

CHAPTER 26
HOSPITAL ACCREDITATION

2/24/83

THIS CHAPTER WILL BE INCORPORATED IN THE MANUAL OF THE MEDICAL INSPECTOR AND EVALUATION OFFICE

CHAPTER 26. HOSPITAL ACCREDITATION

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CHAPTER 26. HOSPITAL ACCREDITATION

26.01 POLICY

The VA Department of Medicine and Surgery has the basic policy and goal of providing the highest quality of medical services to persons entitled to care and treatment. Each VA hospital will meet or exceed the standards of the JCAH (Joint Commission on Accreditation of Hospitals). This chapter interprets the standards of the Joint Commission as they relate to VA policies and procedures.

26.02 REFERENCES

a. The latest editions of the following references will be available in each hospital:

(1) Five Basic Publications of Joint Commission on Accreditation of Hospitals--obtain from JCAH, 645 North Michigan Avenue, Chicago, Illinois 6061 1.

(2) Hospital Accreditation References--obtain from American Hospital Association, 840 North Lake Shore Drive, Chicago, Illinois 6061 1.

(3) Bulletins of Joint Commission on Accreditation of Hospitals--two complimentary copies of bulletin are received by the Hospital or Center Director. Additional subscriptions may be purchased for \$1 per year.

b. This chapter does not contain all of the explanations and supplementary statements regarding JCAH standards. The Hospital or Center Director and his staff will be responsible for familiarizing themselves and others with the information contained in subparagraph a. above.

26.03 JCAH PURPOSE

a. The assumption underlying the Joint Commission is that greater advances can be made in hospital care by pooling the interests of the medical staff and other hospital services than by each working separately toward the same end. The progress in hospital accreditation since the Joint Commission was founded has demonstrated the validity of this assumption. The Joint Commission, organized in 1952, is composed of representatives of the American College of Surgeons, the American College of Physicians, the American Hospital Association, and the American Medical Association.

b. The philosophy of the Joint Commission is best stated by its purpose:

(1) To conduct an inspection and accreditation program which will encourage physicians and hospitals voluntarily:

(a) to apply certain basic principles of organization and administration for efficient care of the patients.

(b) to promote high quality medical and hospital care in all its aspects in order to give patients the greatest benefits that medical science has to offer.

(c) to maintain the essential diagnostic and therapeutic services in the hospital through coordinated effort of the organized medical staff and the governing board of the hospital.

(2) To establish standards for hospital operation.

(3) To recognize compliance with standards by issuance of certificates of accreditation.

(4) To assume such other responsibilities and to conduct such other activities as are compatible with the operation of a hospital accreditation program.

26.04 ACCREDITATION CERTIFICATE

a. There are two types of accreditation--1 year and 3 years. Accreditation for 3 years means that the hospital meets the standards for accreditation to a high degree. A certificate is given only for the 3-year accreditation.

b. Accreditation for 1 year means that the hospital meets the standards to a degree that deserves recognition and indicates ability to make the improvements necessary to attain 3-year accreditation. Hospitals surveyed initially and receiving 1-year accreditation will not receive a certificate.

c. There is no charge for the 3-year accreditation certificate; it is the property of the Joint Commission. If a hospital loses its accreditation, changes the type of care given, or merges with another hospital the certificate must be returned to the Director, Joint Commission Accreditation of Hospitals.

d. Hospitals receiving renewal of 3-year accreditation may either retain their old certificate showing continuous accreditation or may receive a new one, if they so desire. They cannot have both.

e. Hospitals receiving 1-year accreditation following 3-year accreditation may retain their certificate, but if a second 1-year accreditation is received, the certificate must be returned to the Joint Commission.

26.05 ACCREDITATION SURVEYS AND SURVEY COSTS

a. For the initial survey, the Hospital or Center Director will send the request to the Joint Commission. JCAH will determine the hospitals eligibility and schedule a survey date. Whenever possible, the visit will be scheduled within 6 to 12 months of the

request date. Prior to the visit, the Hospital or Center Director will receive notification of the survey date, with survey forms which are to be completed prior to the visit. The Director will appoint a coordinator for the completion of all JCAH forms received prior to the survey. This may be the Chief, Medical Administration Division/Service, or other qualified person on the hospital staff.

b. Following the survey a report is sent by the survey representative to the office of the Joint Commission where the Board of Commissioners acts on the findings and recommendations. The results, with the recommendations, are sent to the Hospital or Center Director and to Central Office by the JCAH.

c. Requests for surveys will not be necessary following a 3-year or 1-year accreditation. The Joint Commission automatically makes the survey as near the anniversary date as possible.

d. Only two consecutive surveys resulting in 1-year accreditation are permitted. The hospital must, on the third survey, achieve 3-year accreditation or be reduced to nonaccreditation.

e. The Department of Medicine and Surgery has negotiated an agreement with the Joint Commission whereby billings for surveys will be handled on a centralized basis. Accordingly, field stations are relieved of responsibility for budgeting and making payment for survey costs.

26.06 RESPONSIBILITIES

a. The station Director will be responsible for the total program and conduct of the accreditation procedures. The survey representative of the JCAH will be provided with necessary information and have available VA staff assistance in the specific areas under review.

b. The Chief of Staff will be responsible for coordinating the professional activities of the accreditation procedures with the survey representative of the JCAH.

c. The Assistant Director will coordinate the administrative portion of the survey with the appropriate hospital staff member.

d. The triumvirate will:

(1) Adopt Bylaws, rules and regulations in accordance with legal requirements.

(2) Meet at regular stated intervals.

(3) Appoint committees.

(4) Coordinate activities of the medical administrative staff.

(5) Provide a physical plant equipped and staffed to maintain the needed facilities and services for care and safety of the patient.

(6) Maintain essential facilities and services.

e. A hospital requesting accreditation will prepare bylaws, rules and regulations which will be adopted by the station management and the professional staff. An agreement has been made with the Joint Commission whereby certain statements, uniformly applicable to all VA hospitals, may be used in developing individual hospital bylaws. (Appendix 26A is a model set of bylaws. The statements listed under the articles may be used verbatim if applicable, or modified to reflect the situation existing at the individual hospital.

f. The professional (including dental) staff is responsible to the patient and to the Director for the quality of medical care rendered and for the ethical and professional practice of its members. Physicians and dentists accepting appointments for staff assignment in a VA hospital will be required to:

(1) Support the medical staff and all hospital policies.

(2) Assist in formulating new policies and standards of patient care.

(3) Maintain high standards of medical ethics.

(4) Properly supervise those less experienced and accept supervision from those more experienced.

(5) Accept controls as a protection to themselves as well as others.

(6) Contribute to the overall effectiveness of the hospital.

These responsibilities will be accomplished through participating in hospital activities with constant analysis and review of the clinical work done in the hospital, maintaining quality medical records, obtaining authorization for necropsies (a minimum of 20 percent in nonteaching hospitals and 25 percent in affiliate hospitals), reviewing consultant and fee basis physician reports, and utilizing the hospital services to insure that patients receive the highest of medical care. The Joint Commission, in accrediting a hospital, places great emphasis on the extent and care with which the professional staff reviews and evaluates clinical practice. Since good medical records, reliable diagnostic services, and a competent, well-organized staff are essential for good clinical review, these important factors are closely surveyed.

g. Other division chiefs are responsible for their related activities involving direct or indirect patient care as stated in JCAH standards. Medical Administration Division/Service has administrative responsibilities regarding appropriate review functions. Fiscal and Personnel Divisions have responsibilities in rendering administrative support to the hospital as required by the Joint Commission. Engineering, Building Management and Supply or Business Services Divisions have important roles in meeting the physical plant standards.

26.07 REVIEW FUNCTIONS

a. The Joint Commission permits a hospital to determine the selection of the mechanism to perform the administrative functions of the professional staff. While JCAH delegates this choice it emphasizes that quality control is a function that should and must be left in the hands of the professional staff. Each professional staff will devote serious thought to the methods by which it can most effectively discharge its medical responsibilities. JCAH Bulletin #40 discontinued the required committee structure but not the required review functions.

b. The effective discharge of the responsibilities of the professional staff will depend on the clear assignment and full acceptance of each responsibility by the entire staff, individual members, committees or other mechanisms formed to deal with the specific tasks assigned under review functions. The form and complexity of organization of the professional staff needed to discharge these responsibilities effectively is a determination which must be made by the Director of each individual hospital. This will vary substantially depending on the size and composition of the hospital. While committee establishment will be a common device, other methods will be acceptable to the Joint Commission provided effectiveness can be demonstrated by the documentation of activities.

c. In view of the new concept expressed in JCAH Bulletin #40, at least one committee with the responsibility of required review functions will be established at each hospital. M-2, part I, paragraph 11.03, outlines the responsibilities of a Medical Executive Committee. The designations of the number of other committees (or other mechanisms) to accomplish required functions will be the responsibility of the Hospital or Center Director with advice of the Chief of Staff. The Medical Executive Committee may recommend to the Director the establishment of other professional committees (or other mechanisms) to carry out required review functions. Appropriate members of the hospital staff will be utilized for program review functions.

d. The required JCAH review functions are: medical records, utilization review, outpatient care (including PBC and PHC), environmental control (including hospital infections), tissue, therapeutic agents and pharmacy review and transfusions. The type and complexity of the hospital will determine the number of special review functions such as radioisotopes, resident review and tumor. If committee structure is used, there may be a combination of review functions in one committee or the assignment of a review function to separate committees. The following subparagraphs describe the recommended procedures for committee action. These elements will be reviewed even though there is a combination of review functions within the committee.

