

## **PROVIDENCE TARZANA MEDICAL CENTER**

### **MEDICAL STAFF RULES AND REGULATIONS**

#### **I. GENERAL RULES AND REGULATIONS**

##### **Section 1. ADMISSION AND DISCHARGE OF PATIENTS**

- 1.1 A patient must be admitted to the hospital only by a member of the Medical Staff who has been granted privileges to admit patients. A member of the medical staff will be responsible for the care and treatment of each patient in the hospital for the prompt completeness and accuracy of the medical record, and for communication with the patient and their family members. A provisional diagnosis or valid reason for admission must be stated.
- 1.1.2 Pre-admission work-up must be completed for all surgical patients prior to commencing the procedure
- 1.1.3 Clinical criteria (e.g. Inter-Qual) must justify hospital admission, and direct the particular level of care within the hospital that the patient is admitted to.
- 1.1.4 A provisional diagnosis or valid reason for admission will be stated upon admission, or in case of an emergency, as soon thereafter as possible. Physicians admitting emergency cases will be prepared to justify to the Medical Executive Committee and Administration of the hospital that the emergency was a bona fide emergency. The History and Physical must clearly justify the admission and the findings recorded on the patient's chart as soon as possible after admission.
- 1.1.5 The admitting physician will first contact the admitting office to ascertain bed availability. If the patient requires direct Intensive Care Unit admission they should be directed first to the Emergency Department.
- 1.1.6 If a patient requires admission to the hospital from the Emergency Department, the patient's physician will be contacted to perform that admission. In the event the patient does not have a physician able to perform the admission, the appropriate physician serving on the Emergency Department Call Panel will be utilized to care for the patient upon admission.
- 1.1.7 Any patient admitted on a Psychiatric Hold must be seen by a psychiatrist within 24 hours of admission and follow-up is required as long as the "hold" is in place. Any patient admitted to the hospital for attempted suicide or suicidal ideation is required to undergo a psychiatric evaluation by a psychiatrist prior to discharge from the hospital. Obstetrical patients with previous history of depression or suicidal ideation or signs of post-partum depression should be seen by a psychiatrist prior to discharge.

**Section 1.2 CONTINUOUS COVERAGE**

Each member of the Medical Staff is required to assure continuous care to their patients and to insure that care can be provided on an emergency basis. As such, each member of the medical staff is required to have a covering physician, of the same specialty, who is to be contacted if they are not available. Additionally, **the Medical Director**, Chairperson of the Department, the Chief of Staff, or the Chief Executive Officer has the authority to call any member of the active staff to obtain coverage for a patient if there is a failure to respond in a timely manner to provide emergency care, or other lapse in clinical coverage.

**Section 1.3 EMERGENCY DEPARTMENT RESPONSE TIME**

Physicians on call for their practices, or those of colleagues, must respond to the Emergency Department within thirty (30) minutes. In the event of failure to do so, the Emergency Department has the option of contacting the panel physician. For STEMI patients, hospital policy will be followed.

**Section 1.4 ADMISSION OF PATIENT FROM EMERGENCY DEPARTMENT**

- 1.4.1 Transfer of responsibility for patient care will occur only after direct communication between the Emergency Medicine Department physician and the admitting physician.
- 1.4.2 The transfer of care to the admitting physician by the Emergency Medicine Department physician will be stated and deemed complete once the Emergency Medicine Department physician and the admitting physician have collaborated and agreed upon the time of official transfer of care. This time must be documented in the patient medical record. In the event a patient admission and transfer from the Emergency Medicine Department to the assigned ward is delayed, the patient will remain in the Emergency Medicine Department or Admission Hold-Over Unit until a bed becomes available. During this time, the attending physician is responsible to see the patient within the required time as indicated in the Medical Staff Rules and Regulations, and is responsible to provide medical orders for the patient while the patient remains in the Emergency Medicine Department or Admission Hold-Over Unit.

**Section 1.5 REFUSAL OF TREATMENT**

If a patient refuses hospitalization, continuous hospitalization, recommended treatment or advice, a waiver consent will be signed stating what was advised, the consequences of refusal, and that the patient accepts responsibility for refusal. Circumstances should be fully documented in a progress note or dictation. Patient refusal to sign a waiver should similarly be documented.

**Section 1.6 NEW DRUG ALLERGY**

Should a patient develop a new drug allergy during hospitalization, the physician will provide a Physician Order documenting the drug allergy.

**Section 1.7 INTRA-FACILITY TRANSFERS**

Patients are transferred upon the order of the responsible physician. The Medical Director of a unit has the authority to transfer patients out or re-direct transfers in.

**Section 1.8 DISCHARGE FROM THE HOSPITAL**

A patient will be discharged, by a member of the medical staff, when they clinically no longer meet criteria for inpatient treatment (e.g. Inter-Qual). It is the responsibility of the attending physician to discharge patients in a timely manner, as early as possible on the day of discharge. Discharges will be coordinated in cooperation with the nursing staff. Information concerning prospective discharges will be made available to the discharge planning coordinator promptly.

**Section 1.9 VISITATION/DAILY VISITS**

All patients cared for in the acute care setting must be seen by a physician at least on a daily basis. Newborns must be seen, by a physician, within 24 hours of birth and no longer than 24 hours prior to discharge.

**2. GENERAL PROVISIONS**

**2.1 NO SMOKING POLICY**

Providence Tarzana Medical Center, in recognition of the serious health hazards associated with smoke and smoking, and in order to reduce the risk of fire associated with cigarette embers has established itself as a non-smoking hospital facility.

Smoking is prohibited in all areas of the hospital facilities, including patient rooms, work areas, corridors, stairwells, lobby, waiting areas, restrooms, elevators, and eating areas. Smoking is also not permitted at the entrances of the hospital facilities. Smoking is permitted only in the designated outdoor areas.

**2.2 DISASTER PLANNING**

There is a Disaster Plan in place for the care of mass casualties at the time of any major disaster, based upon the hospitals' capabilities, in conjunction with other emergency facilities in the community. It is developed by a committee which is multi-disciplinary and includes members of the medical staff. There is a unified medical command under the direction of a designated physician.

## **2.3 OCCURRENCE REPORTS**

If a patient falls, there is an unusual complaint or threat by a patient or relative, or some other unusual occurrence takes place in which a patient or visitor might sustain an injury and an Occurrence Report seems applicable, it is the practitioners' responsibility to have the nurse furnish the necessary information in an occurrence report. It should be sent immediately to the Risk Management Department for reporting to the hospitals' insurance carrier. An Occurrence Report does not become part of the medical record. For this reason, the physician should record information regarding the patients' condition and treatment and a progress note on the chart, but s/he should not make reference that a report was made.

## **Section 2.4 USE OF CELLULAR DEVICES**

In order to assure patient safety at Providence Tarzana Medical Center, the following requirements are put into place:

- The use of cellular devices or their accessories (such as earphones or keyboards) must not compromise the integrity of the sterile field.
- Use of ear pieces is not allowed in the operating or procedure room.
- Whenever possible, members of the OR team, including the operating surgeon, should engage in outside communication only for urgent or emergent reasons during surgery/procedure.
- The surgical/procedural team should leave their cellular phone with the nursing staff while performing a surgery/procedure.
- No surgeon/proceduralist may answer a phone while operating (scrubbed or gloved). This includes, but is not limited to performance of procedures/surgeries performed in the GI Laboratory, Radiology, Cath Lab, Operating Room, or at the bedside. This also includes performance of procedures such as central line placement.
- For emergency in-coming calls, the nurse may answer the telephone for the surgeon/proceduralist and relay information.
- Special care should be taken to avoid sensitive communication within the hearing of awake or sedated patients.

## **Section 2.5 CONFLICT OF INTEREST – CHAIR OF A DEPARTMENT OR DEPARTMENTAL PEER REVIEW COMMITTEE**

- 2.5.1** An individual who (a) provides or is part of a group that provides services pursuant to an exclusive professional services agreement (e.g. anesthesiology, emergency medicine, pathology, radiology), (b) provides compensated administrative services to the Hospital (e.g. medical director), and/or (c) provides or is part of a group that provides coverage for a Hospital department or service (e.g. hospitalist for all unassigned ED patients, NICU

coverage, PICU coverage, Pediatric Hospitalist coverage), cannot be Chair of Department or of a Departmental Peer Review Committee.

- 2.5.2 Absent any other arrangement as listed in item 2.5.1 above, a contract between the Hospital or a hospitalist group and a physician whereby the physician agrees to serve as an on-call physician for the emergency department does not disqualify the on-call physician from serving as the Chair of a Department or of a Departmental Peer Review Committee.
- 2.5.3 If a question or dispute arises regarding whether a particular agreement bars the individual from holding the foregoing Medical Staff leadership position(s), the Medical Executive Committee will resolve the issue as a matter of medical staff self-governance.
- 2.5.4 If an individual holds one of the Hospital administrative arrangements listed above in 2.5.1, the individual cannot be selected as the Chair of a Department or of a Departmental Peer Review Committee unless the individual agrees to terminate the hospital administrative arrangement if the individual is selected. If at any time an individual has been selected to serve as the Chair of a Department or of a Departmental Peer Review Committee, overseeing the peer review process, and then obtains one of the Hospital administrative arrangements listed in 1.1, the physician must immediately terminate the Hospital administrative arrangement in order to retain the position as Chair of the Department or of a Departmental Peer Review Committee.

### **3 GENERAL CONDUCT OF CARE**

#### **Section 3.1 CARING FOR FAMILY**

Members of the medical staff can not provide medical or surgical care for members of their immediate family or domestic partner. This includes treating, observing, writing orders, attending, operating, performing procedures, or consulting. An exception is made for the observation of obstetrical care. *Immediate family members* are defined as parents, siblings, spouses, children, grandparents, and grandchildren. *Domestic partners* are persons not legally married but who have declared relatedness formally through the California Secretary of State (see AMA Code of Medical Ethics Opinion 8/19 issued June 1993).

#### **Section 3.2 HAND WASHING/ARTIFICIAL NAIL REQUIREMENTS**

Handwashing requirements and requirements for artificial nails are in accordance with Hospital Policy

**Section 3.3 START OF SURGERY**

The primary surgeon must be on campus prior to the induction of anesthesia for any patient undergoing an invasive procedure. *On campus* means within the hospital, in the **hospital** parking lot, or within one of the immediately surrounding medical buildings.

**Section 3.4 FLUOROSCOPY PRIVILEGES**

The surgeon or assistant surgeon must possess a current and valid Fluoroscopy License for any procedure requiring the use of Fluoroscopy.

**Section 3.5 CHEST X-RAY FOLLOWING CENTRAL LINE INSERTION**

It shall be a standing order and requirement that a chest x-ray be obtained within one hour of insertion of a central venous catheter into a sub-clavian or internal jugular vein.

**Section 3.6. ORDERS**

- 3.6.1** Telephone orders for other than medications may be received by any licensed, registered, or nationally certified health professional provided that the orders received relate to the area of competence of the individual receiving the orders.
- 3.6.2** All telephone orders must be read back to the ordering physician in order to assure accuracy. These orders must then be signed off (authenticated), and dated & timed, by the responsible physician or any other member of the physician's specialty/medical practice who is involved in, or responsible for the patients' care, within forty-eight (48) hours. Failure to do so will be brought to the attention of the Medical Executive Committee for appropriate action.
- 3.6.3** Discontinuation of orders and any new pertinent instructions is the responsibility of the physician or any other member of the physician's specialty/medical practice who is involved in or responsible for the patient's care. These orders may be given as a verbal order. Order must then be signed off, dated and timed, within forty-eight (48) hours. Failure to do so will be brought to the attention of the Medical Executive Committee for appropriate action.
- 3.6.4** Narcotics and sedatives that are ordered without time limitation of dosage will automatically be discontinued after a maximum of five (5) days. Antibiotics ordered without time limitation of dosage will automatically be discontinued after a maximum of seven (7) days. Drugs should not be discontinued without first notifying the physician.
- 3.6.5** A copy of the approved Hospital Formulary is present at all hospital units and will provide guidance for the ordering of medications.
- 3.6.6** Order sets are developed and amended by each department and approved by the Medical Executive Committee. These orders are to be followed insofar as

proper treatment of the patient will allow and when specific orders are to be documented by the attending physician; they will constitute the order for treatment.

- 3.6.7** All orders must be signed off (authenticated) and dated and timed, by a member of the medical staff/allied health professional staff.
- 3.6.8** Verbal orders are permitted in a medical emergent situation (i.e. code blue) or when medical circumstances prevent the physician from documenting the order.
- 3.6.9 Ordering of Cardiac Stress Tests**
  - 3.6.9.1** Physicians, other than Cardiologists can order cardiac stress tests of any nature (pharmacological or exercise stress)
  - 3.6.9.2** When ordering stress testing a cardiologist should be identified to supervise and interpret the test. Should a Cardiologist not be identified, the Hospital Cardiology Department will contact the ordering physician to designate a Cardiologist to monitor the test.
  - 3.6.9.3** The Cardiologist in turn can decide whether s/he wants to use the nurse practitioner to supervise the test, but will be ultimately responsible for the supervision and interpretation. There is no panel coverage.
- 3.6.10** When a patient is admitted to the hospital from the Emergency Department, the orders of the Emergency Department physician must be carried out to completion, whether the patient remains in the Emergency Department or is admitted to the floor. Exception is for opioids and benzodiazepines or any other sedating drug.

## **4 GENERAL PROVISIONS**

### **Section 4.1 MEDICAL STAFF RULES AND REGULATIONS**

Medical Staff Rules and Regulations will be approved pursuant to the Medical Staff Bylaws.

### **Section 4.2 DEPARTMENTAL RULES AND REGULATIONS/POLICIES AND PROCEDURES**

Subject to approval of the Medical Executive Committee and the Governing Body, each department will formulate its own Rules and Regulations and Policies and Procedures for the conduct of its affairs and the discharge of its responsibilities. Such Rules and Regulations & Policies and Procedures will not be inconsistent with the Medical Staff Bylaws, the General Rules and Regulations of the Medical Staff, or the policies of the hospital.

**Section 4.3 DUES OR ASSESSMENTS**

**4.3.1** The Medical Executive Committee will have the power to assess, collect and to determine the manner of expenditure of funds received and deposited in the medical staff bank accounts.

**4.3.2** Failure to pay the annual medical staff dues in the timeframe specified will result in suspension of membership and/or clinical privileges. Should the suspension remain in effect for 90 consecutive days, the physicians would voluntarily relinquish membership and clinical privileges in accordance with the Medical Staff Bylaws.

