NOVANT HEALTH

Wilmington Endoscopy Center
Governing Board and Medical Staff Bylaws, Rules and Regulations

PREAMBLE

Recognizing that the best interest of the patient is served by concerted efforts of the Medical Staff, the Medical Staff must assume responsibility for the quality of medical care and maintain the highest standards through peer review programs established by the Governing Body. The physicians practicing at this center are organized in conformity with the Bylaws, Rules and Regulations hereinafter stated.

For the purpose of these Bylaws, Rules and Regulations, the following definitions are given:

The term "Governing Board" shall mean the governing authority of the "Center".

The term "Center" shall mean the Endoscopy Suite / Center.

The "Clinical Manager" is a Registered Nurse who is responsible for the daily operations and supervision of the employees and reports to the Medical Director and Director/Administrator.

The "Quality Improvement Committee" shall consist of members of the Board, the Medical Director, the Director/Administrator, the Clinical Manager, and other representatives as required.

The Center will provide high quality treatment for patients on an outpatient basis. It will be staffed and equipped to meet the needs of the patients and staff.

Article I Philosophy and Objectives

The center is a specialty care facility designed to provide individual, quality care for eligible patients undergoing endoscopy procedures on an outpatient basis.

The center is designed as a facility that is planned and administered to provide a safe, comfortable and effective environment for outpatient procedures while maintaining patient dignity and human rights. The center shall strive to assist Medical Staff Members to meet certain health needs for patients without regard to race, color, religion, sex, age, or national origin. The center shall provide the highest quality care, and serve as a resource area for physicians of the community for treatment, diagnosis and management of patients.

Objectives

1. To create a safe physical environment for employees, patients, and family members.
2. To provide an atmosphere of compassion and understanding with minimal stress, anxiety, and pain.
3. To function at a high level of efficiency to accommodate the convenience of both the patient and the physician.
4. To formulate a plan of treatment for each patient to ensure continued care and patient follow-up.
5. To promote knowledge and skills of The Center Staff as a means of meeting technical and scientific progress by keeping abreast of new techniques, advancements and instrumentation by attending workshops and conferences, to update our policies and procedures according to new information obtained, and to plan patient care maintaining the principle of preventive medicine.
6. To initiate and maintain rules and regulations of self-governance for the Medical Staff as set forth by the Governing Body.

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Revised: 03/11/2013, 11/19/2018, 1/31/2022

Article II **Governing Board Responsibilities**

The Governing Board shall be ultimately responsible for the quality of care rendered in the center. The Governing Board shall ensure that all health care personnel for whom state licenses, certification or registration are required are currently licensed, certified or registered as appropriate, in this state.

The Governing Board shall be responsible for total overall operation of the Center, the approval of the Medical Staff appointments as recommended by the Medical Director. The Governing Board shall have documented evidence on file that physicians admitted to practice in the Center are granted privileges consistent with their individual training, experience and other qualifications. The Governing Board shall have the power for granting, restricting, and terminating privileges.

The Governing Board shall ensure the Medical Staff complies with the Medical Staff Bylaws, Rules and Regulations. The Governing Board or designee shall review all policy and procedure manuals, ancillary and/or contracted services, and all other programs at least every three years to ensure that they comply with applicable state and federal regulations.

The Governing Board shall ensure that there is effective review of professional practices of the center including but not limited to the development, implementation and oversight of the organization's safety, infection control, and risk management programs. It shall facilitate improvement in patient care through the Quality Improvement activities. The Governing Board shall review the quarterly reports for Quality Improvement and Safety and approve implementation to ensure safe and quality patient care is being provided. The Governing Board is ultimately responsible for all activities of the Center and will ensure the protection of patient rights and responsibilities, patient privacy and confidentiality.

The Governing Board shall meet regularly *and at least annually*. A permanent record of minutes shall be kept and include the following: quality improvement, infection control, safety, risk management, compliance with regulations changes or inspections, appointment / reappointment of medical staff, and annual review of the scope of services offered in the center. Should the occasion arise for interim decision making prior to the next scheduled meeting, the issue will be addressed and handled accordingly by the President of the Governing Board and the Medical Director, communicated to concerned parties, and reported at the next Board meeting. Special meetings of the Governing Board may also be called as needed by the President of the Governing Board.

