MEDICAL STAFF BYLAWS

APPENDIX "C"

MEDICAL STAFF POLICY REGARDING

BEHAVIOR THAT UNDERMINES A CULTURE OF SAFETY

Objective

The objective of this policy is to promote a culture of professional conduct for all credentialed professionals in order to support the delivery of safe, quality patient care and a reliable process for reporting and addressing behavior that undermines a culture of safety. This objective is accomplished, in part, by providing a mechanism for timely reporting and addressing of behavior that undermines a culture of safety, in order to prevent or eliminate, to the extent possible, conduct that:

1. Negatively impacts patient care and safety, or has the potential to do so;
2. Disrupts the operation of the hospital;
3. Adversely affects the ability of others to do their jobs;
4. Creates a "hostile work environment" for hospital employees or other medical staff members;
5. Interferes with an individual's ability to practice competently; or
6. Adversely affects or impacts the community's confidence in the hospital's ability to provide quality patient care.

Definitions

Behavior that undermines a culture of safety" *is any conduct that intimidates others, affects morale or staff turnover, disrupts the smooth operation of the Hospital, poses a threat to patient care or exposes the Hospital and/or Medical Staff to liability. Such conduct may include, but is not limited to, behavior such as:*

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

2. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, or inappropriate written or verbal statements to patients and/or members of the community impugning the quality of care in the hospital, or attacking particular physicians, nurses, other employees, or hospital policies.

3. Nonconstructive criticism that is addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

4. Refusal to accept or causing a disturbance of medical staff assignments or participation in committee or departmental affairs in a disruptive or non-constructive manner.

5. Discrimination, harassment and/or retaliation.

6. Passive activities such as quietly exhibiting uncooperative attitudes during routine activities, reluctance or refusal to answer questions, return phone calls or pages, condescending language or voice intonation and impatience with questions.

7. Refusal or failure to follow Medical Staff Bylaws, Rules & Regulations, policies or protocols.

Allegations of actions directly impacting clinical practice and involving clinical judgment should be reported through the peer review process or other hospital processes as appropriate, rather than pursuant to this policy.

Reporting and Collegial Intervention

Hospital team members, including credentialed professionals, all share responsibility for exhibiting and promoting professional conduct, including promoting a culture that encourages teamwork and consistent responses to behavior that undermines quality and safety. Appropriate responses depend on the specific behavior and circumstances. Credentialed professionals are encouraged to model behaviors that promote quality outcomes and team performance, and to respectfully and collegially address deviations from such behaviors by colleagues in an informal manner where possible.

All team members are encouraged to report observed or otherwise noted behaviors that appear to be inconsistent with the culture of safety or our commitment to professionalism. Such behaviors should be reported via the Event Reporting System (ERS). While the ERS is the preferred reporting mechanism, if for any reason the team member is not comfortable reporting through the ERS, the team member may report the conduct in writing to any supervisor, the designated quality team member, or to the CEO/CMO. Upon such reporting the designated quality department team member will determine the appropriate routing for the report, as follows:

If the event is an isolated event that does not otherwise require immediate formal action as outlined in this policy, the designated quality team member will forward the event to a designated medical staff leader or professionalism messenger. The leader/messenger will, within three business days of the report where possible, engage in a brief, nonjudgmental conversation with the involved professional for purposes of making the professional aware of the concern and of the appearance of inconsistency with the safety culture. The leader/messenger will also make the professional aware that he/she should not approach the reporting party or perceived reporting party and shall not engage in any conduct that may be construed as retaliatory in nature. The leader/messenger will record in the ERS that the conversation took place and the date thereof, but will not record details of the interaction.

In the event a second minor incident is reported, the "professionalism message" will be delivered by a medical staff leader, in his/her capacity as a leader (i.e., Chief of Staff, Department Chair, etc.), and will address the safety culture and nonretaliation as outlined above. The leader will record in the ERS that the conversation took place and the date thereof, but will not record details of the interaction.

Minor events requiring delivery of a "professionalism message" are not investigated or addressed through a formal peer review process and do not become part of the practitioner's quality file or credentials file. They are simply logged and a communicated to the practitioner in order that the practitioner may consider the event and adjust his/her behavior in response to being made aware of the event.

Upon receipt of a third minor incident report representing a trend, consideration should be given as to implementation of the progressive action process below. In addition, some allegations are of such a nature as to require immediate formal intervention, and are not subject to the collegial intervention process outlined above. These allegations include, but are not limited to, harassment based upon protected status, retaliation for exercise of a protected right (including retaliation for reporting under this policy), physical assault, boundary violations, criminal conduct and other behavioral issues of such a serious nature that immediate intervention is required, and for purposes of this policy shall be referred to as "immediate intervention" allegations. In such instances,

the designated quality team member shall refer the matter to the Chief of Staff and CEO/CMO for action as outlined in the investigation and progressive corrective action provisions below.

Whether reported in the ERS system or through another mechanism, reports should, where possible, provide the following information:

(a) the name of the professional involved in the behavior;

(b) the date and time of the behavior;

(c) a statement of whether the behavior affected or involved a patient in any way, and if so, the chart number of the patient;

(d) the circumstances that precipitated the situation, if known;

(e) a description of the behavior limited to factual, objective language as much as possible;

(f) the consequences, if any, of the behavior as it relates to patient care or hospital operations; and

(g) a record of any action taken to remedy the situation including date, time, place, action, and name(s) of those intervening.

Investigation

1. Reports of immediate intervention allegations as defined herein or a pattern of unprofessional behavior addressed through the collegial intervention process as outlined above without resolution of the behavior, will be investigated by the Chief Medical Officer or designee.