**5 MEDICAL RECORDS**

**5.1** Medical Records Process and Requirements are covered in the Medical Staff Bylaws and Policies and Procedures of the Medical Staff.

**6. CREDENTIALING**

**Section 6.1 TEMPORARY PRIVILEGES CREDENTIALING FOR QUALIFIED APPLICANTS**

**6.1.1 Purpose**

**6.1.1.1** To provide an efficient mechanism for approval of initial appointments and reappointments without compromising overall quality of care, Temporary privilege credentialing provides an expedited review and approval process if specified criteria are met.

**6.1.1.2** Temporary privileges are **not** a right. No applicant is entitled to Temporary privilege processing or entitled to the hearing or appeals process to challenge not being processed through this process. Candidates who do not meet the criteria for this type of privileging will be processed through the full approval process.

**6.1.2 Category Definitions**

**6.1.2.1 New Applicants**

**6.1.2.1.1** Application contains no information that indicates the need for further inquiry or investigation.

**6.1.2.1.2** No difficulty in verifying information on the application

**6.1.2.1.3** All references/verifications readily respond and contain no indications or raise any questions that the physician is anything other than a highly qualified, currently competent physician

who exercises good clinical judgment and behaves in an appropriate professional manner.

**6.1.2.1.4** Few or no prior hospital affiliations

**6.1.2.1.5** No disciplinary or licensure actions, and no pending investigations

**6.1.2.1.6** No pending malpractice suits or arbitrations, no significant malpractice judgment or settlement within the past five years (i.e. resolved for more than nuisance value) and either few or no claims which were resolved for nuisance value.

#### **6.1.2.2 Reapplications**

**6.1.2.2.1** Reapplication contains no information that indicates the need for further inquiry or investigation.

**6.1.2.2.2** Sufficient activity at this facility to evaluate current competency

**6.1.2.2.3** Other hospital affiliations and references readily respond and provide positive evaluations.

**6.1.2.2.4** No new malpractice suits or arbitrations since the prior application for appointment/reappointment.

**6.1.2.2.5** No disciplinary or licensure actions and no pending investigations

**6.1.2.2.6** Not subject to focused reviewed by this Medical Staff

#### **6.1.3 Procedure for Processing**

**6.1.3.1** The application/reapplication initially is received and reviewed by the Medical Staff Office personnel. Determination is then made as to whether an application or reapplication meets the criteria for processing of temporary privileges.

**6.1.3.2** Qualified applications/reapplications are reviewed by the Chair or designee of the Credentials Committee or Interdisciplinary Practice Committee. The Chair or designee confirms the application/reapplication meets the criteria for temporary privileges and reviews the applicant's qualifications.

**6.1.3.3** After review and approval of the applicant's qualifications, the Chair or designee of the Credentials committee or Interdisciplinary Practice Committee forwards the application/reapplication to the Department Chair or designee to confirm the Temporary privileges designation, to review the completed application/reapplication, and to review and recommend delineated clinical privileges.

**6.1.3.4** After review and approval confirmation by the Department Chair or designee, the application/reapplication is submitted to the Medical Executive Committee

for approval. Once a majority approval is received from the Medical Executive Committee the application/reapplication is submitted to the Chief Executive Officer for review and recommendation for approval of Temporary Privileges.

**6.1.3.5** Once the application/reapplication has been signed off by the Chair of the Credentials Committee, Chief of the Clinical Department or designee, the Chief of Staff, and the Chief Executive Officer or designee, the applicant will be notified, in writing, of the Temporary Privilege approval and all hospital systems will be updated accordingly. The application will then be presented at the next Governing Board meeting for final approval of appointment/reappointment.

**6.1.3.6** If the Governing Board does not ratify an appointment/reappointment which has been granted Temporary Privileges, the Governing Board will refer the matter back to the Medical Executive Committee for its re-evaluation.

## **6.2 MEETING ATTENDANCE REQUIREMENTS FOR STAFF STATUS**

In order to be considered from and to maintain Active Staff Status, a physician will be required to attend 50% of the General Medical Staff meetings held as well as 50% of Departmental Meetings or a combination of 25% Departmental Meetings and 25% Medical Staff Committee meetings. Physician members of the medical staff who also attend administrative meetings and represent the medical staff, eg. Antimicrobial Stewardship, Medication Management, may use these meetings to satisfy up to 25% of their meeting attendance.

## **6.3 REQUEST FOR NEW PRIVILEGE TO BE ADDED TO DELINEATION OF PRIVILEGES & ADDITION OF PRIVILEGE FOR PARTICULAR PHYSICIAN**

Process for requesting additional privileges to be added to a delineation of privileges is located in the Medical Staff Policies and Procedures. This also includes how a physician can request the privilege once added.

## **7. PROCTORING/FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)/ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)**

Process for Proctoring, Focused Professional Practice Evaluation (FPPE) and Ongoing Professional Practice Evaluation (OPPE) is located in the Medical Staff Policies and Procedures.

## **8. MEDICAL STAFF CREDENTIAL FILES & RELATED MEDICAL STAFF CREDENTIALING ISSUES**

### **8.1 INFORMATION TO BE INCLUDED IN CREDENTIAL FILES**

**8.1.1** The completed and verified application for medical staff membership, including information on training, experience, references, current licensure, and Drug Enforcement Act (DEA) registration, malpractice insurance verification in the amount required for membership, evidence of continuing education to support

privileges requested, National Practitioner Data Bank information, and a request for clinical privileges.

- 8.1.2** Evidence that the medical staff actually evaluated and acted upon the above information.
- 8.1.3** Evidence of proctoring/**FPPE** for membership and additional privileges.
- 8.1.4** Specific and current clinical privileges recommended by the medical staff and approved by the governing board.
- 8.1.5** Data pertinent to reappraisal and reappointment, including current licensure, DEA registration, continuing medical education, attendance as required at meetings, and health status in order to allow the physician to carry out privileges as requested.
- 8.1.6** Evidence that the medical staff critically evaluated the above information and assessed the current clinical competence for privileges requested, as well as evidence that appropriate action was taken on reappointment and renewal of privileges.
- 8.1.7** Physician specific information generated pursuant to the medical staff's ongoing peer review process.
- 8.1.8** There shall be only one medical staff credential file for each member of the medical staff to help increase the likelihood that the confidentiality afforded medical staff committee records and proceedings by Evidence Code Section 1157 will apply to this information. Quality and Peer Review will be placed in a separate section of the Credential File. This file shall be kept in the medical staff office.
- 8.1.9** This file shall include only well documented and appropriate data, and should not include information that is immaterial, misleading, or of questionable value.

## **8.2 INSERTION OF ADVERSE INFORMATION**

The following applies to actions relating to requests for insertion of adverse information into the medical staff member's credential file:

- 8.2.1** Any person may provide information to the medical staff about the conduct, performance or competence of its members.
- 8.2.2** When a request is made for insertion of adverse information into the medical staff member's credential file, the respective department chief and chief of staff will review such request.
- 8.2.3** After ~~such~~ review, a decision will be made by the respective department

chief and chief of staff to:

**8.2.3.1** Not insert the information;

**8.2.3.2** Notify the member of the adverse information by a written summary and offer him/her the opportunity to rebut this assertion before it is entered in his/her file. or;

**8.2.3.3** Insert the information along with a notation that a request has been made to the executive committee for an investigation.

**8.2.3.4** A decision pursuant to #3 will be reported to the medical executive committee. The medical executive committee may either ratify or initiate contrary actions to the this decision by a majority vote.

### **8.3 REVIEW OF ADVERSE INFORMATION AT THE TIME OF REAPPOINTMENT**

**8.3.1** The following applies to the review at the time of reappointment of adverse information inserted in the medical staff member's credential file based on this policy:

**8.3.1.1** Prior to recommendation on reappointment, the credentials committee, as part of its reappraisal function, shall review any adverse information in the credential file pertaining to a member.

**8.3.1.2** Following this review, the credentials committee shall determine whether documentation in the file warrants **any** further action.

**8.3.1.3** With respect to such adverse information, if it does not appear that an investigation and/or adverse action on reappointment is warranted, the credentials committee shall so inform the executive committee.

**8.3.1.4** However, if an investigation and/or adverse action on reappointment is warranted, the credentials committee shall so inform the executive committee.

### **8.4 MEMBER'S OPPORTUNITY TO REQUEST CORRECTION/DELECTION OF AND TO MAKE ADDITIONS TO INFORMATION IN FILE**

**8.4.1** When a member has reviewed his/her file as provided, he/she may address to the Chief of Staff a written request for correction or deletion of information in the file. Such request will include a statement of the basis for the action requested.

**8.4.2** The Chief of Staff will review the request within a reasonable time and recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion requested. The Medical Executive Committee, when so informed, will either ratify or initiate action contrary to this recommendation, by a majority vote.

**8.4.3** The member will be notified promptly, in writing, of the decision of the Medical Executive Committee.

**8.4.4** In any case, a member will have the right to add to his own credential file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

## **8.5 IMMUNITY FROM LIABILITY FOR ACTIONS TAKEN**

Each representative of the Medical Staff and Hospital will be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief, for any action taken or statements or recommendations made within the scope of duties exercised as a representative of the Medical Staff or Hospital.

## **8.6 FOR PROVIDING INFORMATION**

Each representative of the Medical Staff and Hospital and all third parties will be exempt, to the fullest extent permitted by law, from liability to an applicant or member for damages or other relief by reason of providing information to a representative of the Medical Staff or Hospital concerning each person who is or has been an applicant to or a member of the staff or who did, or does, exercise clinical privileges or provide services at this hospital.

## **8.7 ACTIVITIES COVERED BY IMMUNITY**

The confidentiality and immunity provided by this policy apply to all acts, communications, reports, recommendations or disclosures performed or made in connection with this or any other health care facilities or organization activities concerning but not limited to:

**8.7.1** Application for appointment, reappointment or clinical privileges;

**8.7.2** Corrective action;

**8.7.3** Hearings and appellate reviews;

**8.7.4** Utilization review;

**8.7.5** Other department, committee, or medical staff activities related to monitoring and maintaining quality patient care and appropriate professional conduct, and;

**8.7.6** Peer review organizations, Medical Board, National Practitioner Data Bank and similar reports.

## **8.8. RELEASES**

Each applicant or member will, upon request of the Medical Staff or Hospital, execute general and specific releases in accordance with the express provisions and general intent

of this rule. Execution of such releases will not be deemed a prerequisite to the effectiveness of this rule.

## **8.9 CONFIDENTIALITY OF MEDICAL STAFF INFORMATION**

**8.9.1** The records of the medical staff and its committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital are maintained as confidential. This applies to the credential files as well as all proceedings of the medical staff.

**8.9.2** Access to such records is limited to duly appointed officers and committees of the medical staff and a designee of the board to enable the board to fulfill its required functions, and any and all access to be for the sole purpose of discharging medical staff responsibilities and subject the requirement that confidentiality be maintained.

**8.9.3** Members of the medical staff **office** support staff who may have access to these records should be informed of the confidential nature of these documents and of the procedure to be followed when requests for access are received.

**8.9.4** Information which is disclosed to the Governing Body of the Hospital or its appointed representatives, in order that the Governing Body may discharge its lawful obligations and responsibilities, will be maintained by that body as confidential.

**8.9.5** Information contained in the credential file of any member may be disclosed with the members consent, to any medical staff or professional licensing board or as required by law. However, any disclosure outside of the medical staff, without prior authorization of the member, will require the authorization of the chief of staff and the chairman of the concerned department and notice to the member.

**8.9.6** A medical staff member will be granted access to his/her own credential file, subject to the following provisions:

**8.9.6.1** Timely notice of such will be made by the member to the chief of staff or designee, in writing;

**8.9.6.2** The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, complaints, etc. will be provided to the member in writing, by the designated officer of the medical staff, (within a reasonable period of time, as determined by the medical staff). Such summary will disclose the substance, but not the source of the information summarized.

## **9. PEER REVIEW**

All peer review activities are privileged. Confidentiality is to be maintained. No discussion of the particulars of a case or of a physician's conducted will be discussed outside the framework of the peer review process. Failure to maintain the confidentiality of peer review proceedings may result in disciplinary action.

Purpose, Definitions, Process, External Review and Physician Response requirements are defined in Medical Staff Policies and Procedures for Peer Review.

**Section 9.1 ONGOING PROFESSIONAL PERFORMANCE EVALUATION PROCESS** –The Process for OPPE is delineated in Medical Staff Policy and Procedure

## **10. CLINICAL DEPARTMENT FUNCTIONS**

### **Section 10.1 Clinical Department Functions**

**10.1.1** Each clinical department will recommend, to the Medical Executive Committee, criteria consistent with the policies of the Medical Staff and the Governing Board, for the granting of clinical privileges in the department. Such recommendations for approval may be delegated to the established peer review committee and signed off by the appropriate clinical chair. (4/03)

**10.1.2** Each department will establish a committee responsible for conducting a primary retrospective review of completed medical records of discharged patients and other pertinent sources of medical information related to patient care for presentation to the full department and the Medical Executive Committee at least quarterly. This information should contribute to the continuing education and to the process of developing criteria to assure an acceptable quality of patient care by all members of the department. Such reviews will be conducted monthly and include monitoring as defined in the quality improvement plans for the clinical departments and the medical staff as a whole. This function may be delegated to a monitoring committee.

**10.1.3** Clinical department meetings will be held at least quarterly to review and evaluate the overall medical performance within the department, including the quality monitoring activities of the department and to consider and act upon committee reports, and conduct.

**10.1.4** A report will be submitted at least quarterly to the Medical Executive Committee detailing such departmental analysis of patient care and other important aspects of departmental business.

**10.1.5** Process measurement, assessment, and improvement, including evaluation of medication use, blood and blood components, efficiency of clinical practice patterns, and significant departures from established patterns of clinical procedures, as well as use of operative and other invasive procedure, **and appropriateness of procedure(s)**, if applicable.

## **11. DEPARTMENT OF MEDICINE**

### **Section 11.1 GENERAL**

The Department of Medicine of Providence Tarzana Medical Center is organized to provide inpatient and outpatient services. Care is provided in accordance with the standards of practice outlined by the Profession of Medicine. Additionally, care is provided to ensure compliance with all requirements set forth by the Department of Health Services and all accrediting and certifying bodies. The Department of Medicine is

responsible for the quality of medical care rendered to patients and for the maintenance of the highest standards of medical care provided by its members.

