, and
   4) Any additional facility outside of the above requires preapproval on a case by case basis by the Credentials Committee.

F. Upon successful completion of the proctoring program, the Department Chair shall notify the practitioner of this new status, and will make a report to the Medical Staff Office for the physician’s performance improvement file.

Expiration Date: 12/19/2021
Title: Proctoring Policy and Procedure

G. If a “quality of care” issue is identified during the proctoring process it will be referred to the Department Chair.
   1) The Department Chair shall submit a report to the Credentials Committee.
   2) The Credentials Committee, with consultation from the Department Chair, shall prepare a report/recommendation.
   3) An appointee of the Credentials Committee shall present and discuss the report/recommendation with the proctored physician.
   4) The report/recommendation shall be filed in the proctored physician’s performance improvement file.

H. Waiver of Proctoring will be considered for the following:
   1) Similar to a leave of absence, if a resignation was approved less than 12 months prior to returning to the medical staff and there were no competence or behavior issues during their appointment, no additional proctoring will be required unless deemed necessary by the MEC.
   2) Similar to a reappointment cycle, if a resignation was approved less than 24 months prior to returning to the medical staff and there were no competence or behavior issues during their appointment and the physician maintained practice volumes elsewhere, modified proctoring may be considered requiring MEC approval.
   3) If a practitioner has been gone from SJRMC greater than 24 months, consideration of modified proctoring may be considered if there were no competence or behavior issues during their appointment and the physician maintain practice volumes elsewhere and there were no competence or behavior issues during their time away. This would require MEC approval.

References/Standards:
• Policy Origin Date: May 2000
• Review Date: May 2012, December 2012, December 2015, December 2018
• Revised Date: June 2012, March 2013, June 2014
• Effective Date: June 2000
• Reviewed/Recommended By: Medical Executive Committee
• Policy 84