

**Medical Staff Rules and Regulations
of the Medical Staff
of
Providence Saint John's Health Center**

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I. Admission and Discharge of Patients

1. A patient may be admitted to Saint John's Health Center only by a member of its Medical Staff who has admitting privileges. All practitioners shall be governed by the official admitting policy of the Health Center.
2. Each patient shall be the responsibility of a member of the Medical Staff. The member is responsible for the medical care and treatment, for the prompt completion and accurate of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient of the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
3. Every patient who is admitted as an inpatient or to observation status must have at least one admitting and/or attending physician who must be a member who is qualified and competent to complete a medical history and physical examination, and who is responsible for supervising the overall medical care of the patient. The admitting and/or attending physician must complete an examination of the patient and a documented plan of care within 12 hours of admission for all patients, except well newborns who must be examined by the physician within 24 hours Any member who cannot, or does not wish to, assume all of these responsibilities shall admit patients only with another member who can and will assume such responsibilities.
4. A member shall not admit nor provide direct professional care for any patient who is their spouse, parent, child or sibling, except during an emergency.
5. Except in an emergency, no patient shall be admitted to the Health Center until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, such statement shall be recorded as soon as possible.
6. In any emergency case in which it appears the patient will have to be admitted to the Health Center, the member shall, when possible, first contact the admitting department to ascertain whether there is an available bed.
7. Members admitting emergency cases shall be prepared to justify to the Medical Executive Committee and the Administration of the Health Center that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient's being admitted on an emergency basis and must be recorded on the patient's chart as soon as possible after admission.
8. In the case of an emergency admission, a patient who does not have a private physician who is a member may have a choice of any available member in the department or service to which they need to be admitted or may be assigned in rotation to a member of the active, associate or provisional staff on duty in the department or service to which the illness of the patient indicates assignment. The chair of the appropriate department shall adding members to provide care for patients in the latter case.
9. Each member who does not reside in the immediate vicinity or who is not immediately available shall arrange with another qualified member who is a resident in the area and available, to attend the former member's patients in any emergency or until they arrive. In cases of failure to name such member the Chief Executive Officer of the Health Center, the Chief Medical Officer, the President of the Medical Staff, or the Chair of the Department shall have authority to call any member.
10. The admitting personnel admit patients on the basis of the following order of priorities:

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a. Emergency Admissions

This category of patients includes those who have serious medical problems and who may be at risk of death or serious injury to their health if not admitted within four hours. Such patients have first priority for admission to the Health Center beds. (When requested by the Resource Management Committee, the admitting physician must furnish to that Committee, within 24 hours of the request, a signed, sufficiently complete documentation of the need for emergency admission. Failure to provide this information or evidence of willful or continued misutilization of this category of admission will be brought to the attention of the Medical Executive Committee.)

b. Urgent Admissions

This category includes patients with serious medical problems who may be at risk of substantial injury to their health if not admitted within 24 hours. Admissions so designated by the member shall be reviewed as necessary by the Chief Medical Officer to determine priority when all such admissions for a specific day are not possible.

c. Pre-Operative Admissions

This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief Medical Officer may decide the urgency of any specific admission.

d. Routing Admissions

This category includes elective admissions involving all services.

11. Patient Transfers

Patient priorities are as follows:

a. Emergency Department to appropriate patient bed;

b. From obstetric patient care area to general care area, when medically indicated;

c. From a critical care unit to general care area;

d. From temporary placement in an area designated as a clinical service area to the appropriate area for that patient.

12. The member shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever their patients might be a source of danger from any cause whatever.

13. For the protection of patients, the medical and nursing staff and the Health Center, certain principles are to be met in the care of the potentially suicidal patient, or the patient who is a threat to self or to others.

a. They shall be admitted, if possible, to other institutions where suitable facilities are available.

b. They must have consultation by a member of the psychiatric staff.

c. In the event that any patient is admitted to the general floors of the Health Center and is then or later known to be a threat to self or others, they shall be transferred as soon as medically appropriate to another institution where adequate facilities are available. As a temporary measure, until transfer can be arranged, or until the patient's psychiatric-emotional state is sufficiently corrected, special nurses or companions shall be required for such patient.

14. Admission to, transfer from and discharge from, Intensive, Coronary Care, and Post-Coronary Care Units

a. If any questions as to the appropriateness of admission to, transfer or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the Medical Director of the Intensive Care Unit. In a similar circumstance concerning admission to, transfer from, or discharge from the Coronary Care Unit, or Post-Coronary Care Unit, the Medical Director of the Coronary Care – Post-Coronary Care Unit is to be consulted. Unresolved disputes regarding patient admission, transferability, or discharge from one of the aforementioned units that arise between the appropriate Medical Director and the

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attending physician shall be presented to the Chair of the attending physician's clinical department for resolution, and if necessary, the President of the Medical Staff for determination.

15. The member is required to document the need for continued hospitalization after specific periods of stay as identified by the Resource Management Committee of this Health Center. This statement must contain:
 - a. An adequate written record of the reason for continued hospitalization; a simple reconfirmation of the patient's diagnosis is not sufficient.
 - b. The estimated period of time the patient will need to remain in the Health Center.
 - c. Plans for post-hospital care.
16. Patients shall be discharged only on a written order of the attending member. Should a patient leave the Health Center against the advice of the attending member, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
17. On the day of discharge of a patient, it is the responsibility of the attending member to encourage and facilitate discharge of the patient by 11:00 AM. If the patient is to be discharged with continuing care such as to a Skilled Nursing Facility (SNF), or utilizing post discharge services such as Home Health, Hospice, Dialysis, Infusion, Durable Medical Equipment, etc., it is imperative that the patient's choice be followed. Physicians or the Health Center shall provide names of two or three providers. The physician will disclose to the patient or his/her family or decision maker any relationship the physician or one of his/her first degree relatives has with that provider (e.g., ownership interests, medical directorship, royalties, consultation fees, etc.). The physician shall sign, date and time a Health Center form evidencing that the patient's choice is followed. Failure by the physician to disclose on the form ownership or interest in the facility will result in referral for peer review.
18. In the event of a Health Center death, the deceased shall be pronounced dead by the attending physician or their designee or the house physician, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a physician member of the Medical Staff. Policies with respect to release of the deceased shall conform to local law.
19. It is the duty of all members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Health Center pathologist, or by a pathologist delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record by the pathologist immediately after completion of the autopsy and the complete protocol shall be made a part of the record within six weeks.

II. Medical Records

1. The attending member is responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. For inpatients and observation status patients, this record shall include identification data; complaints; history of present illness; past history; system failure; family history; physical examination; special reports, such as consultations, pathology, and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnoses; condition on discharge; summary or discharge notes; and autopsy report when performed,
2. Except as specified in Section 3 below, an appropriate note including the history and physical examination and/or admission history and physical examination shall be appropriately recorded. This report should include pertinent findings resulting from an assessment of the systems of the body specific to the patient's chief complaint, reason for admission, surgical procedure, and/or diagnosis. If a complete history and physical

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examination has been recorded and a physical examination was performed by the admitting member during the 30 days prior to the patient's admission to the Health Center, a reasonably durable, legible copy of these reports may be used in the patient's medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member. In such instances, an interval admission note that includes all significant additions to the history and any subsequent changes in the physical findings must always be recorded within 24 hours after admission.

3. Pre-Procedure Documentation Requirements

- a. When the history and physical examination are not recorded before an inpatient surgical procedure under general anesthesia, regional anesthesia or moderate sedation or any surgical or diagnosis procedure associated with significant risk to the patient as evidenced by the need for continuous, electronic physiological monitoring, the procedure shall be cancelled unless the attending member states in writing that such delay would be detrimental to the patient. For elective procedures, the history and physical examination must be recorded at least 30 days prior to the procedure and transmitted to the Health Center prior to the scheduled date of the planned procedure(s). This history and physical shall be updated prior to the procedure.
- b. Members who admit patients for approved outpatient surgery under general, regional or spinal/ epidural anesthesia or for surgery which is associated with significant risks shall complete all medical records prior to performance of the procedure which are ordinarily require for inpatient surgery.
- c. Members who admit patients for approved minor outpatient surgery under local anesthesia shall complete at least a brief report prior to the performance of the procedure which includes the pertinent and important medical history and physical findings, and also record the diagnosis, orders and a description of the operative procedure.
- d. The member who admits a patient for an outpatient surgical or diagnostic procedure under moderate sedation or associated with significant risk to the patient as evidenced by the need for continuous, electronic physiologic monitoring shall complete at least a brief report prior to the performance of the procedure, which includes the pertinent and important medical history and physical findings, including heart and lung, and also record the diagnosis, orders, and a description of the operative procedure.

4. The attending member must verify that they have reviewed any reports submitted by a physician not on the medical staff. The attending member shall confirm or correct the contents of the history, physical examination, pre-operative note or other medical record entries when they have been recorded by a certified Physician Assistant, or a Nurse Practitioner. Certified Physician Assistants and Nurse Practitioners may only prepare records for their designated supervising physician(s). When records are prepared in the above manner the attending physician is required to record a pertinent and timely note in the medical record.

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily.

6. **Surgical Plan:** The member performing any surgical procedure under general or regional anesthesia or under moderate sedation or any surgical or other procedure associated with significant risk to the patient as evidenced by the need for continuous, electronic physiologic monitoring during or following the procedure shall document the following in the medical record within 30 days prior to the initiation of the planned procedure:

- a. Assessment and pertinent pre-procedure findings based on a history, physical examination, including heart and lung and diagnostic testing;
- b. Indication;
- c. Rationale, including the risks and benefits;

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- d. Informed consent from the patient or authorized health care surrogate. The informed consent discussion between the member and the patient or surrogate should be sufficient to assure that the patient or surrogate receives known, relevant, applicable information necessary to make informed decisions about the contemplated care.
 - e. If recorded more 30 days prior to surgery, an update note affirming the accuracy of the surgical plan shall be made prior to surgery or a procedure requiring anesthesia services. The surgery or procedure shall be postponed or canceled if neither is done. In an emergency, the member shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery. For the purpose of this section, an "emergency" is defined as a condition in which serious, permanent harm might result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.
7. Operative reports and other high risk procedure reports shall include a detailed account of the findings at surgery or at the procedure as well as the details of the surgical or procedural technique. Operative reports and procedural reports shall be dictated immediately following surgery or the procedure for outpatients as well as inpatients and the report signed by the surgeon and made a part of the patient's current medical record.
 - a. In addition to the dictated operative or other high-risk procedure report, a progress note shall be entered immediately into the patient's medical record after the operation or procedure and before the patient is transferred to the next level of care.
 - b. The operative or procedure report and the progress note must contain at least seven elements:
 - i. The name(s) of the primary surgeon(s) and assistant(s).
 - ii. The name of the procedure(s) performed.
 - iii. A description of each procedure.
 - iv. Findings.
 - v. Estimated blood loss.
 - vi. Specimens removed.
 - vii. Post-operative diagnosis.
 8. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement, such as "I concur," does not constitute an acceptable report of consultation. Except in an emergency, so verified on the record, when operative procedures are involved the consultation note shall be recorded prior to operation.
 9. The current obstetrical record shall include a complete perinatal record; it may be a legible copy of the attending practitioner's office record transferred to the Health Center before admission. In such instances, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
 10. All clinical entries in the patient's medical record shall be accurately dated, time, and authenticated. The authentication may be by a signature or electronic means.
 11. Symbols and abbreviations may be used only when they have been approved by the Medical Executive Committee. An official record of approved abbreviations is kept on file in the Health Information Services Department.
 12. Final diagnosis shall be recorded in full, without the use of unapproved symbols or abbreviations, and dated, timed, and signed by the responsible member at the time of discharge of all patients. The attending member has the responsibility to establish the final diagnosis.

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13. A discharge clinical resume shall be written or dictated on all medical records of patients hospitalized over 48 hours, except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Medical Executive Committee, and for those, a final summation-type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible member.
 - a. An acceptable discharge summary shall contain the following items:
 - i. Admission date
 - ii. Discharge date
 - iii. Admission diagnosis
 - iv. Discharge diagnosis
 - v. Hospital course
 - vi. Operations, procedures
 - vii. Medications upon discharge
 - viii. Disposition of patient
 - ix. Follow-up (who will follow up with patient and when / coordination with PCP)
14. Written consent of the patient or their authorized agent is required for release of medical information to persons not otherwise authorized to receive this information.
15. In case of readmission of a patient, all previous records shall be available for the use of the attending member. This shall apply whether the patient be attended by the same member or by another.
16. The Director of Health Information Services or designee may allow a member of the Medical Staff to review the medical record of any patient for whom the member is currently providing medical care.
17. Whenever information is urgently needed for the welfare of a patient who has been but is not then a patient in this Health Center, the Director of Health Information Services or designee may release essential medical information by telephone to any physician who is currently providing care to this patient.
18. Records may be removed from the Health Center's jurisdiction and safekeeping only in accordance with court order, subpoena, or statute. All records are the property of the Health Center and shall not otherwise be taken away without permission of the Chief Executive Officer.
19. Free access to all medical records of all patients shall be afforded to members for bona fide study, consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Health Center Research Administration Office and may be subject to Institutional review Board approval before records can be studied. Subject to the discretion of the Chief Executive Officer, former members shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Health Center.
20. A medical record shall not be permanently filed until it is completed by all responsible practitioners or is ordered filed by the Medical Executive Committee.
21. A member's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed, and signed by the member.
22. Medical records must be completed promptly and authenticated or signed within two weeks following the patient's discharge. The Director of Health Information Services or designee notifies members whenever they

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have medical record deficiencies as defined in a written Medical Staff "procedure" and the member's clinical privileges are automatically suspended if records remain delinquent after the grace period established by the Medical Executive Committee in the written Medical Staff "procedure." The member's privileges shall remain suspended until the delinquencies which caused the suspension have been corrected

23. Cumulative suspensions of thirty days or more for medical records deficiencies within any 12 month period shall be sufficient cause for assessment of fines, additional dues obligations and/or demotion or termination of a member's appointment and privileges.
24. For good and sufficient reason, the Medical Executive Committee may grant excuses to practitioners for medical record deficiencies when, for example, prolonged absences or illness may prevent the timely completion of medical records.
25. Consultation reports; operative, procedure, and delivery reports; and discharge summaries must be dictated directly into the hospital transcription system.

III. General Conduct of Care

1. Informed consent procedures shall be kept current and approved by the Medical Executive Committee with the aid of legal counsel.
2. All orders for treatment shall be in writing. A telephone order shall be considered to be in writing if the member dictates the order to a registered nurse, licensed pharmacist, or to a duly authorized person functioning within their sphere of competence, and the order is then signed by the responsible member. All orders dictated over the telephone shall be signed by the appropriately authorized person to whom dictated and shall clearly identify the name of the member giving the order. The prescribing member, a covering or attending member, or another member responsible for the care of the patient, even if the order did not originate with the countersigning member, shall countersign, date and time such orders within 48 hours if those orders are within the scope of his/her privileges or competency. Telephone orders should be used infrequently and only when deemed necessary by the ordering member.
3. The member's order must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "renew," "repeat," and "continue orders" are not acceptable. The member's printed name, name stamp and/or dictation code number must accompany any member's signature that is not legible.
4. For categories of medications, including narcotics, antibiotics and anticoagulants, and at intervals recommended by the Pharmacy and Therapeutics Committee and approved by the Medical Executive Committee, the member must rewrite orders, by drug name, for medications that are ordered without specific limitation as to time or number of doses.
5. All previous orders are cancelled when a patient's surgery is completed.
6. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Services, or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration and must be approved by the Health Center Research Administration Office and

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may be subject to Institutional Review Board approval and dispensed by the Health Center pharmacy according to established procedures for handling investigational drugs.

7. All drugs and medications brought to the Health Center by patients will be turned over for safekeeping to the nurse in charge of the patient's care and may be administered to the patient only if clearly identified by the pharmacist and specifically ordered by the attending member.
8. All research undertaken by members or others which in any way involves the Health Center or patients of the Health Center, must be approved by the appropriate chair of department(s) or section(s), and must be approved by and conducted according to the rules and conditions formulated and adopted by the Health Center Research Administration Office.
9. A member may use or allow the use of the name of the Health Center in published works only with the written permission of the chair of the member's department and the Chief Medical Officer. However, they shall have the privilege of self-identification as a member within the limits of accepted professional ethics and practices.
10. It is the duty of the organized Medical Staff, through its departmental chairs and Medical Executive Committee, to see that those with clinical privileges do not fail in the matter of calling consultants as needed.
11. Any qualified member with clinical privileges in this Health Center can be called for consultation within their area of expertise and within the limits of clinical privileges for consultation which have been granted to him/her.
12. Except in an emergency, consultation is required for the following situations:
 - a. In unusually complicated situations or where specific skills of other practitioners may be needed.
 - b. In instances in which the medical or surgical patient exhibits severe psychiatric symptoms.
 - c. When requested by the patient or their family.
13. Except in an emergency, any patient under the age of two years, undergoing surgery, must be attended by a member who has pediatric privileges.
14. The attending member is responsible for requesting consultation when indicated and for calling in a qualified consultant. This does not preclude request for consultation on any patient when the Medical Director of a service, Department Chair, or President of the Medical Staff determine that a patient will benefit from such consultation.
15. One member shall be designated as attending physician for each inpatient or observation status patient. The attending physician has overall responsibility for the medical care of their patient. When clinically appropriate, the attending physician may transfer responsibilities to another qualified physician member. The attending physician may also delegate specific aspects of the medical evaluation and treatment of a patient to another member. The attending physician documents the transfer or delegation of these responsibilities by written orders on the medical record.
16. Each member is required to successfully complete the appropriate general and specialty-specific proficiency training, including applicable proficiency tests on the use of Saint John's electronic health record prior to the hospital's installation or within 30 days of its installation. Each newly appointed member is required to successfully complete the above-noted requirements within 30 days of being appointed to the Medical Staff.

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17. Members who hold surgical privileges are required to document successful completion of a Health Center-approved Operating Room Safety Course no later than December 1, 2012. Initial applicants requesting surgical privileges are required to document successful completion of a Health Center-approved Operating Room Safety Course for their application to be considered complete.
18. Duties and responsibilities for members with inpatient admitting privileges:
 - a. Dictate history and physical within two hours of initial visit and request that a copy be sent to the referring and/or consultant physician(s).
 - b. Initiate necessary consultations directly through physician to physician communication.
 - c. Respond to all non-emergent Health Center pages / phone calls within 30 minutes; respond to urgent pages / phone calls commensurate with patient need.
 - d. Complete a legible, hand-written progress note on admission, documenting the diagnostic impression and the treatment plan.
 - e. Communicate with patient / family on admission regarding the treatment plan, discharge plan, advance directive status, and initiate end-of-life discussions as appropriate.
 - f. Communicate as requested in a timely and professional manner with the case manager / discharge planner regarding the treatment plan and arrangements required for a safe discharge.
 - g. Actively and directly communicate with specialists, physician to physician, throughout the course of care, including advising specialists when their services are no longer needed.
 - h. Write clear, legible, and timely orders for changes in level of care.
 - i. Limit the inpatient diagnostic work-up to testing medically necessary and appropriate to the current acute admission. Facilitates outpatient testing post-discharge, when indicated.
 - j. Document daily and legibly in the progress note the patient's treatment plan and discharge plan, as appropriate.
 - k. Cooperate with Medical Staff-approved Joint Commission "core measures" best practice interventions and documentation.
 - l. Complete rounds on all patients that are potential discharges that day by 11:00 AM and ensure consultant cooperation.
 - m. Ensure dictation of the discharge summary within 14 days of discharge.
 - n. Ensure that covering physician associates communicate in a timely and direct manner with the attending physician to inform of discharge, events of the hospitalization, and discuss the continuum of care.
 - o. Ensure that covering physician associates are informed and knowledgeable about patients and are empowered to make clinical and discharge / disposition decisions.
 - p. Reconcile the patient's previous and current medications at all changes in level of care; communicate the patient's medications to the next provider when a patient is referred or transferred; and provide the patient with a complete list of medications on discharge
 - q. On the day of discharge of a patient, it is the responsibility of the attending member to encourage and facilitate discharge of the patient by 11:00 AM. If the patient is to be discharged with continuing care such as to a Skilled Nursing Facility (SNF), or utilizing post discharge services such as Home Health, Hospice, Dialysis, Infusion, Durable Medical Equipment, etc., it is imperative that the patient's choice be followed. Physicians or the Health Center will provide names of two or three providers. The physician will disclose to the patient or his/her family or decision maker any relationship the physician or his/her first degree relatives have with that provider (e.g., ownership interests, medical directorship, royalties, consultation fees, etc.). The physician shall sign, date, and time a Health Center form evidencing that the patient's choice is followed. Failure by the physician to disclose on the form ownership or interest in the facility will result in referral for peer review.
 - r. If an Admitting Physician cannot admit appropriately, place orders timely, and respond within 30 minutes (per above), bridging orders will be entered for non-complex patients by the Emergency Medicine physician, and/or the patient will be automatically transferred to the current Hospitalist.

IV. General Rules Regarding Surgical Care

1. A patient admitted by a dentist for dental care, or a podiatrist for podiatric care, is a dual responsibility involving the dentist or podiatrist and a physician member.
 - a. Dentists' or Podiatrists' Responsibilities
 - i. The dentist or podiatrist shall arrange with a physician for medical coverage.
 - ii. Provide a detailed dental or podiatric history justifying Health Center admission.
 - iii. Provide a detailed description of the dental or podiatric examination and an admitting pre-operative diagnosis.
 - iv. Complete the operative report, describing the findings and technique.
 - v. Enter progress notes as are pertinent to the dental or podiatric condition.
 - vi. Record a clinical resume (or summary statement).
 - vii. Perform and record the medical history and physical examination in the case of an oral – maxillofacial surgeon or podiatrist who has been granted those specific clinical privileges or to ensure performance by the collaborating physician member.
 - b. Physicians' Responsibilities
 - i. If not performed and recorded by a duly privileged oral – maxillofacial surgeon or podiatrist, complete medical history pertinent to the patient's general health.
 - ii. If not accomplished by a duly privileged oral – maxillofacial surgeon or podiatrist, perform and record results of a physical examination to determine the patient's condition prior to anesthesia and surgery.
 - iii. Supervise the patient's general medical care while hospitalized.
 - c. The discharge of the patient shall be on written order of the dentist or podiatrist member.
2. Written, signed, informed, surgical consent shall be obtained by the physician, dentist, or podiatrist prior to an operative procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies, involving a minor, unconscious or incompetent patient for whom consent to surgery cannot be immediately obtained from parents, guardian, conservator, or authorized agent, these circumstances should be fully explained on the patient's medical record. In such instances, if time permits, a consultation may be desirable before the emergency operative procedure is undertaken.
3. The anesthesiologist shall maintain a complete anesthesia record, to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The anesthesiologist must document in the medical record the nature of any anesthetic complications which are identified during the anesthetic or post-anesthetic evaluation of the patient.
4. Anesthetic induction for elective surgery will not begin until ordered by the attending surgeon or qualified assistant surgeon is prepared to start surgery when patient is fully induced.
5. All tissues, foreign bodies or devices removed at operation and which may have clinical or pathological implications shall be sent to the Health Center pathologist, who shall make such examination as necessary to establish their findings and/or arrive at a diagnosis. Their authenticated report shall be made part of the patient's medical record. Tissues such as prepuces removed at circumcision, placentas, excised scars, normal tissue removed in reconstructive procedures, eye lenses, and devices such as orthopaedic hardware which is not defective and removed in the normal course of treatment, need not be sent to the pathologist for examination.

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6. Freshly cleaned surgical suits, facial masks, and caps or hoods approved by the Department of Surgery Committee, must be worn at all times, by all persons, in the operating rooms. If shoe covers, masks, caps or hoods are worn outside the boundaries of the surgical suite and recovery room, these items are not to be worn again in an operating room. Clean scrub suits may be worn in others areas of the Health Center if covered with an overgown. In such cases, if the scrub suit has been protected from contamination it may be worn again in the surgical suite.
7. Doors into individual operating rooms must be closed during the conduct of surgery.
8. Only members and Health Center staff are permitted in the operating rooms during surgery, unless prior permission has been obtained from the Chair of the Department of Surgery and/or the Chief Medical Officer.
9. The services of an appropriate assistant should be employed by the surgeon whenever the complexity or technological demands of the procedure require additional resources.
10. For every single surgical or invasive procedure, an attending surgeon is to be designated. The attending surgeon, who is identified as the primary surgeon in the operative record, is the member who must assume and will be held accountable for the following responsibilities:
 - a. To ensure that informed consent for the planned procedure has been obtained, including but not limited to, explanation of the anticipated benefits, risks, and alternative therapies.
 - b. To disclose the significant or material portion(s) of the planned procedure, if any, that may or will not be directly performed by the attending surgeon. In the event the attending surgeon will be involved with more than one operation on different patients at the same time through the aid of other qualified persons, the attending surgeon must inform each of those patients so affected that the attending surgeon may not be physically present at the patients operating table through the entire procedure. Representation that the patient has been so informed should be documented in the attending surgeon's preoperative note.
 - c. To supervise and direct any person(s) authorized to act as surgical assistant(s) during the procedure.
 - d. To order induction of anesthesia.
 - e. To "scrub in," direct, and participate in substantial portions of the procedure, including those portions of the surgery that are critical to the outcome.
 - f. To remain readily available to return to the Operating Room through the entire period the patient is present.

V. Emergency Services

1. The Medical Staff shall adopt a method of providing medical coverage in the Emergency Department. This shall be in accord with the Health Center's basic plan for the delivery of such services, including delineation of clinical privileges for all members who render emergency care. Members who have served on the Medical Staff for 25 years or more, or are 65 years of age or older, may request that their Department Committee excuse them from service on emergency department panels.
 - a. Per Medical Staff Bylaw Section 3, article h, "coverage of the Emergency Department on a rotational basis is an obligation which may be imposed by each of the Departments. Service in this coverage is at the discretion of the Health Center and is not a clinical privilege or right of membership on the Medical Staff."
 - b. Service on an ED Call Panel for unassigned patients is an obligation of Staff Membership. No Medical Staff Member has a right to serve on any Call Panel. A decision to remove a Member from the Call Panel shall not construe a denial or restriction of Clinical Privileges and gives rise to only the hearing rights set forth in this rule.
 - c. Medical Staff Bylaw Section 3, article i states "Compliance with the Emergency Medical Treatment and Active Labor Act ('EMTALA') including, but not limited to, the requirement that physician who are providing

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on-call coverage for the Emergency Department must come to the Health Center, if so requested, within a reasonable time following initial contact by the Emergency Department and providing any necessary stabilizing treatment to patients regardless of the patient's ability to pay."

- d. To ensure that the obligation for medical coverage of the Emergency Department is on a rotational basis, a designated Section leader / representative will create shift schedules in six-month increments, for each of the following ED Call Panels for unassigned patients:
 - i. General Surgery
 - ii. Hand / Plastics
 - iii. Neurological Surgery
 - iv. Oral / Maxillofacial Surgery
 - v. Ophthalmology
 - vi. Orthopaedic Surgery
 - vii. Otolaryngology (Head and Neck Surgery)
 - viii. Cardiovascular Surgery
 - ix. Spine Surgery
 - x. Thoracic Surgery
 - xi. Urology
 - xii. Vascular Surgery
 - xiii. Cardiology
 - xiv. Interventional Cardiology
 - xv. Gastroenterology
 - xvi. Neurology
 - xvii. Stroke (Acute, Hospitalist, and Sub-acute)
 - xviii. Internal Medicine / Family Practice
 - xix. Obstetrics and Gynecology
 - xx. Pediatrics
- e. In cases where a patient's diagnosis is uncertain, or crosses specialty lines, the ED physician will have ultimate authority in deciding which specialty should respond in-person to examine the patient in the ED.
- f. A Member may be denied participation on, or terminated from, an ED Call Panel for unassigned patients by the Department Chief to which the Member is assigned, the Medical Staff President, or the Emergency Department Medical Director.
 - i. The decision to deny or terminate participation will be final, subject only to review by the Medical Executive Committee or a subcommittee comprised of at least three members of the Medical Executive Committee (MEC), appointed by the MEC to conduct the review.
 - ii. Prior to a final adverse decision, the affected Member will be given a statement of the reasons for the proposed action and an opportunity to appear before the Medical Executive Committee, or an MEC subcommittee, to explain why the proposed action should not be imposed.
 - iii. The fact that the MEC denied a Member's request to serve, or terminated a Member's participation on the Call Panel shall not affect the Member's Medical Staff Privileges, nor shall it be used as evidence in any disciplinary action. However, the facts which the committee reviewed in reaching its decision may be used for any and all purposes.
- g. Conduct of ED Call Panel Physicians
 - i. Members on call must respond promptly when requested to see a patient and at least call within 15 minutes after they are first called. The response time must be reasonable in view of the patient's clinical circumstances. Each ED Call Panel member must let the Health Center know how to reach him/her immediately and remain close enough to the Health Center to be able to arrive within 30 minutes.
 - ii. A participant who is unable to provide panel coverage during his/her scheduled time (including when he/she is detained due to another medical commitment) is responsible for arranging coverage by another current Panel Member. The participant will inform the Health Center of the back-up coverage.

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- iii. When scheduled on call, each Member shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion, pre-existing medical condition (except to the extent that it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay.
 - iv. All transfers shall be carried out in accordance with Health Center policies and will require that the patient's attending physician or the ED Call Panel member personally examine the patient prior to transfer and finds that the patient is stable. Patients who are not stable may be transferred only if the Member finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient (or his/her authorized decision maker), requests transfer after the Member has explained the medical risks and benefits of transfer.
 - v. If a Member fails to respond to an ED Call Panel obligation, the ER physician shall call the appropriate Department Chair. A report of the incident shall be referred to the Professional Practices Committee.
 - vi. Members are expected to respond appropriately to calls for emergent issues within the Health Center that are not inside the Emergency Department.
 - vii. Members must display behavior that is professional, as a representative of the Medical Staff and Health Center. This will be reflected in their decorum, dress, and interactions with patients and caregivers.
 - viii. Members' fees must be reasonable and not higher than fees for comparable services in the community.
 - h. Members who are placed on a Focused Professional Practice Evaluation (FPPE) may not serve on an ED Call Panel for unassigned patients.
2. The duties and responsibilities of all personnel who service patients within the Emergency Department shall be defined in a procedure manual relating specifically to this outpatient facility.
 3. An appropriate medical record shall be kept for every patient receiving service in the Emergency Department and shall be incorporated in the patient's Health Center record. 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 their arrival at the Health Center.
 - d. Description of significant clinical, laboratory, and imaging studies findings.
 - e. Diagnosis and treatment given
 - f. Condition of the patient on discharge or transfer.
 - g. Final disposition, including instructions given to the patient and/or family, relative to necessary follow-up care.
 4. Each patient's medical record shall be signed by the member in attendance who is responsible for its clinical accuracy.
 5. There shall be a monthly review of Emergency Department medical records by a physician, who shall report thereon to an appropriate committee of the Medical Staff.
 6. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Health Center's capabilities in conjunction with other emergency facilities in the community.
 7. All patients presenting to the Emergency Department (ED) must be seen by an ED clinician in every case).
 - a. Sending a patient to the ED to be seen by an attending, admitting, or consulting physician – and not by an ED clinician – is not allowed. Even in situations where the patient was seen in an outpatient office and is now being sent to the ED to wait for an available bed or procedure, the patient must be given a documented medical screening exam by an ED clinician.

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- b. The reasons for this practice are as follows:
 - i. Patients admitted without being seen by an ED clinician are at higher risk for not meeting core measures (as mandated by The Joint Commission and the Centers for Medicare and Medicaid Services), including those mandated for the management of pneumonia and sepsis.
 - ii. Unstable patients may deteriorate while waiting for a physician to "meet them in the ED."
 - iii. The patient's perception of customer service by the ED is negatively impacted.
 - iv. ED metrics, such as turnover times, are negatively impacted.
 - v. The risk for an EMTALA violation is increased.
 - vi. ED clinicians are specifically trained to navigate a patient through the ED in an optimal manner.
8. The Medical Executive Committee designates Physician Assistants and Labor and Delivery Registered Nurses as Qualified Medical Personnel.

VI. Medical Staff Committees

1. The standing committees shall be the Credentials, Health Information Management, Utilization Management, Pharmacy and Therapeutics, Infection Control, Cancer, Transfusion, Quality and Patient Safety and Physicians' Health Committee. Each year the President shall appoint the Medical Staff members to these committees, shall select the chair of each, and shall fill any vacancies that may occur. These committees shall consist of members of the Staff selected on a basis that will insure representation of the major clinical specialties, the Health Center based specialties, and representatives of Health Center management, and those paramedical services that affect the specific areas of a committee's responsibilities. Each Committee shall meet as needed on dates established by the chair, shall maintain a permanent record of its proceedings and activities, and shall report as directed by and to the Medical Executive Committee.
2. As Health Center interests and services expand, the Medical Staff shall develop appropriate committees to direct or monitor and review and analyze these services on a regular basis. These may include, but are not limited to, committees of clinical sections and committees for the following: Bylaws, Nominating, Disaster, Emergency, Critical Care, Medical Education, and Radiation Safety.
3. Composition: These committees shall be composed of a chair and members from the Medical Staff appointed each year by the President of the Medical Staff and appropriate members of the Health Center appointed by the Chief Executive Officer as required by law or regulations or for effective functioning.
 - a. Credentials Committee
 - i. The duties of the Committee shall be as follows:
 1. To review the credentials of all applicants and to make recommendations or membership and delineation of clinical privileges in compliance with Articles VI, VII, and VIII of these Bylaws, taking into consideration the current departmental, Health Center, and community needs for professional medical services;
 2. To review periodically all information available regarding the competence of staff members and as a result of such reviews to make recommendations for the granting of privileges, reappointments, and the assignment of practitioners to the various departments or services as provided in Articles VI, VII, and VIII of these Bylaws;
 3. To investigate any breach of ethics that is reported to it;
 4. To make a report to the Medical Executive Committee on each applicant for Medical Staff membership or clinical privileges, giving specific consideration to the recommendations from the departments in which such applicant requests privileges.
 - b. Health Information Management Committee

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- i. The duties of the Committee shall be as follows:
 - 1. The Committee shall be responsible for assuring that all medical records meet the appropriate standards of patient care, usefulness, and of historical validity.
 - 2. The Medical Staff representatives shall be specifically responsible for assuring that the medical records reflect realistic documentation of medical events.
 - 3. The Committee shall conduct periodic reviews of currently maintained medical records to assure that they properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken, and that they are sufficiently complete at all times so as to meet the criterion of medical comprehension of the case in the event of transfer of the patient.
 - 4. It shall also conduct a retrospective review of records of discharged patients to determine the promptness, pertinence, adequacy, and completeness thereof, and coordinate all medical care audits in order to evaluate the quality of medical care and to assure educational and/or corrective measures in response to audit findings.
 - 5. The Medical Records Committee shall also be responsible for developing guidelines for the form, content, and evaluation of nursing audits. The responsibility for executing the nursing audits may be delegated to the nursing staff under the supervision of, and pursuant to, the guidelines developed by the Committee.
 - 6. The Committee shall review all nursing audits in order to evaluate the quality of nursing care and to initiate any necessary corrective measures.

- c. Utilization Management Committee (see Resource Management/Utilization Review Plan for details)

- d. Pharmacy and Therapeutics Committee (see Pharmacy and Therapeutics Committee Charter for details)

- e. Infection Control Committee (see Infection Prevention Annual Plan for details)
- f. Cancer Committee
 - i. Composition
 - 1. The Committee is a multidisciplinary committee which includes physician representation from the diagnostic and therapeutic specialties as well as Allied Health Professionals involved in the care of cancer patients. Physician members must include but are not limited to representatives of the major sites of cancer, surgery, medical oncology, radiation oncology, diagnostic radiology, pathology, and the cancer liaison physician. Membership composition is to be consistent with that recommended by the American College of Surgeons' Commission on Cancer. Non-physician members may include Administration, Nursing, Social Services, Cancer Registry, Pharmacy, and Quality Improvement.
 - ii. The duties of the Committee shall be as follows:
 - 1. develop and evaluate the annual goals and objectives for the clinical and educational activities related to cancer, thereby promoting a coordination of multiple approaches to clinical treatment;
 - 2. recommend policies and procedures concerning care of cancer patients;
 - 3. promote the participation of Medical Staff and patients in research programs designed to further knowledge and quality of care of cancer patients;
 - 4. plan and participate in the conduct of a quality management program;
 - 5. maintain liaison with the Registry Service, recommend procedures for its functioning, review its findings and assist in developing policies to assure accurate and timely reporting of cancer data;
 - 6. inform the Medical Staff of pertinent information derived from the Registry Service; and

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7. plan and present educational and consultative "Cancer Conferences" for members of the Medical Staff, thereby promoting a multidisciplinary approach to cancer treatment.
- g. Transfusion Committee
 - i. The duties of the Committee include:
 1. at least quarterly review of transfusion statistics and practices and of blood donor and special transfusion programs, i.e., autologous, frozen plasma, pheresis;
 2. review of transfusions of blood components flagged as "at variance from criteria for use"; and
 3. review of all transfusion reactions and complications or problems.
- h. Quality and Patient Safety Committee
 - i. The duties of the Committee shall include:
 1. review and evaluation of incidents reported to the Risk Manager, including Root Cause Analysis (RCA) reports;
 2. review and evaluation of hospital-wide quality monitoring reports from all service lines, inpatient and outpatient;
 3. review and evaluation of regulatory monitoring requirements including but not limited to The Joint Commission, California Department of Public Health (CDPH) and the Centers for Medicare and Medicaid Services (CMS); and
 4. review and evaluation of hospital-wide performance improvement activities.
- i. Physicians' Health Committee
 - i. The Committee is comprised of members with special interest and/or expertise in physician wellness concerns who have been appointed by the President of the Medical Staff. The Committee meets and reports to the Medical Executive Committee, quarterly. It does not keep minutes of its proceedings. The Physicians' Health Committee is consultative in nature and chartered to develop programs to provide education and support for physician health and wellbeing, address prevention of physical, psychiatric or emotional illness and facilitate confidential diagnosis, treatment, and rehabilitation of members who suffer from potentially impairing conditions. These programs encompass:
 1. Educating the Medical Staff and Health Center staff about prevention and recognition of illness and impairment issues to include education of specific conditions as deemed relevant.
 2. Disseminating information for contacting the Committee for timely help, for self-referrals, referral by other Medical Staff or Health Center employees.
 3. Reminding the Medical Staff of the Committee's function, availability, and membership.
 4. Providing forums as needed to provide timely topics and promote collegiality and interaction with members of the Committee.
 5. Responding to special incidents that affect the emotional welfare of Medical Staff members with consultation as appropriate.
 6. Providing such advice, counseling, or referrals to appropriate professional resources for diagnosis and/or treatment of the condition or concern.
 7. Evaluating the credibility of a complaint, allegation or concern, including such investigation as reasonably deemed necessary.
 8. Monitoring the affected member and the safety of patients until the rehabilitation or any corrective action process is complete; and in the event the member fails to complete a required rehabilitation program, informing the Medical Executive Committee so the need for other appropriate actions may be assessed.

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9. Enduring appropriate confidentiality with respect to the affected practitioner; however, if the Committee receives information that indicates that the health status of a member may pose a risk of harm to Health Center patients (or prospective patients), that information shall be referred to the President of the Medical Staff who will determine whether corrective action is necessary.
 10. Recommending to the Medical Executive Committee education or outreach programs benefitting the Medical Staff.
- j. Postgraduate Training Oversight Committee (PTOC)
- i. Purpose
 1. The Committee coordinates and reviews all aspects of training programs that operate within Providence Saint John's Health Center (PSJHC) licensed facilities.
 - ii. Duties
 1. Develop policies and procedures to ensure appropriate supervision and oversight for trainees rotating at PSJHC.
 2. Provide a formal mechanism for trainees to participate in the development, review, and evaluation of trainee patient care responsibilities and functions.
 3. Advise the Credentials Committee regarding credentialing of trainees.
 4. Review training programs proposed by Medical Staff Members.
 5. Evaluate existing training programs on an annual basis.
 - iii. Composition
 1. The Committee shall include at least two Active Staff Members.
 - iv. Meeting Frequency
 1. The Committee shall meet as often as necessary, at least annually.
 - v. Reporting
 1. The Committee will report to the Medical Executive Committee at least annually.