## **Section 11.2 MEMBERSHIP**

The Department of Medicine of Providence Tarzana Medical Center is composed of the following specialties: Psychiatry, including Clinical Psychology; Family Practice, including General Practice, Internal Medicine, including Medical Sub-specialties, and Palliative Care. The Department is divided into the following Divisions: Medicine, Radiology, Cardiology, and Emergency Medicine.

## **Section 11.3 DIVISIONS**

Pursuant to the Medical Staff Bylaws, any group of physicians may organize themselves into a division within a department. Any division, if organized, will not be required to hold any number of regularly scheduled meetings, attendance will not be required unless the Division chairperson calls for a special meeting to discuss a particular issue. A division may develop rules which specify the method of selection its chair and its purposes and responsibilities. Exception to this is the Emergency Medicine Division and the Cardiology Division, both of whom have been delegated peer review responsibilities and are required to meet at least quarterly and to report to the Medical Executive Committee as well as the Department of Medicine.

## **Section 11.4 DEPARTMENTAL PEER REVIEW REQUIREMENTS**

**11.4.1** Physicians are obligated to review and attend the peer review meeting when requested or to make arrangements to switch with another physician. This will be required for all members of the active medical staff in the department with the exception of Cardiologists and Emergency Medicine physicians who already participate in the peer review process through their division meetings.

### **11.4.2 No/Low Volume Physicians**

11.4.2.1 Procedures not performed during the reappointment period will be deferred pending current clinical competence or be granted under FPPE with the next three elective procedures performed to be proctored concurrently. The proctor may deem the first procedure sufficient to demonstrate current clinical competence. This will be monitored during OPPE with physician notification as to the monitoring to assure current clinical competence.

11.4.2.2 Inpatient admitting privileges may be granted under FPPE with the next three admissions retrospectively reviewed.

## **Section 11.5 DIVISION OF CARDIOLOGY**

### **11.5.1 MEETING REQUIREMENTS**

Members of the Cardiology Division must meet active staff meeting requirements in order to join and remain on the Cardiology Reading Panel.

#### **11.5.2 DUTIES AND RESPONSIBILITIES**

The Cardiology Division has been delegated the responsibility for conducting peer review for cardiology care provided to patients at the hospitals. They have also been delegated the responsibility of reviewing credentialing requests and **establishing** criteria for privileging. Reporting of findings is required to be made to the Department of Medicine for recommendation to the Medical Executive Committee.

#### **11.5.3 ICD FORM AND DOCUMENTATION OF INDICATIONS REQUIREMENTS**

The ICD form must be completed at the time the patient is booked in the Cath Lab/Surgery for a procedure, except in the case of a true emergency. In this case, the form must be completed immediately following the case.

Also required is that the implanting physician provide evidence of ejection fraction, such as a MUGA or echocardiogram. This documentation should be attached to the ICD implant Form.

#### **11.5.4 MEDICAL DIRECTOR – CARDIAC CATH LAB**

**Duties and Responsibilities of the Medical Director of the Cath Lab are in accordance with their Medical Directorship Agreement.**

#### **11.5.5 SURGICAL STANDBY**

**11.5.5.1** It is the responsibility of the primary angioplaster to determine the appropriate level of stand-by required for any given case. This determination should be based upon the risks and cost/benefit associated with the performance of the Angioplasty on a given vessel, under given circumstances. It is also the responsibility of the primary angioplaster to clearly define the level of the stand-by required to the Cath Lab staff at the time of scheduling the procedure. The levels of cardiac surgical stand-by are as follows:

##### **11.5.5.1.1 Full Cardiac Surgical Stand-by**

**11.5.5.1.1.1** An anesthesiologist present and caring for the patient during the procedure;

**11.5.5.1.1.2** One of the cardiac surgical suites prepared for emergency surgery with the surgical team and perfusionist on premises, and;

**11.5.5.1.1.3** A Cardiovascular Surgeon immediately available on the premises or in the immediate vicinity of the hospital

**11.5.5.1.2 No Cardiac Surgical Stand-by**

The O.R. Team is available on a normal emergency basis, i.e. within 30-40 minutes of the hospital;

**11.5.5.1.3 Personalized Cardiac Stand-by**

Specific individuals or groups are requested at the discretion of the primary angioplaster.

**Section 11.6 DIVISION OF EMERGENCY MEDICINE**

**11.6.1 Emergency Services Description**

**11.6.1.1** The Emergency Department offers level II basic emergency medical care twenty-four (24) hours a day with at least one emergency medicine physician specialist on duty in the emergency department at all times.

**11.6.1.2** There is an on-call/back-up panel of physician specialists established and maintained in accordance with the medical staff by-laws, rules and regulations and policies.

**11.6.1.3** Effective 11/10/08, Patients triaged as Urgent Care or Fast Track (ESI levels 4 and 5/lower acuity patients) may be cared for by a physician with appropriate expertise in Fast Track and Urgent Care (i.e. Family Practice Physician).

**11.6.2 Organization of Emergency Services**

**11.6.2.1** Emergency Medical Services are organized as a division of the Department of Medicine as outlined in the general rules and regulations.

**11.6.2.2** There is a Chairperson of the Division of Emergency Medicine who oversees the Committee of the Division of Emergency Medicine.

**11.6.2.3** Additionally, there is a Medical Director of the Division of Emergency Medicine. The Medical Director and the Chairperson may be the same person.

**11.6.2.3.1 Qualifications of Medical Director and Chairperson**

The Medical Director and/or Chairperson must be a member of the Active Medical Staff, must be Board Certified in Emergency Medicine and must hold clinical privileges in Emergency Medicine.

**11.6.2.4** The Emergency Medicine Division has been delegated the responsibility for conducting peer review for the care provided in the Emergency Department as well as for the development of credentialing criteria.

### **11.6.3 Duties and services**

Services provided by the Emergency Medicine physician specialist will include, but not be limited to the following:

**11.6.3.1** The emergency department physician on duty will be physically present in the hospital at all times.

**11.6.3.2** Will evaluate and treat all individuals seeking care in the Emergency Department in accordance with the physician's clinical privileges, the policies and procedures of the division, and all federal and state statutes as they pertain to the provision of emergency care services (See COBRA-EMTALA).

**11.6.3.3** Will respond to emergency situations arising in the intensive care units or on the floor provided that these situations, in the judgment of the emergency physician specialist, do not interfere with the care and services required by patients in the emergency department.

**11.6.3.4** Evaluation and treatment of visitors and hospital employee accidents or injuries

**11.6.3.5** Pronouncing of patient expirations in the hospital in the absence of other primary care or attending physicians or hospitalists.

**11.6.3.6** May be asked to perform, and may provide for, delivery of a newborn infant in the obstetrical area in the absence of an obstetrician, in the case of a precipitous delivery.

**11.6.3.7** Plan and respond to any catastrophic or disaster type condition within the hospital or community in accordance with the hospital and department disaster plans.

**11.6.3.8** Manage the emergency department team in the care of patients with life-threatening illnesses and injuries as well as the official handling of those patients with more routine and minor problems.

**11.6.3.9** Provide initial emergency health services twenty-four (24) hours a day to all individuals of all ages and in accordance with COBRA-EMTALA, making recommendations for appropriate follow-up care in or out of the hospital as may be required.

**11.6.4 Emergency Physician Obligation to COBRA-EMTALA Regulations**

**11.6.4.1** All patients will receive a medical screening examination (MSE) provided by the emergency physician specialist to determine the absence or presence of an emergency medical condition. The medical screening examination will be performed on every individual who presents to the emergency department, will be performed in a like and similar fashion, regardless of the individual's race, disability, non-medical factors, and the ability to pay for the medical care.

**11.6.4.2** All patients seeking care in the Emergency Department will be stabilized according to the capabilities of the hospital.

**11.6.4.3** If the medical screening examination indicates that the patient has an ongoing emergency medical condition, and when such emergency medical condition requires consultation or treatment beyond the capability of the Emergency Department and the emergency department physician, an appropriate consultation will be obtained and the patient will be admitted or transferred in accordance with the COBRA - EMTALA regulations.

**11.6.4.4** Treating physicians may transfer a patient if the patient has been stabilized, the patient requires higher level of care, or the patient requests transfer.

**11.6.4.5** It is recognized that no further EMTALA obligations exist if an appropriate medical screening exam identifies that no emergency medical condition exists.

**11.6.4.6** Patients with an incompletely stabilized emergency medical condition may be transferred under EMTALA if one of the two conditions exist as follows:

**11.6.4.6.1** The patient or someone acting on the patient's behalf provides a written request for transfer despite being informed of the hospital's EMTALA obligations to provide treatment.

**11.6.4.6.2** A physician certifies that medical benefits reasonably expected from the transfer outweigh the risk to the individual.

**11.6.4.7** Once a decision is made to transfer the individual, the following must be undertaken:

**11.6.4.7.1** The receiving facility and physician must accept the transfer, must have space availability, and qualified personnel to treat the individual.

**11.6.4.7.2** Copies of all medical records related to the emergency medical condition will be transferred with the patient

**11.6.4.7.3** Qualified personnel with the appropriate medical equipment must accompany the patient during transfer.

**11.6.4.8** Definition of an Emergency Medical Condition

Medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric conditions, and/or substance abuse) such that the absence of immediate medical attention could be expected to result in:

- Placing the patient or unborn child in serious jeopardy.
- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

With respect to a pregnant woman who is having contractions:

- There is inadequate time to effect a safe transfer to another hospital before delivery, or
- The transfer may pose a threat to the health or safety of the woman or unborn child.

**11.6.4.9** Definition of Stabilize

To stabilize means, with respect to a medical condition, as defined herein: To provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or, with respect to an emergency medical condition involving a pregnant woman; that the woman has delivered including the placenta.

**11.6.5 General COBRA Guidelines**

**11.6.5.1** Signs as required by COBRA-EMTALA regulations should be posted in all patient care areas delineating patients' rights

**11.6.5.2** On-call medical staff rosters will be maintained and posted at all times for referral purposes.

**11.6.5.3** The designated individual to report alleged COBRA-EMTALA violations will be the Administrative Director, Risk Management.

**11.6.5.4** An assigned and qualified emergency department registered nurse will carry out the responsibility of the process of triage and the emergency

physician specialist on duty will provide the medical screening examination.

#### **11.6.6 On-Call/Back-Up Physician Panels**

It is the policy of Providence Tarzana Medical Center to comply with the Emergency Medical Treatment and Active Labor Act (EMTALA)

EMTALA requires that any patient who presents to the Emergency Department must receive an appropriate medical screening examination to determine if that patient has an emergency medical condition. If so, the patient's condition must be stabilized prior to discharge.

The medical screening exam will include the use of appropriate emergency department resources including specialized tests or consultants.

- 11.6.6.1** Only members of the medical staff will be allowed to provide back-up/on-call coverage for the Emergency Department
- 11.6.6.2** On-call panels will be arranged in accordance with agreement amongst medical staff members and administration, and shall be coordinated by the medical staff office.
- 11.6.6.3** Copies of the on-call panel schedule shall be maintained by the medical staff office and posted in the Emergency Department for reference purposes. A copy is emailed to the participating physicians. All members of the Emergency Department on-call/back-up panel are expected to abide by the rules and regulations of this service as well as by-laws, general rules and regulations, **and policies** of the hospital **and medical staff**, as well as the current federal and state regulations inclusive of COBRA - EMTALA.
- 11.6.6.4** The call time period is a twenty-four (24) hour period beginning at 7 a.m. until 6:59 a.m. of the following day.
- 11.6.6.5** Once the call panel schedule has been completed and a physician requires a change, it is the responsibility of the individual physician to find his or her own replacement. The replacement physician must be another qualified panelist with appropriate privileging. The medical staff office must be notified and must approve any and all changes.
- 11.6.6.6** If a change in the call panel is requested or required when the medical staff office is closed, notification must be made directly to the administrator on duty. The administrator on duty then must inform the nursing supervisor on duty, who will then inform the Emergency Department and provide written changes directly into the on call panel system.
  - 11.6.6.6.1** Members of the on-call backup panel must respond to a request for

consultation within thirty (30) minutes when they are called by the Emergency Department.

- 11.6.6.7** Panel physicians are required to see or consult on all patients who present to the Emergency Department when requested to do so by the emergency department physician on duty.
- 11.6.6.8** The on-call physician must come to the Emergency Department when requested to do so by the emergency department physician, another physician, a nurse, or any hospital worker making the request on behalf of a physician or a nurse who is not available to call the on-call physician directly.
- 11.6.6.9** When the Emergency Department staff has been unable to reach the on-call physician after three (3) documented calls within thirty (30) minutes, his or her physician alternate shall immediately be contacted. If the physician alternate cannot be contacted or is unavailable, then the nursing supervisor on duty and the chairperson of the involved department shall be contacted concurrently. When, within thirty (30) more minutes these actions fail to satisfy the situation, the administrator on duty shall be contacted.
- 11.6.6.10** If the on-call physician disagrees or disputes the need to come to the Emergency Department, that on-call physician must come to the hospital and render consultation and care irrespective of the disagreement. On-call/panel physicians are required to accept any patient requiring admission and who otherwise is not transferable, regardless of the patient's ability to pay, insurance status, or managed care insurance status, in accordance with all current COBRA - EMTALA guidelines. Any violation of the rules and regulations or failure to meet the qualifications of the on-call panel may result in removal from the on-call/backup panel as deemed necessary by the Division of Emergency Medicine. Furthermore, such violations or lack of compliance may lead to further disciplinary action as indicated by the Medical Executive Committee and the medical staff by-laws.
- 11.6.6.11** It is required that the Emergency Call Panel Physician, on call at the time The Emergency Department decision is made for admission and/or specialty consultation, be responsible for the admission/consultation of the patient.
- 11.6.6.12** If a patient between the ages of 0-17 years of age presents to the Emergency Department and requires the attention of a surgeon, the pediatric surgery on-call physician will be called to evaluate and care for the patient. Any patient over the age of 17 years, the general surgery panel physician will be called.

**Section 11.7 Medical Records Documentation and Maintenance**

**11.7.1** All patients requesting emergency services shall have a record prepared. This record shall be incorporated into the patient's permanent hospital medical record and the record shall include but not be limited to the following:

- 11.7.1.1 Adequate patient identification. When not obtainable, the reason for failure to obtain this information must be entered in the medical record.
- 11.7.1.2 Time and means of the patient's arrival.
- 11.7.1.3 Pertinent history of illness or injury, physical findings and patient's vital signs.
- 11.7.1.4 Pre-hospital care that may have been provided by paramedics or other personnel.
- 11.7.1.5 Description of diagnostic and therapeutic orders including significant clinical laboratory and x-ray findings.
- 11.7.1.6 Clinical observations and the results of treatment.
- 11.7.1.7 Diagnostic impressions.
- 11.7.1.8 Conclusion at the termination of evaluation and/or treatment, including final disposition, the patient's condition upon discharge or transfer or any aftercare instructions given to the patient and/or family members for management.
- 11.7.1.9 Documentation of a patient's leaving against medical advice.
- 11.7.1.10 The medical record must be authenticated by the practitioner who is responsible for its clinical accuracy.

