PROVIDENCE
Holy Cross
Medical Center

General Medical Staff Rules & Regulations

DEFINITIONS

The following definitions apply to the provisions of these General Rules and Regulations for the medical staff. The definitions are in alphabetical order.

1. **BOARD OF TRUSTEES** or **BOARD** means the governing body of the corporation, or, as appropriate to the context, any committee or individual authorized by the board to act on its behalf on certain matters

2. **CHIEF EXECUTIVE (CE)** means the individual appointed by the board as the chief executive to act on its behalf in the overall executive and administrative management of the hospital. The CE may, consistent with his responsibilities under the bylaws of the corporation, designate a representative to perform his responsibilities under the Medical Staff Bylaws and General Medical Staff Rules and Regulations.

3. **CLINICAL PRIVILEGES** or **PRIVILEGES** means the permission granted by the board to a practitioner to provide those diagnostic, therapeutic, medical, or surgical services specifically delineated to him.

4. **CORPORATION** means Providence Health System

5. **EX OFFICIO** means service as a member of a body by virtue of office or position held. When an individual is appointed ex officio to a committee or other group, the provision or resolution designating the membership must indicate whether it is with or without vote.

6. **GOOD STANDING** means a member who is currently not under suspension or serving with any limitation of voting or other prerogatives imposed by operation of the bylaws, rules and regulations, or policy of the medical staff.

7. **HOSPITAL** means Providence Holy Cross Medical Center, Mission Hills, California.

8. **INTENSIVIST** will be experienced in critical care and be board certified or eligible in pulmonary medicine and/or critical care. Within eight years from the date this rule is in effect (effective 06/2015), the Intensivist definition will narrow to require the physician to be critical care board certified or eligible.

9. **MEDICAL STAFF** or **STAFF** means that component on the hospital chart of organization that stands for all practitioners, as defined in number 14 below, who are appointed to membership and are privileged to attend patients or to provide other diagnostic, therapeutic, teaching or research services at the hospital.

10. **MEDICAL STAFF AND BOARD AUTHORITIES** or **AUTHORITIES OF THE MEDICAL STAFF AND BOARD** means any committees, officers, and clinical units of the staff, and the board and any committees or officers thereof, who have defined responsibilities in effecting the particular function or activity that is the subject of the particular provision in which the above defined phrase is used.

11. **MEDICAL STAFF MEMBER IN GOOD STANDING** or **MEMBER IN GOOD STANDING** means a practitioner who has been appointed to the medical staff or to a particular category of the staff, as the context requires, and who is not under either a full appointment suspension or a full or partial suspension of voting, office-holding or other prerogatives imposed by operation of any section of the Bylaws and General Medical Staff Rules and Regulations or any other policies of the medical staff or the hospital. (Rev. 8/97)

12. **MEDICAL STAFF YEAR** means the 12-month period commencing on January 1st of each year and ending on December 31st of the same year.

13. **PEDIATRIC PATIENT** means a patient 13 years of age or under.(Added 4/97)

14. **PHYSICIAN** means an individual with an M.D. or D.O. degree, who is licensed to practice medicine.

15. **PRACTITIONER** means, unless otherwise expressly provided, any physician, dentist, oral surgeon, or podiatrist who

either: (a) is applying for appointment to the medical staff and for clinical privileges; or (b) currently holds appointment to the medical staff and exercises specific delineated clinical privileges; or is applying for or is exercising temporary privileges pursuant to Section 5.9 of the Medical Staff Bylaws.

DEFINITIONS CONTINUED

16. **PREROGATIVE** means a participatory right granted, by virtue of staff category or otherwise, to a staff member or allied health professional, and exercisable subject to the ultimate authority of the board and to the conditions and limitations imposed in the Medical staff Bylaws and General Medical Staff Rules and Regulations and in other hospital and medical staff policies. (Rev. 8/97)

17. **SPECIAL NOTICE** means written notification sent by certified mail, return receipt requested, or by personal delivery service with signed acknowledgment of receipt.

General Medical Staff Rules & Regulations

PART ONE. ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS

The hospital accepts patients for care and treatment except for the following categories:

(a) Communicable Diseases as specified by the Los Angeles County Health Department and in concurrence with the Infection Control Committee of the Medical Staff, including Cholera; Diphtheria; Measles; Plague; Rabies; Relapsing Fever (louse-borne); Typhus Fever (louse-borne); and Viral Hemorrhagic Fevers (e.g. Crimean-Congo, Ebola, Lassa and Marburg viruses). (Rev 4/00)
(b) Psychiatric;
(c) Drug - Alcohol;

Within these guidelines, patients are admitted without regard to race, creed, color, sex, sexual preference, national origin. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the chief executive officer after consultation with the applicable department chairman or Chief of Staff.

1.2 ADMITTING PREROGATIVES

1.2-1 GENERALLY

Only a member in good standing of the medical staff may admit patients to the hospital, subject to the conditions provided below and to all other official admitting policies of the hospital as may be in effect from time to time. Names of members not in good standing are submitted to the admitting office by the medical staff office or medical records department.

1.2-2 STAFF PRIORITIES WHEN RESOURCES STRAINED

At times of full hospital occupancy or of shortage of hospital beds or other facilities, as determined by the chief executive officer, priorities among the members of the various staff categories for access to beds, services or facilities for patients of similar status (i.e. elective, urgent, emergency) shall be determined by each clinical department and defined in the departmental rules and regulations after approval by the Medical Executive Committee.

When two or more practitioners with the same priority status have made a reservation for an elective admission and all such reservations cannot be accommodated, priority is determined by the order in which the reservations were received.

1.2-3 LIMITATIONS FOR DENTISTS AND PODIATRISTS

Dentist and podiatrist members of the staff may admit patients to the hospital, but, except as provided below, a physician member of the staff must record a basic medical appraisal (including history and physical examination) for each dental and podiatric patient within 24 hours (as outlined in Section 7.2 of these Rules and Regulations.

An oralmaxillofacial surgeon with the requisite qualifications may be granted the privilege of performing an admission history and physical examination and assessing the medical risks of the proposed procedure to the patient. (Revised 10/13/92)

1.3 ADMISSION PRIORITIES BASED ON PATIENT CONDITION

1.3-1 EMERGENT CONDITION - FIRST PRIORITY

A case may be declared an emergency by the attending practitioner. Prior to referral of an emergency patient for admission to the hospital, the attending practitioner must, when possible, call the admitting office to determine bed availability.

For each patient admitted as an emergency, the attending practitioner must provide the following documentation or information within the time frames indicated:

(a) within four (4) hours of the patient's arrival at the hospital, an admission note which indicates involvement in the immediate care of the patient; and
(b) within 24 hours of the admission, sufficient documentation on the chart to justify the emergency admission.

Failure to furnish this documentation or information, or evidence of willful or continued misuse of this category is grounds for such disciplinary action as the medical executive committee (MEC) deems appropriate. (Rev. 8/97)

1.3-2 URGENT CONDITION - SECOND PRIORITY

The attending practitioner must document as part of his request for an urgent admission the specific reason for admission supportive of the request and the degree or urgency involved. When all such admissions for a specific day are not possible, the applicable department chairman *will* review the urgent cases listed in the admitting office and determine the priority of the admissions. Failure to furnish the required documentation, or evidence of willful or continued misuse of this category, is grounds for such disciplinary action as the MEC deems appropriate. (Rev. 8/97)

1.3-3 SCHEDULED ELECTIVE ADMISSIONS - THIRD PRIORITY

This category includes all elective medical and surgical patients scheduled in advance. When all such admissions for a specific day are not possible, the applicable department chairman will review the cases listed in the admitting office and determine priority.

1.3-4 CURRENT DAY REQUESTS FOR ELECTIVE ADMISSIONS

This category includes all elective admissions that are not covered under Section 1.3-3.

1.4 TIME OF ADMISSION

Except in emergency cases, the attending practitioner shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient or same admission day surgery, the attending practitioner must comply with hospital policies concerning presurgical laboratory tests, documentation, and scheduling.

1.5 RESTRICTED BED USE AREAS

Areas of restricted bed utilization and assignment of patients are as follows:

(a) Intensive Care Unit
(b) DOU
(c) Obstetrical
(d) Pediatric

Questions regarding admission to or discharge from any of the above areas shall be referred to the appropriate physician director, or his designee, or, if there is no available physician director, to the applicable department chairman, chief of staff or Chairman of the Critical Care Committee. When deviations are made from assigned areas, the admitting clerk will correct these assignments at the earliest possible moment, in keeping with the transfer priorities set forth in these Rules and Regulations.

1.6 ADMISSION INFORMATION

Except in an emergency, a patient will not be admitted to the hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. Other required documentation or information specific to the type of admission involved is detailed in Section 1.3. The admitting practitioner is also responsible for providing the following information concerning a patient to be admitted: any source of communicable or significant infection; behavioral characteristics that would disturb or endanger others; need for protecting the patient from self-harm.

