Red Rules

**Please Review and sign the attestation on the last page.**
RED RULES
WHAT IS A RED RULE?

- A Red Rule is a procedure which should always be followed and rarely if ever deviated from.
- A Red Rule focuses our attention on an action or process that is critical to the safety of our patients.
- Red Rules are an example of our highest commitment to MacNeal's core value of safety first.
EXAMPLES OF RED RULES

• Buckling the seatbelt prior to driving
• Stopping the car at a red light or stop sign
• Wearing scrubs, cap and mask in the operating room
• Washing hands prior to performing an operation or procedure
MacNeal's New Red Rule

- The Red Rule we will follow at MacNeal Hospital is the pre-procedural time-out.
- The "time-out" is a safety strategy to ensure the correct procedure is performed on the correct patient on the correct side.
- A time-out consists of a deliberate pause by the healthcare team immediately prior to beginning a surgery or invasive procedure. All team members must suspend all activities until the time-out has been completed.
WHAT PROCEDURES REQUIRE A TIME OUT?

- Perform a time-out prior to any procedure that requires informed consent.
- Procedures performed outside the operating room should also have a time-out if informed consent was obtained.
- This includes procedures performed in the ED, cath lab, GI lab, radiology, at the bedside, or elsewhere.
HOW DO I COMPLETE THE TIME OUT?

• STOP all activity!

• Identify the patient by using 2 identifiers (Name and Date of Birth)

• Confirm the correct procedure, site, side

• Focus in on the time-out and participate.
WHAT IS THE PENALTY FOR NON-COMPLIANCE WITH THE TIME-OUT RED RULE?

- The emphasis is compliance with the time-out process for patient safety.
- Should a physician, nurse, resident, or other hospital employee fail to perform or not participate in the time-out process, then a 3 day suspension may occur.
- Appropriate investigation of possible non-compliance with the time-out process will occur.
- Repeat non-compliance may result in repeat suspension and possible termination.
• I have read and understand the "Red Rules Policy."
• I understand that failure to comply with this policy may result in a 3 day suspension of my employment, residency training, or medical staff privileges.
• A repeat violation may result in further suspension or lead to the termination of my employment, residency training, or medical staff privileges at MacNeal Hospital.

• Print Name______________________________
• Signature_________________________ Date

RED RULES ATTESTATION
Code of Conduct Policy

**Please read through and sign the last page**
Date: September 1, 2006

TO: All New Applicants to the Medical Staff at MacNeal Hospital

FROM: Charles Bareis, M.D.
Chief Medical Officer

RE: Code of Conduct Policy

Included in the application for Medical Staff membership is a copy of our Code of Conduct policy.

Please review this policy and take it to heart. At MacNeal Hospital, we view professional behavior as the foundation for good patient care.
MacNeal Hospital Medical Staff Code of Conduct Policy

Because of their unique standing in society in general, and within the hospital environment specifically, the multiple stressors physicians face place them in particularly vulnerable position. Additionally, based on their level of stature, their behavior is expected to be exemplary at all times.

In the best of interests of patient safety, collaborative teamwork, and professionalism, physicians should remain ever vigilant to their own unique set of circumstances that may precipitate a complaint of disruptive behavior. By doing so, they may prevent a serious breakdown in communications and patient care.

Physicians should avail themselves of all of the support systems available for help, including the 24 hour physician hot line, the open doors of communication with senior management and medical staff leadership, self referral to the Physicians Assistance Committee, and when necessary, professional evaluation and counseling.

I. POLICY STATEMENT

A. All Medical Staff members practicing at the Hospital or in its offsite locations must treat others with respect, courtesy, and dignity and conduct themselves in a professional manner.

B. The objective of this policy is to assure optimum patient care by promoting a safe, cooperative, professional healthcare environment, and to prevent or eliminate conduct that:

- Puts the safety of patients at risk
- Interferes with an individual's ability to practice competently
- Disrupts the operation of the hospital or affects the ability of others to do their jobs through intimidation
- Creates a "hostile work environment" for hospital employees or other medical staff members
- Adversely affects or impacts the community's confidence in the Medical Staff or hospital's ability to provide quality patient care

C. This Policy outlines the collegial and educational efforts to be used by Medical Staff Leaders (the President, Vice President and Secretary of the Medical Staff and the Chief Medical Officer or their designees) to prevent or rapidly address any episode of inappropriate conduct, including sexual harassment. The Medical Staff’s goal is to prevent disruptive behaviors, and to promote voluntary and responsive actions by the involved practitioner, in a collegial and professional manner.