Article III **Organization and Credentialing**

The medical staff is organized as a whole with no departments or subdivision.

Medical Staff Membership Qualifications

An applicant of Medical Staff membership shall be registered and legally licensed to practice medicine or anesthesia in this state. All physician applicants must have active admitting privileges at the local hospital.

Terms of Appointments

Appointments shall be made by the Governing Board for a period of two (2) years for active status. Verification of all credentials and pertinent documents will be maintained on each staff physician in his/her credentials file by the Centralized Medical Staff Office.

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Determination of Privileges

Privileges for specific outpatient procedures are determined by the Medical Staff and approved by the Governing Board. A current copy of each physician's *Privilege List* will be maintained in each physician's credentials file identifying which procedures they will be performing.

Medical Staff Appointment

As stated in Article II, Governing Board Responsibility, physicians *and anesthesia staff* will be granted privileges consistent with individual training and experience and other qualifications. The granting of privileges will be performed by the Governing Board and reappointment will be reviewed every two (2) years upon recommendation by the Medical Director. A credentials file will be maintained for each physician with the following documents:

1. Current Medical Staff Application with Privilege List
2. Current State License with Primary Source Verification
3. Current DEA License *(Not applicable for CRNA's)*
4. Current Malpractice Insurance Certificate
5. BCLS / ACLS completion
6. Educational Training (i.e. medical/anesthesia school, residency, fellowship) with Primary Source Verification. *The AMA profile will be used for physician verification. Education verification for CRNA's will be obtained through the National Student Clearing House or via letter to the anesthesia school.*
7. Two Reference letters or Peer recommendations
8. Verification of Privileges at Local Hospitals and Medical Staff Standing *(Not applicable for CRNA's)*
9. American Medical Association Profile (Board Certification verification, education verification, and sanctions).
10. National Practitioner Data Bank Query (Sanctions and Liability Cases)
11. Office of Inspector General Query for Medicare/ Medicaid Exclusions

All of the above documents shall be submitted to the Medical Director or designee and once the information is verified and the credentials file is deemed complete, the Medical Director will review and/or request additional information. Upon recommendation by the Medical Director, the Governing Board shall approve, disapprove, or defer recommendation to grant requested privileges accordingly.

When final action has been taken by the Governing Board, the Medical Director or designee shall be authorized to transmit the decision to the applicant for membership, and if accepted, to secure his signature to the Bylaws, Rules and Regulations. Such signature shall constitute his agreement to be governed and abide by the said Bylaws, Rules and Regulations of the Center.

An applicant whose membership is denied shall be entitled to the procedural rights provided in these Bylaws, Rules and Regulations.

Reappointment

Staff appointments are for a period of two (2) years. The procedure for reappointment shall be as follows:

1. The Medical Director or designee shall, at least 60 days prior to the expiration date of the present staff appointment of each medical staff member, provide such staff member with an Application for Reappointment for completion.
2. Physicians who desire reappointment shall submit the Application for Renewal of Clinical Privileges at least 30 days prior to such expiration date to the Medical Director.

3. The Medical Director or designee shall compile information including primary source verification for current license, one peer recommendation, and quality improvement data After the Medical Director has reviewed the completed file, he shall submit a recommendation to the Governing Body.
4. After the Governing Body has reviewed the request for reappointment and acted upon it, the Medical Director shall be authorized to transmit the Governing Body's decision to the applicant. The applicant will be notified in writing of any additions, deletions or restrictions in the privileges granted.
5. The Medical Director shall notify the scheduling staff of any changes in delineation of privileges.