e. Medical record review function is an important indication of the quality of medical care being given. This function includes the review of medical records of patients currently hospitalized as well as those of patients discharged from the hospital (also outpatients). It includes the surveillance and control of all medical record forms, their overprinting, assembly and use. It includes the surveillance and control of use of medical records and medical record data, and the creation of secondary indexes. It includes the responsibility for recommending policy and procedures to the Director and Chief of Staff and the follow-up to assure subsequent action, if any. The duties and responsibilities inherent in this review function are very important in view of JCAH's emphasis on medical records as an indicator of the quality of patient care. Meetings of the group or committee assigned this function will be monthly unless the Chief of Staff approves a request for other time intervals. The chairman will be appointed by the Chief of Staff for a 1-year term. Each diagnostic and treatment service will be represented and other service chiefs invited to attend when agenda items concern their functions. When appropriate, a resident staff member will be included in medical record review function. The medical record librarian, or designated medical administrative person will serve its recorder. The file of documented activities will be maintained in the office of Chief of Staff. Minutes and reports pertaining to this function will be sent to the Chief of Staff and circulated to all professional staff members and others invited to meetings by the chairman. All professional staff members contributing to the medical record as well as medical administration personnel should be kept up to date on medical record review activities.

f. Utilization review function involves the periodic review of patient care activity to assure that optimum use of facilities and services is being made for the best patient care. Mechanisms for review include regular study of representative samples of medical records of patients both currently hospitalized, discharged, and/or the sampling of data or special reports. Through such planned and organized activities of clinical and laboratory services, of existing committees, or of a special committee, attention is focused on ascertaining that admissions are medically necessary; that medically indicated diagnostic procedures, consultations, and treatments are initiated and carried out promptly; and that patients are discharged or transferred to more appropriate facilities as soon as their condition permits. A thorough understanding on the part of professional staff members and administrative personnel is fundamental to the success of this review function and their informed support is necessary. This function may be assigned to one or more existing committees. Members of the attending and/or consulting staffs should be involved in this review. The composition of the group or subgroup assigned this review function will be broadly representative of the entire scope of professional practices carried out in the hospital. In some hospitals it may be necessary to form several subgroups for each of the major clinical services. However, the main body or group responsible for this review function should not number more than 15 members. Services of laboratory, radiology and anesthesiology should be represented and the Director or his designee should be present at all meetings. Members of the professional staff who are not assigned to this review function may be invited to serve temporarily when specific areas of study are selected in which they have special competence. The chairman will be appointed by the Chief of Staff for a 1-year term. Resident physicians, Chiefs of Services (including Social Work, Psychology, etc.), Chief, Medical Administration Division/Service, and/or medical record librarian should be invited to attend these meetings when appropriate. Administrative support of the group's or committee's projects (including the design of any data review sheets) will be provided by the medical record librarian or other Medical Administration Division/Service personnel. The format of documentation of activities including follow-up for subsequent action will be the decision of the chairman. The Medical Executive Committee will be kept informed of progress by a special report or copies of minutes, subgroup reports, etc. A file of reports, minutes, etc., will be maintained in the office of the Hospital or Center Director. Meetings of main group or committee will be monthly unless the Chief of Staff approves a request for other time intervals.

g. Tissue review function is that of improving surgical care of patients by the review of documented work and that of continuing education. It includes the review and evaluation of all surgery performed in the hospital on the basis of agreement or disagreement among the preoperative, postoperative, and pathological diagnoses, and on the acceptability of the procedure undertaken. The adequacy of an operation often is as important, if not more important, than mere agreement on diagnoses. Meetings of the group or committee will be held at time intervals determined by the Chief of Staff. The composition of the group or committee assigned the responsibility for this review function will include one or more members of Surgical Service, one or more member of Medical Service and the Chief, Laboratory Service, or his designee. The medical record librarian or other designated person will serve as recorder. The medical record librarian or other Medical Administration Division/Service personnel will assist the Chief, Laboratory Service, regarding collection of information from medical records or other sources.- The group or committee members will determine the need of subgroups, the review of medical records for the final decision as to whether the record shows that the surgical procedure performed was clearly indicated and whether the quality of work was acceptable to the committee. Reports will be made to the Chief of Staff. Work sheets will be held for 1 month after report is submitted and then disposed of in accordance with Records Control Schedule 10-1. The minutes file of this function will be maintained in the office of the Chief of Staff.

h. changed by II 10-75-

i. The review function of environmental control concerning physical plant is presented in paragraph 26.09. Post hospital care review function is in M-1, part I, paragraph 17.20. M-2, part I, chapter 3, contains the function of the Therapeutic agents and pharmacy review.

26.08 MEDICAL RECORDS

a. Medical records will contain sufficient recorded information to support the diagnosis and warrant the treatment and end results. Medical records are an important tool in the practice of medicine. They serve as a basis for planning patient care; provide a means of communication between the physician and other professional groups contributing to the patient's care; furnish documentary evidence of the course of the patient's illness and treatment; and serve as a basis for review, study, and evaluation of the medical care rendered to the patient. Hospital staff members contributing to the medical record have the responsibility of complying with the hospitals policies and procedures based on the requirements of DM&S and the Joint Commission.

b. The medical record content requirements of JCAH standards will be met. The responsibility for the overall content of the medical record is that of the physician in charge of the patient. He is responsible for ascertaining that the evidence documented in the record by laboratory, X-ray, nursing, etc., is accurate and pertains to his patient, accomplishes his orders, and reflects all treatment and services given his patient. This documentation must be present in the basic medical record before a hospital summary is completed. The group or committee assigned the medical record review function will inform the medical staff of medical record requirements of JCAH. Among these are:

- (1) Current records of patients should be completed insofar as possible within 24 to 48 hours.
- (2) Original signed laboratory, X-ray, and other medical reports are to be entered in the medical record.
- (3) If a patient is readmitted within a month's time for the same condition, the previous history and physical examination with an interval note will suffice.
- (4) Operative notes should be dictated immediately after surgery and should contain both a description of the findings and a detailed account of techniques used and tissues removed.
- (5) All tissue including teeth removed in the surgical operating suite, should be sent to the laboratory. Tissues, including teeth removed in the dental clinic, will not be sent to the laboratory unless specifically requested by patient's dentist.
- (6) In long-term cases the patient should have at least an annual physical examination.
- (7) Progress notes on new admissions, acute cases, and intensive therapy cases should be written frequently and regularly. Progress notes on chronic and domiciliary cases should be written as needed but preferably at least monthly. In VA hospitals, the medical record review function group or committee will recommend the policy concerning the frequency of progress notes for long-term cases.
- (8) After discharge, medical records should be completed insofar as possible within 10 days. In VA hospitals, this is interpreted to mean that all component parts of the medical record including final summary should be completed within 10 days following the discharge of the patient. The component parts of a medical record are governed by the type and number of diagnoses and operations documented for the patient during a period of hospitalization. The component parts are those medical record sheets necessary for the dictation of a complete, adequate and accurate

summary. A medical record containing progress notes indicating performance of three operations should contain three operation reports (with pathology reports, if appropriate) before the physician-begins his dictation of the final summary. The average medical record will have at least the following component parts: hospital summary, history and physical examination sheets, medical certificate of the hospital application, progress notes, consultations (if any), pertinent laboratory reports, pertinent X-ray reports, operation and pathology report(s) (if appropriate), doctor's orders, temperature--pulse--respiration, nursing notes and other appropriate nursing care forms, and copy of the death certificate (if appropriate).

(9) Administrative responsibilities including the quantitative review of the record, coding of diagnoses and operations and indexing should be done within 10 to 15 days after the final summary has been reviewed and signed by the physician. No medical record is considered complete until it contains all the appropriate medical record sheets as defined above. All component parts should be properly signed and assembled before the medical record is considered a completed record. No medical record should be filed until it is complete, except on the order of the Chief of Staff. A 90-day period for completion of a necropsy protocol will be permitted (the protocol is not included in these requirements of the component parts of a medical record).

c. The Medical Administration division/Service will have the following administrative responsibilities as required under JCAH standards:

- (1) There shall be a medical record maintained on every patient admitted for care in the hospital.
- (2) Records shall be kept inviolate and preserved for a period of time not less than that determined by the records disposition outlined in DM&S Records Control Schedule 10-1.
- (3) Sufficient qualified personnel shall be available to supervise and conduct the medical record function.
- (4) A system of identification and filing to insure the rapid location of a patient's medical record shall be maintained.
- (5) All clinical information pertaining to a patient shall be centralized in the patient's record.
- (6) The Standard Nomenclature of Diseases and Operations and the Diagnostic and Statistical Manual of the American Psychiatric Association will be used to provide uniform disease and operative diagnoses. M-1, part I, chapter 5, contains information concerning the VA's medical records and requirements.
- (7) Records shall be indexed according to disease and operation and will be kept up to date. For indexing, VA hospitals will use International Classification for Diseases, Adapted. VA hospitals are not required to maintain a physician index.