**Section 11.8 Patient/Private Physician Relationships**

- 11.8.1 Every effort shall be made to protect any pre-existing relationship between a patient and their private practitioner.
- 11.8.2 Patients under the care of the emergency department physician specialist, and who have a private physician and whose medical condition warrants, shall have the private physician called so that physician may assist in the coordination of care.

- 11.8.3 If a patient requires immediate hospitalization and the private physician (other than the on-call panel physician) cannot be reached within 30 minutes, then the patient will be admitted to a physician serving on the on-call/back-up panel.
- 11.8.4 If a physician, wishing to provide care to his/her patient in the Emergency Department sends a patient to the Emergency Department, he/she may evaluate his/her patient. In all of these cases a medical screening exam will be performed by the emergency physician specialist in accordance with COBRA - EMTALA regulations.
- 11.8.5 Physicians who choose to see their patients in the Emergency Department must remain available by phone or in person to receive the results of the tests they have ordered for their patient in the Emergency Department.
- 11.8.6 When a consultation is required, it will be arranged whenever possible, with a practitioner as requested by the patient in conjunction with his or her primary care physician, or his or her prepaid health plan, or a member of the back-up panel. Any physician contacted for consultation must respond to the Emergency Department within 30 minutes. When there is failure to respond within the allotted timeframe, the Emergency Department physician has the option of contacting the backup on-call panel physician.
- 11.8.7 Assignment of unassigned patients.
  - 11.8.7.1 A patient who has been evaluated by the emergency department physician specialist and who is without a private medical doctor and for whom admission is necessary will be assigned to the on-call physician for the appropriate specialty.
  - 11.8.7.2 When admission is necessary and the patient has a specific physician request, all attempts to honor that request will be made.
- 11.9. Once a decision to admit a patient has been made, and the appropriate admitting physician has been notified, admission from the Emergency Department to the hospital should not be delayed while waiting for the admitting physician to arrive.
- 11.10 An unassigned patient (no PMD) who does not require hospitalization subsequent to the medical screening exam will be given a physician list for follow-up care. This list will include the name of the on-call physician for the appropriate specialty.
- 11.11 Obstetrical patients whose gestational age is 20 weeks or greater shall be screened in labor and delivery in accordance with obstetrical medical screening policy and procedure.

## Section 11.12 Transfer of Emergency Patients

11.12.1 All patients transferred from the Emergency Department shall be done so in accordance with the transfer policy contained in the Emergency Department Policy and Procedure Manual, and in accordance with COBRA - EMTALA regulations.

11.12.2 Receiving a transferred patient.

11.12.2.1 All transfers into Providence Tarzana Medical Center will be coordinated through the Providence Tarzana Medical Center Transfer Center per policy.

11.12.2.1.1 Inter-hospital transfers should result in a direct admission unless the unstable patient requires treatment in the Emergency Department while waiting for a critical care bed to become available.

11.12.2.1.2 From time to time an outside facility or physician may request transfer directly to the

Emergency Department for the emergency department physician specialist to evaluate said patient. Prior to accepting a transfer to the Emergency Department, the emergency department physician and/or his/her designee, will refer back to the Providence Tarzana Medical Center Transfer Center to determine whether or not the hospital has the appropriate facilities and personnel to accommodate the transfer.

The acceptance of a transfer Providence Tarzana Medical Center shall be done in accordance with COBRA - EMTALA regulations.

### 11.13.1 Definition of Appropriate Attempts to Contact a Private or On-Call Physician

An appropriate attempt to contact the physician shall be considered to have been made when the Emergency Department has:

11.13.1.1 Attempted to reach the physician in the hospital.

11.13.3.2 Called the physician at his/her office, and

11.13.3.3 Called the physician's pager **system/cell phone** on at least two (2) occasions.

11.13.2 The physician shall be called three (3) times within thirty (30) minutes. If the physician cannot be contacted, the emergency department personnel shall then contact the nursing supervisor who may then attempt to call the physician at home **and on their cell phone**.

## Section 11.14 Sexual Assault Victims

11.14.1 Providence Tarzana Medical Center is not a designated center for the handling of victims of sexual assault. Furthermore, Providence Tarzana Medical Center does not have a specific sexual assault response team.

11.14.2 Upon completion of a medical screening examination and once an emergency medical condition has been ruled out, in accordance with COBRA - EMTALA legislation, these patients are to be transferred to a facility that can collect the necessary and appropriate evidence in the proper clinical setting per Providence Tarzana Medical Center Policy and Procedure.

## Section 11.15 DIVISION OF RADIOLOGY

### 11.15.1 MEMBERSHIP

The radiology division is a necessary and integral part of the hospital and in order to function most effectively in the best interest of staff physicians, the hospital and its patients, it operates under the sole supervision and management of staff radiologists who have direct contractual relationships with the hospital to the exclusion of other physicians specializing in radiology.

### 11.15.2 DIAGNOSTIC RADIOLOGIC EXAMINATIONS

#### 11.15.2.1 Requests

The requests should indicate the type of examination to be performed. The requests need not indicate the views unless variations from the routine views is desired. As far as possible, the referring physicians should explain to the parent or patient the nature of the examination especially when instrumentation of any kind is necessary. In accordance with the requirements of the Joint Commission on Hospital Accreditation, the request must list the indications for the examination and pertinent clinical information to insure appropriate studies. This should include at least a provisional diagnosis. Referring physicians should indicate, on the request, any circumstances that would necessitate variation from the routine that would necessitate variation from the routine to facilitate safety of the patient, allergic history or injury or disease that would preclude the routine positioning or infection requiring special precautions.

Should an exam be for line placement, documentation should indicate if any other lines are in place.

### 11.15.3 RADIATION SAFETY

**11.15.3.1** The importance of minimalizing both total body and gonadal radiation, especially in children, will be considered in all decisions, relative to the indications for and type of examinations performed.

**11.15.3.2** All hospital personnel **and medical staff** whose duties require occupational exposure to ionizing radiation is required to wear a film badge monitor.

11.15.3.2.1 Film badges will be provided to the department of radiology.

11.15.3.2.2 Badges will be collected and replaced at specified time

intervals and records of exposure will be kept in the department of radiology. The committee on radiation safety will be responsible for maintenance review of these records.

**11.15.3.3.** All sources of radiation at Providence Tarzana Medical Center are registered by the Department of Health of the State of California. Physician-Radiologists are certified by the Department of Health of the State of California for the supervision of radiologic technologists and for the operation of the x-ray equipment.

## **12 DEPARTMENT OF OB/GYN**

### **12.1 MINIMUM ACTIVITY REQUIREMENTS are delineated on the OB/GYN Clinical Privileges**

### **12.2 CRITERIA FOR ADMISSION TO THE WOMENS PAVILION**

**12.2.1 ADMISSION** - Only patients whose admitting or consulting physicians are members of the Department of OB/GYN at Providence Tarzana Medical Center or physicians who have been granted Temporary Privileges, may be admitted to the Women's Pavilion.

**12.2.2 GRAVID PATIENTS LESS THAN 20 WEEKS GESTATION** - Gravid patients less than

20 weeks gestation presenting with a condition that is an immediate or a potential threat to the pregnancy may be evaluated and/or treated in Labor & Delivery and then transferred to High Risk, if close monitoring is required or to Post Partum for further observation as the physician chooses. If the patient's condition does not present an immediate threat to the pregnancy (e.g. medical complication) and fetal monitoring is not indicated, the patient is not to be admitted to Labor & Delivery and the physician may choose a Medical/Surgical Unit or Post Partum Unit, as appropriate.

**12.2.3 GRAVID PATIENTS GREATER THAN 20 WEEKS** - All patients greater than 20 weeks

gestation may be admitted to Labor & Delivery for evaluation and stabilization prior to transfer to the High Risk, Medical/Surgical, or Post Partum Unit, as the attending physician desires.

**12.2.4 ADMISSION TO THE HIGH RISK UNIT** - Admission to the High Risk Unit is intended for

those patients who require close nursing care and management for conditions that are of immediate or potential threat to the pregnancy. Gravid patients with primarily medical complications and 20 weeks or more may be admitted to the High Risk Unit as bed space is available, but may be transferred to a Medical/Surgical or Post Partum Unit by the order to the Nurse Manager with the approval of the Chief of the Department if such bed space is required by a patient who has a condition which is of a more immediate or potential threat to the pregnancy.

**12.2.5 ADMISSION OF GRAVID PATIENT FOR SURGERY** - Pregnant patients of any gestational age who are being admitted for surgery are not to be admitted to Labor & Delivery or High Risk (e.g. scheduled cerclage, appendectomy). They may be admitted to a Medical/Surgical Unit or Post Partum Unit as desired post-operatively. The patient may be admitted to High Risk after surgery with limitations as indicated above.

**ADMISSION TO LABOR & DELIVERY IS INTENDED FOR PREGNANT**

**PATIENTS OF ANY GESTATIONAL AGE FOR EITHER DELIVERY, OR EVALUATION AND STABILIZATION AND THEN TRANSFER TO ANOTHER NURSING UNIT.**

**12.3 EMERGENCY SURGICAL SCHEDULING (GYN CASES)**

Emergencies are scheduled in accordance to their urgency **and in accordance** with operating room policies and procedures.

**12.4 EMERGENCY SURGICAL SCHEDULING (OBSTETRICAL CASES)**

In the event that both Women's Pavilion operating rooms are in use, and an emergency need to do a Cesarean Section presents, the LDR may be used as a temporary operating room. For the purpose of this policy Emergency is defined as, A threat of death or injury to mother or fetus.

**12.5 SURGICAL ASSISTANT**

Selection of an appropriate assisting physician will be at the primary surgeon's discretion. Assistants will be required for cesarean sections or exploratory laparotomy. Assistants may include a member of the Department of OB/GYN, a GYN Oncologist, Surgeon, or an approved RNFA.

**12.6 PROCEDURES**

**12.6.1 STERILIZATION** – In cases which have been reviewed and approved by the Bioethics Committee, a signed consent for sterilization must be in the patient's chart prior to sterilization. Sterilization will not be done without the presence of the signed consent on the patient's chart.

**12.6.2 VACCUUM DELIVERIES**

All vacuum deliveries shall require documentation of the following either in the operative report or delivery note: The Department of Ob/GYN subscribes to the obstetric and gynecologic principles contained in the Manual of Standards published by the American College of Obstetrics and Gynecologists.

- Station
- Indication
- Number of Pop-Offs
- Complications

Failure to document the above shall result in the medical record being deemed incomplete. (2/1/07)

### **12.6.3 VAGINAL BIRTH FOLLOWING PREVIOUS CESAREAN SECTION**

When an Obstetrician requests a VBAC delivery, s/he must be immediately available. As soon as an Obstetrical patient is admitted to the hospital, in active labor, the Obstetrician and Anesthesiologist must be on campus (in hospital or adjacent office building(s)).

### **12.6.4 ELECTIVE INDUCTIONS**

#### **12.6.5.1 Elective Inductions/Elective Cesarean Deliveries**

No elective inductions or elective cesarean deliveries will be performed prior to 39 weeks gestation without medical justification being documented in the medical record. "Maternal request" is not considered an acceptable medical justification.

All elective inductions or elective cesarean section deliveries performed prior to 39 weeks gestation and VBAC deliveries will be reviewed by the Department of OB/GYN Peer and Chart Review Committee with tracking and trending by physician.

## **12.7 INDUCTION OF LABOR**

**12.7.1 OXYTOCIC AGENTS** - When any oxytocic agent is used, the physician(s) shall be readily accessible to manage any complications that may arise during infusion (ACOG Technical Bulletin, Number 110, November 1987). After a qualified nurse or physician has evaluated the patient to determine that induction or augmentation is beneficial to the mother or fetus. Induction or augmentation of labor with oxytocin may be initiated after receiving orders from the physician. (revised 1/26/09)

Although the ultimate responsibility of the patient's medical management lies with the physician, if for any reason nursing is uncomfortable with following the physician's orders, the physician must be present for oxytocin to be administered.

## **12.8 ANESTHESIA**

**12.8.1. GENERAL ANESTHESIA** - General anesthesia shall not be given by any physician other than an anesthesiologist.

**12.8.2 CONTINUOUS EPIDURAL** - Requirements for presence of obstetricians during the use of continuous epidurals in labor are as follows:

12.8.2.1 The obstetrician accepts full responsibility and is in charge of the patient.

- 12.8.2.2. If the patient is not medically compromised, or not considered as significant high risk, the obstetrician is not required to be in attendance at the initiation of epidural anesthesia or for administration of subsequent doses. The Obstetrician must, however, be available by phone (not via pager) and have an arrival time of 20 minutes or less.
- 12.8.2.3 If the Anesthesiologist states that the medical status of the patient requires the attendance of the obstetrician, the obstetrician or his/her alternate will be present throughout the procedure.
- 12.8.2.4. Violation of the above guidelines shall result in referral to the OB/GYN Peer and Chart Review Committee for appropriate follow-up including prohibition from further participation in this program.

## **12.9. PHOTOGRAPHS**

Photographs and/or video may be taken if the obstetrician, anesthesiologist, and nursing staff all agree that it will not disrupt the provision of patient care.

## **12.10 GENERAL RULES**

- 12.10.1 At the discretion of the attending physician and agreement between the attending anesthesiologist, and pediatrician, if in attendance, the father or significant other will be admitted to view the delivery. The number of observers permitted to view the delivery will be at the discretion of the attending physician.
- 12.10.2 Laboratory work obtained after the 34th week of pregnancy will be satisfactory for meeting the requirements of hospital re-admission and admission.
- 12.10.3 Recommendations /Requirements - Fetal Monitoring:
  - 12.10.3.1 Monitoring is recommended on all patients
  - 12.10.3.2 Monitoring is mandatory in the following:
    - 12.10.3.2.1 Clinical fetal distress
    - 12.10.3.2.2 Oxytocin stimulations
    - 12.10.3.2.3 High risk pregnancy
    - 12.10.3.2.3 Conduction anesthesia
- 12.10.4 If the external monitor gives an inadequate record or shows decreased variability or decelerations are present, direct monitoring should be instituted, if possible.