1.7 TIMELY VISITATIONS AFTER PATIENT ADMITTED

The attending practitioner or his designee (i.e. another member of the staff in good standing with the requisite privileges to care for the patient) must see the patient within the times frames provided below or within any shorter time frame if the patient's condition requires it:

(a) Patients designated as emergency cases and those admitted directly to or transferred into an intensive or critical care area from the admitting office, emergency department, or general care area -- ***within 4 hours***
(b) Patients admitted via the emergency department to a general care area -- ***within 12 to 24 hours*** **depending on the urgency.**
(c) Elective admissions ***-- within 24 hours***
(d) Patients accepted for transfer from outside facilities without being seen by the admitting physician at this facility must be evaluated by the emergency room physician or be seen by the admitting physician or his designee in the emergency room **prior to inpatient bed assignment.** (Added 4/97, rev 6/08)
(e) Patients in the Transitional Care Unit must be seen within forty-eight (48) hours of admission and at least every seven (7) days thereafter by the primary physician or his alternate (Added 12/03)
(f) All long term ventilator patients in the acute hospital must be seen daily by a physician with long term ventilator privileges (added 8/04)

1.8 DIAGNOSTIC TESTS REQUIRED UPON ADMISSION

There are no specific requirements. Please see Preoperative Testing Guidelines for recommendations on all patients.

1.9 ADMISSIONS FROM EMERGENCY ROOM WITHOUT PRIVATE PHYSICIAN

When a patient in the Emergency Service does not have a private physician and requires hospitalization, a member of the medical staff shall be assigned to the patient from the Emergency Service Consulting Panel. The Emergency Service Committee will select qualified individuals to serve on the Emergency Room Panel, as per the departmental rules and regulations and hospital policies.

1.10 PATIENTS WITH SUSPECTED SUICIDAL POTENTIAL, DRUG OR ALCOHOL DEPENDENCY, EMOTIONAL ILLNESS AND/OR PSYCHIATRIC DISORDERS

No patient with a known or suspected suicidal potential, drug dependency, emotional illness and/or psychiatric disorders shall be admitted to the hospital unless there is also a medical/surgical/obstetrical problem. Special nursing and monitoring shall be required in the care of these patients. Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff. Emergency Room patients presenting themselves in the same condition shall be referred for psychiatric evaluation.

Patients who develop suicidal potential, emotional illness, drug or alcohol withdrawal or psychiatric disorders while hospitalized should have a consultation by a member of the psychiatric/psychological staff. Appropriate services, whether available in the Hospital or requiring outside referral, shall be offered to such patients. Special nursing and monitoring shall be required in the care of these patients.

Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric/psychological staff. Emergency Room patients presenting themselves in the same condition shall be referred for psychiatric evaluation. (Rev 4/00)

PART TWO. ASSIGNMENT AND ATTENDANCE OF PATIENTS

2.1 ASSIGNMENT TO SERVICE

All patients are assigned to the service concerned with the treatment of the problem or disease which necessitated Admission.

2.2 ATTENDANCE OF PATIENTS

2.2-1 PRIVATE PATIENTS

Consistent with the conditions of Sections 2.2-3 below, each patient will be attended by the practitioner of his choice provided said practitioner is a member of the medical staff and has appropriate clinical privileges. When any patient is attended by two or more members of the staff, the name of each attending practitioner must be entered officially on the hospital records. A patient admission who has no personal practitioner may request any practitioner who is a member of the medical staff and who has appropriate clinical privileges. When no such request is made or when the requested practitioner chooses not to undertake the care of the patient, a member of the Medical Staff with the requisite privileges will be assigned to the patient according to the E.R. panel schedule applicable to the appropriate department. (Rev. 8/97)

2.3 PARTICIPATION IN THE E.R. PANEL ROSTER

Unless specifically exempted by the medical executive committee and the Board for good cause shown, each member of the *medical* staff agrees that, when he is the designated practitioner on call, he will accept responsibility during the time specified by the published schedule for providing care to any patient in any unit of the hospital referred to the service for which he is providing on-call coverage. If there is a conflict with the published schedule, it is the staff member's responsibility to notify the applicable department chairman and the emergency room director at least 72 hours prior to the scheduled rotation. In cases where a patient's diagnosis is uncertain, or crosses specialty lines, the ER physician will have ultimate authority in deciding which specialty should respond in-person to examine the patient in the ER. (Added 12/03)

PART THREE. GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

3.1 GENERALLY

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of those portions of the medical record for which he is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is effected pursuant to Section 3.2.

3.2 TRANSFER OF RESPONSIBILITY

When the primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff members, a note covering the transfer of responsibility and acceptance of the same must be entered on the order sheet and progress notes.

3.3 ALTERNATE COVERAGE

Each practitioner must assure timely, adequate professional care for his patients in the hospital by being available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this hospital to care for the patient. Each member of the staff who will be out of town or unavailable in case of emergency must indicate in writing on the order sheet the name of the practitioner who will be assuming responsibility for the care of the patient during his absence. In the absence of such designation, the chief executive officer, the Chief of Staff or the applicable department chairman has the authority to call any member of the staff with the requisite clinical privileges. Failure of an attending practitioner to meet those requirements may result in disciplinary action as the medical executive committee deems appropriate. (Rev. 8/00)

3.4 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has any reason to doubt or question the care provided to that patient or feels that appropriate consultation is needed and has not been obtained, such individual shall bring the matter to the attention of the individual's supervisor who, in turn, may refer the matter to the chairman of the department wherein the practitioner has clinical privileges or to the Chief of Staff. Where circumstances are such as to justify such action, the department chairman or Chief of Staff may request a consultation. (Rev. 8/00)

3.5 CONSULTATIONS

3.5-1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for calling a consultation from a qualified staff member when indicated or required pursuant to the guidelines in Section 3.5-2 below. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

When a consultation is required under these Rules or when the best interest of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable department chairman; the physician director of a special unit; or the Chief of Staff. If the attending practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the Chief of Staff or the applicable department chairman for final decision and direction. (Rev. 8/00)

3.5-2 GUIDELINES FOR CALLING CONSULTATIONS

Unless the attending practitioner's expertise is in the area of the patient's problem, consultation with a qualified physician is required in the following cases:

(a) When these Rules or the policies of any clinical unit, including any intensive or special care units, of the staff require it.
(b) When the patient is under two (2) years of age.
(c) When the patient requires mechanical ventilation.
(d) Problems of critical illness in which any significant question exists of appropriate procedure or therapy.
(e) When the patient is not a good risk for operation or treatment.
(f) Cases of difficult or equivocal diagnosis or therapy.
(g) When required by state law.
(h) When requested by the patient or family.
(i) ICU - A cardiology consult is required for complicated MI's within one hour of recognition of the complication. (Added 4/93, rev 1/97, rev 5/99)

3.5-3 QUALIFICATIONS OF CONSULTANT

Any qualified practitioner may be called as a consultant regardless of his staff category assignment. A consultant must be a recognized specialist in the applicable area as evidenced by certification by the appropriate specialty or subspecialty board or by a comparable degree of competence based on equivalent training and extensive experience. In either case, a consultant must have demonstrated the skill and judgment requisite to evaluation and treatment of the condition or problem presented and have been granted the appropriate level of clinical privileges.

3.5-4 CONSULTATION PROCEDURE

Physicians are responsible for obtaining necessary consultations in a timely manner, consistent with good medical care, and the Rules & Regulations of the Department involved.

Emergent and urgent consultations must be called personally by the Physician. All other consultations may be called by the R.N. in charge of the case. (Rev. 8/00)

3.5-5 DOCUMENTATION

(a) Consultation Request: When requesting consultation, the attending practitioner should indicate in writing in the record the reason for the request.

(b) Clinical Consultant's Report: The clinical consultant must make and sign a report of his findings, opinions and recommendations that reflects an actual examination of the patient and the medical record. Such report shall become part of the patient's medical record.

(c) Attending Practitioner's Response to Consultant's Opinion: In cases of elective consultation when the attending practitioner elects not to follow the advice of the consultant, he shall either seek the opinion of a second consultant or record in the progress notes his reasons for electing not to follow the consultant's advice. In cases of required consultation when the attending practitioner does not agree with the consultant, he shall either seek the opinion of a second consultant or refer the matter to the applicable department chairman for final advice. If the attending practitioner obtains the opinion of a second consultant and does not agree with it either, he shall again refer the matter to the applicable department chairman.

3.5-6 RESPONSE TIME/TIMELY VISITATION

Response and visitation of the patient for a consultation shall not exceed a maximum of 24 hours.

PART FOUR. TRANSFER OF PATIENTS

4.1 INTERNAL TRANSFER

Internal patient transfer priorities are as follows:

(a) Emergency patient to an available and appropriate patient bed
(b) From obstetric patient care area to general care area
(c From critical and cardiac care units to any general care room
(d) From DOU unit to any general care room
(e) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

4.2 TRANSFER TO ANOTHER FACILITY

4.2-1 GENERAL REQUIREMENTS

A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for

transport. All pertinent medical information necessary to insure continuity of care must accompany the patient, including a transfer summary which includes all necessary information to assure assumption of care by the receiving physician. (Revised 4/92)

4.2-2 DEMAND BY EMERGENCY OR CRITICALLY ILL PATIENT

A transfer demanded by an emergency or critically ill patient or his family or significant other (SO) is not permitted until a physician has explained to the patient or his family or SO the seriousness of the condition and generally not until a physician has determined that the condition is sufficiently stabilized for safe transport. In each such case, the appropriate release form is to be executed. If the patient or agent refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

PART FIVE. DISCHARGE OF PATIENTS

5.1 REQUIRED ORDER

A patient may be discharged only on the order of the attending practitioner or his designee. The attending practitioner is responsible for documenting the principal diagnosis, secondary diagnoses, co-morbidities, complications, principal procedures, and additional procedures on the front sheet of the patient's medical record within 14 days of discharge. (See Section 6.7-1 of these Rules)

The physician ordering the discharge of a patient is responsible for the appropriate follow-up instructions and prescriptions given to the patient. The nursing staff shall assist the physician in the task of preparing the written discharge instructions, which will be given to the patient. The physician must communicate with the nursing staff as to his/her plans and instructions for discharge medications, follow-up laboratory tests, follow-up visits, and any other specific instructions. These will be summarized by the nursing staff and given to the patient in writing, at time of discharge.(Added 12/98)

5.2 TIME OF DISCHARGE

The attending practitioner is responsible for discharging his patients in a timely manner consistent with good medical practice. Patient's awaiting special diagnostic reports on work completed the preceding day shall be discharged after tests ordered are completed. The attending physician is encouraged to indicate the tentative discharge date for the purpose of discharge planning. (Rev. 8/97, 12/97)

5.3 LEAVING AGAINST MEDICAL ADVICE

If a patient desires to leave the hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident must be made in the patient's medical record. The attending practitioner should document that the risks and potential consequences of leaving against medical advice have been discussed with the patient and that the patient is competent to understand those risks as explained.