Inherent in these responsibilities is the provision of services and facilities to physicians and other professional staff members to facilitate the accomplishment of their responsibilities for prompt notes, reports and summaries. The medical record librarian or other designated person will be responsible for the quantitative review of records, the accuracy and completeness of diagnosis and operation coding, indexing, and other related duties. The medical record librarian will serve as the resource person in the hospitals medical record program.

d. In the hospitals medical record program, the method of medical audit may be used either in the medical record review function, in the combination of review functions, or in the review and appraisal function of a service contributing to the content of the medical record; for example, a nursing service audit may be done regarding clinical recording by nurses on medical records and to provide data for utilization in the improvement of patient care programs. In some hospitals, the functions of medical record review, tissue review and utilization review may be combined as a medical audit function. The size and complexity of the hospital will determine the modus operandi of the audit.

26.09 PHYSICAL PLANT

a. Construction. The JCAH has not established standards on types of construction for hospitals. It does not approve architectural plans or endorse building materials. Federal, State, and local laws will govern what are acceptable standards and whether building codes are complied with in hospital construction.

b. Environmental Controls. The JCAH expects the following items will be available in all VA hospitals to provide an environment that will insure the well-being and safety of patients:

(1) Distribution of patients by services.

(2) Facilities for isolation.

(3) Adequate space per bed. (NOTE: This will vary between States but a general average is 100 square feet in private rooms and 80 square feet in multiple-patient rooms.)

(4) Facilities for emergency electrical power.

(5) Emergency fuel and water supply.

(6) Fire and explosion controls.

(7) Safety controls.

(8) Adequate ventilation or air conditioning systems.

c. Maintenance. The JCAH will expect a thoroughly clean hospital without exception. The following areas will require special attention:

(1) Air intake sources, screens and filters with special attention given to "high risk areas" such as operating rooms and recovery units.

(2) Bathrooms and lavatories.

(3) Utility rooms.

(4) Kitchens and dish washing facilities.

(5) Laundries.

(6) Corridors.

d. Admitting Activities. In addition to JCAH standards, the VA expects special attention to be given to the following:

(1) When possible, the admitting activity should be on ground floor with easy access from the outside. Curbs, etc., should be eliminated to permit wheelchair accessibility.

(2) The ambulance entrance should be near the admitting area. The area will be well lighted and posted with pertinent directional instructions.

(3) A waiting room, appropriately furnished and possessing adequate seating space, will be located in proximity to the admitting office. Visitors and applicants will be received in a manner that results in a favorable impression of the hospital. Special emphasis should be given to the public service aspects of this activity.

(4) Facilities will be available for public telephone service. Drinking fountain and restrooms should be conveniently located near the waiting room. Location of other public facilities, such as the canteen, will be included in the information provided to the visitor. Adequate provisions will be made to insure accessibility of facilities to individuals in wheelchairs.

26. 10 MASS CASUALTY PLAN

a. The Joint Commission requires that there be a written and widely published plan for mass casualties and that this plan be coordinated and rehearsed, at least twice annually, with all of the services of the hospital participating.

b. Each VA hospital will devise such a disaster plan in sufficient detail and depth to enable adequate training and guidance to all employees in the evacuation and treatment or the reception and treatment of patients involved in a disaster.

26. 11 THE ADMITTING SERVICE

a. VA definition of "emergency service" differs from concept implied in the JCAH standards in that VA renders care only to eligible and potentially eligible beneficiaries and to those individuals needing emergency care for humanitarian reasons. The following paragraphs are to be interpreted within the framework of existing VA policies and procedures.

b. The admitting activity will be organized under the hospital's outpatient service. This function will be considered an integral part of each treatment service in that coordination of admissions and related activities are necessary. Careful selection of the physician and other staff assigned should be made to insure that prompt, courteous and efficient attention is given to each applicant for care and to the general public.

c. Representatives from the major medical services, Nursing Service and Medical Administration Division/Service will be included for committee action in the functional review of the following:

(1) That immediate medical attention is given to emergencies. Nonemergent applicants will be seen by an employee of the admitting service as rapidly as possible after the patient's arrival.

(2) That physician coverage be available in the event of unexpected or unusual contingencies.

(3) That specialized medical service can be obtained promptly when needed.

(4) That a roster of available specialists, showing their office and home telephone numbers is conspicuously posted in the admitting activity.

(5) That there is adequate staff coverage.

(6) That a poison control chart is available including the location and telephone number of the nearest poison control center.

(7) That a guide for use of the staff will include specific instructions to meet certain emergencies. Included in this guide will be information about the location of items of supplies and equipment needed in most emergencies.

Department of Veterans Affairs
Veterans Health Administration
Washington, DC 20420

M-1, Part I
Chapter 26
Change 102

December 12, 1991

1. Transmitted is a change to Department of Veterans Affairs, Veterans Health Administration manual M-1, "Operations," Part I, "Medical Administration Activities," Chapter 26, "Hospital Accreditation." M-1, part I, chapter 26, is currently being completely revised and will be reissued at a later date.

2. The purpose of the changed appendix is to provide a template for use by VA medical centers, outpatient clinics and domiciliary in preparing facility medical staff bylaws and rules.

3. Filing Instructions

Remove pages

Insert pages

26A-1 through 26B-1

26A-1 through 26A-34

4. Rescissions: M-1, part I, chapter 26, appendices 26A and 26B, dated October 12, 1967.

James W. Holsinger, Jr., M.D.
Chief Medical Director

Distribution: RPC: 1143 is assigned
FD

Printing Date: 12/91

NOTES TO TEMPLATE USERS

1. Bylaws and rules provide guidance to medical staff members to assist them to meet the expectations of the Medical Staff and to comply with VHA (Veterans Health Administration), JCAHO (Joint Commission on Accreditation of Healthcare Organizations) and local facility requirements and expectations. They should provide a framework that will allow medical staff members and applicants to knowledgeably agree to abide by the rules and policies of the medical staff.

2. This "template" is to be used in preparing bylaws and rules for individual facilities. With exception of the mandatory items, each facility is expected to subtract from and add to this framework as it prepares a complete document that reflects the will of the Medical Staff and the programs and services offered at the facility. Items that MUST be stated are identified by an (*) following the item. Notes offer comments and suggestions for consideration.

3. The Rules section contains topics to be included in local rules, as applicable to the individual facility's mission and programs. This may be accomplished by including all relevant information in the rules or by including the required information in the rules and referencing facility memoranda that provide full direction. Remember, however, the items marked with an (*) MUST be in the rules document. When policies and procedures provide the information, it must be clear that the policies and procedures are considered to be a part of the Rules; are available to all medical staff and include the elements listed in 4. below as applicable to the mission and programs offered at the Medical Center.

4. All special programs/services provided by facilities will be guided by locally developed policies and procedures that include at a minimum: scope and leadership of the program/service; levels, competencies and responsibilities of staff; patients served including any special conditions under which patients are accepted and received; methods of patient assessment, plans of care, treatment, discharge plans including plans for continuity of care; quality management; special supplies and equipment; safety; regular review of policies and procedures with provision for revision, and continuing education for staff. (See JCAHO standards and VA guidance for detailed program/service requirements.)

5. This template was prepared using VA regulations and policies and the JCAHO Accreditation Manual for Hospitals as guidance. Facilities surveyed under other accreditation manuals must assure that all relevant standards from those references are addressed.

December 12, 1991

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6. Nothing in the Bylaws and Rules can have any effect inconsistent with, or otherwise be inconsistent with, law or VA regulations. Because much of the Bylaws and Rules follow VA regulations and VA policy manuals, when these regulations and manuals are changed, the Bylaws and Rules must also be revised accordingly.

MODEL TEMPLATE - BYLAWS AND RULES

Bylaws and Rules of the Medical Staff

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BYLAWS AND RULES OF THE MEDICAL STAFF
OF VHA MEDICAL CENTER (OPC, DOMICILIARY)

(Location)

PREAMBLE

Recognizing that the medical staff is responsible for the quality of care delivered by its members and accountable to the Governing Body for all aspects of that care, the medical staff practicing at the VA Medical Center (OPC or domiciliary) at (Location) hereby organize themselves for self governance in conformity with the laws, regulations and policies governing VHA (Veterans Health Administration) and the bylaws and rules hereinafter stated. These Bylaws and Rules are consistent with all laws and regulations governing VA (Department of Veterans Affairs) , and they do not create any rights or liabilities not otherwise provided for in laws or VA Regulations.

NOTE: It would be appropriate to incorporate the facility mission statement in this section.

DEFINITIONS

1. Medical Staff

(Definition must specify the professions and/or groups composing the medical staff and assure that those professions/groups are fully licensed physicians and other licensed individuals permitted by law and the facility to provide patient care services independently in the facility, its satellite clinics and outreach facilities.) The Medical Staff is organized under a single category of membership known as the active Medical Staff.

NOTE: If the Medical Staff is divided into multiple categories, modify the definition and define each subset, e.g., active, associate, affiliate, etc.

2. Governing Body

The term "governing body" refers to the Chief Medical Director, the individual to whom the Secretary of the Department of Veterans Affairs has delegated authority for administration of the Veterans Health Administration; and, for purposes of local facility management and planning, it refers to the VA medical center director.

3. (Facility) Director

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The Director ("Chief Executive Officer") is appointed by the Governing Body to act as its agent in the overall management of the (facility). The Director is assisted by the Chief of Staff (with the Clinical Executive Committee) and the Associate Director(s) (with the Administrative Executive Board).