A complete reappointment file will include the following elements:
1. Reappointment application with privilege list
2. Current State License with primary source verification
3. Current DEA License *(Not applicable for CRNA's)*
4. Current Malpractice Insurance Certificate
5. BCLS / ACLS completion
6. One Peer Recommendation
7. Verification of Privileges at Local Hospitals and Medical Staff Standing (Not Applicable for CRNA's)
8. Current Board Certification
9. National Practitioner Data Bank Query (Sanctions *and Liability Cases)*
10. Office of Inspector General Query for Medicare/ Medicaid Exclusions

Temporary Privileges:
Temporary privileges shall be granted only under the following circumstances and only when the application and verification process is complete:

1. To Fulfill an Important Patient Care Need
   Temporary privileges may be granted on a case by case basis when there is an important patient care need that mandates an immediate authorization to practice, for a limited period of time, while the full credentials information is verified and approved.
   Examples would include, but are not limited to:
   Any situations where a physician becomes ill or takes a leave of absence and a Licensed Independent Practitioner (LIP) would need to cover his/her practice until he/she returns (locum tenem).
   A specific LIP has the necessary skills to provide care to a patient that an LIP currently privileged does not possess.
   In these circumstances, temporary privileges may be granted by the Medical Director upon recommendation/approval of the Governing Board.

2. When an applicant with a completed application packet is awaiting review and approval of the Governing Board, temporary privileges may be granted by the Medical Director and Administrator.

Temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the Medical Director upon recommendation of the Governing Board provided there is verification of current licensure, relevant training or experience, current competence, ability to perform the privileges requested, other criteria required by medical staff bylaws, the results of the American Medical Association, NPDB, and OIG queries have been obtained and evaluated and the applicant has a complete application, no current or previously successful challenge to licensure or registration, has not been subject to involuntary limitation, reduction, denial, or loss of clinical privileges.

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Temporary privileges are not used for other administrative purposes such as the following:

(a) The applicant fails to provide all information necessary to the processing of his/her reappointment in a timely manner

(b) Failure of the staff to verify performance data and information in a timely manner

In the above situation, the applicant would be required to cease providing care until the reappointment process is completed.

If in the above reappointment situation, the failure to allow the practitioner to continue to provide care would result in a problem meeting an important patient care need, then temporary privileges could be granted.

Ethics and Ethical Relations

The code of ethics as adopted or amended by the American Medical Association and the American College of Physicians, respectively, shall govern the professional conduct of the members of the Staff.

Upon becoming a member of the Medical Staff, each provider shall agree not to engage in the practice of the division of fees under any guise whatsoever. Specifically, each member of the taff shall pledge himself as follows:

- I agree to abide by the Bylaws of the Medical Staff and by such Rules and Regulations as may be from time to time enacted. Moreover, I hereby declare that I shall not engage in the practice of the division of fees under any guise whatsoever. In complying with this principle, I understand that I am not to collect fees for me, not to make joint fees with Physicians or Surgeons referring patients to me for operation or consultation, nor permit any agent or associate of mine to do so. Further, I agree to comply with the principle that all physicians and surgeons participating in the care of the patient shall render separate bills and receipts.

Peer Review Process

Peer Review is an integral part of the quality improvement program and consists of charts reviews by the medical staff, peer review for any adverse events / complications, and annual compilation of data for each credentialed medical staff member. This data will be reviewed by the Medical Director or designee at time of reappointment.

When deficiencies are identified through the peer review or quality improvement process that question a current Medical Staff member's:

- clinical competence
- health status
- his/her care/treatment of a patient or management of a case
- suspected violation of bylaws or policies

An investigation will be initiated by the Medical Director. An investigation team will include the Administrator, the Medical Director, and one other member of the Governing Board. This team will have the full resources of the facility and Medical Staff as well as the authority to use outside consultants to conduct the investigation.

The individual under investigation will have an opportunity to meet with the team prior to any recommendations being made. At this meeting, but not in advance, the individual will be informed of the general nature of the evidence supporting the investigation and will be invited to discuss, explain, or refute the evidence. This interview will not constitute a hearing, and none of the procedural rules for hearings will apply.