5.4 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or other responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record.

5.5 TRIAGE (Added 3/02)

In the event of clinical services overflow (unmanageable patient demand), the following empowered triage physicians may speed patients along the continuum of care in the following areas if the attending physicians are

unable to assist:

a. Emergency Department: Emergency Medicine Director or designee;
b. ICU: Critical Care Director or designee;
c. Operating Room: Chairperson of Surgery or designee;
d. Subacute/TCU: Medical Director or designee;
e. Non-ICU medical floors or medical patients: Chairperson of Medicine or designee;
f. Non-ICU surgical floors or surgical patients: Chairperson of Surgery or designee;
g. OB/L&D: Chairperson of Ob/Gyn or designee;
h. Pediatrics: Chairperson of Pediatrics or designee.

If any of the above are unavailable, Chief of Staff or designee; Medical Staff Officer or designee; Medical Administrator; Chief Medical Officer or Hospital Administrator or designee, in that order, may assume the function.

PART SIX. ORDERS

6.1 GENERAL REQUIREMENTS

All orders for treatment or diagnostic tests must be written clearly, legibly and completely and signed by the practitioner responsible for them. Printed name must accompany each signature. Orders which are illegible or improperly written will not be carried out until rewritten. Orders for diagnostic tests which necessitate the administration of test substances or medications will be considered to include the order for this administration. (Rev 4/00, 12/01)

6.2 STANDING ORDERS

Standing orders for any department or other clinical unit may be formulated by the department chairman or the physician director of the unit in consultation with the Pharmacy & Therapeutics Committee, the nursing service, and the appropriate representatives of administration, subject to approval by the appropriate department. Additional standing orders may be formulated by a member of the medical staff, subject to the approval of the applicable department, and the Pharmacy & Therapeutics Committee. All standing orders shall be listed on an "Instructions and Orders" sheet that must be included in the patient's medical record and signed and dated by the attending practitioner. Standing orders shall be considered as a specific order by the attending practitioner for that patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow. All standing orders must be reviewed at least annually and revised as necessary.

6.3 VERBAL ORDERS

6.3-1 BY WHOM AND CIRCUMSTANCE

Telephone or other verbal orders may be taken only by a practitioner, registered nurse, or a licensed vocational nurse, except that the following personnel, if approved in accordance with hospital policy, may take verbal orders for treatment and/or procedures within their respective areas of practice and which they will prepare, deliver, or perform: *registered pharmacists, LVNs within their scope of practice, respiratory care practitioners within their scope of practice, physical therapist, laboratory technician, radiology technician, certified registered nurse anesthetist, occupational therapist, speech pathologist, certified social worker, dietician and clinical perfusionist.* Telephone orders for medications may only be taken by physicians, registered nurses, respiratory care practitioners or registered pharmacists. They will be accepted only from the responsible practitioner and when it is not practical for the order to be given in writing. Telephone or verbal orders for chemotherapy are not allowed. (Rev. 4/97; Rev. 8/97; Rev. 12/97; Rev. 1/01; Rev. 12/01; Rev. 6/03; Rev. 5/04)

6.3-2 DOCUMENTATION

All verbal orders shall be transcribed in the proper place in the medical record, shall include the date, name and signature of the person transcribing the order and the name of the physician, and shall be authenticated as per section 7.8. Some specific requirements are:

Restraint orders	twenty-four (24) hours
Do not resuscitate orders	twenty-four (24) hours
Medication orders	forty-eight (48) hours. (Revised 7/96; 10/96; 4/97; 8/97)

6.3-3 VERIFICATION OF ORDERS

All telephone or verbal orders must be read back to the physician by the approved provider/practitioner taking the order. (Added 7/92; 4/03)

6.4 ORDERS BY ALLIED HEALTH PROFESSIONALS

An allied health professional (AHP) may write orders only to the extent, if any, specified in the position description developed for that category of AHPs and consistent with the scope of services individually defined for him. Any authorized order by an AHP must be countersigned by the responsible supervising practitioner within the time frame required in said position description or defined scope of services and, in all circumstances, within 14 days. Exceptions will be:

Restraint orders	twenty-four (24) hours
Do not resuscitate	twenty-four (24) hours
Medication orders	forty-eight (48) hours. (Rev 6/05)

6.5 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically discontinued, unless a specific order is written otherwise, when the patient goes to surgery or is transferred to another service or another level of service. The medical record shall be flagged to indicate this has occurred and a listing of the discontinued orders shall be attached thereto. The attending practitioner must indicate each order to be reinstituted in writing. (Rev. 4/96)

6.6 STOP ORDERS

6.6-1 DRUGS/LAB TESTS/TREATMENT COVERED AND MAXIMUM DURATION

When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified. When that has not been done, a stop order will be placed automatically at the terminal date and time. In implementing the stop order, nursing/pharmacy/respiratory therapy will calculate the maximum duration permissible so as to cover the total number of hours indicated. In no event shall the drug or treatment be given for the maximum duration permissible if the last effective order specifies a shorter interval or particular dosage.

A) DRUG/TREATMENT CATEGORY	MAXIMUM DURATION FOR ADULT AND PEDIATRICS
- Respiratory therapy medication orders	3 days
- Antibiotics	10 days
- Narcotics	72 hours
- Narcotic and sedatives in the Transitional Care Unit (excluding phenobarbital which is being used as seizure therapy) (Rev. 6/03)	14 days

6.6-2 EXCEPTIONS

Exceptions to the stop order rule are made under the following conditions:
(a) The last effective order indicated an exact number of doses to be administered;
(b) The last effective order specifies an exact period of time for the medication; or
(c) The prescribing practitioner re-orders the medication or treatment.
(d) Narcotics for oncology patients.(Added 6/03)

6.6-3 NOTIFICATION OF STOP

The applicable unit (nursing/pharmacy/respiratory therapy) notifies the prescribing practitioner within 12-36 hours before an order is automatically stopped.

6.7 SPECIAL ORDERS

6.7-1 PATIENT'S OWN DRUGS AND SELF-ADMINISTRATION

Drugs (including over-the-counter medications, prescribed medications or holistic preparations) brought into the hospital by a patient, or any other outside source or person, may not be administered unless the drugs have been identified and there is a written order from the attending practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner and in accordance with established hospital policy. (Rev. 5/99)

6.7-2 ORDERS TO WITHDRAW OR TO WITHHOLD LIFE-SUSTAINING TREATMENT

(a) Documentation and Charting:
1) The attending physician or designated consultant(s) is expected to document the DNR status of all adult medical/surgical patients upon admission. If a patient's DNR status has not been documented within seventy-two (72) hours of admission, the attending physician will be asked by the nursing staff to determine the code status. Telephone calls to physicians regarding DNR status should occur only during normal office hours if the DNR status has not been documented within seventy-two hours of admission. (Added 12/03)
2) All orders to withhold or withdraw life-sustaining treatment must be written and signed by the physician on the physician order sheet in the patient's medical record. In addition, the physician must verbally inform the nursing staff that such an order has been given to assure that the order is known and understood at the time that it is written.
3) The order or decision to withhold or withdraw life-sustaining treatment must be supported by documentation in the progress notes of the circumstances surrounding the decision and a statement summarizing the outcome of consultations with the patient, parent, guardian, attorney-in-fact, conservator, family, and/or significant others.
4) An order or decision to withhold or withdraw life support must contain a statement indicating the basis upon which a particular person or persons have been identified as appropriate surrogate decision maker(s) for the patient.

(b) Prior Notice Required (Minors, Incompetent Patients, etc.):
In cases involving minors, incompetent patients, or other unusual situations, designated hospital administration shall be notified before an order to withhold or withdraw treatment is issued.

(c) Periodic Review:

All decisions to withhold or withdraw life-sustaining treatment must be reviewed periodically, as medically indicated, and whenever a change in the patient's condition warrants review. All reviews must be documented in the patient's chart.

6.7-3 GUIDELINES FOR "DO NOT RESUSCITATE ORDERS"

(a) Do Not Resuscitate Orders:
A do not resuscitate (DNR) order is a written order which states that in the event of a respiratory or cardiac arrest, no cardiopulmonary resuscitation (closed chest cardiac massage and Ambu bag or mouth-to-mouth ventilation), endotracheal intubation, precordial thump or DC cardioversion (defibrillation) will be initiated. No Code (NC), No Cardiopulmonary Resuscitation (No CPR) and Do Not Resuscitate (DNR) all mean the same for the purpose of these rules and regulations.