4. Dean's Committee (if applicable)

Committee established by a formal memorandum of affiliation between the facility and medical or dental school and approved by the Chief Medical Director; composed of deans and senior faculty members of the affiliated medical and dental schools and other academic institutions as appropriate, representative(s) of the medical/dental staffs of the facility; and such other faculty of the affiliated schools and staff of the facility

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(including the Chief Nurse) as are appropriate to consider and advise on development, management and evaluation of all educational and research programs conducted at the facility.

5. Practitioner

Define this term as it will be used throughout the Bylaws taking care to assure its fit wherever used, e.g., a physician, dentist, podiatrist, optometrist, psychologist, _____ (specify all that apply including any other professions represented) who is fully licensed, or otherwise granted authority, to practice in a State, Territory or Commonwealth of the U.S. or District of Columbia will be referred to as a practitioner in these Bylaws.

6. Appointment

As used in this document the term refers to appointment to the Medical Staff. It does not refer to appointment as a VA employee but is based on having an appropriate personnel appointment action, scarce medical specialty contract or other authority for providing patient care services at the facility. Both VA employees and contractors may receive appointments to the medical staff.

7. Rules

Refers to the specific rules set forth in this document which govern the medical staff of the medical center. It does not refer to formally promulgated VA Regulations.

NOTE: Define other terms that will be used throughout the Bylaws that are open to interpretation and not defined in JCAHO or relevant VA documents.

ARTICLE I. NAME

The name of this organization shall be the Medical Staff of the VA _____ (facility)
-.

ARTICLE II. PURPOSE

The purpose of the Medical Staff shall be to:

- a. Ensure that all patients treated at the (facility) or on any of the services will receive efficient, timely, appropriate care that is subjected to continuous quality improvement practices.

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b. Ensure all patients being treated for the same health problem or with the same methods/procedures receive the same level of care.

c. Establish, and assure adherence to, an ethical standards of professional practice and conduct.

d. Develop and adhere to facility specific mechanisms for appointment to the Medical Staff and delineation of clinical privileges.

e. Provide educational activities that relate to: care provided, findings of quality of care review activities and expressed need of caregivers.

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f. Ensure a high level of professional performance of practitioners authorized to practice in the facility through continuous quality improvement practices and appropriate delineation of clinical privileges.

g. Assist the Governing Body in developing and maintaining rules for Medical Staff governance and oversight.

h. Bring the dimension of Medical Staff leadership to deliberations by the Medical Center Director and the Governing Body.

i. Develop and implement continuous quality improvement activities in collaboration with the (facility) staff.

NOTE: Statements of purpose above provide a base. Purposes adopted by the Medical Staff should be facility specific based on VA mandates and facility programs and goals.

ARTICLE III. Medical Staff MEMBERSHIP

Section 1. Membership Eligibility

a. Membership on the Medical Staff is a privilege extended only to, and continued for, professionally competent (specify all professions that are included e.g., physicians, dentists, podiatrists, optometrists, psychologists) who continuously meet the qualifications, standards and requirements of VHA, this (Facility), and these Bylaws. Membership may be considered for other licensed practitioners who are permitted by law to provide patient care services independently and who meet the qualifications, standards and requirements of VHA, this (Facility), and these Bylaws.

b. Categories of Medical Staff membership* include:

NOTE: Must specify unless fully described under definitions including all professions represented on the Medical Staff whether they are utilized on a full-time, part-time, intermittent, WOC (without compensation), consulting, attending, on-station - fee basis, on-station - contract, or on-station - sharing agreement.

c. Decisions regarding Medical Staff membership are made without discrimination for such reasons as race, color, religion, national origin, sex, lawful partisan political affiliation, marital status, physical or mental handicap when the individual is qualified to do the work, age, or membership or nonmembership in a labor organization or on the basis of any other criteria unrelated to professional qualifications.

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Section 2. Qualifications for Medical Staff Membership
and Clinical Privileges*

To qualify for Medical Staff membership and clinical privileges, individuals who meet the eligibility requirements identified in Section 1 must submit evidence of:

a. Active, current, full and unrestricted license* to practice individual's profession in a State, Territory or Commonwealth of the U.S. or the District of Columbia as required by VA employment and utilization policies and procedures.

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b. Education* applicable to individual Medical Staff members as defined, e.g., hold a degree of Doctor of Medicine, Osteopathy, Dentistry, _____ (add others as applicable to the disciplines of the Medical Staff and those with clinical privileges) from an approved college or university.

c. Relevant Training and/or Experience*, consistent with the individual's professional assignment and privileges for which applying. This includes any internships, residencies, board certification or specialty training.

d. Current Competence*, consistent with the individual's assignment and the privileges for which applying.

e. Health Status* consistent with physical and mental capability of satisfactorily performing the duties of the Medical Staff assignment within clinical privileges.

f. Complete information consistent with requirements for application and clinical privileges as defined in Articles IV or V of these Bylaws for a position for which the Medical Center has the patient care need, adequate facilities, support services and staff.

g. Satisfactory Findings relative to previous professional competence and professional conduct.

h. English Language Proficiency.

i. Current professional liability insurance as required by Federal and VA acquisition regulations. (For those individuals providing service under contracts),

j. Ability to meet response time criteria established for the _____ Service or _____ (Specify service and, as applicable, specific position(s) within the service).

NOTE: This item should be included as applicable to the individual facility and provider groups e.g., surgeons

Section 3. Basic Responsibilities of Medical Staff Membership

Medical Staff members (and others with individual clinical privileges) are accountable for and have responsibility to:

a. Provide for continuous care of patients assigned to their care.

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- b. Observe Patients' Rights in all patient care activities.
- c. Participate in continuing education, peer review, Medical Staff monitoring and evaluation.
- d. Maintain standards of ethics and ethical relationships including a commitment to:
 - (1) Abide by Federal law and VA rules and regulations regarding financial conflict of interest and outside professional activities for remuneration.

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(2) Provide care to patients within the scope of privileges and advise the (facility) Director through the Chief of Staff of any change in ability to meet fully the criteria for Medical Staff membership or to carry out clinical privileges which are held.

(3) Advise the medical center Director, through the Chief of Staff, of any challenges or claims against professional credentials, professional competence or professional conduct within 15 calendar days of notification of such occurrences and their outcome consistent with requirements under Article IV of these Bylaws.

(4) Contribute to, and abide by, high standards of ethics in professional practice and conduct.

e. Abide by the Medical Staff Bylaws and Rules and all other lawful standards and policies of the (facility) and Veterans Health Administration.

NOTE: The responsibilities are extracted from JCAHO standards and VA guidelines. Responsibilities included in facility bylaws should include items specified by the Medical Staff.

ARTICLE IV APPOINTMENT AND INITIAL CREDENTIALING

Section 1. General Provisions

a. All members of the Medical Staff as defined in Article III, Section 1.b. and all non-Medical Staff practitioners who hold clinical privileges will be subjected to full credentials review at the time of initial appointment, appraisal or reappraisal for granting of clinical privileges, and after a break in service or utilization of more than 15 workdays as outlined in this Article. Credentials that are subject to change during leaves of absence will be subjected to review at the time the individual returns to duty.

b. Appointments to the Medical Staff occur in conjunction with VA employment or utilization under a VA contract or sharing agreement. The authority for these actions are based upon:

(1) Provisions of 38 U.S.C. in accordance with Department of Veterans Affairs Manual MP-5, part II, chapter 2 and its supplements (add Title 5 references if applicable to the individual Medical Staff composition) and applicable Agreement(s) of Affiliation in force at the time of appointment.

(2) Federal law authorizing VA to contract for health care services.

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c. Probationary Period*. Initial and certain other appointments made under (specify all that apply, e.g., 38 U.S.C. 7401(1), 7401(3), 5 U.S.C. 3301) are probationary. During the probationary period, professional competence, performance and conduct will be closely evaluated under applicable VA policies and procedures. If, during this period, the employee demonstrates an acceptable level of performance and conduct, the employee will successfully complete the probationary period. Supervisors and managers apply similar processes to the evaluation of individuals employed under provisions of 38 U.S.C. 7405 and those utilized under contracts and sharing agreements.

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Section 2. Application Procedures

NOTE: The items listed in Section 2 constitute the full range of possible requirements. The list will require tailoring for applicability to the various professions represented on the Medical Staff pursuant to personnel appointment authorities applicable to the professional discipline.

a. Applicants for appointment to the Medical Staff must submit a complete application. To be complete*, applications for appointment must be submitted by the applicant on forms approved by the VA and/or the facility and include authorization for release of information pertinent to the applicant and information regarding:

(1) Items specified in Article III, Section 2, Qualifications for Medical Staff Membership:

- (a) Active, current, full and unrestricted license,
- (b) Education,
- (c) Relevant training and/or experience,
- (d) Current competence,
- (e) Physical and mental health status,
- (f) Response time from residence (for on-call responsibility)
- (g) English language proficiency
- (h) Professional liability insurance (contractors)

(2) U.S. Citizenship. Applicants must be a citizen of the United States. When it is not possible to recruit qualified citizens, practitioners otherwise eligible for Medical Staff appointment who are not citizens will be eligible for consideration for appointment, with proof of current VISA status and documentation from Immigration and Naturalization Service of employment authorization, pursuant to qualifications as outlined in 38 U.S.C. 7405 and VA Manual MP-5, part II, chapter 2 (add others as appropriate to Medical Staff composition).

(3) References. Names and addresses of a minimum of three (3) individuals who are qualified to provide authoritative information regarding training/experience, competence, health status and/or fulfillment of obligations as a Medical Staff member within the privileges requested.