At any time during the investigation, the team may suspend all or any part of the clinical privileges of the person being investigated. The suspension will be deemed administrative in nature for the protection of the patients. It will remain in effect during the investigation only, will not indicate the

validity of the charges and will remain in force, without appeal, during the course of the investigation. The investigation will be completed in 30 days when a suspension is initiated or reasons for the delay will be transmitted to the Governing Board so that it may consider whether suspension should be lifted for the remainder of the investigation.

A summary of the investigation and meeting with recommendations will be submitted to the Governing Board. The Governing Board will approve any action to be taken. Actions may include, (1) issuing a written warning, (2) issuing a letter of reprimand, (3) imposing terms of probation, (4) imposing a requirement for consultation, (5) recommending enhanced training and proctoring, (6) reducing clinical privileges, (7) suspending privileges for a term, and (8) terminating staff appointment. Any action by the Board for reduction of clinical privileges, or suspension of clinical privileges for a term of one month or more, or revocation of staff appointment, will entitle the individual to the procedural rights for a hearing. The Medical Director will promptly notify the individual by certified mail, return receipt requested. No further action will be taken until after the individual has exercised or has waived his/her right to a hearing. If the action of the Board is less severe than a reduction, suspension, or revocation of clinical privileges, the action will not take effect until the individual has met with the Medical Director.

Hearing Appeals Process

Recommendation to the Governing Board for withdrawal of any privileges or dismissal from the Medical Staff shall be made only after a thorough investigation, with the subject member being given the right of hearing before the Governing Board.

An appeals process will follow these guidelines:

1. All notification and communication between a physician and the Center will be by certified mail, return receipt requested.
2. Initial correspondence between the Center and the physician will advise the practitioner of his right to a hearing and right to review specific charges against him.
3. Failure to request a hearing or review within fourteen (14) days of proper notification by certified mail will constitute a waiver of rights for hearing or review.
4. The Medical Director / Board representative will be present at all formal hearings and reviews.
5. During any hearing or review, the Physician's acts of omission or commission will be stated in concise language.
6. A record of proceedings will be maintained.
7. Either party will be allowed to have an attorney present at the hearing or review. Should either party elect to have an attorney present, then the other party should be notified at least five (5) working days prior to the meeting.
8. A hearing or review will be initiated within thirty (30) days of the date posted by the Physician for receipt of the initial notification.
9. The Physician will be notified of the Governing Board's decision with ten (10) days of completion of the hearing.

Impaired Practitioner

The purpose of this program is to ensure the safety of our patients, to address prevention of patient or staff harm as a result of practitioner physical, psychiatric or emotional illness, and to facilitate confidential diagnosis, treatment and rehabilitation of practitioners who suffer from a potentially impairing condition. The goal of this program is assistance and rehabilitation, rather than discipline, and to aid practitioners in retaining or regaining optimal professional functioning consistent with the protection of patients.

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Definitions:
Practitioners include Medical Staff as defined in the Medical Staff bylaws, as well as, Licensed Independent Practitioners (LIP) such as Allied Health Professionals who are credentialed to practice in the Center. An Impaired Practitioner is one who is unable to skillfully, reasonably, and safely care for his or her patients because of substance abuse, disruptive behavior, or mental disorders.

If a health care provider exhibits signs of incapacitation prior to the beginning of the surgical procedure, the staff will notify the Medical Director and Administrator to intervene. The patient will not be placed in the OR/ Procedure Room. If a health care provider becomes incapacitated during the procedure, the staff will maintain the patient until another physician / CRNA can arrive.