(b) General Policy Applicable:
The policy stated in section 6.7-2 above is fully applicable to DNR orders. This section identifies certain additional considerations specifically applicable to such orders.

(c) Special DNR Considerations:
The following rules apply specifically to DNR orders:

1) Patients who suffer cardiac or pulmonary arrest shall receive full cardiopulmonary resuscitation unless DNR orders or other orders specifying limited resuscitative methods have been written in the patient's chart.
2) No code does not mean no care. Patients for whom a DNR order has been written, shall continue to receive care to maintain their comfort, spiritual welfare and hygiene, including for example basic nursing care, analgesics, suction, hydration/nutrition and oxygen.
3) With regard to patients who have DNR orders that are scheduled for a surgical procedure, a conference should be conducted prior to surgery with the attending physician and/or surgeon, anesthesiologist, patient and/or family/surrogate to determine how to handle emergencies. (Rev. 8/97)

6.7-4 RESTRAINT ORDERS

Orders for restraints may be verbal or written by the physician and must be in accordance with the hospital policy on restraints.(Added 4/97)

6.8 FORMULARY AND INVESTIGATIONAL DRUGS

6.8-1 FORMULARY

The hospital formulary lists drugs available for ordering from stock. Each member of the medical staff assents to the use of the formulary as approved by the medical executive committee. All drugs and medications administered to patients, with the exception of the drugs for bonafide clinical investigations, shall be those listed in the latest edition: United States Pharmacopoeia; National Formulary, New and Non-Official Drugs; American Hospital Formulary Service; or AMA Drug Evaluations.

6.8-2 INVESTIGATIONAL DRUGS

Use of investigational drugs must be in full accordance with all Regulations of the Food and Drug Administration and must be approved by the Institutional Review Board and Medical Executive Committee. Investigational drugs shall be used only under the direct supervision of the principal investigator. The principal investigator shall be responsible for receiving all necessary consents and completing all necessary forms and shall prepare and clarify directions for the administration of investigational drugs as to (1) untoward symptoms, (2) special precautions in administration, (3) proper labeling of the container, (4) proper storage of drug, (5) methods of recording doses when indicated, and (6) method of collection and recording specimens of urine and/or other specimens.

PART SEVEN. INPATIENT MEDICAL RECORDS

7.1 REQUIRED CONTENT

The attending practitioner and other medical staff members as applicable shall be responsible for the preparation of a complete and legible medical record for each patient. The record's content shall be pertinent, accurate, legible, timely and current. The record shall include:

(a) Identification data
(b) Personal and family medical histories
(c) Description and history of present complaint and/or illness
(d) Physical examination report
(e) Diagnostic and therapeutic orders
(f) Evidence of appropriate informed consent
(g) Treatment provided
(h) Progress notes and other clinical observations, including results of therapy
(I) Special reports, when applicable (such as, clinical laboratory, radiology radiotherapy, EEG, EKG, consultation, pre- and post- anesthesia, operative and other diagnostic and therapeutic procedures, etc)
(j) Pathological findings
(k) Final diagnosis without the use of symbols or abbreviations
(l) Condition on discharge, including instructions, if any, to the patient or significant other on post-hospital care
(m) Autopsy report, when available.

7.2 HISTORY AND PHYSICAL EXAMINATION (See Medical Staff Bylaws)

7.3 PREOPERATIVE DOCUMENTATION

7.3-1 HISTORY AND PHYSICAL EXAMINATION (See Medical Staff Bylaws)

7.3-2 LABORATORY TESTS

Appropriate advance lab tests must be performed within one week prior to admission for elective surgery and for outpatient or same day surgery and the results in the chart prior to induction of anesthesia.

7.3-3 PREOPERATIVE ANESTHESIA EVALUATION

The anesthesiologist (or other licensed independent professional responsible for the patient's anesthesia care) should conduct and document in the record a preanesthesia evaluation of the patient including pertinent information relative to the choice of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for preop medication. Except in cases of emergency, this evaluation should be recorded before preoperative medication has been administered. (Rev. 4/96)

7.4 PROGRESS NOTES

7.4-1 GENERALLY

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending practitioner must be written at least daily on acutely and critically ill patients and on those where there is difficulty in diagnosis or management of the clinical problem.

7.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

7.5-1 OPERATIVE AND SPECIAL PROCEDURE REPORTS

Operative and special procedure reports must be dictated by the primary performing practitioner and (rev. 12/96) must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants.

The practitioner must enter a summary operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use by any practitioner who is required to attend the patient.

The operative and special procedure reports **must be dictated** by the primary performing practitioner and must contain, as applicable, the following:

1. Name and hospital identification number of the patient,
2. Date and times of the surgery,
3. Pre-operative diagnosis,
4. Postoperative diagnosis,
5. Name of the procedure performed,
6. Name of the attending surgeon, the primary surgeon, any assistants,
7. Type of anesthesia administered,
8. Indication for the procedure,
9. Technical procedure used,
10. Operative findings,
11. Any Complications,
12. Any specimens/tissues removed, and
13. Any estimated blood loss.

The complete report must be dictated within 24 hours following the procedure and filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner.(Rev. 12/97, 12/08, 02/12)

7.5-2 TISSUE EXAMINATION AND REPORTS

All tissues, foreign bodies, artifacts and prostheses removed during a procedure except those specifically excluded by policy of the medical executive committee as defined in the Departmental Rules & Regulations, shall be properly labeled, packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

7.6 OBSTETRICAL RECORD

The current obstetrical record must include a complete prenatal record. The prenatal record may be a durable, legible copy of the attending practitioner's office or clinic record transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. All obstetrical patients undergoing surgery must have a history and physical examination recorded as required under Sections 7.2 and 7.3 of these Rules and Regulations.

7.7 DISCHARGE OR DEATH SUMMARY

(a) In General: The discharge or death summary concisely recapitulates the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent. Consideration is given to instructions relating to physical activity, medication, diet and follow-up care which is documented in the physician or nursing discharge summary. (Revised 07/96)

(b) Exceptions: A final progress note may be substituted for the discharge summary in the case of the following categories of patients:
(1) those with problems of a minor nature who require less than 48 hours of hospitalization;
(2) normal newborn infants;
(3) patients having uncomplicated vaginal deliveries;
(4) patients who are noted to be dead on arrival in the Emergency Department. (Rev. 7/96)

7.8 AUTHENTICATION

All clinical entries in the patient's record must be accurately dated and individually authenticated. Authentication means to establish authorship by written signature or computer key. The use of rubber stamp signatures is acceptable only under the following conditions: (Rev 4/20/93; 10/9/96)

(a) The practitioner whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who uses it, and
(b) The practitioner has provided the administration with a signed statement to the effect that he is the only one that has the stamp and is the only one who will use it.

The following areas of the medical record require the responsible practitioner's signature:
(a) Face sheet
(b) Admission progress notes and orders
(c History and physical examination
(d) Immediate pre-operative and post-operative progress note
(e) All operative or special procedure reports
(f) Discharge summary
(g) Narcotic orders and all other clinical entries, diagnoses, orders, reports and progress notes written by him.(Rev. 8/97)

7.9 USE OF SYMBOLS AND ABBREVIATIONS

7.9-1 GENERAL USE

Symbols and abbreviations may be used only when they have been approved by the Medical Record Committee and Medical Executive Committee. An official record of approved symbols and abbreviations is available in the nursing office and in the medical records department.

7.9-2 MEDICATION ORDERS

Abbreviations of the names of medications may not be used within medication orders (exception: abbreviations for recognized chemical symbols). (Added 7/92)

7.10 FILING

No medical record shall be filed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Medical Executive Committee, upon recommendation of the Medical Records committee shall consider the circumstances and may enter such reasons in the record and order it filed.

7.11 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including x-ray films, pathological specimens and slides, are the property of the hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the chief executive officer. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization. Unauthorized removal of a medical record or any portion thereof from the hospital is grounds for such disciplinary action, including immediate and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the medical staff and board.

7.12 ACCESS TO RECORDS

7.12-1 BY PATIENT

A patient may, upon written request, have access to the patient's medical record or summary (which must include information as specified by the statute).

7.12-2 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

Patient medical records shall be made available to authorized hospital personnel, medical staff members or others with an official, hospital-approved interest for the following purposes:
(a) Automated data processing of designated information
(b) Activities concerned with assessing the quality, appropriateness and efficiency of patient care
(c) Clinical unit/support service review of work performance
(d) Official surveys for hospital compliance with accreditation, regulatory and licensing standards
(e) Approved educational programs and research studies.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

7.12-3 ON READMISSION

In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner.

7.12-4 TO FORMER MEDICAL STAFF MEMBERS

Subject to the discretion of the chief executive officer, former members of the medical staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the hospital.

7.12-5 PATIENT CONSENT REQUIRED UNDER OTHER CIRCUMSTANCES

Written consent of the patient or his legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 7.12 or by law to receive this information.

7.13 SUSPENSION FOR DELINQUENT MEDICAL RECORDS

All medical records shall be completed within 14 days of discharge. If medical records have not been completed by then, suspension per Bylaws Article 8.3-5 will be imposed. In addition, if history and physical examinations are not dictated within 24 hours of admission, suspension per Bylaws Article 8.3-5 will also be imposed immediately (not after 14 days). If operative, non-invasive, invasive procedure notes are not completed immediately following the procedure, suspension per Bylaws Article 8.3-5 will be imposed immediately (not after 14 days). Failure to

complete TNM Staging form is considered a deficiency. (Rev. 12/97; 12/98; 8/00)

Any member of the Medical Staff accumulating **10 suspension days for delinquent History & Physical** and/or **operative, non-invasive, invasive procedure notes within a 12 month** period the following process will apply:

First Occurrence	$250.00 penalty
Second Occurrence	$500.00 penalty
Third Occurrence	$1,000.00 penalty (the penalty doubles with each occurrence thereafter)

Suspension days will accrue until the records are complete and the payment is received. (Added 5/04)

7.13-1 DELINQUENT MEDICAL RECORDS - REAPPOINTMENT: (Added 4/95)

If it is determined while undergoing the reappointment process, that a member of the Medical Staff has accumulated sixty (60) suspension days, thirty (30) history and physical examinations not dictated within twenty-four (24) hours, or thirty (30) operative notes not dictated immediately in any one (1) year during the reappointment cycle, the following process shall occur. (Rev. 12/97)

A. FIRST OCCURRENCE:

The practitioner's term of reappointment shall be limited to one (1) year.

B. SECOND OCCURRENCE:

If, at the end of the one (1) year reappointment term, it is determined that the practitioner has accumulated thirty (30) suspension days in any one (1) year during the reappointment cycle, the following process shall apply:

1. The practitioner shall be reappointment for an additional year; however, clinical privileges will be suspended until all medical records are completed. Exception: Medical Staff Bylaws, Article VIII, Section 8.3-5;

2. A contract for medical record completion must be entered into between the practitioner and the Medical Staff.

3. When a contract has been in effect as part of a practitioner's past medical record completion performance, **any further accumulation of thirty (30) suspension days,** whether intermittent or cumulative, shall be deemed as voluntary resignation from the Medical Staff, effective immediately. This shall apply for a period of two years. The practitioner shall not be eligible for membership or privileges for a period of 30 days from the time of voluntary resignation.(Rev. 6/97; 8/00; 4/02) The reapplication fee is as follows:

1st occurrence application fee is	$1,000.00
2nd occurrence application fee is	$5,000.00
3rd occurrence application fee is	$10,000.00 and an additional $5000.00 for each occurrence thereafter.

The practitioner is not eligible for Temporary Privileges pending the application process. (Add 6/03)

Medical records which are deemed delinquent of substantive documentation (i.e., operative reports, history and physical examination reports, etc.) and signatures shall be the basis for the process outlined above.

7.13-2 SUSPENSION OF PRIVILEGES

While a physician is on suspension, all clinical privileges (except those required by the Medical Staff Bylaws Section 8.3-5) are suspended. Only extreme circumstances preventing completion of records will be considered an exception on appeal to the Department Chair.(Added 4/97, Rev 6/00)

7.13-3 NOTIFICATION OF PHYSICIAN

While on suspension, a physician shall receive weekly notification calls from the Medical Records Department. The physician shall receive monthly calls from the Medical Director or his designee. The physician shall receive a registered letter notification at 20 days and at least one week prior to his 60 day termination. (Added 4/97; Rev 1/05)

7.14 REHAB ADMISSION/DISCHARGE DOCUMENTATION REQUIREMENTS

In order to allow for the efficient discharge and readmission of an inpatient to/from the medical/surgical unit to/from the Rehabilitation Unit, the following medical record requirements will apply:

a) The discharge of a patient who is readmitted as noted above requires a pertinent discharge summary as outlined in Section 7.7 Discharge Summary.

For a patient discharged from the medical/surgical unit who is readmitted to the Rehabilitation Center, the following requirements will apply:

a) The admission history and physical of the original admission will suffice for the related readmission, so long as the following additional information is written or dictated within 24 hours:
   1) Reason for the readmission
   2) Pertinent history and physical findings are updated
   3) Treatment plan
   4) New pertinent diagnosis for the readmission

For a patient discharged from the Rehabilitation Center who is readmitted to the medical/surgical unit, the following requirements will apply:

a) A new admission history and physical examination report must be written or dictated. (Added 4/16/91)

PART EIGHT. CONSENTS (Rev. 8/97)

8.1 **GENERAL**

Each patient's medical record must contain evidence of the patient's or his legal representative's general consent for treatment during hospitalization. More importantly, the physician has a special obligation to obtain informed consent. Hospital personnel should not be involved in providing the information to secure this consent. In recognition of this, the informed consent is signed by the physician.

8.2 INFORMED CONSENT

8.2-1 WHEN REQUIRED

Informed consent must contain:
(a) the nature of the procedure;
(b) the risks, complications, and expected benefits or effects of the procedure; and,
(c) any alternatives to the treatment and their risks and benefits.

It is required for all medical treatments or procedures which the Medical Staff defines as "complex". The following is a list of those identified for which informed consent is required:

(a) surgical and other invasive and special procedures;
(b) use of experimental drugs;
(c) anesthesia and moderate or deep sedation (Rev. 12/03)
(d) blood and blood products.

8.2-2 DOCUMENTATION REQUIRED

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

(a) Patient identity
(b) Date when patient informed and date when patient signed the form, if different
(c) Nature of the procedure or treatment proposed to be rendered
(d) Name(s) of the individual(s) who will perform the procedure or administer the treatment
(e) Indication that the risks and complications of the procedure or treatment and of the alternatives available, if any, and the risks of foregoing the proposed or alternative procedures or treatments have been explained to the patient, or the patient's legal representative, with sufficiency and in terms that a patient would reasonably consider material to the decision whether or not to undergo the procedure or treatment
(f) Name of the practitioner who informs the patient and obtains the consent.

8.2-3 SIGNATURES

Informed consent is signed by the physician as evidence that the patient has been given the required information. This may be documented on the appropriate form or in the progress notes.

8.2-4 SPECIAL CIRCUMSTANCES IN WHICH A PHYSICIAN IS NOT REQUIRED TO OBTAIN FULL INFORMED CONSENT

(a) Emergency treatment for alleviation of severe pain or to prevent serious disability or death. It is important to note that only the emergency condition may be treated. It is recommended that the rationales are clearly documented in the medical record.

(b) Refusal to receive informed consent. The physician need not disclose the risks of the recommended treatment when the patient has requested that he or she not be so informed. Again, full documentation in the medical record of the rationales for this decision are required.

(c) Harm to the patient. The physician is not required to disclose information to the patient if such disclosure would seriously harm, rather than benefit the patient.

8.2-5 DURATION OF INFORMED CONSENT

Informed consent may be considered to have continuing force and effect until the patient revokes the consent or until circumstances change so as to materially affect the nature of, or the risks of, the procedure and/or the alternatives to the procedure to which the patient consent.

PART NINE. SPECIAL SERVICES UNITS AND PROGRAMS

9.1 DESIGNATION

Special services units and programs include, but are not limited to the following:

(a) Intensive care units of all types (ICUs, CCUs, etc).
(b) DOU
(c Emergency Room
(d) Operating Room
(e) Post Anesthesia Care Unit
(f) Labor and Delivery

(g) Newborn nurseries
(h) Day-Surgery Program
(I) Outpatient Department
(j) Home Care program.
(k) Skilled Nursing Facility (Villa)

9.2 POLICIES

Appropriate officers, committees, and representatives of the medical staff and its departments will develop, in coordination with applicable hospital departments, specific policies for the special services units and programs, covering, when applicable, such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, consultation requirements, admission/discharge/transfer protocols, direction/organization of the unit/program, authority of the physician director of the unit/program, special record-keeping requirements, scheduling of patients, etc. These policies are subject to the approval of the Medical Executive Committee and the Chief Executive Officer.

PART TEN. CRITICAL CARE PAVILION

10.1 MEDICAL DIRECTOR

The administrative responsibility for the medical care rendered in the Critical Care Pavilion has been assigned by the Medical Executive Committee to the Medical and/or Surgical Director of Critical Care. In his/her absence, the Director shall designate a qualified physician to be available to make administrative and consultative decisions.

The Directors are responsible for implementing policies established by the Medical Staff for the continuing operation of the Critical Care Pavilion. These include:

- Making decisions, in consultation with the physician responsible for the patient for the disposition of a patient when patient load exceeds optimal operational capacity;

- Assuring the quality, safety, and appropriateness of patient care services provided within the Pavilion are monitored and evaluated on a regular basis and that appropriate actions are taken.

10.2 RESPONSIBILITY FOR SEEING PATIENTS UPON ADMISSION TO THE CRITICAL CARE PAVILION

The Medical Staff has established the following policy requiring that attending physicians visit and examine patients admitted to the Pavilion as follows:

1) Immediately prior to admission; OR
2) Within four hours following admission; OR
3) Sooner at the request of the supervising nurse in the Pavilion.

10.3 EMERGENCY CARE

In the event that a patient in the Pavilion develops a potentially life-threatening situation and the attending physician, or a consultant involved in the care, cannot be reached, the Director of Critical Care in Medicine and/or Surgery, as appropriate, will be called for emergency management of the patient. In the event that a patient develops an imminently life-threatening situation, and the patient's attending physician, or a consultant involved in the care, or the appropriate Medical Director is not immediately available, the physician on duty in the Emergency Services Department will be called to provide emergency medical management.