#### **12.10.5 Pneumatic Stockings for Cesarean Sections**

All patients undergoing cesarean section should be placed in pneumatic stockings at the time of surgery unless the section is a crash section. If the section is a crash section, the stockings should be put on the patient immediately following the procedure. (44/04)

**12.10.6** Members of the Department of OB/GYN are required to have two (2) physicians on file who have agreed to back them up should they be unavailable.

### **12.11 TOCOLYTIC THERAPY ADMINISTRATION**

**12.11.1** All patients admitted to the Women's Pavilion for the initiation of IV tocolytic therapy must be evaluated by a physician prior to admission or within 12 hours of admission and prior to discharge.

### **12.12 MATERNAL TRANSPORTS**

All maternal transports must be seen and evaluated by their admitting physician in this hospital within four (4) hours of arrival. All maternal transports by a physician who is not a member of the medical staff of Providence Tarzana Medical Center will be required to obtain mandatory consultation by a Perinatologist who will be responsible for monitoring and proctoring of the case. All physicians requesting privileges for maternal transports will further be required to submit the name of an alternate who is a member in good standing of the medical staff.

### **12.13 HIGH RISK PATIENTS**

Any high risk patient must either have been seen immediately prior to admission by her private obstetrician or be seen within four (4) hours of admission to the hospital by her private obstetrician. If she has been admitted from home or after being evaluated by Fetal Medicine, it is the responsibility of the obstetrician to examine the patient within four (4) hours. If the private obstetrician relinquishes care to another obstetrician, there must be clear documentation in the record of this with agreement by the other physician who will then be responsible for the examination within the four (4) hours. If there is co-management, it remains the responsibility of the primary care obstetrician to complete the examination and evaluation.

## **13. DEPARTMENT OF PEDIATRICS**

### **Section 13.1 GENERAL**

**13.1.1** The Department of Pediatrics is organized to provide pediatric inpatient services as necessary for the proper medical care of patients and for compliance with all requirements of any accrediting or certifying agencies. The Department of Pediatrics is responsible for the quality of medical care rendered to patients and for the maintenance of the highest standards of medical care.

- 13.1.2 The definition of the pediatric patient is age birth to age 21 years for the purposes of privileging and peer review activities
- 13.1.3 All members of the Department of Pediatrics are required to maintain a back-up should they not be available. This information must be on file in the Medical Staff Office.
- 13.1.4 Direct Admissions to the PICU or NICU are permissible as long as there is direct communication between the referring physician and the accepting intensivist prior to admission of the patient.
- 13.1.5 Patients admitted to or transferred to the Pediatric Intensive Care Unit for the following do not need to be seen within four (4) hours of admission to the Unit:
  - 13.1.5.1 Electronic monitoring (telemetry equivalent) only
  - 13.1.5.2 Nursing monitoring (e.g. head injury previously evaluated in ED, possible ingestion, suicidal precautions, baby who has chocked but is clear and stable), or
  - 13.1.5.3 Administration of intravenous Potassium for correction of Hypokalemia of a level of 2.5 or above.

**Section 13.2 MEMBERSHIP**

13.2.1 The Department of Pediatrics consists of members of the Medical Staff who specialize in pediatrics, as well as those whose practices indicate a particular interest in this field.

**13.3.2 PRE AND POST OPERATIVE MONITORING/CARE**

Pre and Post Operative Monitoring and care will be undertaken in accordance with hospital policy.

**13.3.3 CARE BY PEDIATRICIAN IN THE PICU OR NICU**

Care of pediatric patients, by a pediatrician in the PICU or NICU, may be provided only by physicians who have applied for and been granted privileges to provide such care.

**13.3.4. CARE ON THE PEDIATRIC FLOOR AND NEWBORN NURSERY/COVERAGE REQUIREMENTS**

Care of patients on the pediatric floor and newborn nursery may be by physicians who have applied for and been granted privileges to provide such care.

**13.3.5 PHYSICIAN COVERAGE REQUIREMENTS IN THE NEONATAL INTENSIVE CARE UNIT**

13.3.5.1 Each neonatologist who has NICU privileges must comply with each of the following:

13.3.5.1.1 Either (1) be certified by the American Board of Pediatrics and certified by the American Board of Pediatrics in the subspecialty of

Neonatal-Perinatal Medicine or, (2) have completed a neonatology fellowship, be eligible for certification by both the American Board of Pediatrics and the American Board of Pediatrics in the subspecialty of Neonatal-Perinatal Medicine, and become certified by both the American Board of Pediatrics and the American Board of Pediatrics in the subspecialty of Neonatal-Perinatal Medicine within four (4) years of completing neonatology fellowship.

**13.3.5.1.2** When on call:

**13.3.5.1.2.1** Be in the hospital or no more than fifteen (15) minutes away from the NICU at any time;

**13.3.5.1.2.2** Not be on-call for more than one hospital at the same time

**13.3.5.1.2.3** Have a coverage arrangement with a neonatologist who has NICU privileges

**13.3.5.1.2.4** Document current successful completion of the Neonatal Resuscitation Program course of the AAP and AHA

**13.3.5.1.2.5** When the neonatologist has an infant in the NICU, attend the weekly NICU multi disciplinary team conference meetings (rounds), participate in the team's discussion of that infant's plan of care and then document the approved plan of care in the infant's chart.

**13.3.5.1.2.6** When the neonatologist has an infant in the NICU who requires neonatal transport, be responsible for, in conjunction with the NICU Medical Director, selecting the method of transport to be used, the medical care during transport and determining the neonatal transport team members to be used to transport unstable, potentially unstable, and stable infants.

**13.3.5.1.3** Each neonatologist and pediatrician who treats CCS-eligible infants must be a CCS-paneled neonatologist or CCS-paneled pediatrician.

**13.3.5.1.4** A neonatologist with NICU privileges must comply with each of the following:

**13.3.5.1.4.1** Initially evaluate each infant within one hour of admission to the NICU

**13.3.5.1.4.2** Be called and come to the NICU to evaluate every infant upon admission to the NICU and when there is a major change in the condition of an infant in the NICU which requires re-evaluation.

**13.3.5.1.4.3** Be called, come to the NICU and remain in house while an infant is unstable. The Medical Director may establish guidelines

regarding when an infant is deemed unstable. If there are disputes or questions regarding whether an infant is unstable, the NICU's Medical Director shall determine if the infant is unstable.

**13.3.5.1.4.4** Be responsible for the ongoing care and clinical management of each infant who meets the criteria set forth in these Rules and Regulations for Primary Neonatal Management in the NICU.

**13.3.5.1.4.5** If the neonatologist has a patient in the NICU, be on-site to evaluate the infant at least on a daily basis.

**13.3.5.1.4.6** Be responsible for ensuring that information is provided, on an ongoing basis to the referring physicians regarding their patients.

**13.3.5.1.5** Infants in the NICU who do not meet the criteria set forth in the Rules and Regulations as requiring Primary Neonatal Management in the NICU may be managed by a pediatrician with NICU privileges or a neonatologist with NICU privileges.

**13.3.5.1.5.1** A neonatologist with NICU privileges or a pediatrician with NICU privileges must review, evaluate, and document the care and clinical management, on-site, at least daily, each infant who is in the NICU but who is not required to be under the management of a neonatologist, i.e., does not meet the criteria set forth in these Rules and Regulations for Primary Neonatal Management in the NICU.

**13.3.5.1.5.2** If care is provided by a pediatrician with NICU privileges, the pediatrician must meet the criteria set forth in Section F below for NICU privileges and provide NICU care in consultation with a neonatologist with NICU privileges; the neonatologist to be responsible for ensuring that information is provided, on an ongoing basis, to referring physicians regarding their patients.

**13.3.5.1.6** To obtain intermediate care or continuing care NICU privileges, a pediatrician must:

**13.3.5.1.6.1** Be certified by the American Board of Pediatrics with evidence of current experience and practice in neonatal medicine, and

**13.3.5.1.6.2** Attend the NICU's monthly neonatal/perinatal continuing education programs and document a minimum of thirty-six (36) hours of continuing education in neonatal medicine every three years, and

**13.3.5.1.6.3** Have evidence of current successful completion of the Neonatal Resuscitation Program course of the AAP and AHA.

**13.3.5.1.7** The neonatologist or pediatrician responsible for the NICU infant shall be responsible for the discharge planning for the infant, including but not limited to:

- 13.3.5.1.7.1** Work with coordinator for discharge planning,
- 13.3.5.1.7.2** Identifying the responsibilities and involvement of the NICU multi disciplinary team members in discharge planning activities
- 13.3.5.1.7.3** Ensuring culturally and linguistically appropriate discharge information shall be given to the parent(s) or primary caretaker(s) participating in the infant's care at the time of discharge and including, but no limited to, the infant's diagnoses, medications, follow-up appointments, including community agencies and High-Risk Infant Follow-up program appointments and instructions on any medical treatment(s) that will be given by the parent(s) or primary caretaker(s).
- 13.3.5.1.7.4** Ensuring that infants who are determined by a neonatologist to be discharged from the NICU to a facility closer to the home of the parent or primary caretaker shall be transferred to an appropriate facility.
- 13.3.5.1.7.5** Providing for teaching the parent, legal guardian, and/or primary caretaker about the medical needs of the infant, including the use of necessary technology to support the infant in the community, when appropriate.
- 13.3.5.1.8** Each neonatologist and pediatrician who has NICU privileges must collect and timely submit to the NICU Director or his/her designee such data as may be required to be compiled by CCS, the Medical Staff, or other organizations and entities which review, track, license, or accredit NICU's. Such data shall be submitted in the format required by CCS or such other organization or entity. Each neonatologist and pediatrician who is required to submit data shall be promptly available to review his/her data with the Medical Director or his/her designee and to participate in the NICU's ongoing education for NICU staff which includes or addresses NICU data.
- 13.3.5.1.9** To best serve the needs of the infants and their families being cared for in the NICU the response time or availability requirements are as follows:
  - 13.3.5.1.9.1** All patients must be seen within one hour of admission
  - 13.3.5.1.9.2** Physical response time of beeper call initiation in the NICU less than 15 minutes
  - 13.3.5.1.9.3** Any neonatologist on call for the NICU shall not be on call for any other hospital at the same time. (Consistent with CCS guidelines)
  - 13.3.5.1.10** If a patient requires primary neonatal management in the NICU the responsible attending must be either in the hospital or within 15 minutes of the NICU at all times

## **Section 13.4 ACTIVITY REQUIREMENTS**

- Physicians holding privileges for examination of normal newborns only would be required to provide documentation of inpatient experience with 10 patients during a two year period. Activity may be provided from Providence Tarzana Medical Center or from another accredited Hospital.
- Physicians with privileges to care for pediatric patients whose disease severity does not require an intermediate level of care, they would be required to demonstrate in patient experience with a minimum of 10 patients during a two year period. Activity may be provided from Providence Tarzana Medical Center or from another accredited Hospital.
- Physicians providing an intermediate level of care or above, as defined by the American Academy of Pediatrics (e.g., high oxygen requirement, continuous nebs, patients requiring close monitoring for apnea, initial 24 hours of bacteria meningitis, etc.) would be required to demonstrate inpatient experience with a minimum of 50 patients in a two year period which should include at least 20 patients cared for at an intermediate level of care or above. Activity may be provided from Providence Tarzana Medical Center or from another accredited Hospital.
- Pediatric sub-specialists, practicing solely within their sub-specialty are exempt from the aforementioned requirements. They will, however, be required to assure documentation of current competence relating to privileges held from either Providence Tarzana Medical Center or another accredited Hospital.

## **14. DEPARTMENT OF SURGERY**

### **Section 14.1 MEMBERSHIP**

Members of the Providence Tarzana Medical Center medical staff whose practice is devoted, but not limited to, anesthesiology, cardiovascular/thoracic surgery, general surgery, gyn oncology, neurosurgery, ophthalmology, orthopedic surgery, otorhinolaryngology, pathology, plastic surgery, podiatry, colo-rectal surgery, thoracic surgery, urology, vascular surgery, pediatric surgery, and all allied specialties related to surgery, constitute the Department of Surgery.

### **Section 14.2 SURGICAL ASSISTING**

Although the Department of Surgery strongly recommends having surgical assistance for all major operations, it is up to the surgeon's discretion to make the final determination as to the need for and selection of an appropriate assistant. However, physician surgical assistance is mandatory for the following procedures:

- Open Heart Surgery
- Pancreaticoduodenectomy
- Esophagectomy
- Major Liver Resection
- Radical Neck Dissection
- Repair of Thoracoabdominal Aortic Aneurysm
- Radical Cystectomy

## **Section 14.3 GENERAL RULES AND REGULATIONS**

- 14.3.1** Staff surgeons are permitted to bring their private scrub nurses with them. Private scrub nurses must have completed ahp application with delineation of privileges and been approved by Medical Staff. (See operating room policies and procedures and medical staff bylaws/rules and regulations requirements)
- 14.3.2** Standard preoperative requirements must be met. (See operating room policy and procedure manual)
- 14.3.3** The starting time for surgery is 7:30 a.m. The check-in time for the surgeon is 7:15 a.m. If surgeon is consistently late (3 or more times) the O.R. Supervisor will not schedule a 7:30 a.m. starting time for this surgeon. After the third documented late of 30 minutes or more, the anesthesiologist may bump the case to the end of the day.
- 14.3.4** Post Procedure Assessment Criteria is defined in the operating room and PACU policy and procedure manual.
- 14.3.5** If all tests and other pre-operative data are not completed in time for the anesthesiologist's pre-operative evaluation, the case will be delayed, postponed or canceled. In an effort to be both reasonable and flexible, the on-call anesthesiologist will be available for consultation by the surgeon to clarify any special circumstances to avoid such delays or cancellations, but the responsibility for assuring that all data is available is that of the surgeon.
- 14.3.6** A pre-operative surgical consultation will be completed on all surgical patients and be in the computer system/and or on the patient's medical record prior to surgery.
- 14.3.7** The department of surgery defines extreme emergency surgical procedures as situations where the patient is at risk of loss of life or limb. Extreme emergency surgical procedures may be performed without a full dictated and transcribed History & Physical and/or required pre-operative testing per policy.
- 14.3.8** A pre-operative surgical consultation is required for each surgical patient, in addition to a medical history & physical if the history and physical was not performed by the operating surgeon. The surgical note/consultation must contain the clinical problem, indications for surgery, risks, benefits, and alternatives to treatment.
- 14.3.9** The patient is discharged as per approved medical staff criteria which is delineated in hospital policy.
- 14.3.10** There will be pediatric surgical case review to include review of morbidity, mortality and other identified management problems in the surgery peer and chart review committee. Committee composition will include neonatologists and pediatric surgeons.