In performing all functions hereunder, all individuals participating in the process shall be deemed authorized agents of the Medical Executive Committee and shall enjoy all immunity and confidentiality protection afforded under state and federal law.

Where possible, the employee or other person completing the report will be interviewed as soon as reasonably practical, usually within three (3) business days of having received the Report, in order to gather additional, more complete information. If the Chief of Staff or designee is unable to complete the interview within this time period, the documentation of the investigation will indicate why the interview could not occur within three (3) business days. The Chief Medical Officer or designee will document the time, date and substance of this meeting.

2. In general, investigations of behavior that undermines a culture of safety should be completed within five (5) business days after the initial interview of the complaining party, whenever practical. Any investigation should include an opportunity for the affected professional to respond. Once an investigation is completed, the Chief Medical Officer or designee will follow-up with the reporting employee or other individual to inform them (in general terms and without disclosing peer review information or other confidential or sensitive information), of the conclusions of the investigation, and that appropriate actions will be taken. The employee or person reporting should be encouraged to report any further behavior that undermines a culture of safety. In addition, the employee or other reporting individual and the professional who is the subject of the reporting shall be advised that retaliatory nor any action, such as confronting the reporting party or attempting to engage the reporting party in discussion about the report, will not be tolerated. The reporting party will be encouraged to report any action which appears to have been taken in retaliation for making a report pursuant to this policy.

3. Reports which are determined to be credible, based on the facts and information gathered during the investigation, will be addressed through the procedure set out below and will become a part of the quality file.

Progressive Corrective Action

1. A pattern of incidents of unprofessional behavior warrants a formal discussion with the offending professional by a medical staff officer, department chair, service chief or other appropriate leader. The CMO or CEO shall/may also participate. The professional shall be contacted personally by the medical staff leader in order to schedule a face to face meeting. At the meeting, any history of behavior will be discussed with the practitioner, and the practitioner shall be informed that the conduct in question was inappropriate. The party conducting the meeting will also review the substance of this policy with the practitioner, and explain to the practitioner the possible results of continued behavior that undermines a culture of safety. A follow-up letter to the practitioner shall state that the practitioner is required to behave professionally and cooperatively.

2. If there is a second incident of behavior that undermines a culture of safety after the intervention described in step 1 above, the same process as described above shall be followed. During this meeting, the practitioner will be advised that further incidents will be referred to the hospital's Medical Executive Committee for appropriate corrective action, which may include disciplinary interventions, educational or coaching requirements, a referral to the Board of Trustees , or limitation or termination of the practitioner's medical staff privileges.

3. If behavior that undermines a culture of safety persists after these interventions, or in the event of a validated immediate intervention allegation, the CEO and/or Chief of Staff shall refer the matter to the Medical Executive Committee for recommendation and to the Board of Trustees for final action and resolution of the matter. Any action, recommendation or communication by the MEC and/or the Board becomes a part of the practitioner's quality file. More formal corrective action may be pursued at this juncture if deemed warranted.

4. Nothing herein shall be deemed to prohibit more formal corrective action as a result of a single incident, or at any time during the investigative or corrective action process, should the seriousness of the incident justify such action.

5. If at any time during the process any participant has reason to believe that the practitioner's behavior may result from a physician health issue, the procedures set forth in the Practitioner Wellness Policy should be followed.

6. Summary suspension may be appropriate pending the completion of this process, depending on the substance and seriousness of the reported offense. Any summary suspension pursuant to this policy must meet the requirements for summary suspension as outlined in the Medical Staff Bylaws.

Disciplinary Action Pursuant to Medical Staff Bylaws

1. The CEO and Chief of Staff shall be responsible for presenting the history of conduct to the Medical Executive Committee.

2. The Medical Executive Committee shall be fully apprised of any reports of behavior that undermines a culture of safety, and any meetings and warnings, so that it may pursue whatever action is necessary to terminate the unacceptable conduct.

3. The Medical Executive Committee may refer the matter to the Board of Trustees with or without recommendation as to action. If the Medical Executive Committee makes a recommendation, it shall be processed as provided in the corrective action section of the Medical Staff Bylaws.

4. Should the Medical Executive Committee forward the matter without a recommendation, any further action, including hearing and appeal, shall then be initiated by the Board of Trustees and shall be processed as provided in the corrective action section of the Medical Staff Bylaws.

Although this policy is intended to outline a suggested method of progressive counseling and discipline, nothing herein shall be deemed to require such progressive discipline in the event that the seriousness of the individual's behavior warrants immediate corrective action. A single validated immediate intervention incident as described herein, including but not limited to harassment based on protected status, retaliation for exercise of a protected right, physical assault, boundary violations, criminal conduct and other behavioral issues of such a serious nature that immediate intervention is required, may result in immediate corrective action.

Documentation and Document Retention

1. With the exception of informal, collegial meetings described in the "collegial intervention", section above, all meetings with the practitioner and/or relating to the reported behavior that undermines a culture of safety shall be documented and maintained in the practitioner's quality file. Reports of minor issues resulting in a collegial "messenger" meeting are merely maintained in the ERS system and are not included in the quality file or credentials file. However, at reappointment a notation will be provided merely addressing whether the professional had an excessive number of incidents reported during the appointment period.

2. With the exception of informal, collegial meetings described in the collegial intervention, Section above, after each meeting with the practitioner, a letter summarizing the substance of the meeting shall be sent to the practitioner.

3. With the exception of informal collegial meetings described in the collegial intervention Section above, a copy of all original Reports shall be maintained in the practitioner's quality file with all of the documents and notes on the matter. The practitioner may also submit a written response to be placed in the file if he/she so desires.

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