10.4 ROLE OF THE ATTENDING PHYSICIAN

Members of the Providence Holy Cross Medical Center Medical Staff shall maintain individual responsibility for the management of their patients admitted to the Critical Care Pavilion. The attending physician is the designated admitting physician, or the "physician-in-charge" whose name has been entered on the face sheet of the patient's chart. The attending physician may arrange for the transfer of the patient's medical care to another appropriate physician, or to a consultant, and such transfer of care shall be written as a physician order and/or documented in the physician's progress notes in the patient's chart. The physician accepting care of the patient must document his acceptance in the MD progress notes or via telephone order, if necessary.

The attending physician is responsible for patient management and the coordination of care provided by consultants and paramedical personnel for each of his/her patients admitted to the Critical Care Pavilion. Depending on the circumstances of the case, the attending physician or consulting cardiologist will be designated to coordinate cardiac care. (Added 4/93)

10.5 ATTENDING PHYSICIAN ADMITTING AND/OR TRANSFER ORDERS

Whenever a patient is admitted to, or transferred from the Critical Care Pavilion, all physician orders must be signed by the 'physician-in-charge' or his/her designee. (Added 4/93)

10.6 CONSULTATION POLICY (Rev. 1/97)

Appropriate Specialty consultation may be requested by the admitting physician in conjunction with intensivist. Response time by consultant will be determined by the urgency of the problem. Medical Director of ICU, or the supervising nurse of ICU may request emergency consultations as needed.

For patients with Acute Myocardial Infarction, or suspected AMI, the code AMI policy will guide the response time and follow-up care. (see PHC-CCP-C05.5.5, 10/06/2014)

10.6-1 Critical Care Consultation

All patients admitted to the Critical Care Unit will get a consultation by an Intensivist Specialist. The Intensivist will have oversight for all patients in the intensive care unit, including decisions regarding the admission or discharge to or from the intensive care unit and management of the patients while in the ICU. A collaborative team approach to management of these patients will be fostered between the intensivist group and the attending/consulting physicians.

PART ELEVEN. EMERGENCY SERVICES

11.1 EMERGENCY SERVICE COVERAGE

The medical staff shall adopt a method of providing medical coverage in the emergency services department. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care. Only members of the medical staff may render care in the department.

Each clinical department of the medical staff may establish requirements for participation on the Emergency Room Consulting Panel subject to the approval of the Medical Executive Committee.

11.2 MEDICAL SCREENING EXAMINATIONS

An appropriate medical screening examination within the capability of the emergency department and Maternal Child Health department (including routinely available ancillary services) shall be provided to all individuals who come to the emergency service department and request (or on whose behalf a request is made for) examination or treatment. Such medical screening shall be provided by qualified medical persons. For the purposes of this medical screening examination, qualified medical persons includes qualified physician members of the Medical Staff, and, within the limits established by the Governing Body, the Medical Staff and the applicable State Practice Acts, including the scope of their licensure, certification, education and experience, physician assistants, nurse

practitioners, registered nurse midwives, or registered nurses functioning under standardized procedures. (11/95; rev 12/95; rev 4/97)

11.3 DUTIES AND RESPONSIBILITIES OF ER PERSONNEL

The duties and responsibilities of all personnel serving patients within the emergency service department shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multispecialty committee of the Medical Staff, including representatives from nursing services and hospital administration. It shall be approved by the Medical Staff and by the governing body.

11.4 EMERGENCY SERVICES COMMITTEE

The committee for Emergency Services shall be composed of representatives from all major specialties and from the professional physicians groups.

11.5 MEDICAL RECORD DOCUMENTATION

An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:

a) Adequate patient identification;
b) Information concerning the time of the patient's arrival, means of arrival, and by whom transported;
c) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital;
d) Description of significant clinical, laboratory, and radiological findings;
e) Diagnosis;
f) Treatment given;
g) Condition of the patient on discharge or transfer; and
h) Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.

11.6 MONITORING & EVALUATION OF CARE

There shall be a review of emergency room medical records by the Emergency Service Committee to evaluate quality of emergency medical care. Reports shall be submitted to the Medical Executive Committee.

11.7 DISASTER PLANNING

There shall be a plan for the care of mass casualties at the time of any major disaster upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a disaster planning committee which includes at least one (1) member of the Medical Staff, the Director of Nursing services or her designee, and a representative from hospital administration. The plan shall be approved by the Medical Staff and governing body and be appended to this document.

PART TWELVE. HOSPITAL DEATHS AND AUTOPSIES

12.1 HOSPITAL DEATHS

12.1-1 Pronouncement

In the event of a hospital death, the deceased shall be pronounced dead by the attending physician or his

designee within a reasonable period of time.

12.1-2 Reportable Deaths

Reporting of deaths to the Medical Examiner's Office shall be carried out when required by and in conformance with local law.

12.1-3 Death Certificate

The death certificate must be signed by the attending physician unless the death is a Medical Examiner's case in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician issues the death certificate.

12.1-4 Release of Body

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the medical staff. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law.

12.2 AUTOPSIES

It is the responsibility of every member of the medical staff to secure autopsies. The attending physician is encouraged to request autopsy in the following cases:

1) Deaths in which autopsy may help to explain unknown or unanticipated complications to the attending physician.
2) All deaths in which the cause of death is not known with certainty on clinical grounds.
3) Cases in which autopsy may help to allay concerns of and provide reassurance to family and/or the public regarding the death
4) Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapy.
5) Deaths of patients who have participated in clinical trials (protocols) approved by the institutional review board.
6) Unexpected or unexplained deaths that are apparently natural and not subject to a forensic medical jurisdiction.
7) Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at hospital; deaths occurring in the hospital within 24 hours of admission; and deaths in which the patient sustained or apparently sustained an injury while hospitalized.
8) Deaths resulting from high-risk infectious and contagious diseases.
9) All obstetrical deaths.
10) All neonatal and pediatric deaths.
11) Deaths in which it is believed that autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.
12) Deaths known or suspected to have resulted from environment or occupational hazards.

PART THIRTEEN. INFECTION CONTROL

13.1 CULTURES

All suspected clinically significant infections of the skin or surgical incisions shall be cultured for organism and sensitivity to the organism. Suspected infection of other organs by communicable organisms shall be cultured when practical. Cultures shall be ordered by the physician in charge of the case. The infection control nurse shall call suspected cases of infection to the attention of the attending physician. If the attending physician refuses to order a culture in such cases, this information shall be given to the chairman of the Infection Control Committee who shall then consult with the attending physician and make the final decision concerning ordering a culture.

13.2 PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES

Any patient with a suspected infectious or communicable disease will be treated using appropriate isolation techniques, as ordered by the attending physician and consistent with the principles outlined in the Infection Control Manual of PHCMC. The infection control nurse may call cases which may need isolation to the attention of the attending physician. If the attending physician refuses to order isolation, this information shall be given to the chairman of the Infection Control Committee who will consult with the chairman of the department involved. Said chairman shall consult with the attending physician and make the final decision concerning isolation of the case for the protection of hospital employees and other patients.

13.3 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

All cases of infection and communicable disease must be reported to the infection control committee. Those found in special service units must also be reported to the physician in charge of the unit. Those found in other areas of the hospital should be reported to the applicable department chairman. Every staff member should also report promptly to the infection control committee infections which develop after discharge and which may be hospital-acquired.

13.4 GENERAL AUTHORITY

The infection control committee has the authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

PART FOURTEEN. DELINEATION OF ALLIED HEALTH PROFESSIONAL CATEGORIES

14.1 CATEGORIES OF AHP'S

The following personnel have been designated as Allied Health Professionals for the purpose of these Rules and Regulations:

14.2 CLINICAL PSYCHOLOGIST'S

14.2-1 MODE OF PRACTICE - Independent

14.2-2 QUALIFICATIONS

1) Currently licensed by the California Medical Board in Clinical Psychology at the independent practice level of psychology.
2) documentation of their experience, background, training, demonstrated ability, physical health status, and upon request of the medical executive committee or of the Board of Trustees, mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency and that they are qualified to provide a needed service within the hospital; and

3) determination, on the basis of documented references, to adhere strictly to the ethics of their respective professions as applicable and to work cooperatively with others.
4) PhD level and two years documented hospital training and experience for each privilege requested. Applicants should also be listed in the National Register of Health Service Providers in Psychology or equivalent. Equivalent should be defined as the following:
   i. A doctoral degree in psychology from a regionally accredited educational institution.
   ii. Two years of supervised experience in health service in psychology, of which at least one year is in an organized health service training program, and one year is post doctoral.

14.2-3 CLINICAL PRIVILEGES

Clinical Privileges should be limited to the following:
1) Psychiatric history and mental status examination (including suicide, drug dependence and 5150 evaluations)
2) Recommend treatment plan (including medications)
3) Psychometrics (child, adolescent, adult/geriatrics, neuropsychological)
4) Psychotherapy [individual as adjunctive therapist (adolescent, adult, geriatric), Family, Group]
5) Hypnosis
6) Biofeedback

(Rev. 5/99)

14.2-4 PREROGATIVES

The prerogatives of a clinical Psychologist should be to:
1) Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff.
2) Exercise independent judgment within the areas of his professional competence, and may participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care,
3) Serve on staff, department and hospital committees,
4) Attend meetings of the staff, Department of Medicine and hospital education programs.

14.2-5 RESPONSIBILITIES

Each Clinical Psychologist should:
1) meet the same basic responsibilities as required by the Medical Staff Bylaws, Article 3.6 for medical staff members,
2) retain appropriate responsibility within his area of professional competence for the care and supervision of each patient in the hospital for whom he is providing services, or arrange a suitable alternative for such care and supervision,
3) participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the staff, in supervising initial appointees of his same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

14.2-6 TERMS AND CONDITIONS

Each Clinical Psychologist shall be required to adhere to all terms and conditions outlined for allied health professionals and medical staff members within the Medical Staff Bylaws, General Medical Staff Rules & Regulations and the Rules and Regulations of the Department of Medicine.

14.3 PHYSICIAN ASSISTANT FOR THE CARDIOVASCULAR SURGERY PROGRAM (Added 4/93)

14.3-1 MODE OF PRACTICE - Dependent

14.3-2 QUALIFICATIONS

1) Successful completion of a course in primary care, emergency room or general surgery physician's assistant training.
2) Currently certified by the California Medical Board as a Physician Assistant.
3) Documentation of their experience, background, training, demonstrated ability, physical health status, and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service within the hospital; and
4) Determination, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others.
5) Specific training for the thoracic and cardiovascular physician's assistant will include:
   a) To have performed a minimum of 100 vein harvestings under the supervision of the supervising physician
   b) To have performed a minimum of 20 tracheal intubations under the supervision of the cardiac anesthesiologist
   c) To have reviewed basic materials pertaining to electrocardiographic monitoring, blood gas analysis and electrolyte evaluation
   d) To hold a valid ACLS certificate
   e) To have been directly involved in the care of patients who need intra aortic balloon assist. This will be under the direct supervision of the certified extracorporeal technologist and under direct supervision by the cardiovascular surgeon.

14.3-3 CLINICAL PRIVILEGES

Clinical Privileges may include the following:

1) Take histories and perform physical examinations upon hospital patients of his Supervising physician. Record pertinent data from such history & physical examinations performed by himself on forms provided by the hospital. (Rev. 6/05)
2) Take electrocardiographic tracings in some particular cases.
3) Recognize and evaluate situations which call for the immediate attention of the attending physician and, when necessary, institute any treatment considered essential for the life of the patient.
4) Assist the thoracic and cardiovascular surgeon in the hospital setting by arranging hospital admissions, by providing services to patients requiring continuing care, including the review of treatment and therapy plans, and by evaluating patients and performing the procedures and tests specified.
5) Facilitate the thoracic and cardiovascular surgeon's referral of patients to the appropriate health facility agencies and resources in the community.
6) Medications can be transmitted orally or in writing by the physician assistant in a patient's record providing it has been approved by his or her supervising physician. (Rev. 6/03, 6/05)
7) Perform therapeutic procedures as delineated on the Cardiovascular Surgery Physician Assistant Privilege Card.

14.3-4 PREROGATIVES

The prerogatives of a CVS Physician Assistant should be to:

1) Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff.
2) Attend hospital education programs.

14.3-5 RESPONSIBILITIES

Each CVS Physician Assistant should:
1) meet the same basic responsibilities as required by the Medical Staff Bylaws, Article 3.6 for medical staff members;
2) participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

14.3-6 TERMS AND CONDITIONS

Each CVS Physician Assistant shall be required to adhere to all terms and conditions outlined for allied health professionals and medical staff members within the Medical Staff Bylaws, General Medical Staff Rules & Regulations and the Rules and Regulations of the Department of Surgery.

14.4 R.N. FIRST ASSISTANT (added 4/95)

14.4-1 MODE OF PRACTICE - Dependent

14.4-2 QUALIFICATIONS

1) Successful completion of an R.N. First Assistant Program (RNFA) as evidenced by a Certificate of Course Completion. Certification as C.R.N.F.A. to be completed within two years of completion of RNFA program.(rev. 3/02, 12/04)
2) Currently licensed by the California State Board of Registered Nurses.
3) Documentation of their experience, background, training, demonstrated ability, physical health status, and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service within the hospital; and
4) Determination, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others.

14.4-3 CLINICAL PRIVILEGES

Clinical Privileges may include the following:
1) Tissue handling
2) Providing exposure
3) Using instruments
4) Suturing
5) Providing hemostasis
6) Vein graft harvesting (Added 5/97)

14.4-4 PREROGATIVES

The prerogatives of a RN First Assistant should be to:
1) Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff.

14.4-5 RESPONSIBILITIES

Each R.N. First Assistant should:

1) meet the same basic responsibilities as required by the Medical Staff Bylaws, Article V, Section 5.5 for allied health professionals. Item (k) of Section 3.6 (as it pertains to Article V, Section 5.5) is not applicable to the practice of AHP's.
2) participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

14.5 PHYSICIAN ASSISTANT (added 4/95)

14.5-1 MODE OF PRACTIC - Dependent

14.5-2 QUALIFICATIONS

1) Successful completion of a course in primary care, emergency room or general surgery physician's assistant training.
2) Currently certified by the California Medical Board as a Physician Assistant.
3) Documentation of their experience, background, training, demonstrated ability, physical health status, and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service within the hospital; and
4) Determination, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others.

14.5-3 CLINICAL PRIVILEGES

Clinical Privileges may include the following:

1) Take histories and perform physical examinations upon hospital patients of his/her Supervising physician. Record pertinent data from such history and physical examinations performed by him/her on forms provided by the hospital. (Rev 6/05)
2) Other such privileges as are specifically requested in the application, which are not excluded by law, which have been previously approved by the California Medical Board and which have been approved by the appropriate medical staff department.

14.5-4 PREROGATIVES

The prerogatives of a Physician Assistant should be to:

1) Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff.
2) Attend hospital education programs.

14.5-5 RESPONSIBILITIES

Each Physician Assistant should:

1) meet the same basic responsibilities as required by the Medical Staff Bylaws, Article V, Section 5.5 for allied health professionals. Item (k) of Section 3.6 (as it pertains to Article V, Section 5.5) is not applicable to the practice of AHP's.
2) participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

14.6 NURSE PRACTITIONER (added 4/95)

14.6-1 MODE OF PRACTICE - Dependent

14.6-2 QUALIFICATIONS

1) Currently licensed in the State of California as a Registered Nurse and shall retain such licensure for continued approval.(Rev. 3/01)
2) Documentation of their experience, background, training, demonstrated ability, physical health status, and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service within the hospital; and
3) Determination, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others.

14.6-3 CLINICAL PRIVILEGES

Clinical Privileges may include the following under the supervision of a physician member of the medical staff, who need not be physically present (unless required by state law), but is immediately available for consultation by telephone:

1) Coordinate care of supervising physician's patients with hospital department as directed by supervising physician.
2) Assist supervising physician with any procedures he/she may perform.
3) Document nursing orders and verbal orders from the physician supervisor, to be documented on the nursing treatment plan.
4) Visit patients of the physician supervisor with documentation in the ancillary progress notes.
5) Assist patient in completing history form, perform nursing assessment and report findings to physician supervisor.
6) Transcribe phone orders received from supervising physician.
7) Communicate orders by phone that are ordered by supervising physician.
8) Participate in patient education.
9) Other such privileges as are specifically requested in the application, which are not excluded by law, which have been previously approved by the California Board of Registered Nurses and which have been approved by the appropriate medical staff department.

14.6-4 PREROGATIVES

The prerogatives of a Nurse Practitioner should be to:

1) Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff.

14.6-5 RESPONSIBILITIES

Each Nurse Practitioner should:

1) meet the same basic responsibilities as required by the Medical Staff Bylaws, Article V, Section 5.5 for allied health professionals. Item (k) of Section 3.6 (as it pertains to Article V, Section 5.5) is not applicable to the practice of AHP's.
2) participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

14.7 OPTOMETRIST (Added 8/00)

14.7-1 MODE OF PRACTICE - Dependent.

14.7-2 QUALIFICATIONS

1) Currently licensed in the State of California to practice optometry and shall retain such licensure for continued approval, and
2) Graduated from an accredited school or college of optometry, and
3) Certification by a state board of optometry for the use of diagnostic pharmaceutical agents (DPA's) and
4) Documentation of their experience, background, training and demonstrated ability, physical health status, and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and that they are qualified to provide a needed service within the hospital, and
5) Determination, on the basis of documented references, to adhere strictly to the ethics of their respective professions and to work cooperatively with others.

14.7-3 CLINICAL PRIVILEGES

Clinical privileges may include the following:

Category I Core Privileges

1) Comprehensive examination of the eye and its adnexa, diagnosis and treatment of visual disorders and anomalies within the limits set by current California Optometric Law, Title 16 Professional and Vocational Regulations.
2) Utilization of topical diagnostic pharmaceutical agents per the requirements set forth by the current California Optometric Law, Title 16 Professional and Vocational Regulations.
3) Prescribing eyeglasses, contact lenses and other optical devices
4) Ordering visual function and laboratory tests when indicated, except for any tests which involve the injection of intravenous substances.
5) Pre and post-operative care of cataract and refractive surgery patients for those who are TPA certified.

Category II Supplemental Criteria

(Limited to optometrists who have fulfilled the didactic, clinical, preceptorship requirements, and passed the test as mandated in Title 19, the State of California Code)

1) Prescribe appropriate Therapeutic Pharmaceutical Agents (TPA's) when indicated, within the limits and specifications of current state law for optometric practice, California Optometric Practice Law and licensure.

14.7-4 PREROGATIVES

The prerogatives of an Optometrist should be to:

1) Provide specified patient care services under the supervision or direction of a physician member of the Medical Staff.
2) Exercise independent judgment within the areas of his professional competence, and may participate directly in the medical management of patients under the supervision of a physician who has been accorded privileges to provide such care and who has ultimate responsibility for the patient's care.
3) Serve on staff, department and hospital committees.
4) Attend meetings of the staff, Department of Medicine and hospital education programs.

14.7-5 RESPONSIBILITIES

Each Optometrist should:

1) meet the same basic responsibilities as required by the Medical Staff Bylaws, Article V, Section 5.5 for allied health professionals. Item (k) of Section 3.6 (as it pertains to Article V, Section 5.5) is not applicable to the practice for AHP's.
2) participate as appropriate in the patient care audit and other quality review, evaluation and monitoring activities required of the staff, in supervising initial appointees of his/her same profession during the observation period, and in discharging such other staff functions as may be required from time to time.

PART FIFTEEN. MALPRACTICE INSURANCE REQUIREMENTS

15.1 GENERAL

In accordance with Health and Safety Code 1319 of the State of California, members of the Medical Staff and members of the Allied Health Professional Staff shall be required as a condition of privileges to possess and maintain professional liability insurance coverage in amount and type specified by the Medical Executive Committee of the Medical Staff of Providence Holy Cross Medical Center.
(Revised 3/2/94)

15.2 INSURANCE CARRIER

Practitioners shall carry professional liability insurance with an insurance carrier or risk retention group that is

a) an admitted insurance carrier, as determined by the State of California Department of Insurance, with a Bests (or equivalent rating system) rating of B+ or better or;
b) a non admitted insurance carrier or risk retention group as long as the practitioner meets the following criteria:

Annually any physician whose professional liability insurance is provided through either a non-admitted insurance carrier or risk retention group must furnish to the medical staff office a written statement from such risk retention group or non-admitted insurance carrier certifying to the following:

Non-Admitted Insurance Carriers

1. An A.M. Bests Rating (or equivalent) of B+ or better
2. A positive Standard and Poor's Outlook (or equivalent)
3. Confirmation that the non-admitted insurance carrier meets all applicable legal and regulatory requirements of the state in which such carrier is domiciled, and assurance that such carrier is not on such state insurance commissioner's supervision or watch list.
4. Meets National Association of Insurance Commissioners ("NAIC") accreditation or equivalent requirements.
5. Meets financial solvency requirements of the state or country of its domicile.

Risk Retention Group

1. Evidence of good standing with insurance commissioner's office in state or country of domicile.
2. Meets financial solvency requirements of its state or country of domicile.
3. No adverse financial information on risk retention group website (www. RRR. Com).
4. Positive Standard and Poor's Outlook (or equivalent)

It is the responsibility of the medical staff member to furnish such information annually in a format satisfactory to the hospital. Additional criteria may be sought if the carrier is unable to provide the necessary certification as required above. The Medical Staff may elect to waive one or more of the above criteria, based on evaluation and recommendation of the Providence Health and Services office of Risk Management. (Rev 5/07)

15.3 LIMITS OF COVERAGE

Each practitioner shall maintain in force professional liability insurance in not less than the minimum amounts determined by the Medical Executive Committee of the Medical Staff of Providence Holy Cross Medical Center.

Initial limits of coverage shall be as follows:
$1 million per occurrence
$3 million annual aggregate

15.4 COVERAGE TYPE

Practitioners shall be required to carry coverage which insures all acts or omissions which occur within the policy period regardless of when the claim is made. Claims made insurance policies may be converted to occurrence coverage through the purchase of the tail coverage option.

15.5 APPOINTMENT AND REAPPOINTMENT

Following initial compliance with the Medical Executive Committee's required coverage, application for appointment or reappointment with specific privileges shall include the name of the applicant's carrier for professional liability insurance, the type and amount of coverage provided under his policy, a copy of the "certificate of insurance" as provided by the carrier, as well as the date of expiration of the policy. The applicant's insurance carrier and the minimum amount of coverage must be in accordance with the guidelines established by the Medical Executive Committee.

The Medical Staff Office may request provision of information regarding malpractice experience, including a consent to the release of information from present and past malpractice insurance carrier(s).

15.6 ENFORCEMENT

Failure to maintain the required professional insurance after written warning of delinquency may result in automatic suspension of clinical privileges until the practitioner provides evidence of professional liability coverage.

Practitioners are required to inform the Medical Staff Office of any change in insurance status within 30 days prior to the implementation of a new policy, carrier, etc.

15.7 DATE OF IMPLEMENTATION

These requirements of the Medical Executive Committee shall be effective as of October 1, 1986.

15.8 METHOD OF IMPLEMENTATION

Each practitioner who holds membership, or who is in process of applying for membership on the Medical Staff of Providence Holy Cross Medical Center shall be notified by mail of these requirements for professional liability insurance coverage mandated by the Medical Executive Committee. Thereafter, each applicant to the staff shall be provided a copy of these Rules and Regulations at the time an application form is requested.
(Added 4/6/92)

PART SIXTEEN. PATIENTS UNDERGOING MODERATE OR DEEP SEDATION (Rev 4/97, 12/03)

16.1 GENERAL

Moderate or deep sedation may only be administered by members of the medical staff who have been granted privileges for administration by their respective departments. Administration of moderate or deep sedation must

follow the current hospital policy for patients undergoing moderate or deep sedation. (Rev. 12/03)

PART SEVENTEEN FAST TRACKING (Added 8/98)

17.1 FAST TRACKING

Fast tracking is a method of speeding document flow through the Medical Staff structure in certain cases.

17.2 DECLARATION

Fast tracking can only be declared by a Department Chairperson (not the acting chair or vice chair) or the Department itself, and only after the document has been presented at the full Department for review.

17.3 DOCUMENTS THAT MAY BE FAST TRACKED

The following documents may be fast tracked: protocols, guidelines, policies, procedures, orders, credentials, privileges. The following documents may not be fast tracked: bylaws, rules and regulations, disciplinary actions of all types.

17.4 RESPONSIBILITY FOR FAST TRACKING

The Chairperson or the delegated sponsoring physician is personally responsible for transmitting the document to the appropriate higher or lower Committee chairperson for discussion. If the receiving chair agrees, the document bypasses their Committee and moves to the next chairperson. This continues either vertically and/or horizontally until it reaches the Medical Executive Committee. If, at any point, a chairperson disagrees, the document must be presented to the full Committee of that chairperson. (Rev. 6/01)

17.5 MEDICAL EXECUTIVE COMMITTEE APPROVAL

The Medical Executive Committee must review, at a regularly scheduled meeting, all fast track documents for final approval.

17.6 SPECIAL CARE

Special care must be exercised by the chairperson of the appropriate Committees to review the document. The fast tracking process must be personally performed by the appropriate chairperson throughout its movement. It may not be delegated. A signature log must be kept attached to the document with the signatures and dates of approval recorded by the pertinent person.

PART EIGHTEEN ORGANIZED HEALTHCARE ARRANGEMENT (Added 4/03)

18.1 PROVIDENCE HEALTH AND SERVICES CALIFORNIA REGION ORGANIZED HEALTHCARE ARRANGEMENT

Providence Holy Cross Medical Center, as part of the Providence Health and Services California Region, and the medical staff members have established a
California Region Organized Health Care Arrangement under 45 CFR 164.51, as a clinically integrated health care setting, including all Providence Health System facilities, services and programs, the Providence employees, and practitioners and other clinicians who are members of the medical staff and/or who otherwise have medical staff privileges at the Hospital or other Providence facilities, services, or programs in the Providence California Region ("Providence OHCA"). Under the Providence OHCA, all of the members, including members of the medical staff, may rely on a Joint Notice of Privacy Practice and Acknowledgement. Further, members of the Providence OHCA may use and disclose protected health information in the conduct of their joint operations and

joint activities, all in a manner consistent with the requirements of HIPAA. (Rev. 3/08)

18.2 NOTICE OF PRIVACY PRACTICES

Each member of the medical staff shall be required to use and conform to the terms of the Joint Notice of Privacy Practice developed and used by the Providence California Region with respect to protected health information created or received as part of each medical staff member's participation in the Providence PHCA and to comply with all applicable Providence, medical staff and HIPAA requirements, policies and procedures relating to the confidentiality of protected health information. (Rev 3/08)

Each medical staff member is responsible for his or her own compliance with applicable state and federal laws relating to protected health information. The establishment of the Providence OHCA shall not in any way create additional liabilities by or among the members of the Providence OHCA or cause one or more Providence OHCA members to assume responsibilities for the acts or omissions of any other member of the Providence PHCA, and each member of the Providence PHCA shall be individually responsible for his or her own acts or omissions with respect to compliance with HIPAA requirements.

The Medical Executive Committee may establish from time to time such additional rules and requirements to assure conformity with the above requirements, including requiring each medical staff member at the time of their initial appointment and any subsequent reappointment, to sign and acknowledge their individual responsibilities with respect to the above requirements.

ADOPTION

APPROVED BY THE MEDICAL STAFF:

07/18/11
Date

APPROVED BY THE COMMUNITY MINISTRY BOARD/BOARD OF TRUSTEES:

07/15/2015
Date

Adopted: Board of Trustees - 1/15/91, 07/15/2015

Revised: MEC -12/04, 03/05, 04/07, 03/08, 07/11, 06/15

CMB - 01/05, 05/05, 05/07, 04/08, 08/11, 07/15