- 14.3.12** All prophylactic pre-operative antibiotics are to be administered in the Operating Room by the Anesthesiologist

**Section 14.4 PREVENTION OF WRONG SITE SURGERY**

Prevention of Wrong Site Surgery shall be in accordance with the Hospital Policy on Surgical/Procedural Verification and Time Out.

**Section 14.5 MINIMUM ACTIVITY REQUIREMENTS**

- 14.5.1** Courtesy Staff members of the Department of Surgery are required to perform a minimum of 12 cases/patient contacts at Providence Tarzana Medical Center during the two (2) year monitoring period in order to remain on the Medical Staff. Failure to maintain this level of activity would be deemed a voluntary resignation from the Medical staff for non-utilization, without hearing rights.
- 14.5.2** If a surgeon has less than three (3) patient care contacts at Providence Tarzana Medical Center during any OPPE monitoring period, the surgeon would be deemed to be voluntarily resigned based on non-utilization without hearing rights.
- 14.5.3** The Department of Surgery reserves the right to look at specialties which do not usually care for patients in the hospital as an exception to the above noted rules, i.e. Dentists, Oral Surgeons, and Ophthalmologists.

**Section 14.6 PROCTORING – SPECIFIC TO DEPARTMENT OF SURGERY**

- 14.6.1** All new members of the Department of surgery will be proctored according to the Medical Staff Bylaws/Rules and Regulations **and Policies and Procedures**. This will also apply to all existing staff members requesting additional privileges, depending upon the type of privileges requested, as recommended by the department chair. Proctoring may be waived upon the recommendation of the Chair of the Department with concurrence by the Medical Executive Committee and approval of the Governing Board based on standing in the community and demonstration of current competence. The physician would, however, be required to undergo at least one retrospective chart review under FPPE during the first year of membership.
- 14.6.2** Former medical staff members re-applying to the medical staff may be required to undergo proctoring upon individual consideration and/or depending upon the quality improvement outcome data and demonstrated competency. A minimum of one FPPE would be required for all members who re-apply.
- 14.6.3** During the reapplication process, staff members must demonstrate continued competence in their specialty based on volume and variety of procedures performed at Providence Tarzana Medical Center or at other accredited facilities. Otherwise, additional proctoring/**FPPE** may be required.
- 14.6.4 Proctor Qualifications**

- 14.6.4.1** The proctoring must be a member of the Department of Surgery at Providence Tarzana Medical Center who has unrestricted privileges for the procedure(s) s/he is proctoring.
- 14.6.4.2** Physicians who serve as a proctor can also act as an assistant surgeon
- 14.6.4.3** Associates will not be eligible to proctor each other except in special circumstances which will be considered by the department chair.
- 14.6.4.4** In a situation where no staff member is deemed qualified to supervise the work of an applicant, the department may consult external sources for assistance.

#### **14.6.5 NEW MEDICAL STAFF MEMBERS RESPONSIBILITIES**

- 14.6.5.1** The physician being proctored is responsible for obtaining an appropriate proctor.
- 14.6.5.2** The physician being proctored must provide the proctor's name to the operating room at the time that the procedure is scheduled. The Operating Room staff will not place any case on the OR schedule until the name of the proctor has been provided.
- 14.6.5.3** The physician may provide proctoring reports from local accredited institutions (not to exceed 50% of the proctored cases), if the proctor is someone who is eligible to serve as a proctor at Providence Tarzana Medical Center.

### **Section 14.7 CARDIOVASCULAR OPERATIVE SERVICE**

#### **14.7.1 MEDICAL STAFF DIRECTOR**

A physician will have overall responsibility for this service. The Medical Staff Director must be certified by the American Board of Thoracic Surgery or the American Board of Surgery with training and experience in cardiovascular surgery. He/she will be responsible for, but not limited to:

- Implementing established policies and procedures
- Training and supervision of the clinical perfusionists.

#### **14.7.2 INTERDISCIPLINARY MEDICAL STAFF**

**14.7.2.1** Anesthesia for cardiac surgical procedures will be administered by an anesthesiologist who has completed a fellowship in cardiac anesthesia or has completed an approved residency program in

anesthesiology and has demonstrated appropriate training and current competence in order to be granted clinical privileges to provide cardiac anesthesia.

**14.7.2.2** Clinical perfusionists will operate the extracorporeal equipment under the immediate supervision of the cardiovascular surgeon or cardiologist.

**14.7.2.3** A physician who is certified by the American Board of Radiology with special training or experience in cardiovascular radiology will be available to the cardiovascular surgery services staff.

### **14.7.3 CARDIOVASCULAR OPERATIVE PROCEDURES - which require extracorporeal bypass**

A minimum of two (2) surgeons shall constitute the surgical team during the performance of extracorporeal bypass. The primary surgeon shall be certified by the American Board of Thoracic Surgery.

#### **14.7.3.1 FIRST ASSISTANT**

Complex cardiovascular procedures which require a first assistant (CABG and valve surgery) may be performed by one board certified cardiovascular surgeon and one surgeon. The first assistant must possess unrestricted privileges in assisting on cardiovascular procedures, having provided documentation of adequate surgical training and experience in assisting on cardiovascular procedures to the Surgery Department. The primary surgeon is responsible for the conduct of the operation and must assure that the first assistant has the skill and experience necessary for the safe completion of the case.

The first assistant will have the ability to begin an open heart case and prepare the patient for cardiopulmonary bypass in the absence of the primary surgeon and will have the ability to close the chest with the second assistant.

MD assist must be on campus prior to induction and may leave after closure of the chest.

#### **14.7.3.2 SECOND ASSISTANT**

The second assistant may be a Physician Assistant, Registered Nurse First Assistant (RNFA) or a physician with surgical assisting privileges.

The second assistant must be specifically trained to assist in the surgical procedure. The second assistant may act only as a second assistant. The second assistant is the responsibility of the cardiovascular surgeon performing the procedure, who must assure that the second assistant has the necessary skills and experience.

**14.7.4 CARDIOVASCULAR OPERATIVE PROCEDURES - which do not require extracorporeal bypass**

For non-complex cardiovascular procedures, the requirement of a minimum of two (2) surgeons constituting the surgical team is not obligatory.

**14.7.5 CARDIAC SURGERY PRIVILEGING CRITERIA-** In addition to the Qualifications for Membership as delineated in the Medical Staff Bylaws, the following criteria are proposed:

**14.7.5.1 Initial Applicant**

**14.7.5.1.1 Category 1 - Recent Graduate:**

- 14.7.5.1.1.1** For purposes of determining whether an applicant is to be evaluated under Category I, a recent graduate is a physician who completed a cardiac/thoracic surgery fellowship within the immediately prior 2 years.
- ! **14.7.5.1.1.2** Must be (i) Board Certified by the American Board of Thoracic Surgery, or (ii) Board Qualified and obtain Board Certification from the American Board of Thoracic Surgery within two years following completion of a cardiac/thoracic surgery fellowship.
- ! **14.7.5.1.1.3** Must maintain a physical response time of 30 minutes or less (both residence and office).
- ! **14.7.5.1.1.4** Must be part of a team of cardiac surgeons that performs a minimum of 150 open-heart procedures per physician per year. At least one member of the group or team, with cardiac surgery privileges at Providence Tarzana Medical Center, must be available for coverage at all times. The group or team must also include support staff who are regularly in-house at Providence Tarzana Medical Center, in order to provide continuous coverage, (i.e., minimum of 30 hours per week to assist with counseling of family, significant others and the patient, to help coordinate care, round with the cardiac surgeons, and to assist with emergencies that may arise in the hospital whether involving a patient of the group or a patient being referred to the group). (Such support staff may be other than physicians, specialty certified physician assistants, (PA-C), nurse practitioners, or other certified nurses, who have been credentialed for this purpose by the Medical Staff.)
- ! **14.7.5.1.1.5** Must have performed at least 75 open-heart cases as the primary surgeon, either while in training or in prior practice, and provide statistical data to demonstrate morbidity and mortality. If the surgeon has graduated within the past two years, another cardiac surgeon with cardiac surgery privileges at Providence Tarzana Medical Center, must assist on all cases for the first year of membership.
- ! **14.7.5.1.1.6** Proctoring must be completed in accordance with the Providence Tarzana Medical Center Proctoring Protocol as outlined in the Providence Tarzana Medical Staff Medical Staff Rules and

Regulations. Physicians granted cardiac surgery privileges shall be proctored for a minimum of (10) cases, including a minimum of (2) valve cases, by a Providence Tarzana Medical Center Medical Staff physician holding the same privilege. The physician performing the procedure must arrange for his/her own proctor.

! **14.7.5.2 Category II – Established Surgeon**

- 14.7.5.2.1 Must be Board Certified by the American Board of Thoracic Surgery
- 14.7.5.2.2 Must be part of a team of cardiac surgeons that performs a minimum of 150 open-heart procedures per physician per year. At least one member of the group or team, with cardiac surgery privileges at Providence Tarzana Medical Center, must be available for coverage at all times. The group or team must also include support staff who are regularly in-house at Providence Tarzana Medical Center, in order to provide continuous coverage, (i.e., minimum of 30 hours per week to assist with counseling of family, significant others and the patient, to help coordinate care, round with the cardiac surgeons, and to assist with emergencies that may arise in the hospital whether involving a patient of the group or a patient being referred to the group). (Such support staff may be other than physicians, specialty certified physician assistants, (PA-C), nurse practitioners, or other certified nurses, who have been credentialed for this purpose by the Medical Staff.)
- ! 14.7.5.2.3 Must be able to physically respond within 30 minutes, or less (both residence and office).
- ! 14.7.5.2.4 Must provide documentation of performance of at least 150 open-heart procedures per year as the primary surgeon for the last two years.
- ! 14.7.5.2.5 Must provide statistical data to demonstrate that the surgeon's risk adjusted morbidity and mortality rate is equal to a mortality ratio of 1.0 or less for the past two years.
- ! 14.7.5.2.6 Proctoring must be completed in accordance with the Providence Tarzana Medical Center Proctoring Protocol as outlined in the Providence Tarzana Medical Center Medical Staff Rules and Regulations. Physicians granted cardiac surgery privileges shall be proctored for a minimum of (10) cases, including a minimum of (2) valve cases, by an Providence Tarzana Medical Center physician holding the same privilege. The physician performing the procedure must arrange for his/her own proctor.

**14.7.6 Applicant for Reappointment**

**14.7.6.1 Category III - Maintain Privileges:**

- ! 14.7.6.1.1 Within two years after initial granting of cardiac surgical

- ! privileges at Providence Tarzana Medical Center, must perform a minimum of 150 open-heart cases per surgeon per year, as the primary surgeon.
- ! **14.7.6.1.2** Must maintain a physical response time of 30 minutes or less (residence and office).
- ! **14.7.6.1.3** Must continue to be part of a team of cardiac surgeons and surgeons that perform at least 150 open-heart procedures per physician per year. At least one member of the group or team, with cardiac surgery privileges at Providence Tarzana Medical Center, must be available for coverage at all times. The group or team must also include support staff who are regularly in-house at Providence Tarzana Medical Center, in order to provide continuous coverage, (i.e., minimum of 30 hours per week to assist with counseling of family, significant others and the patient, to help coordinate care, round with the cardiac surgeons, and to assist with emergencies that may arise in the hospital whether involving a patient of the group or a patient being referred to the group). (Such support staff may be other than physicians, specialty certified physician assistants, (PA-C), nurse practitioners, or other certified nurses, who have been credentialed for this purpose by the Medical Staff.)
- ! **14.7.6.1.4** Must provide documentation of performance of at least 150 open-heart procedures per year as the primary surgeon for the last two years.
- ! **14.7.6.1.5** Must provide statistical data to demonstrate that the surgeon's risk adjusted morbidity and mortality rate is equal to a mortality ratio of 1.0 or less for the past two years.

## **Section 14.8 DIVISION OF ANESTHESIOLOGY**

The Anesthesiologist is practicing medicine dealing with, but not limited to the management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures; the support of life functions under stress of anesthetics and surgical procedures; the clinical management of the patient unconscious from whatever cause such as when called in for consultation, i.e., drug overdose, post-cardiac arrest, or for insertion of endotracheal tube; the management of problems in pain relief; the management of problems in cardiac and respiratory resuscitation and life support; the application of specific methods of inhalation therapy; the clinical management of various fluid, electrolyte, and metabolic disturbances; insertion of arterial lines and central venous lines when needed; arterial, central venous and right heart catheterization; etc;

### **14.8.1 Types of Anesthesia**

1. General Anesthesia
2. Inhalation
3. Intravenous

#### **14.8.2. Regional Anesthesia**

1. Spinal
2. Epidural
3. Peripheral Nerve Block
4. Bier Block
5. Epidural
6. Sympathetic and Nerve Plexus Blocks

**14.8.3** **Types of anesthesia** and its procedures may be provided in the accordance with approved policies and procedures maintained in the surgery department.

#### **14.8.4** **GENERAL RULES AND REGULATIONS****-can this be moved to a policy?**

**14.8.4.1** The Anesthesiologist will provide anesthesia of the type and in the manner required by the patients' age and condition with the hospital providing and maintaining the appropriate staff, space, equipment, and supplies.

**14.8.4.2** The Division will oversee the post-anesthesia care of the patient.

**14.8.4.3** The Division of Anesthesiology will provide Optimal Standards of Anesthesia Care as set forth in the anesthesiology panel of the American Society of Anesthesiologists.

**14.8.4.4** The anesthesia staff shall participate in the coordination of training programs on Cardiopulmonary Resuscitation within the hospital through it's representation on the Critical Care Committee.

**14.8.4.5** The Division of Anesthesiology will participate in continuing medical education including giving in-service to medical and nursing staff.

**14.8.4.6** The Anesthesiologist shall be responsible for leading the code should a code occur in the Operating Room or PACU

**14.8.4.7** An anesthesiologist who is unable to perform assigned duties because of illness, fatigue, or personal crisis, shall not accept cases and/or continue with duties.

#### **14.8.5 HOURS AND CALL COVERAGE**

**14.8.5.1** Daily schedule: Monday – Friday 7:00 a.m. – 3:30 p.m.

**14.8.5.2** Evenings and Weekends

- .14.8.5.2.1 An anesthesiology call schedule will be placed in the surgical department
- 14.8.5.2.2 The Chair of the Division or designee will have the responsibility for assigning the call schedule
- 14.8.5.2.3 The Anesthesiologist on call will be available by telephone or portable page unit (beeper)/**cell phone** at all times
- 14.8.5.2.4 Two Anesthesiologist will be on call 24 hours a day, 7 days a week, and they are to be available for both surgical and obstetrical emergencies within thirty (30) minutes.