Elements of Program:

1. Referrals are made through self-referral or from any member of the organization. It is the responsibility of all staff and medical staff to report impairment issues that may place the patient or staff at risk.
2. An ad hoc committee of the Board will review and investigate referrals. The committee will be made up of two independent practitioners and the Administrator. The committee members will keep a list of referral sources and external organizations that specialize in the diagnosis and treatment of impaired healthcare practitioners

Procedure:

1. All practitioners and Allied Health Professionals may participate in the impaired practitioner program through the state medical board.
2. The practitioner may self refer to the impaired practitioner program by contacting the Administrator or Medical Director.
3. Any individual within the organization has the responsibility to refer impaired practitioners. Reports of potential impairment are made to the Medical Director or Administrator who will designate an ad hoc committee to investigate.
4. All allegations, concerns or complaints will be brought before the committee to be investigated and evaluated by the committee.
5. Any practitioner under investigation may provide information to the committee or Medical Director that he/she feels may clarify any allegation, concerns or issues brought before the committee.
6. After thorough investigation, the committee will confidentially refer needed cases to the North Carolina Physician Health Program for assessment and diagnosis.
7. Affected practitioners will be monitored through mechanisms determined by the committee members and program advisor.
8. If at any time during the diagnosis, treatment or rehabilitation phase of the process, it is determined that the practitioner is unable to safely perform the privileges he/she has been granted, the matter will be forwarded to the Medical Director for the appropriate action, to mandate state and federal reporting requirements.
9. While the goal of the Impaired Practitioner Program in to provide assistance, rather than disciplinary action, in some instances the committee members may request discipline of the practitioner as a necessary action to improve or resolve quality of patient care issues. Any request for disciplinary action will be forwarded to the Board.

Required Reporting to State and National Entities
The Health Care Quality Improvement Act of 1986 requires this organization to report sanctions, reduction or revocation of privileges, improper professional conduct, impairment that interferes with clinical practice, or professional incompetence to the state medical board and Medicare. At the

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conclusion of the investigation and appeals process, necessary information will be reported to the appropriate authorities such as the state licensing board, the National Practitioner Data Bank, etc.

Confidentiality:
The confidentiality of the individual referred to the Impaired Practitioner program will be strictly maintained with the following exceptions:

- State and Federal Regulator limitations (if applicable)
- Ethical obligations
- When maintaining confidentiality threatens the safety of a patient or patients
- In all instances, every effort to protect the confidentiality of the individual referred for assistance will be made.

Article IV **Quality Improvement**

Physicians play an integral role in providing quality patient care and improving processes and outcomes. The Board and Medical Staff have elected to establish the Quality Committee to coordinate improvement measurement and activities. The Quality Improvement Committee shall consist of the Board, the Administrator, the Clinical Manager, and others as needed.

The committee shall meet in conjunction with the Governing Board at least quarterly and must maintain a permanent record of its proceedings and actions. All plans and findings from the Committee are approved by the Governing Board for implementation and follow-up. Further functions and responsibilities of the Quality Improvement Committee shall include, but not be limited to the following: (See the Quality Improvement Plan for details)

1. To create a safe physical environment for the patient and staff during patient preparation, the procedure, and post procedure recovery process.
2. To provide an atmosphere of compassion and understanding with minimal stress and anxiety.
3. To function at a high level of efficiency to accommodate the convenience of both the patient and the physician
4. To promote knowledge and skills as a means of meeting technical and scientific progress by keeping abreast of new techniques, advancements and instrumentation by attending workshops and conferences, to update our policies and procedures according to new information obtained, and to plan patient care maintaining the principle of preventive medicine.
5. To maintain that all information regarding patients is kept private and confidential.
6. To monitor and evaluate performance measures that result in continuous improvement of the quality and appropriateness of patient care.
7. Communicate the results of improvement activities to all staff.

An annual evaluation of the Quality Improvement program shall be conducted to determine the effectiveness of the described methodology in the identification of patient care issues, problem solving techniques, improvement of patient care, achievement of objectives, and plan review and revisions.

The following required measurements shall be performed and reported to the QI Committee and Board at least quarterly:

- Invasive Procedure and Tissue Review
- Peer Review
- Medical Record Review
- Pharmacy Review
- Patient Satisfaction
- Risk Management -Adverse Events and Incidents and Complaints
- Safety and Infection Control

The QI Committee / Board will review the data, identify trends or issues, recommend or approve actions to be taken, and assist with implementation by removing barriers.

Article V **Teaching Services**

Residents and health care students will be allowed to observe procedures in the Center under direct and continuous supervision of one of the staff physicians.

Article VI **Adoption of Bylaws, Rules and Regulations**

The Medical Staff shall adopt such Bylaws, Rules and Regulations as may be necessary for the proper conduct of its work. Such Rules and Regulations as pertaining to the Medical Staff as a whole shall be a part of these Bylaws. These Rules and Regulations, or amendments to them, shall become effective when approved by the Governing Board.

Article VII **Amendments or Revisions**

To revise or amend the Bylaws of the Medical Staff, it requires a majority vote of those present with previous notice to the entire membership.

Article VIII **Adoption**

These Bylaws, together with the Rules and Regulations shall be adopted at any regular meeting of the Medical Staff/ Board and shall become effective when approved. They shall, when adopted and approved, be equally binding on the Governing Board and the Medical Staff. Physicians will receive approved revisions of the Bylaws, Rules and Regulations within thirty days of approval.

Attachments:

1. Rules and Regulations
2. Peer Review for Adverse Events

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Medical Staff Rules and Regulations

Sedation

Sedation used for procedures include intravenous medications such as Propofol ®, Fentanyl ®, Versed ®, Valium®, Diprivan in trade or generic form. The medication may be administered by a Certified Registered Nurse Anesthetist under direction of a physician or by anesthesia personnel with appropriate privileges. The medications are to be used to achieve moderate sedation and pain relief. No general anesthetic of any type will be given in the center. The physician performing the procedure supervises and accepts responsibility for the administration of sedation.

Drugs

Drugs used shall meet the standard of the U.S. Pharmacopeia, National Formulary.

Admission

Every patient shall be admitted by and remain under the care of a member of the Medical Staff until discharge. The Center will not provide accommodations for overnight observation. Any patient requiring prolonged or overnight observation must be transferred to the hospital by the admitting physician. Pediatric patients will not be admitted to the center.

Admission

Every patient shall be admitted by and remain under the care of a member of the Medical Staff until discharge. The Center will not provide accommodations for overnight observation. Any patient requiring prolonged or overnight observation must be transferred to the hospital by the admitting physician. Pediatric patients will not be admitted to the center.

Admission Criteria:

Patients who are candidates for outpatient endoscopy must meet the following criteria:

1. The patient's past and current health status must be evaluated by a physician prior to the procedure being performed, and documented in the H&P. Appropriate patients for outpatient procedures will be ASA classifications of I, II, and stable III's. Patients must be *18* years or older. The H&P must be dictated or written prior to the procedure being performed. A determination will be made by the physician, based on this assessment, as to whether the patient is an appropriate candidate for outpatient endoscopy and sedation.
2. The patient and/or person signing the consent for diagnostic or treatment procedures must agree with the concept of outpatient surgery and anesthesia and must exhibit the ability to use judgment and follow instructions.
3. The patient's physical and emotional environment must be conductive to a successful outcome.
4. The patient must have a responsible adult present to drive the patient home.

Discharge

Patients shall be discharged as outlined in the policy and procedure manual.

1. Discharge from the center is based upon the patient's ability to meet the outpatient Discharge Criteria and to leave the facility safely when accompanied by a reasonable individual and when the physician's post-op orders have been completed.
2. Physicians must see the patient at least once prior to discharge.
3. A physician must remain in the building until all patients meet the criteria for discharge.

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Medical Records

The following medical record criteria shall apply:

Medical Record Documentation Criteria:

1. A summary of past and current medical diagnoses or problems in addition to past procedures is documented if the patient has multiple visits / admissions or the clinical record is complex and lengthy.
2. A current medication list with dosages, if known, will be included in the medical record. Any changes in prescription and non-prescription medications will be entered in the list with each visit including dosages, if known.
3. Any allergies or abnormal drug reactions shall be documented.
4. The physician shall be responsible for the preparation of a complete medical record for each patient.
5. Significant medical history and results of physical exam shall be documented within 30 days of a procedure requiring sedation and placed on the chart prior to the procedure being initiated. A reassessment immediately prior to the procedure will be completed and documented by the physician to indicate that the patient continues to be an appropriate candidate for the procedure and moderate sedation.
6. All orders for treatment shall be documented in the EMR. An dictated to a Licensed Nurse, must signed by the physician. Orders dictated over a telephone shall be signed by the person to who dictated, with the name of the physician per his or her own name and signed by the ordering physician.
7. Documentation of properly executed informed patient consent shall be a part of the medical record prior to the initiation of the procedure.
8. Procedure Note - An accurate and complete description of findings and technique of the procedure shall be documented immediately after the procedure by the physician who performed the procedure in addition to a dictated note.
9. All tissue and foreign objects removed during the procedure shall be sent to the Pathologist, who shall make such examination as may be considered necessary to arrive at a pathological diagnosis. The Pathologist shall sign this report, which shall become a part of the permanent medical record.
10. All records shall remain the property of the Center and shall not be taken from the building without the expressed written permission of the Medical Director or upon approval of the patient. In the case of readmission of the patient, all previous records shall be made available to the physician.
11. The physician shall be responsible for the preparation of a complete medical record for each patient. The medical record shall contain information to justify diagnosis and treatment.
12. Medical records remaining incomplete for one (1) month following the patient's discharge will be considered delinquent and must be brought to the attention of the physician for completion.
13. Discharge diagnosis shall be documented.
14. All nursing notes and observations shall be signed by a licensed nurse.
15. For complex patients or those seen for three procedures, a summary sheet including the patient's allergies, current medications with doses, significant medical problems, and past surgical and procedure history will be completed and placed in visible location in the medical record. This summary sheet will be updated by the staff on a regular basis to maintain a current list of medications, etc.
16. Medical records shall be maintained in retrievable form for at least ten years. If the patient has not been seen for a period of ten years, the medical record can be disposed of by archiving in computer form. It will be the Office Manager's responsibility to ensure that the chart is completed properly with all signatures and reports before being filed. Patients with more than one admission ill have each admission separated.

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Scheduling

Treatment provided at the Center shall be scheduled in advance except in selected cases or emergencies. Patients for diagnostic and treatment procedures shall be admitted thirty (30) to sixty (60) minutes before the scheduled procedure. Instructions regarding the above are the responsibility of the attending physician. These instructions are given to the patient and/or parents, family or legal guardian, depending on the family situation prior to the procedure.

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NOVANT HEALTH

By Laws / Medical Staff Rules and Regulations
Review and Revision

These have been reviewed, revised, and approved for implementation.

The Bylaws of The Endoscopy Center NHRMC Physician Group, are adopted with minor revisions and transferred to the under the new branded name Novant Health Wilmington Endoscopy Center

Medical Director — Date: 3/20/22

Governing Board Representative — Date: 3/20/2022

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Peer Review for Adverse Events

Patient Name: _____ Chart # _____

Adverse Event: ( ) Reversal agent used ( ) Excessive pain with ED visit
( ) Bleeding with ED visit ( ) Perforation
( ) Hospital admission related to the procedure
( ) Medication error

Procedure done: Procedure date: _____
( ) Upper Endoscopy with possible biopsy
( ) Colonoscopy with possible biopsy, possible polypectomy
( ) Flexible sigmoidoscopy with possible biopsy
( ) _____

Was there adequate work up / pre-procedure assessment for this patient? ( ) Yes
Recommendations: _____
_____
_____

Was the procedure and treatment appropriate for this patient? ( ) Yes
Recommendations: _____
_____
_____

Was the post procedure care and instructions appropriate for this patient? ( ) Yes
Recommendations: _____
_____
_____

What could have been done to prevent or avoid this adverse event? _____
_____
_____
_____
_____

I have conducted an independent medical evaluation of this case and recommend the following:
( ) No changes needed to improve care or prevent occurrence in the future.
( ) Changes recommended as listed below:

_____
_____
_____
_____
_____

MD Signature: _____ Date: _____

_____

This form is completed by the Medical Director and placed with the incident report forms. These will be reviewed for each physician at time of reappointment.

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