8/15/2014
II. DEFINITION AND EXAMPLES OF INAPPROPRIATE CONDUCT

Examples of "inappropriate conduct" include, but are not limited to:

A. Verbal attacks or unwanted physical contact leveled at medical staff, health care personnel, hospital personnel, patients, or patients' families, that are personal or are beyond the bounds of professional conduct.

B. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents that impugn or attack particular physicians, nurses, the hospital, or hospital policies.

C. Criticism of any individual that is intended to intimidate, undermine confidence, belittle, or imply stupidity or incompetence.

D. "Sexual harassment," which is any verbal and/or physical conduct of a sexual nature that is unwelcome and considered offensive by those individuals who are subjected to it or who witness it, or unwelcome sexual advances, requests for sexual favors and other verbal or physical conduct of a sexual nature when:
   
   i. Submission to or rejection of such conduct is made either explicitly or implicitly a term or condition of an individual's employment,
   
   ii. Submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual, or,
   
   iii. Such conduct has the purpose or effect of unreasonably interfering with an individual's work performance or creating an intimidating, hostile or offensive working environment.

E. Making or threatening retaliation as a result of an individual's report of sexual harassment shall be considered sexual harassment in and of itself.

III. GENERAL GUIDELINES/PRINCIPLES

A. Conduct by members of the Medical Staff ("Practitioners") will be addressed in accordance with this Policy (and in accordance with the Bylaws and Rules and Regulations of the Medical Staff).
B. Hospital employee conduct will be addressed in accordance with the Hospital's Human Resources Policies.

C. In general, there should be an attempt to resolve the conflict and eliminate the inappropriate behavior in a collegial and collaborative fashion. However, there may be a single incident of inappropriate conduct, or a series of episodes, that is so unacceptable as to make such collegial steps inappropriate and that requires immediate disciplinary action. Therefore, nothing in this Policy precludes either an immediate referral to the Executive Committee for a corrective action or the elimination of any particular step in the Policy when the conduct is deemed to be egregious by Medical Staff Leadership.

D. The Medical Staff leadership and Hospital Administration shall provide orientation and education to make employees, members of the Medical Staff, and other personnel in the Hospital aware of this Policy prohibiting inappropriate conduct. The Medical Staff Leadership and Hospital Administration shall institute the following procedures to facilitate prompt reporting of conduct which may violate this Policy and prompt action as appropriate under the circumstances.

IV. PROCEDURE WHEN A BEHAVIORAL CONCERN IS RAISED

A. Physicians, House staff, Medical Students, Nurses and other Hospital employees who observe, or who are subjected to inappropriate conduct by a practitioner shall notify his/her supervisor or department chair about the incident. If their supervisor or department chair's behavior is at issue, or there is no direct supervisor or department chair available, the individual shall notify one of the Medical Staff Leaders.

B. The Medical Staff Leaders, department chair or the supervisor will document the incident in writing or request that the individual reporting the incident document it in writing. The documentation will then be reviewed by the Medical Staff Leadership.

C. The documentation should include:
   (i) Date and time of the incident;
   (ii) Factual description of the questionable behavior;
   (iii) Any circumstances that precipitated the incident;
   (iv) Name of any patient(s)/ patient's family member who may have been involved in the incident, including any patient or family member who may have witnessed the incident;
(v) Names of other witnesses to the incident;
(vi) Consequences, if any, of the behavior relating to patient care, personnel, or Hospital operations;
(vii) Any action taken to intervene in, or remedy, the incident; and
(viii) The name and signature of the individual reporting the complaint of inappropriate conduct. (This shall remain confidential unless meeting the requirements in paragraph "IV, G"

D. The Medical Staff Leaders will review the report and meet in a timely fashion with:

(i) the individual who prepared it and/or any witnesses to the incident to investigate the details of the incident; and
(ii) The Practitioner about whom the report has been filed.

The Medical Staff Leaders should also review any and all information related to any prior complaints or incidents involving the practitioner.

E. After thorough review, the Medical Staff Leader(s) may:

(i). Indicate that no evidence of disruptive behavior was found, and/or
(ii) Recommend guidance about the incident, and/or
(iii) Send the practitioner a letter of warning or reprimand with specific recommendations, and/or
(iv) Refer the practitioner to the Physician's Assistance Committee for further evaluation and recommendations. Referral to the Physician's Assistance Committee will be done under the guidelines of that committee. The committee will report back to the Medical Staff Leaders on their evaluation and follow up recommendations.

(v) If the Medical Staff Leaders cannot reach a consensus in their deliberations, then the matter shall be referred automatically to the MEC for investigation and recommendations.
F. The findings of the committee shall be documented in writing and communicated to the practitioner.

G. The findings of the Medical Staff Leaders and all documentation related to the incident will be filed in the practitioner's confidential quality file. The practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the Medical Staff Leaders' documentation.

H. The identity of an individual reporting a complaint of inappropriate conduct will generally not be disclosed to the practitioner during these efforts, unless the Medical Staff Leaders agree in advance that it is appropriate to do so. In any case, the practitioner shall be advised that any retaliation against the person reporting a concern, whether the specific identity is disclosed or not, will be grounds for immediate corrective action pursuant to the Medical Staff Bylaws.

I. If additional complaints are received concerning a practitioner, the Medical Staff Leaders may continue to follow this Policy and Procedure if there is a reasonable likelihood that those efforts will resolve the concerns. At any point in this process, however, the Medical Staff Leaders may refer the matter to the Medical Executive Committee for review and action in accordance with the Medical Staff Bylaws. When it makes such a referral, the Medical Staff Leaders may also suggest a recommended course of action for the practitioner (e.g., behavior modification course, development of conditions for continued practice or the individual, suspensions).

J. If a matter is referred to the Medical Executive Committee for review and action, the Medical Executive Committee shall be fully apprised of the previous warnings issued to the practitioner and the actions taken to address the concerns. The Medical Executive Committee may, at any point in the investigation, refer the matter to the Board with or without a recommendation. Any further action, including any hearing or appeal, shall then be conducted under the direction of the Board.

V. PROCEDURE WHEN A SEXUAL HARASSMENT CONCERN IS RAISED:

A. Because of the unique legal implications surrounding sexual harassment, a single reported episode requires the actions set forth in Section IV, Paragraphs A-E of this Policy and Procedure.

B. A meeting with the Medical Staff Leaders shall be held with the practitioner to discuss the incident once the facts have been gathered.
C. If after review the Medical Staff Leaders have identified a case of sexual harassment, and if the practitioner has agreed to stop the conduct the meeting shall be followed up with a formal letter of admonition and warning to be placed in the confidential portion of the practitioner's quality file. This letter shall also set forth those additional actions if any that result from the meeting. The practitioner shall be apprised of that documentation and given an opportunity to respond in writing. Any such response shall then be kept in the practitioner's confidential file along with the original concern and the Medical Staff Leaders documentation.

D. If the practitioner refuses to agree to stop the conduct immediately, this refusal shall result in the matter being immediately referred to the Medical Executive Committee as a recommendation for corrective action to be formally investigated pursuant to the Medical Staff By Laws.

E. Any reports of retaliation or any further reports of sexual harassment, after the practitioner has agreed to stop the improper conduct, shall result in an immediate investigation by the Medical Staff Leaders (or its designee(s)). If the investigation results in a finding that further improper conduct took place, a formal investigation and corrective action in accordance with the Medical Staff Bylaws shall be conducted. Should this investigation result in an action that entitles the individual to request a hearing under the Medical Staff By Laws, the individual shall be provided with copies of all relevant complaints so that he or she can prepare for the hearing.

F. In order to effectuate the objectives of this Policy, and except as otherwise may be determined by the MEC, the practitioner's counsel shall not be entitled to attend any of the meetings described above except as otherwise indicated in the Medical Staff Bylaws.

VI. COMMUNICATIONS TO MEC:

All proceedings of the Medical Staff Leadership shall be communicated to the MEC describing in a summary, anonymous fashion, the number of complaints referred, their dispositions, and any pending actions or recommendations.
Recommended by the Executive Committee this ____ day of ____________, 20__. 

______________________________
Chief of Staff

Approved by the Board this ____ day of ____________, 20__. 

______________________________
Chair, Board of Directors
I am aware of the Code of Conduct policy and I agree to abide by it.

Signature                      Date