**14.8.6 ASSIGNMENT OF CASES**

- 14.8.6.1 An Anesthesiologist designated by the Chair of the Division of Anesthesiology is to be responsible for coordinating the surgeries for that day.
- 14.8.6.2 Anesthesiologists will visit patients prior to surgery as defined in part 1 of the procedural guidelines.

**14.8.7 PROCTORING PROTOCOL – ANESTHESIOLOGY**

**14.8.7.1 OBSTETRICAL ANESTHESIA**

A minimum of one (1) additional case is required on Obstetrical Anesthesia. The proctor must be an active staff anesthesiologist who holds these privileges.

**14.8.7.2 CARDIAC ANESTHESIA**

An additional six (6) cases are required in Cardiac Anesthesia. The proctor must be an active staff anesthesiologist who holds these privileges.

**14.8.7.3 PAIN MANAGEMENT**

An additional three (3) cases are required in the area of Pain Management for physicians requesting Pain Management privileges. The proctor must be an active staff anesthesiologist who holds these privileges.

**Section 14.9 DIVISION OF PATHOLOGY**

**14.9.1 MONITORING AND EVALUATION**

The Division of Pathology has approved criteria based screening of all tissue cases including screening for appropriateness of surgical and other invasive procedures. These will be coded by number and letter as delineated in the Plan for Provision of Care/Quality

Improvement Plan. This Plan also encompasses the monitoring and evaluation of Blood Usage which is overseen by the Pathology Department.

#### **14.9.2 SCAR REVISION TISSUE**

Any scar revision performed by an OB/GYN must be submitted for gross pathologic evaluation. Should adipose tissue be removed at this time, it must also be submitted for gross pathology.

### **15. CRITICAL CARE UNITS**

#### **Section 15.1 ADULT INTENSIVE CARE UNITS**

**15.1.1** No “direct admits” will be admitted to the adult intensive care units. This is to insure that critically ill patients sent from physician’s offices will not be on hospital grounds unattended, and to insure that a patient does not arrive in an ICU direct from the physician’s office to find no bed or nurse currently available to care for them. All adult patients that are seen in the physician office and felt to need immediate admission to the ICU should be directed through the emergency room.

**15.1.2** Admission and Discharge Criteria for the Adult Critical Care Units is defined in Hospital Policy and approved by the Medical Staff.

**15.1.3** The attending or consulting physician will see a patient within two (2) hours of admission to an intensive care unit when admitted for Acute or Suspected MI. Patients admitted for other diagnoses will be seen within four (4) hours of admission. The unit registered nurses will notify the physician if s/he feels the patient’s condition warrants more immediate attention. The patient need NOT be seen within two (2) hours for patient admitted with MI or Suspected MI or four (4) for patients admitted with other admission diagnoses if:

**15.1.3.1** The patient was seen immediately prior to unit admission by the admitting or consulting physician in the office, the emergency department or on the ward, OR

**15.1.3.2** The patient was seen earlier the same day as an inpatient and the medical condition requiring transfer to the adult critical care area was known at that time but worsened or failed to improve as expected. (If an inpatient develops a new problem necessitating ICU admission, a physician needs to see the patient within four (4) hours unless the new problem involves an MI or suspected MI, which would necessitate consultation within two (2) hours

**15.1.4** Certain diagnoses or situations will require consultation:

**15.1.4.1** Complicated myocardial infarction (complex arrhythmias or pump failure), recurrent or continued chest pain, requires a cardiology consult if the admitting physician is not a cardiologist. This consultation will take place within one (1) hour of recognition of the complication (May be telephone consultation)

**15.1.4.2** Suicide patients need psychiatric evaluation prior to discharge from the hospital.

**15.1.4.3** Upon patient or family request

**15.1.4.4** Medical Director request

**15.1.5** When more than one physician is involved in a patient's care there will be a physician designated to coordinate care. This may or may not be the admitting or attending physician.

**15.1.6** All patients in a Critical Care Unit for longer than thirty-six (36) hours will be required to undergo a critical care consultation. Consultation may be performed by a board certified cardiologist, pulmonologist, intensivist, or nephrologist. The specialist should be determined based on the patient's diagnosis/condition.

## **Section 15.2 MEDICAL DIRECTORS RESPONSIBILITIES**

Medical Directors responsibilities in the Critical Care Units are defined in contracts which are reviewed and approved by the Medical Executive Committee and delineated in Medical Staff policies and procedures.

## **Section 15.3 ADMISSION/DISCHARGE TO/FROM PEDIATRIC INTENSIVE CARE UNIT**

### **15.3.1 PEDIATRIC INTENSIVE CARE UNITS**

No "direct admits" will be admitted to the pediatric intensive care unit (PICU). This is to insure that critically ill patients sent from physician's offices will not be on hospital grounds unattended, and to insure that a patient does not arrive in the PICU direct from the physician's office to find no bed or nurse currently available to care for them. All pediatric patients seen in the physician's office and felt to need immediate admission to the Pediatric ICU should be directed through the emergency room.

### **15.3.2 ADMISSION/DISCHARGE TO/FROM PEDIATRIC INTENSIVE CARE UNIT**

Admission and Discharge to and from the Pediatric Intensive Care Unit will be in accordance with Hospital Policy. Direct Discharges are made when the patient does not need further hospital care, hospital discharge may be made directly from the ICU, CVICU, NICU or PICU.

**Section 15.4 ADMISSION/DISCHARGE TO/FROM NEONATAL INTENSIVE CARE UNIT**

Admission and Discharge to and from the Neonatal Intensive Care Unit will be in accordance with Hospital Policy. Direct Discharges are made when the patient does not need further hospital care, hospital discharge may be made directly from the ICU, CVICU, NICU or PICU.

**Section 15.5 FAMILY CONFERENCE**

All patients that are in the Intensive Care Unit for two weeks will have a family conference to discuss the progress of the patient, the treatment plan, and alternative measures, unless the patient's condition does not warrant it. Recommended participants are: Attending physician, ICU medical director, nurse manager, clergy, social worker, patient's nurse, consultants, family, case manager, dietician, respiratory therapy, physician advisor.

**16. MEDICAL STAFF COMMITTEES**

**Section 16. MEDICAL STAFF COMMITTEES**

There is a Medical Executive Committee and other standing and special committees of the medical staff responsible to the Medical Executive Committee as may be necessary to perform staff functions as described in the medical staff bylaws.

Only members of the Active Medical Staff have voting rights for Departmental and Division meetings. Non-members of the Medical Staff are not able to serve as voting members of the Committee with the exception of the Institutional Review Board Committee and the Physician's Well-Being Committee.

**16.1 Standing Committees of the medical staff are:**

Duties and Responsibilities of each Committee are delineated in the Medical Staff Policies and Procedures with the exception of the Medical Executive Committee which is delineated in the Medical Staff Bylaws.

**16.1.1 Medical Executive Committee** - Duties and functions of which are delineated in the medical staff bylaws.

**16.1.2. Continuing Medical Education Committee**

**Composition**

Membership consists of the chair of the medical education committee who is appointed by the Chief of Staff, actively practicing representatives from each clinical department, hospital education, and nursing representation. Other

members may be added as appropriate in order to assure input from all disciplines of the medical staff.

**16.1.3 Credentials Committee**

**Composition**

The committee will consist of a chair, who is the Immediate Past Chief of Staff Committee membership will be appointed by the Committee Chair.——

**16.1.4. Interdisciplinary Practice Committee**

**Composition**

The committee will consist of the same individuals serving on the credentials committee with the addition of the director of nursing or her/his designee, the chief executive officer or designee, and a minimum of two (2) nurses, appointed by the chair and vice president of patient care services respectively. In addition, representatives of the categories of allied health professionals permitted to practice in the hospital may also be invited to participate in the committee function in order to lend necessary expertise.

**16.1.6 Institutional Review Board Committee**

**Composition:**

IRB members are selected from the different departments of the ministry, Providence Health & Services regional office, and from the community-at-large to ensure representation of professional expertise and community attitudes. The IRB staff will notify OHRP each time there is a change in membership. There are no term-limit restrictions and that any change in appointment, removal, or resignation requires written notification.

The IRB will have at least five members with varying backgrounds to promote complete and adequate review of research activities commonly conducted by the institution. The IRB shall not consist entirely of members of one profession.

Reasonable efforts will be made to ensure that IRB membership represents diversity in race/ethnicity, gender, and academic discipline, and exercises sensitivity to community attitudes.

The IRB includes at least one member whose primary concerns are in scientific areas and at least one member whose primary concerns are in nonscientific areas.

The IRB includes at least one member who is not otherwise affiliated with the institution and who is not part of the immediate family of a person who is affiliated

with the institution. One member may satisfy more than one membership category.

When the IRB reviews research that involves a vulnerable category of subjects (e.g. children, pregnant women, or handicapped or mentally disabled persons, or prisoners) consideration will be given to the inclusion of one or more individuals on the IRB (either as a member of the IRB or as a consultant) who are knowledgeable about and experienced in working with these subjects.

**16.1.7 Nominating Committee**

**Composition:**

The committee will be composed of the current chief of staff, the two prior chiefs of staff (if active members of the medical staff), the current chairs of Family Practice/ Internal Medicine, OB/GYN, Pediatrics, Surgery, and one physician representative of the contract services (Anesthesiology, Emergency Medicine, Pathology, and Radiology), on a rotating basis. If the two prior chiefs of staff are not eligible to participate, the medical executive committee will select an alternate member(s). The immediate past chief of staff will be the chair of the committee. The committee will offer one or more nominees for each office. Notice of the nominees will be given to the medical staff at least thirty (30) days prior to the June meeting of the medical executive committee.

**16.1.8 Performance Improvement Committee** (Including oversight of Appropriateness of admission and hospital stays, Case findings and identification of demographically important nosocomial infections, Medical Records review for completeness, accuracy, and timely completion, Blood and blood component/Operative and Invasive Procedures review). Also included are reviews for palliative care/pain management and code blue and critical care reporting.

**16.1.9 Physician's Well-Being Committee**

**Composition**

**The Chair of the Committee will be appointed by the Chief of Staff.** In order to improve the quality of care and promote the competence of the medical staff, the executive committee shall establish a physicians well-being committee comprised of no less than three (3) members of the active medical staff, a majority of which, including the chair, will be physicians. Other members, who may not be members of the Medical Staff may be added as needed based on expertise. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality improvement committees while serving on this committee.

**16.1.10 Bylaws Committee**

**Composition**

Membership of the Bylaws Committee will be determined by the Medical Executive Committee and will include the immediate past chief of staff, who will serve as the chair, the current chief of staff, and the secretary/treasurer. Also members would be each clinical department chief or designee. Committee or Division Chairs or designees may be invited as needed without a vote.

**16.1.11 Diabetes Committee**

**Composition**

The committee shall be composed of at least the following: a Chairperson, chosen by the Chief of Staff, Endocrinologists, Diabetologists, Representation from: Anesthesiology, Vascular Surgery, Clinical Departments, Nursing Services, Pharmacy, Food and Nutritional Services, Diabetes Care Nursing, and Representation from Administration. Other representatives, including physicians with an area of interest in Diabetes, with advanced approval of the Chair

**16.1.12 Multidisciplinary Peer Review Committee**

**Composition**

The committee shall be multi-disciplinary in nature. For the purposes of the MPRC meetings, membership shall include, but not be limited to the following:

- The Committee will be chaired by the Immediate Past Chief of Staff
- Physician members appointed by the Chair of the Committee
- Elected Medical Staff Officers (Ex-officio Members)
- Ad Hoc Members of the Medical Staff will be invited to participate based on the case(s) to be reviewed
- Other attendees shall include representatives from the offices of Performance Improvement, Risk Management, and Medical Staff Services.
- The Committee shall be chaired by the Immediate Past Chief of Staff or designee.

**16.1.13 Cancer Committee**

**Composition**

The Cancer Committee Chair is appointed by the Chief of Staff. Within the limits of those disciplines available to the institution, the Committee will consist of at least, but not limited to, board certified physicians representing all medical

specialties involved in the care of patients with cancer. Required to be included are Board Certified physician representatives from Surgery, Medical Oncology, Diagnostic Radiology, Radiation Oncology, and Pathology. Other disciplines should be included as appropriate, such as internal medicine and family practice. In selection of other disciplines, the Cancer Committee should consider the major sites that are diagnosed and treated at the institution and include representatives from the specialties that manage these types of cancers, for example, gynecology, urology, thoracic surgery, and otolaryngology. The aforementioned members are voting members of the Committee.

The committee also must include the Cancer Center Director (Cancer Liaison Physician) and the Cancer Registrar, who serves as staff to the Cancer Committee in coordinating the cancer program; they are permanent non-voting members.

The Committee must also include the American College of Surgeons Field Liaison(s).

Administration, nursing, social services, and to provide liaison between the Cancer Committee and Cancer Data Service (tumor registry), Performance Improvement must also be represented. Whenever possible, nursing should be represented by an oncology-certified nurse. Other specialties may be represented such as Pharmacy, Nutrition, Medical Records, Clergy, Rehabilitation, Home Health/Hospice, or other departments as required by the committee.

**16.1.14**      **Utilization Review Committee**  
**Composition**

The Committee will be Chaired a member of the Medical Staff designated by the Chief of Staff

Membership will include at least the following:

- At least one representative from Administration
- At least one representative from Case Management/Social Services
- At least one representative from Nursing Services
- Physician Advisor(s) for Case Management
- A representative from the Health Information Management Staff
- Physician representation from the Hospitalists Staff as well as others assigned by the Chair of the Committee, as appropriate

- Physician Advisor(s) for Utilization Review

**16.1.15**      **Patient Coordination Care Committee**  
**COMPOSITION**

The committee Chair will be appointed by the Chief of Staff and be a physician able to input into the EDIE System. The Committee will be a dedicated, interdisciplinary team with membership that may include, but not limited to representatives from the following: Ethics, Palliative Care, Anesthesiology, Care Management, Social Services, Administration, Nursing, Spiritual Care, Internal Medicine, Hospitalists, Surgeon, Emergency Medicine, Risk Management, Quality, and Clinical Informatics.

**16.1.16**      **Radiation Safety Committee**  
**COMPOSITION**

The Committee will be chaired by an Active member of the Radiology Division in conjunction with the Radiation Safety Officer. Members should include but not be limited to representatives from radiation oncology, administration, nursing, cardiology, nuclear medicine, vascular surgery and radiology and should also include the Medical Directors for Cath Lab and Cardiology.