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(4) Previous Employment. List of all health care institutions where the practitioner is/has been appointed, utilized or employed, including:

(a) Name of health care institution or practice,

(b) Term of appointment or employment, and

(c) Privileges held and any disciplinary actions taken against the privileges, including suspension, revocation, limitations, or voluntary surrender.*

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- (5) DEA (Drug Enforcement Administration) registration
 - (a) Of those who have, or have had, DEA registration.
 - (b) previously successful or currently pending challenges to DEA registration or the voluntary relinquishment of such registration*.
 - (6) Challenges to License*, including whether a license or registration ever held to practice a health occupation by the practitioner has been suspended, revoked, voluntarily surrendered or not renewed.
 - (7) Status of any claims* made against the practitioner in the practice of any health occupation. (NOTE: Final judgments or settlements of professional liability actions are minimum requirement.)
 - (8) Voluntary or involuntary termination of Medical Staff membership or voluntary or involuntary limitation, reduction, or loss of clinical privileges at another health care facility*.
 - (9) Pending challenges* against the practitioner by any hospital, licensing board, law enforcement agency, professional group or society.
 - (10) Authorization for release of information, including written consent to the inspection of records and documents pertinent to applicant's licensure, training, experience, current competence, and health status.

b. Documents required in addition to those listed include:

- (1) A minimum of three references from individuals able to provide authoritative information regarding the individual's training/ experience, professional competence and conduct and health status. At least one of the references must be from the current or most recent employer(s) or institution(s) where clinical privileges are/were held. In the case of individuals completing residencies, one reference must come from the residency program director.

NOTE: Facility Medical Staffs may desire additional information, e.g., references from other hospitals where privileges are held.

- (2) Documentation of current or most recent clinical privileges held, if available.
- (3) Verification of status of licenses for all states in which the applicant has ever held a license.

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(4) For foreign medical graduates, evidence and verification of the ECFMG (Educational Commission for Foreign Medical Graduates) certificate.

(5) Evidence and verification of board certification, if claimed.

(6) Verification of education credentials used to qualify for appointment (and privileges) including all postgraduate training.

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(7) Reports of queries to FSMB (Federation of State Medical Boards), for physicians, and evidence of submission of query to National Practitioner Data Bank (NPDB), for all members of the Medical Staff and those practitioners with clinical privileges.

(8) Confirmation of health status.

(9) Results of review of VA Cautionary List.

(10) Agreement to Bylaws and Rules and to provide continuous care of applicant's patients.

NOTE: Verification is defined as primary source documentation by letter, telephone call, computer printout or in the case of confirmation of board certification, by listing in specific directories. See VHA policies on Credentialing and Privileging of Physicians and Dentists and VHA Supplement, MP-5, pt. II, ch.2.

c. Burden of Proof. The applicant has the burden of obtaining and producing all needed information for a proper evaluation of applicant professional competence, character, ethics, and other qualifications. The information must be complete and verifiable. The applicant has the responsibility for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information in _____ (specify time period) may serve as a basis for denial of employment consideration.

Section 3. Process and Terms of Appointment

a. The chief of the service to which the applicant is to be assigned is responsible for recommending appointment to the Medical Staff based on evaluation of the applicant's credentials and determination that service criteria for clinical privileges are met.

b. The (specify: executive committee of the Medical Staff) recommends Medical Staff appointment based on evaluation of credentials of each applicant and a determination that Medical Staff criteria for clinical privileges are met.

NOTE: This item will require modification if the facility processes Medical Staff appointments through other bodies prior to consideration by the executive committee, e.g., credentialing committee.

c. Appointments to the Medical Staff should be acted upon by the Medical Center Director within 45 days* of receipt of a fully complete application

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including all required verifications, references and recommendations from the appropriate service chief, PSB (credentialing committee), (specify: executive committee of the Medical Staff) and (specify others based on local requirements, e.g., the Dean's Committee).

NOTE: Appointments of certain clinically privileged employees are based on recommendations of "Standards Boards" which are different from Professional Standards Boards.

d. Candidates for appointment who have submitted complete applications as defined by these Bylaws will receive written notice of appointment or nonappointment. In the case that appointment is not approved, reasons will be provided.

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f. Temporary Appointment. When there is an emergent or urgent patient care need, a temporary VA employment appointment, under the provisions of 38 U.S.C. 7405(a)(1) and VHA Supplement MP-5, part II, chapter 2, and a temporary Medical Staff appointment may be approved by the (facility) Director upon recommendation of the Chief of Staff prior to receipt of references or verification of other information and action by (specify: PSB and other recommending committees). Verification of current licensure, confirmation of possession of clinical privileges comparable to those to be granted, NPDB query will be initiated, and a reference will be obtained prior to making such an appointment. Additionally, for physicians, FSMB screening will be initiated prior to appointment, or if that is not possible, on the next administrative workday.

ARTICLE V CLINICAL PRIVILEGES

Section 1. General Provisions

a. Medical Center specific privileges are granted for a period of ____* (specify-may not be more than 2) years.

b. Biennial (may be annual but not less often than biennial) reappraisal* of each Medical Staff member and any other practitioner who holds clinical privileges is required. Reappraisal includes a review of performance and an evaluation of the individual's physical and mental status, as well as assessment of the individual's current privileges. It also requires verification of satisfactory completion of sufficient continuing education to satisfy _____ (specify any minimum requirements, e.g., local Medical Staff requirements). Reappraisal is initiated by the practitioner's service chief at the time of a request by the practitioner for new and renewed clinical privileges.

c. A practitioner's request for modification/enhancement of existing clinical privileges is made by practitioner submission of a formal request for the desired change(s) with full documentation to support the change.

d. Other licensed practitioners (allied health professionals) who are presently permitted by law and (facility) to provide patient care services independently, will be granted clinical privileges based on their assignments and responsibilities.

e. Requirements and processes for requesting and granting privileges are the same for all practitioners who hold privileges regardless of the type of appointment or utilization authority under which they function, their professional discipline or position.

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f. Practitioners with clinical privileges are assigned to and have clinical privileges in one clinical department/service, but may be granted clinical privileges in other clinical departments/services.

g. Exercise of clinical privileges within any service is subject to the rules of that service and to the authority of that service chief.

h. When certain clinical privileges are contingent upon appointment to the faculty of affiliates, loss of faculty status results in termination of those privileges specifically tied to the faculty appointment.

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Section 2. Process and Requirements for Requesting Clinical Privileges*

a. Burden of Proof. The practitioner requesting clinical privileges must furnish all information needed for a proper evaluation of professional competence, conduct, ethics, and other qualifications. The information must be complete and verifiable. The practitioner is responsible for furnishing information that will help resolve any doubts concerning such qualifications. Failure to provide necessary information within _____ (specify time period) may serve as a basis for denying clinical privileges.

b. All practitioner requests for clinical privileges must be made in writing and include privileges requested "within well defined limits" (specify meaning of well defined limits, e.g., categories or levels) in a format approved by the Medical Staff.

c. The practitioner applying for initial clinical privileges must submit a complete application for privileges which will include*:

- (1) Complete appointment information as outlined in Section 2 of Article IV.
- (2) Application for clinical privileges as outlined in Section 2b of this Article.

d. The practitioner applying for clinical privileges subsequent to those granted initially will provide the following information:

(1) An application for clinical privileges as outlined in Section 2b of this Article. (Since practice, techniques, and facility missions change over time, it is expected that modifications, additions or deletions to existing clinical privileges will occur. Practitioners are encouraged to consider carefully and discuss appropriateness of specific privileges with the appropriate service chief prior to formal submission of the request.)

(2) Supporting documentation of professional training* and/or experience* not previously submitted.

(3) Physical and mental health status* as it relates to practitioner's ability to function within privileges requested including such reasonable evidence of health status that may be required by the executive committee of the medical staff.

(4) Documentation of continuing medical education* related to area and scope of clinical privileges, (specify any minimum requirements, e.g., consistent with minimum state licensure requirements, local Medical Staff requirements, etc.) not previously submitted.

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(5) Status of all licenses, certifications held.

(6) Any sanction(s) by a hospital, state licensing agency or any other professional health care organization; voluntary or involuntary relinquishment of licensure or registration; any malpractice claims, suits or settlements (specify what must be reported, e.g., final judgments or settlements); reduction or loss of privileges at any other hospital within 15 days of the adverse action.

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- (7) Response time from residence to facility (for on-call responsibilities)

NOTE: This item should be included as applicable to the individual facility and provider groups, e.g., surgeons.

- (8) Names of other hospitals at which privileges are held and copies of the privileges held

e. Bylaws Receipt and Pledge. Prior to the granting of clinical privileges, Medical Staff members or applicants will pledge to provide for continuous care of their patients and will receive a copy of the Bylaws and Rules and agree to abide by the professional obligations therein.

NOTE: This requirement can be satisfied for those individuals seeking privileges subsequent to those granted initially by having a signed acknowledgement of receipt and agreement on file for the most current Bylaws and Rules.

f. Verification*

(1) Verification of credentials prior to granting of initial privileges will be accomplished as described in Article IV, Section 3, "Appointment and Initial Credentialing."

(2) Before granting subsequent clinical privileges, the Chief of Staff will assure that the following information is on file and verified with primary sources, as applicable:

- (a) Current and former licenses in all states*.
- (b) Current and former DEA license and/or registration*.
- (c) National Practitioner DataBank* query.
- (d) Physical and mental health status* information from applicant.
- (e) Physical and mental health status confirmation* and professional competence information from peers, service chief.
- (f) Continuing education* to meet any local requirements for privileges requested.
- (g) Board certification(s).
- (h) Quality of care information.

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Section 3. Credentials Evaluation and Maintenance

a. Determination will be made (through evaluation of all credentials, peer recommendations, available quality of care information including Medical Staff monitors) that the practitioner applying for clinical privileges, has demonstrated current competence in professional performance, judgment and clinical and/or technical skill to practice within clinical privileges requested.

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b. Effort will be made to verify, with primary sources, all credentials claimed. A good faith effort to verify is defined as (specify).

c. A Credentialing and Privileging Folder will be established and maintained for each practitioner requesting privileges. These folders will be the responsibility of the Chief of Staff and will contain all documents relevant to credentialing and privileging. At any time that a folder is found to lack required documentation for any reason, effort will be made to obtain the documentation. When it is not possible to obtain documentation, an entry will be placed in the Folder stating the reason. The entry will also detail the effort made to obtain the information with dates and signature of the individual(s) responsible for the effort.

Section 4. Recommendations and Approval*

a. Peer recommendations will be obtained from individuals who can provide authoritative information regarding training/ experience, professional competence and conduct and health status.

b. The service chief to whose service the applicant for clinical privileges is assigned is responsible for assessing all information and recommending approval of clinical privileges.

(1) Recommendation for initial privileges will be based on determination that applicant meets criteria for appointment and clinical privileges for the service including requirements regarding education, training, experience, references and health status.

(2) Recommendation for clinical privileges subsequent to those granted initially will be based on, at least, reappraisal of physical and mental health status, peer recommendations, continuing education, professional performance, judgment and clinical and/or technical skills and quality of care including results of monitoring and evaluation activities* (such as surgical case review, drug usage evaluation, medical record review, blood usage review, pharmacy and therapeutics review, monitoring and evaluation of quality and appropriateness of clinical aspects of patient treatment and risk management activities.

c. The (specify: executive committee of the medical staff) recommends granting clinical privileges based on each applicant's successfully meeting the requirements for clinical privileges as specified in these Bylaws.

d. Clinical privileges are acted upon by the Medical Center Director within 45 days* of receipt of a fully complete application for clinical privileges that includes all requirements set forth in Article V, Section 2.

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e. Originals of approved clinical privileges documents are placed in the individual practitioner Credentialing and Privileging Folders. Copies are distributed to the practitioner, service chief and OR, ER, ICU, pharmacy (tailor list), as appropriate, for comparison with practitioner orders and procedures.

Section 5. Exceptions

a. Temporary clinical privileges for emergent or urgent patient care needs may be granted at the time of a temporary appointment for a limited period of time (specify

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time limit, not to exceed 45 days) by the (facility) Director or the acting Director, in the absence of the Director, on the recommendation of the Chief of Staff. Temporary privileges will be based on documented evidence of a current State license and other reasonable, reliable information concerning training and current competence related to the privileges to be granted.

b. Emergency care may be provided by any individual who is a member of the Medical Staff or who has been granted clinical privileges, within the scope of the individual's license, to save a patient's life or save the patient from serious harm.* Emergency care may also be provided by properly supervised members of house staff.

ARTICLE VI. Fair Hearing and Appellate Review*

Section 1. Denial of Medical Staff Appointment

When review of credentials and recommendations contained in a complete application result in denial of appointment, the applicant will be notified by the chairperson of the PSB in a letter over the signature of the chairperson of (specify: executive committee of the medical staff). The notification will briefly state the basis for the action.

Section 2. Self-Governance Actions

Specify in this section those locally established actions that the Medical Staff is taking to ensure effective self governance, e.g., counseling, mandatory CME, training.

Section 3. Actions Against Clinical Privileges*

a. When recommendations regarding clinical privileges are adverse to the applicant, including but not limited to reduction and revocation, procedures in VHA policy on credentialing and privileging of physicians and dentists will be followed.*

b. Disciplinary and performance based privilege changes are undertaken after due process procedures consistent with those outlined in VHA policy on credentialing and privileging of physicians and dentists and the National Practitioner Data Bank - Reports, as applicable, are exhausted.

c. The (facility) Director, may on the recommendation of the Chief of Staff, summarily suspend privileges*, on a temporary basis, pending the outcome of

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formal action when there is sufficient concern regarding patient safety or specific practice patterns consistent with requirements in VHA policy on credentialing and privileging of physicians and dentists.

Section 4. Reporting Adverse Actions

a. Disclosure of information to State licensing boards regarding practitioners separated from VA service will be completed under the provisions of M-2, part I, chapter 34.

b. Disclosure of information to the National Practitioner Data Bank through State licensing boards regarding adverse action against clinical privileges of more than 30 days

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will follow provisions of the VHA policy on National Practitioner Data Bank - Reports.

Section 5. Reporting Malpractice Payments

Disclosure of information regarding malpractice payments determined by peer review to be related to professional incompetence or professional misconduct on the part of a practitioner will follow provisions of the VHA policy on National Practitioner Data Bank - Reports.

Section 6. Termination of Appointment*

Termination of Medical Staff appointments will be accomplished in conjunction with, and follow procedures for, terminating appointments of practitioners set forth in MP-5, part II, chapters 4, 8 and 9, Federal and VA acquisition regulations. (Specify Title 5 authorities including MP-5, part I, chapters 752, 315, 316 and other relevant authorities based on the composition of the Medical Staff.)

ARTICLE VII. ORGANIZATION OF THE MEDICAL STAFF

Section 1. Officers*

VA has no requirement for "officers" of the medical staff.

NOTE: If the facility chooses to have officers, appropriate modification of this Section will be necessary.

Section 2. Leadership

a. The Chief of Staff functions as the President of the Medical Staff.

b. The Medical Staff, through its committees, services and service chiefs, provides counsel and assistance to the Chief of Staff and (facility) Director regarding all facets of the patient care services program, including continuous quality improvement, goals and plans, mission, and services offered.

c. All Medical Staff members are eligible for membership on the (specify committee that functions as executive committee of the medical staff).

ARTICLE VIII. COMMITTEES

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NOTE: JCAHO requires an executive committee of the medical staff. Facilities may choose to have a separate committee so named or may have some appropriate existing committee function as the Executive Committee. The latter option requires that the description below be met by the body that functions as the Executive Committee.

Section 1. Executive Committee of the Medical Staff*

a. Size*, Membership*

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(1) The (facility) Director or designee is an ex-officio member, with (or without) vote and attends each meeting*.

(2) Specify remaining membership composition*. This is to include the method of selecting members*, making provision for all Medical Staff members to be eligible for membership, e.g., rotating membership. Assure that a majority of members are fully licensed physician members of the Medical Staff actively practicing at the facility.

b. Functions*

(1) Act for the Medical Staff between Medical Staff meetings*.

(2) Act to ensure effective communication between the Medical Staff and the facility Director*.

(3) Make recommendations directly to the Governing Body (facility Director) regarding the:

(a) Structure of Medical Staff*.

(b) Mechanisms used to review credentials and delineate clinical privileges*.

(c) Recommendation of individuals for Medical Staff membership*.

(d) Recommendations for delineated clinical privileges for each eligible individual*.

(e) Organization of quality improvement activities of the Medical Staff as well as mechanism used to conduct, evaluate, and revise such activities*.

(f) Mechanisms by which membership on Medical Staff may be terminated. (NOTE: This is VA policy issue. Any recommendations would be couched in terms of proposed change in VA mechanisms.)*

(g) Mechanisms for fair-hearing procedures (consistent with approved VA mechanisms or couched in terms of proposed changes to VA approved mechanisms)*.

(h) Medical Staff ethics and self governance actions.

(4) Receive and act on reports and recommendations from Medical Staff committees including those with quality of care responsibilities, clinical services, and assigned activity groups.

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(5) Receive, act on and approve criteria for granting clinical privileges for each service*.

Section 2. Clinical Executive Board

Include requirements outlined in M-1, part I, chapter 1, except that the executive committee of the medical staff need not be the CEB (Clinical Executive Board).

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Section 3. Professional Standards Boards/Standards Boards

Include broad responsibilities of the PSB/SB specific to the individuals who are part of facility Medical Staff outlined for PSBs in MP-5, part II, chapter 2 and VHA Supplement, MP-5, part II, chapter 2.

Section 4. Standing Committees

NOTES:

1. Only committees identified with a (!) must exist based on JCAHO or VA requirements. All others identify FUNCTIONS that must be carried out in some appropriate forum that is clearly specified by the facility. Neither Safety nor Infection Control are considered medical staff monitoring committees.

2. Facility Medical Staffs may add other medical staff committees, e.g., Ethics Committee, etc.

- a. Surgical Case
- b. Drug Usage Evaluation
- c. Medical Record Review
- d. Blood Usage Review !
- e. Pharmacy and Therapeutics !
- f. Quality Management
- g. Infection Control!
- h. Disaster
- i. Special Care Unit Committees! (as indicated)

Section 5. Committee Records

a. Committees prepare and maintain reports of conclusions, recommendations, actions taken and results of actions taken. These reports are to be forwarded in a timely manner through channels established by the Medical Staff (specify).

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b. Provide for appropriate and timely feedback to the service regarding all information regarding the service and its providers

Section 6. Committee Attendance

Medical Staff members, or their designated alternates, will attend ___% (50% is minimum acceptable) of meetings of committees of which they are members unless specifically excused by the committee chairperson for appropriate reasons, e.g., illness, leave, clinical requirements, etc. Committee minutes will specify members absent, alternates and members present.

ARTICLE IX. CLINICAL SERVICES

Section 1. Characteristics

- a. Organized to carry out services under leadership of the service chief.
- b. Holds monthly meetings

Section 2. Functions

a. Provide for continuous quality improvement within the service including considering findings of ongoing monitoring and evaluation of quality, (including access, efficiency, effectiveness); appropriateness of care and treatment provided to patients (including that provided under temporary privileges or emergency care absent privileges); patient satisfaction activities; risk management activities; and utilization management.

b. Assist in identification of important aspects of care for the service, identification of indicators used to monitor quality and appropriateness of important aspects of care, and evaluation of the quality and appropriateness of care.

c. Maintain records of meetings that include conclusions, recommendations, actions taken, and evaluation of actions taken.

d. Develop criteria for recommending clinical privileges for its members.

e. Define/develop clinical privileges statements including levels (or categories) of care that currently include:* (specify).

f. Develop policies and procedures to assure effective management, ethics, safety, communication and quality within the service.

NOTE: JCAHO makes provision for meeting the requirements above without monthly meetings. Only when clinical services are not in existence in all or some areas should an alternative method of addressing the functions listed in sections 3 and 4 be utilized and then it should be used in only those areas without services and must provide for mechanisms outlined in the most current AMH manual.

Section 3. Selection and Appointment of Service Chiefs

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Service chiefs are appointed by the Regional Director based upon the recommendation of the (facility) Director, Dean's Committee (if appropriate), Central Office Service Director, and the appropriate Central Office Professional Standards Board.

Section 4. Duties and Responsibilities of Service Chiefs

Service chiefs are responsible and accountable for:

a. All professional and administrative activities within the service including selection, orientation and continuing education of staff*.

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b. Monitoring and evaluating the quality of care* provided in the service. This includes access, efficiency, effectiveness and appropriateness of care and treatment of patients served by the service and the clinical/professional performance of all individuals in the service.

NOTE: This monitoring and evaluation must include relevant elements such as surgical case review, drug usage evaluation, medical record review, blood usage review, risk management, infection control, utilization review as reported by committees tasked with these functions and/or direct evaluation of the service chief.

c. Assuring that individuals with clinical privileges competently provide service within the scope of privileges granted*.

d. Recommending to the Medical Staff the criteria for clinical privileges in the service after development and approval of such criteria by the service members*.

NOTE: VHA policy on Credentialing and Privileging of Physicians and Dentists identify that the bylaws will specify the process utilized by each service when levels or categories of care are defined. Language is inserted to suggest that this could be included here.

e. Recommending appointment and clinical privileges for each member of the service and others requesting privileges within the service*.

ARTICLE X. MEDICAL STAFF MEETINGS

1. The Medical Staff meets as a whole _____ times per year* (specify, must be at least annually).

2. Regular meetings are convened at the call of the chairperson. Special meetings may be convened at the call of (specify).

3. Medical Staff members will attend their service staff meetings and meetings of committees of which they are members unless specifically excused by the service chief for appropriate reasons, e.g., illness, leave or clinical requirements*.

4. Medical Staff members, or their designated alternates, will attend at least one meeting of the Medical Staff as a whole unless specifically excused by the committee chairperson for appropriate reasons, e.g., illness, leave, or clinical requirements*.

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5. Members of the active (or specify-based on categories of Medical Staff) Medical Staff are voting members.

6. Minutes of all meetings will reflect (at minimum) attendance, absences, issues discussed, conclusions, actions, recommendations, evaluation and follow up.

7. A quorum for purposes of (Medical Staff meetings, committee meetings, service staff meetings) is defined as (specify).

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ARTICLE XI. RULES

The Medical Staff shall adopt such rules* as may be necessary to implement more specifically the general principles found within these Bylaws and guidelines of the Governing Body, subject to approval of the (facility) Director. Such rules shall be a part of these Bylaws. (Specify how and when amendments may occur.) Such changes shall become effective when approved by the (facility) Director.

ARTICLE XII. AMENDMENTS*

1. The Bylaws and Rules are reviewed at least (specify frequency), revised as necessary to reflect current practices with respect to Medical Staff organization and functions, and dated to indicate the date of last review. Proposed amendments to the Bylaws and Rules and attendant policies may be submitted in writing to the Chief of Staff by any service chief or member of the Medical Staff. (Specify circumstances under which changes may be made, e.g., in what body with quorum, after what notification, by whom.)

2. Written text of proposed significant changes are to be provided to Medical Staff members and others with clinical privileges. Medical Staff members will be given time to review proposed changes and be notified of the date proposed changes will be considered.

3. All changes to the Bylaws require action by both the Medical Staff and medical center Director. Neither may amend unilaterally.

4. Changes are effective when approved by the medical center Director.

ARTICLE XIII. ADOPTION*

1. These Bylaws, together with the appended Rules, shall be adopted upon recommendation of the Medical Staff at any regular or special meeting of the active (or otherwise specify based on categories of Medical Staff) Medical Staff or (executive committee of the medical staff) at which a quorum is present; shall replace any previous Bylaws and Rules and shall become effective when approved by the medical center Director.

Adopted by the Medical Staff of VA Medical Center, _____ on this ____
(date)_____.

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RECOMMENDED:

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Chief of Staff

APPROVED:

(Facility) Director

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RULES

A. GENERAL

1. The Rules relate to role and/or responsibility of members of the Medical Staff and individuals with clinical privileges (specify any others) in the care of inpatients, emergency care patients and ambulatory care patients as a whole or to specific groups as designated.

2. Rules of departments or services will not conflict with each other, with bylaws, rules, and policies of the Medical Staff or requirements of the Governing Body.

B. PATIENTS RIGHTS

1. Patients' Rights and Responsibilities

a. Organization supports the rights of each patient (and publishes policy and procedures to address rights) including:

(1) Reasonable response to requests and need for service within capacity, mission, laws and regulations;

(2) Considerate and respectful care;

(3) Collaboration with physician in matters regarding personal health care;

(4) Formulation of advance directives and appointment of surrogate to make health care decisions;

(5) Access to information necessary to make care decisions that reflect patient's wishes;

(6) Access to information about patient rights, handling of patient complaints;

(7) Participation of patient or representative in consideration of ethical decisions regarding care;

(8) Access to information regarding any human experimentation or research/education projects affecting patient care;

(9) Personal privacy and confidentiality of information;

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(10) Action by legally authorized person to exercise patient's rights if patient is judged incompetent in accordance with law or is found by physician to be medically incapable of understanding treatment or is unable to communicate wishes; and,

(11) Foregoing or withdrawing life-sustaining treatment including resuscitation.

2. Living Will

3. Informed Consent (may include access to practitioner privileges).

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C. GENERAL RESPONSIBILITY FOR CARE

1. Conduct of Care

a. Management of the patient's general medical condition - responsibility of a qualified physician member of the Medical Staff

b. Same quality of patient care provided by all individuals with delineated clinical privileges, within and across departments/services and between all staff members who have clinical privileges

c. Comparable level of quality of surgical and anesthesia care throughout the medical center

2. Emergency Services

a. Designation of the level of emergency services using JCAHO Levels I, II, III or IV.

b. Guided by written policies and procedures appropriate to the designated level

c. Physician staffing consistent with the facility designation ER Level designation

d. Evaluation of applicants regarding emergent need and treatment or referral

e. Referral of applicants without emergent/urgent care needs or legal eligibility for care

3. Admissions

a. Individuals with admitting privileges are members of the medical staff or others with clinical privileges to admit.

b. Criteria for standards of medical care re patient admissions including:

(1) Prompt medical evaluation by a qualified physician for those patients admitted by non physicians.

(2) Exceptions.

c. H&P (History and Physical) Examination

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(1) Performed by a physician who has such privileges within 24 hours of admission and exceptions, e.g., house staff.

(2) Other individuals permitted to perform H&P based on privileges and providing for confirmation or endorsement of findings, conclusions and assessment of risk by a qualified physician prior to major (as defined by Medical Staff) diagnostic or therapeutic intervention or within 24 hours, whichever occurs first:

(a) Responsibility of dentists for the part of their patients' history and physical examination that relates to dentistry.

NOTE: Similar sections should be added for other practitioners, as applicable, e.g., podiatrists.

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d. Procedures

Patients assigned to care of member of medical staff who is responsible for:

- (1) Medical care and treatment.
- (2) Prompt completion and accuracy of medical record.
- (3) Special instructions.
- (4) Transmitting reports on condition of patient to referring practitioner and family of patient.
- (5) Except in emergency, not admitting until after admitting diagnosis entered in medical record.

e. Tests

- (1) Automatic on admission.
- (2) Consents for, e.g., HIV.

f. Areas of restricted admission

- (1) Written criteria for admission to special care units
- (2) Circumstances under which consultation is required.
- (3) Responsibilities of unit director.

4. Transfers

a. Prohibition of arbitrary transfers when hospital has means to provide adequate care (Include appropriate statements referencing eligibility, emergency and humanitarian responsibilities.)

b. Relationship to facility ability to meet patient needs and/or patient eligibility for treatment in a VA facility and receiving facility consent to accept stabilized patient:

- (1) Responsibility for patient during transfer.
- (2) All pertinent medical information accompanies patient.

c. To and from Special Care Units

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Unit director responsibility with attending physician consultation.

5. Consultations

a. Written and reflective of actual examination of the patient and patient's records.

b. Requirement for consultation by a qualified specialist (may need to define qualified specialist) is required for patients in special care units when (specify). NOTE: State in

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Rules OR medical staff policy.

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c. Time limits for completion of consultation in:

(1) Emergency.

(2) Preoperative workup that includes necessity of completion prior to patient going to surgery except in emergency.

(3) Routine.

6. Discharge Planning

a. Initiated as early as determination of need made.

b. Provide for continuity of care to meet needs.

c. Documented in medical record.

d. Criteria

(1) Availability of appropriate services to meet patient needs.

(2) (Add others.)

7. Discharge

a. Criteria.

b. Exceptions acceptable to delay discharge.

c. From Special Care Units based on written criteria, including priority determinations.

d. From PAR (Post Anesthesia Recovery) based upon order of licensed independent practitioner familiar with the patient or when the practitioner is not available, based on relevant medical staff approved criteria. Practitioner's name is recorded in the patient's medical record.

8. Autopsy*

a. Criteria that identifies deaths in which autopsy should be performed.

b. Use of autopsy findings in quality improvement activities.

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D. PHYSICIANS' ORDERS

1. General Requirements

a. Written, timed, dated, legible, and signed.

b. Written only by (specify), e.g., medical staff members, physicians (and dentists) in training status and by other individuals within the authority of their clinical privileges.

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c. Medication orders

- (1) Administration time or time intervals between doses.
- (2) Use of terms such as "prn" and "on call" are qualified.
- (3) Required for patients to take medication brought into the medical center or engage in self administration.

2. Standing Orders

- a. Desirability.
 - b. Where used.
 - c. Limitations.
 - d. Regular review and revision as needed.
3. Automatic stop orders*
- a. For drugs, as follows:*
 - (1) When patient undergoes surgery.
 - (2) (Add others.)
- b. Automatic cancellation of standing orders when patient undergoes surgery*.

4. Verbal Orders*

- a. Specify circumstances in which verbal orders are accepted.
- b. May be accepted and transcribed by the following qualified personnel:*(specify by title or category)
- c. Are authenticated within ___* hours by the prescribing practitioner.

Categories of diagnostic or therapeutic verbal order associated with any potential hazard to the patient and requirement for signature within 24 hours by practitioner responsible for the patient

5. Investigational Drugs

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Used only when approved by appropriate medical staff committee, administered under approved protocol with patient informed consent, under the direct supervision of the authorized Principal Investigator.

6. Informed Consent

a. Consistent with legal requirements and ethical standards, e.g., potential conflict of interest in research as researcher and clinician.

b. Includes provision for evidence in the medical record before procedures or treatment for which it is required.

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7. Submission of Surgical Specimens

a. Exceptions to sending specimens removed at surgery to laboratory*. NOTE: Unless stated in bylaws or rules, most strict requirements are applicable (federal regulations or requirements of training program apply).

8. Special Treatment Procedures*

a. DNR (Do Not Resuscitate) and Withholding/Withdrawal of Life Sustaining Treatment

(1) Role of physician, family members and when applicable, other staff in decision.

(2) Mechanisms for reaching decisions about withholding of resuscitative services, including mechanisms to resolve conflicts in decision making.

(3) Documentation in the medical record.

b. Protective Security

(1) May be required in the care of combative or emotionally disturbed patients.

(2) Confused patient - outpatient/inpatient.

(3) Incident reporting.

(4) Restraint and seclusion.

(a) Condition under which used (justification).

(b) Order must be obtained within 1-hour*.

(c) Maximum time for use of each intervention.

(d) Periodic observation of the patient, including maximum time between observations.

(e) Documentation that needs of patient are attended.

(5) Emergency commitment.

d. Multidisciplinary treatment plan (if have psychiatry or substance abuse program)*.

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e. Convulsive Therapy

Types of, e.g., electroconvulsive, etc.

f. Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental, or behavioral disorder.

g. Behavior modification procedures that use aversive conditioning.

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h. Impaired Mentation

- (1) Drugs, alcohol, emotionally ill.
- (2) Emergency care, referral.
- (3) Ongoing care.

E. ROLE OF ATTENDING STAFF

1. Supervision of Residents* and Non-Physicians

a. Mechanisms by which house staff are supervised by members of the Medical Staff in carrying out their patient care responsibilities*.

b. Specify that house staff may write patient care orders* and do not prohibit a member of the Medical Staff from writing orders*.

c. Provide that Medical Staff members who choose not to participate in the teaching program are not subject to denial or limitation of privileges for this reason alone.

d. Mechanisms by which non-physician members (e.g., PAs, NPs, etc.) of the Medical Staff or with clinical privileges are supervised by the Medical Staff.

2. Documentation of Supervision

a. Sufficient evidence is documented in the medical record to substantiate active participation in, and supervision of, the patient's care by the attending physician (Specify frequency and critical junctures, e.g., within 24 hours of admission, at time of any significant change in clinical course or therapeutic plan, within 24-hours of discharge, prior to any invasive procedure)

b. Entries in the medical record, made by house staff or non-physicians (e.g., PAs, NPs, etc.), that require countersigning by supervisory or attending medical staff members are:* (MUST specify all.)*

- (1) Medical history and physical examination.
- (2) Medical orders that require cosignature (specify).
- (3) (Add others.)

F. MEDICAL RECORDS

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1. Basic Administrative Requirements

a. Legible, dated, authenticated with method to identify author, may include written signatures, initials, or electronic signature. (Specify requirement regarding use of rubber-stamp signatures and signed statement regarding stamp.)

b. Responsibility of medical practitioner for authentication.

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c. Use of Approved Abbreviations and Symbols

(1) Final diagnosis and complications are recorded without use of abbreviations and symbols.

(2) (Add others.)

d. Time requirements for completion and filing of reports of diagnostic and therapeutic procedures (within 24 hours, if possible).

e. Release of Information

(1) Requirements for release of information.

(2) Removal of medical record.

2. Basic Patient Information Requirements

a. Patient identification (name, address, DOB, next of kin).

b. Medical history including history and details of present illness/injury.

c. Observations, including results of therapy.

d. Diagnostic and therapeutic orders.

e. Report of procedures, tests and their results.

f. Progress notes.

g. Consultation reports.

h. Conclusions at termination of hospitalization, or evaluation/treatment.

i. Informed consent before procedures or treatments undertaken and if not obtainable, reason.

3. Inpatient Medical Records

In addition to information in paragraph f2, include the following:

a. Patient identification including identification number.

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b. History that includes relevant past, social, family, (military and occupational) and inventory of body systems completed within 24-hours of admission:

Exceptions.

c. Physical Examination

- (1) Within 24 hours of admission.
- (2) Exceptions.

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- (3) Prior to surgery.
- (4) Authenticated by physician.
- d. Statements regarding:
 - (1) Conclusions or impressions drawn from H&P.
 - (2) Planned course of action.
- e. Discharge plan.
- f. Condition on Discharge
 - (1) Death note.
 - (2) Autopsy. Anatomic diagnoses within 3 days; complete protocol within 60 days.
 - (3) AMA (Against Medical Advice).
- g. Chart to be complete within ___* (may not exceed 30) days of discharge:
Completion of record to retire.
- h. Discharge summary.
- 4. Outpatient and Emergency Area Medical Record
 - a. Frequency of notes.
 - b. Relevant history of history of illness or injury and physical findings including vital signs.
 - c. Diagnostic impression.
 - d. Patient disposition and instruction for followup care.
 - e. Immunization status, as appropriate.
 - f. Allergies.
 - g. Referrals and communications to other providers.

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h. List of significant diagnoses, conditions, procedures, drug allergies, medications aka Medication and Problem Lists.

i. Content and timeliness of description of surgical procedures.

j. Additional requirement for records of patients treated in the Emergency area:

(1) Time and means of arrival.

(2) Care received prior to arrival.

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(3) Condition at discharge.

(4) Information reference to patient's leaving AMA.

5. Operating Room Record

a. Preoperative

(1) Workup and exceptions.

(2) Diagnosis.

(3) Anesthesia evaluation.

b. Intraoperative documentation.

c. Evaluation of postoperative status on admission to and discharge from PAR and documentation requirements for discharge.

d. Operative reports dictated or written in the medical record IMMEDIATELY after surgery.

e. Documentation requirements regarding:

(1) Organs or tissue obtained from a living donor for transplantation.

(2) Cadaveric organs or tissue are removed for donation.

6. Medical record requirements relative to special programs of the facility, e.g., HBHC, etc.

G. INFECTION CONTROL

1. Isolation

Universal Precautions

2. HIV (Human Immunodeficiency Virus)

3. Reportable Cases

H. DISASTERS

1. Local

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a. Plan

b. Staff responsibilities

2. National

a. Local role

b. VA/DOD Contingency Plan

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c. Staff responsibilities

I. IMPAIRED PROFESSIONAL PROGRAM

1. Responsibility to the impaired professional
2. Employee Assistance Program

Medical Center memoranda are considered an extension of the Rules. They are available to all staff directly, through Service Chiefs and from the office of the Chief of Staff. They are available to prospective staff for review upon request.