**16.1.17**      **Ad Hoc Resolution Committee**  
**COMPOSITION**

The AHDRC will be composed of two (2) members, appointed by the Governing Board, and two (2) members appointed by the Medical Executive Committee. The four (4) members will appoint a fifth member. Appointees will not include individuals with direct administrative responsibility at the facility. In even numbered years the AHDRC chair will be designated by the Chair of the Governing Board and in odd numbered years the AHDRC chair will be designated by the Chief of Staff.

- 16.2**      Special committees will be appointed from time-to-time as may be required to properly carry out the duties and responsibilities of the medical staff. Such committees will confine their work to the purpose for which they were appointed and will report to the Medical Executive Committee.
- 16.3**      The chief of staff will be an ex-officio member of all committees of the medical staff, without vote, except at the Medical Executive Committee, Bylaws Committee, Nominating Committee, and the clinical department in which s/he is an active member.
- 16.4**      Committee chairpersons are chosen by the Chief of Staff. Membership on the committee will be left to the discretion of the chairperson of the committee and meet the requirements for membership as described in these rules and regulations.

**17 ALLIED HEALTH PROFESSIONALS**  
**NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS**

**Section 19.1** Allied Health Practitioners (AHP, also known as Mid-level practitioners or ‘physician extenders’) may be used by members of the medical staff to assist in patient care. Their use does not replace physician care requirements.

**19.1.1** This section applies exclusively to Nurse Practitioners and Physician Assistants.

**19.1.2** Each clinical department’s rules and regulations may be more restrictive and would supersede these general rules and regulations.

**19.1.3** Each of these Allied Health Professionals must have a designated supervising physician.

**19.1.4** An Allied Health Practitioner may be an employee of the hospital or be an employee of a member of the Medical Staff

**19.1.5** An Allied Health Practitioner is authorized to function without the direct or immediate observation of the supervising physician except as described below.

**19.1.6** Supervising physician consultation must be available at all times, either physically or by electronic means.

**19.1.7** An Allied Health Professional must clearly identify themselves with an appropriately titled name badge readily visible.

**19.1.8** When phoning the hospital, the Allied Health Practitioner must clearly identify themselves as a Nurse Practitioner or Physician Assistant.

**19.1.9** The Allied Health Practitioner will not give the impression that they are physicians or allow patients, families, or staff to assume that they are physicians.

**19.1.10** An Allied Health Practitioner will not identify themselves as “Doctor”.

**19.1.11** An Allied Health Practitioner who wishes to order medications must possess a full DEA schedule.

**19.1.12** An Allied Health Practitioner may not see patients in the Intensive Care units, which include CVICU, ICU and PICU. Patients must be seen by a physician.

**Section 19.2 Supervising Physicians Must:**

**19.2.1** Make the decision on admission or transfer of a patient into a critical care unit. This may be via telephone discussion with the AHP. This discussion must be documented in the medical record. A physician must see these patients within four (4) hours.

**19.2.2** Consulting physicians who utilize AHPs must perform the initial evaluation of the patient.

**19.2.3** Communicate directly with the Emergency Department physicians regarding decisions to either admit a patient to the hospital or discharge them from the Emergency Department. Initial management decisions are to be made physician-to-physician.

- 19.2.4 Each time an AHP makes a chart entry, the supervising physician must see the patient and co-sign chart entries within 24 hours. The physician will review all pertinent data and direct the overall care of the patient.

**Section 19.3 Allied Health Practitioners may carry out the following duties in the acute care setting:**

- 19.3.1 Perform and dictate admission and pre-operative Histories and Physicals (note exception above)
- 19.3.2 Write daily progress notes
- 19.3.3 Write orders (including DNR orders)
- 19.3.4 Orders are not to be given over the telephone.
- 19.3.5 Order diagnostic testing and therapeutic modalities
- 19.3.6 Collect and Interpret data
- 19.3.7 Initiate End of Life Protocols, after discussion with the supervising physician and documentation of such discussion, and if there is a completed DNR form on the chart cosigned by the supervising physician.
- 19.3.8 Call consults when directed to do so by the supervising physician.

**Section 19.4 Nurse Practitioner/Physician Assistant Duties and Responsibilities**

- 19.4.1 The scope of an Allied Health Professional's duties will be specifically listed in the delineation of privileges for each category. For those AHP's who are hospital employees or hospital contact employees, they will also be governed by the standardized procedures as reviewed and approved by the Medical Staff and Governing Board.
- 19.4.2 Any new duties requested would require appropriate documentation of training and experience as well as coverage under the scope of licensure for that category and Malpractice coverage.
- 19.4.3 Allied Health Professions may participate directly in patient management as consistent with the practice privileges granted and with the allied Health Professional's licensure or certification.
- 19.4.4 May be extended to include service on Medical Staff Departments and Committees, attendance at the meetings of the Department to which s/he is assigned, as permitted by the Departmental Rules and Regulations, and attendance at Continuing Medical Education programs in his/her field of practice.
- 19.4.5 Nurse Practitioners and Physician Assistant may participate, as appropriate, in patient care audits and other quality review evaluations and monitoring activities required of the Allied Health Professional, supervising initial appointee's of his/her same occupation or profession or of a lesser included occupation or profession, and in discharging such other functions as may be required from time to time.
- 19.4.6 Nurse Practitioners may order out-patient testing (i.e. imaging) and receive results without the direct supervision/signature of a physician.

**Section 19.5 Peer Review**

- 19.5.1** Although ultimate responsibility for patient for patient care will always rest with the member of the Medical Staff, an Allied Health Professional will retain appropriate responsibility within his/her area of professional competence for the care and supervision of the patient in the hospital for who s/he provides service(s).
- 19.5.2** Maintain the confidentiality of all peer review related matters and waive any right under State law to voluntarily disclose such matters.
- 19.5.3** At all times, the Allied Health Professional will meet the responsibilities specified in the Medical Staff Bylaws/Rules and Regulations.

**20. MEDICAL STAFF LEADERSHIP POSITIONS**

**Section 20.1 CHIEF OF STAFF**

The Chief of Staff will serve as the Chief Executive Officer of the Medical Staff. Duties and responsibilities are delineated in the Medical Staff Bylaws.

**Section 20.2 VICE CHIEF OF STAFF**

In the absence of the Chief of Staff, s/he will assume all of the duties and have the authority of the Chief of Staff. Duties and responsibilities are defined in the Medical Staff Bylaws.

**Section 20.3 IMMEDIATE PAST CHIEF OF STAFF**

Duties and responsibilities are defined in the Medical Staff Bylaws.

**Section 20.4 SECRETARY/TREASURER**

**20.4.1** The Secretary/Treasurer will assume all duties and authority of the Chief of Staff in the absence of the Chief of Staff and the Vice Chief of Staff or if the Chief of Staff and Vice Chief of Staff are unable to fulfill their duties for any reason. Other duties and responsibilities are delineated in the Medical Staff Bylaws.

**20.5 MEDICAL STAFF STIPENDS**

Medical Staff Stipends will be determined by the Medical Executive Committee. They will be approved annually. Failure to meet the duties and responsibilities assigned will result in a reduction of withholding of a stipend, as determined by the Chief of Staff.

**21. AUTOPSIES**

**Section 21.1** An autopsy may be performed, in accordance with Health & Safety Code, Section 7113, by the hospital pathologists on any remains in his/her custody. If the decedent, prior to

death, authorized/consented for an autopsy in his/her will or other written document or upon receipt of a written authorization by telegram of a person representing himself/herself to be any of the following:

- 21.1.1** An “attorney-in-fact” appointed as a result of the decedent’s execution of a Durable Power of Attorney for Health Care and authorized consent to the autopsy.
- 21.1.2** Spouse (not legally separated or divorced, unless s/he has custody of the eldest child who is a minor).
- 21.1.3** Adult child age 18 or over.
- 21.1.4** Adult grandchild
- 21.1.5** Parent
- 21.1.6** Adult sibling
- 21.1.7** Grandparent
- 21.1.8** Adult uncles and aunts
- 21.1.9** Other adult relatives
- 21.1.10** Friends accepting responsibility for disposition of the body.
- 21.1.11** Public official (Curator of the Unclaimed Dead) acting within his or her legal authority according to the County of Los Angeles, Department of the Coroner (Code 10250).
- 21.2** Authorization for Autopsy must be completed.
- 21.3** Any person mentioned above in the stipulated order of authorization may consent for autopsy even if a person(s) lower on the list opposes it. If there is a conflict, the administration will seek advice from hospital legal counsel.
- 21.4** California Health and Safety Code 10250 and Government Code 27491 require that certain deaths must be reported to the Coroner and direct the Coroner inquire into and determine the circumstance, matter, and cause of a specific death. Deaths reportable to the Coroners’ office are delineated in the Plan for Provision of Care and Improving Organizational Performance.
- 21.5** An attempt to obtain permission for autopsy should be made in those cases where a postmortem examination is likely to include information that may lead to improvement

in the diagnosis and quality of care. A recognized benefit of the autopsy falls into seven broad categories:

- Benefits to physicians and health care organizations
- Benefits to family of the deceased
- Benefits to public health
- Benefits to medical education
- Benefits to medical discovery and applied clinical research
- Benefits to specific biomedical research
- Benefits to law enforcement and jurisprudence.

It must be noted that the Coroner has primary jurisdiction in all reportable cases as outlined in the current information booklet for hospital and nursing home facilities as provided for by the County of Los Angeles, Department of the Coroner.

- 21.6** In those cases in which the Coroner does not elect to do an autopsy, an autopsy can be performed only after proper written authorization is obtained by the attending physician. Coordination of the autopsy is established in the Policies and Procedures of the Pathology, Laboratory, and Nursing Departments..
- 21.7** Findings of autopsy are used as a source of clinical information in the continuous quality improvement activities and presented to the Performance Improvement Committee as well as the Department of the attending physician, if necessary.
- 21.8** Prior to performing the autopsy, the pathologist will discuss the case with the attending physician and/or appropriate consultants and will notify them as to when the autopsy will be performed.
- 21.9** Deaths in which an autopsy may be of value to the attending physician are:
- Death in which there is a question as to the primary diagnosis, in which the cause of death is not known with certainty on clinical grounds.
  - Unexpected or unexplained death, which is apparently natural and not subject to forensic medical jurisdiction.

- Death resulting from the presence or suspicion of a disease, which may have implications to the family or contact such as an inherited illness or infectious disease.
- Death in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide assurance to them regarding the same.
- Death occurring during or immediately following any diagnostic or therapeutic procedures, including surgery or experimental treatment.
- Obstetric death, including up to seven days postpartum.
- Neonatal or pediatric death.
- Death in which it is believed that autopsy will disclose a known or suspect illness, which may have a bearing on survivors or recipients of organ transplant.
- Death known or suspected to have resulted from environment or occupational hazards.
- All deaths occurring on a “psychiatric basis”/deaths occurring on a Mental Health Unit (72 hour hold for altered mental status).

#### **HIPAA PRIVACY RULE COMPLIANCE**

**Section 22.1. Commitment to Privacy Rule Compliance.** The use and disclosure of health Information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (the "Privacy Rule"). Medical Staff members and allied health providers authorized to provide services at the Hospital shall protect the privacy of patients' health information as required by the Privacy Rule, other applicable law and the Hospital's privacy policies and procedures. Further, the Medical Staff and allied health providers are committed to protecting the privacy of patient health information in a manner that reasonably minimizes disruption to quality patient care.

**Section 22.2 Organized Health Care Arrangement.** The Privacy Rule permits multiple health care providers that are Covered Entities (as defined in the Privacy Rule) and provide health care in a clinically integrated care setting, such as the hospital setting, to declare themselves an “organized health care arrangement.” Organized health care arrangement status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations activities of the arrangement. As such, it protects patient privacy while minimizing disruption to quality patient care. Accordingly, the Hospital has organized an organized health care arrangement to facilitate the appropriate sharing of health information in the Hospital

between and among the Hospital, its workforce members and business associates, Medical Staff members and allied health providers authorized to provide services at the Hospital (the "Hospital OHCA").

**Section 22.3 Agreement to Participate in OHCA.** By applying for and exercising clinical privileges at the Hospital, each Medical Staff member and allied health practitioner with service authorization agrees to participate in the Hospital OHCA.

**Section 22.4 Joint Notice of Privacy Practices.**

**22.4.1 Agreement to Comply with Terms of Joint Notice.** The Privacy Rule requires a direct treatment provider that is a Covered Entity to deliver a notice of privacy practices to a patient no later than the provider's first date of service to the patient. Health care providers that participate in an organized health care arrangement may comply with this requirement by a joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a Medical Staff member or an allied health provider in connection with his or her provision of services in the Hospital, the Medical Staff member or allied health provider agrees to abide by the terms of the joint Notice of Privacy Practices of the Hospital OHCA then in effect.

**22.4.2 Revisions to Joint Notice.** The Hospital may revise the Hospital OHCA's joint Notice of Privacy Practices, in its reasonable discretion, upon thirty days notice of a revision (with a copy of the revised joint notice) to the Executive Committee (unless the compliance date of a law necessitates a shorter notice period). If the Executive Committee does not object to the revised joint Notice of Privacy Practices before the expiration of the notice period, it shall become effective and binding upon Medical Staff members and allied health providers with service authorization upon expiration of the notice period. Any changes which would affect these Rules and Regulations or Bylaws shall be processed in accordance with requirements of the Bylaws/Rules and Regulations.

**22.4.3. Corrective Action.** Whenever a Medical Staff member or allied health provider with service authorization uses or discloses health information in a manner inconsistent with the Privacy Rule, other applicable law, the Hospital's privacy policies and procedures or the Hospital OHCA's joint Notice of Privacy Practices, such use or disclosure will be deemed disruptive to the operations of the Hospital and contrary to these Rules and Regulations and Hospital policies. If the Executive Committee determines that such an inconsistent use or disclosure has occurred, it may undertake such corrective action as it deems appropriate in accordance with the Bylaws/Rules and Regulations. Participation in OHCA is a requirement of medical staff members at Providence Tarzana Medical Center.

## 22. STUDENTS

**23.1** Prior to a student coming to round with a member of the Medical Staff, the Medical Staff Office should be notified so that necessary information can be obtained which must include, at a minimum, the timeframe in which they will be at the hospital. The student will then be issued a badge for identification purposes. An observer consent should be completed anytime the student will be observing a procedure.

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Approved by Active Medical Staff:

Approved by Governing Board: