PIH HEALTH | Good Samaritan Hospital

Medical Staff Rules

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MEDICAL STAFF RULES

RULE 1: MEDICAL STAFF MEMBERSHIP

1.1 Qualifications for Membership

1.1.1 Basic Qualifications

A practitioner must demonstrate compliance with all the basic standards set forth in this section in order to have an application for Medical Staff Membership accepted for review. The practitioner must:

1.1.1.1. be licensed to practice medicine, podiatry, or dentistry in California or qualify under California law to practice with an out-of-state license;

1.1.1.2. if practicing medicine, podiatry, or dentistry and having privileges to prescribe controlled substances, have a Federal DEA certificate number;

1.1.1.3. be certified in his or her principle field of practice by a recognized specialty board or have an active application for certification followed by certification within five years from the date of appointment. Practitioners who are not certified or actively seeking board certification may nevertheless qualify for Medical Staff Membership and clinical Privileges if they have practiced with unrestricted Privileges at a hospital accredited by The Joint Commission for at least five years prior or can demonstrate unusual qualifications and training in their specialty area;

1.1.1.4. be a Medicare eligible provider;

1.1.1.5. have liability insurance or equivalent coverage meeting the standards specified fellow in the Rules; and,

1.1.1.6. if requesting Privileges in a Department or service operated under an exclusive contract, be a member, employee, or subcontractor, or the group or person that has the contract.

A practitioner who does not meet these basic standards is ineligible to apply for Medical Staff Membership and the application shall not be accepted for review, except that applicants for the Honorary staff category of Medical Staff Membership do not need to comply with any of the basic standards. If it is determined during the processing of the application that the applicant does not meet all of the basic qualifications, the review of the application shall be discontinued. An applicant who does not meet the basic standards is not entitled to the procedural rights set forth in the Bylaws and Rules, but may submit comments and a request for reconsideration of the specific standards which adversely affected the applicant. Those comments and requests shall be reviewed by the Medical Executive Committee and the Board of Trustees, which shall have the sole discretion to decide whether to consider any changes in the basic standards or to grant a waiver as allowed in Section 1.1.4 below.

1.1.2 Qualifications for Membership

In addition to meeting the basic standards, a practitioner applicant must:

1.1.2.1. document his or her (i) adequate experience, education, and training for the requested Privileges or practice prerogatives; (ii) current professional competence; (iii) adequate physical and mental health status (subject to any necessary reasonable accommodation) to demonstrate to the satisfaction of the Medical Staff that he or she is professionally and ethically competent to that patients can reasonable expect to receive the generally recognized high professional level of quality care for this community; and,

1.1.2.2. be determined (i) to adhere to the lawful ethics of his or her profession; (ii) to be able to work cooperatively with others in the Hospital setting so as not to adversely affect patient care or Hospital operations; and, (iii) to participate in any properly discharge Medial Staff responsibilities.

1.2 Administrative and Contract Practitioners

1.2.1 Contracts with No Clinical Duties

A practitioner employed by or contracting with the Hospital in a purely administrative capacity with no clinical duties or Privileges is subject to the Hospital's regular personnel policies and to the terms of his/her contract or other conditions of employment and need not be a Medical Staff Member.

1.2.2 Contractors with Clinical Duties

1.2.2.1. A practitioner with whom the Hospital contracts to provide services which involve clinical duties or Privileges must be a Medical Staff Member, achieving his or her status by the procedures described in the Bylaws and Rules. Unless a contract or agreement executed after this provision is adopted provides otherwise, or unless otherwise required by law, those Privileges made exclusive or semi-exclusive pursuant to a closed-staff or limited-staff specialty policy will automatically terminate, without the right of access to the review, hearing and appeal procedures of the Bylaws and Rules, upon termination or expiration of such practitioner's contract or agreement with the Hospital.

1.2.2.2. Contracts between practitioners and the Hospital shall prevail over the Bylaws and Rules, except that the contracts may not reduce any hearing rights that are legally mandated when an action will be taken that must be reported to the Medical Board of California or the National Practitioner Data Bank.

1.2.3 Subcontractors

Practitioners who subcontract with practitioners who contract with the Hospital may lose any Privileges granted pursuant to an exclusive or semi-exclusive arrangement (and their Medical Staff Membership if all Privileges are automatically terminated) if their relationship with the contracting practitioner is terminated, or the Hospital and the contracting practitioner's agreement or exclusive relationship is terminated. The Hospital may enforce such an automatic termination even if the subcontractor's agreement fails to recognize the right.

1.3 Basic Responsibilities of Medical Staff Membership

Except for Honorary Medical Staff categories (see Rule 2.1), each Medical Staff Member and each practitioner exercising temporary privileges shall continuously meet all of the following responsibilities:

1.3.1 provide his or her patients with care of the generally recognized professional level of quality and efficiency;

1.3.2 actively help educate patients and families;

1.3.3 coordinate care, treatment, and services with other practitioners and Hospital staff, as relevant to the care, treatment, and services for individual patients;

1.3.4 abide by the Medical Staff Bylaws and Rules and all other lawful standards, policies, and rules of the Medical Staff and the Hospital;

1.3.5 abide by all applicable laws and regulations of governmental agencies and comply with applicable standards of The Joint Commission;

1.3.6 discharge such Medical Staff Department, Committee, and Service functions for which he or she is responsible by appointment, election, or otherwise;

1.3.7 prepare and complete in an accurate, legible, and timely manner the medical and other required records for all patients to whom the practitioner in any way provides services in the Hospital and maintain confidentiality of patient-identifiable information;

1.3.8 abide by the ethical principles of his or her profession;

1.3.9 refrain from unlawful fee splitting or unlawful inducements relating to patient referral;

1.3.10 refrain from any unlawful harassment or discrimination against any person (including any patient, Hospital employee, Hospital independent contractor, Medical Staff Member, volunteer, or visitor) based upon the person's age, sex, religion, sexual orientation, race, creed, color, national origin, health status, ability to pay or source of payment;

1.3.11 delegate responsibility for diagnosis or care of hospitalized patients only to a practitioner, practitioner in training or Allied Health Practitioner, who is qualified to undertake this responsibility and who is adequately supervised;

1.3.12 seek consultation whenever warranted by the patient's condition or when required by the Rules;

1.3.13 actively participate in and regularly cooperate with the Medical Staff in assisting the Hospital to fulfill its obligations related to patient care, including, but not limited to, continuous quality improvement, peer review, utilization management, quality evaluation, and related monitoring activities required of the Medical Staff and in discharging other such functions as may be required from time to time;

1.3.14 upon request, provide information from his or her office records or from outside sources as necessary to facilitate the care of, or review of, the care of specific patients;

1.3.15 recognize the important of communicating with appropriate Department Chiefs and/or Medical Staff Management Department personnel when he or she obtains credible information indicating that a fellow Medical Staff Member may have engaged in unprofessional or unethical conduct or may have a health condition which poses a significant risk to the care of patients and then cooperate as reasonably necessary toward the appropriate resolution of any such matter;

1.3.16 complete continuing medical education (CME) that is appropriate to the practitioner's specialty;

1.3.17 work cooperatively with Members, nurses, Hospital administrative staff, and others so as not to adversely affect patient care or Hospital operations;

1.3.18 participate in emergency service coverage and consultation panels as allowed and required by the Rules;

1.3.19 cooperate with the Medical Staff in assisting the Hospital to meet its uncompensated or partially compensated patient care obligations;

1.3.20 cooperate in peer review and quality improvement, and refrain from harassing those who are participating in peer review and quality improvement activities;

1.3.21 continuously inform the Medical Staff of any significant changes in the information required at the time of appointment and reappointment;

1.3.22 continuously meet the qualifications for membership as set forth in the Bylaws and Rules. A Member may be required to demonstrate continuing satisfaction of any of the requirements of the Bylaws and Rules upon the reasonable request of the Credentials and Privileging Committee or Medical Executive Committee; and,

1.4 Professional Liability Insurance

1.4.1 General

1.4.1.1 Each practitioner granted clinical privileges or practice prerogatives (including temporary privileges) shall maintain professional liability coverage from an insurer admitted to sell malpractice insurance in California or on the Approved Surplus Line Insurance list of California and with a Best rating of A-:X or a risk retention, cooperative or other arrangement that has been specifically approved in advance by the Medical Executive Committee and Board of Trustees as credit worthy, with the limits of $1 million per occurrence and $3 million aggregate.

1.4.1.2 The insurance shall apply to all patients the practitioner treats and to all procedures the practitioner has been granted privileges or practice prerogatives to perform in the Hospital.

1.4.1.3 If the professional liability insurance is on a "claims made" rather than "occurrence" basis, the practitioner shall assure that he or she maintains the coverage required by the Rules for all acts or omissions occurring while the practitioner has privileges or practice prerogatives to practice. If there is any change in insurers or any cessation of coverage, the practitioner shall obtain extended reporting malpractice insurance coverage ("tail" or "nose" coverage) in an acceptable form, with liability limits of not less than $1,000,000.00 per occurrence and $3,000,000 in the aggregate in any one year. Each practitioner must maintain this coverage after the termination of all privileges in the form of continuing coverage or consistently arranging for tail or nose coverage if insurers are changed or insurance is discontinued.

1.4.2 Proof of Insurance

1.4.2.1 Proof of insurance coverage must be provided in the form of a current certificate of insurance or confirmation provided by the insurer. The proof shall be maintained in each practitioner's credentials file. Information about insurance coverage must be provided at the time of appointment and reappointment and upon request from any Medical Staff Officer, committee, or Department Chief.

1.4.2.2 At the time of initial appointment and at the time of reappointment, each applicant or Member must provide information on any professional liability claims filed against him or her, any malpractice claims reported to the insurance carrier, any letter of intent to sue he or she has received, any claims pending, any judgment entered against him or her, and any settlement made where there was a monetary payment. In addition, the applicant or Member must state whether he or she has been denied professional liability insurance, had his or her policy cancelled, had limitations placed on his or her scope of practice, or has been notified of any intent to deny, cancel, or limit coverage.

1.4.3 Reporting Changes

Each Medical Staff Member shall report any reduction, restriction, cancellation, or termination of the required professional liability insurance, or change in insurance carrier, as soon as reasonably possible to the Credentials and Privilege Committee and the Chief Executive Officer via written notice sent to the Medical Staff Management Department.

1.4.4 Failure to Maintain Professional Liability Insurance

The automatic suspension procedure set forth in Section 11.1.3 shall be followed in the event a practitioner fails to maintain insurance that complies with these rules.

1.4.5 Availability of Information

Upon receipt of a written request from a Medical Staff Member, the Medical Staff Management Department may supply information to the Member regarding another Member's insurance coverage.

RULE 2: GRADUATE MEDICAL EDUCATION

2.1 Interns, Residents, and Fellows

2.1.1 Interns, Residents, and Fellows participating in formal, approved training programs in the Hospital shall not hold appointments to the Medical Staff and shall not be granted specific clinical Privileges in the training programs. Rather, they shall be permitted to perform only those clinical duties set out in the training program protocols developed by the directors of education, curriculum requirements, and/or affiliation agreements developed by the Hospital.

2.1.2 Residents and Fellows practicing independently of an approved training program must apply for and qualify for Medical Staff Membership and Privileges. Residents and Fellows who will train in non-approved programs for less than three months must apply for Temporary Privileges for training. Fellows practicing independent of an approved training program for more than two years will not be required to pay the application fee.

2.1.3 Patient Participation

2.1.3.1 In fulfillment of Graduate Medical Education goals, all patients shall be available for teaching purposes unless the patient or a surrogate decision-maker objects or there is specific contraindication and the patient's attending Practitioner issues a specific order indicating that the patient shall not be involved in any medical education activities.

2.1.4 Medical Students, Residents, and Fellows Supervision and Privileges

2.1.4.1 Medical Students, residents, and fellows participating in training programs at the Hospital shall be supervised by Medical Staff Members and act in accordance with the Agreement governing their training at the Hospital.

2.1.4.2 The supervision and assessment of a participant's care, treatment, and services provided, as well as accuracy of the medical record, will be documented by the supervising physicians' countersignature.

2.1.5 Record Keeping

2.1.5.1 General

Medical Students, residents, and fellows shall be responsible for completing records pertaining to the clinical services they provide while participating in the Medical Student training program, Residency, or Fellowship at the Hospital.

2.1.5.2 Countersignatures

The attending and supervising physicians shall review and then countersign the following reports prepared by the medical student or resident:

a. Admission History and Physical Examination Report

b. Consultation Reports

c. Pre-operative Reports

d. Operating Reports

e. Discharge Summaries

2.1.5.3 Designation in Operative Reports

a. Residents who act as an assistant surgeon shall be designated in the operative report as the "assisting resident surgeon" and the primary operating surgery shall be designated as the "primary operating surgeon" in the operative report.

b. Medical Students who observe surgery shall be designated as observers. Medical Students who assist with simple procedures during surgery shall be designated in the operative report as the "assisting medical student" and the primary operating surgeon shall be designated as such.

RULE 3: ALLIED HEALTH PRACTITIONERS

3.1 Overview

3.1.1 Allied Health Practitioners may exercise only the scope of practice specifically granted them by the Board of Trustees. The scope of practice for which each Allied Health Practitioner may apply and any special limitations or conditions on the exercise of such scope of practice shall be based on recommendations of the Interdisciplinary Practices Committee and Medical Executive Committee and subject to the approval of the Board of Trustees.

3.1.2 Practitioners who desire to supervise or direct Allied Health Practitioners who provide dependent services must apply and qualify for privileges to supervise approved Allied Health Practitioners.

3.1.3 Until the Allied Health Practitioner has been granted practice prerogatives and assigned to a Department, an Allied Health Practitioner should not be practicing within the Hospital.

3.1.4 Each Allied Health Practitioner shall be assigned to a Department appropriate to his or her occupational or professional training and, unless otherwise specified in the Bylaws or Rules, shall be subject to terms and conditions paralleling those specified for practitioners as they may logically be applied to Allied Health Practitioner and appropriately tailored to the Allied Health Practitioner in question.

3.1.5 When an Allied Health Practitioner in a category that has not been approved as eligible to apply to practice at the Hospital requests to practice at the Hospital, he or she may submit an application at the same time the request for recognition of the profession is processed; however, no right to practice in the Hospital is thereby created or implied.

3.2 Approved Categories of Allied Health Practitioners

3.2.1 The categories of Allied Health Practitioners allowed to practice in the Hospital and their practice prerogatives will be ultimately determined by the Board of Trustees. The Board of Trustees shall periodically study which categories of Allied Health Practitioners should be permitted to practice in the Hospital, and delineation of practice prerogatives and responsibilities to be assigned to the category. Prior to making any changes, the Board of Trustees shall consult with the relevant Department Chief, Interdisciplinary Practices Committee and Medical Executive Committee.

3.2.2 The categories of Allied Health Practitioners currently approved by the Board of Trustees and eligible to practice at the Hospital include:

3.2.2.1. Certified Nurse Midwives

a. Education

i. In order to qualify for Allied Health Practitioner practice prerogatives, a Certified Nurse Midwife must be certified by the American Midwifery Certification Board.

b. Practice Prerogatives

i. Licensed Nurse Midwives shall be eligible to apply for practice prerogatives to provide services as delineated on the approved Certified Nurse Midwife Practice Prerogative request form. A Certified Nurse Midwife is authorized, under supervision of a board eligible obstetrician, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care. All complications must be referred to a board certified or eligible obstetrician immediately.

ii. The practice of midwifery does not include the assisting of childbirth by any artificial forcible or mechanical means, nor the performance of antepartum version. Certified Nurse Midwives are prepared to make obstetrical value judgments within their role and to accept responsibility for managing normal obstetrical care throughout the maternity cycle in association with the attending physician.

c. Supervision

i. Supervision shall not be construed to require the physical presence of a supervising physician, but a supervising physician must be immediately available. Certified Nurse Midwives must be sponsored by a member of the Active Staff category.

d. Proctoring

i. The Department of Obstetrics and Gynecology shall be responsible for credentials verification and review, quality improvement and peer review activities of / for Certified Nurse Midwives. Certified Nurse Midwives shall be proctored per the requirements on the Certified Nurse Midwife Practice Prerogative request form.

e. Charting

i. Certified Nurse Midwives may enter notes in a patient's medical record (chart). The supervising physician shall be required countersign only on the following medical record documentation:

a. Admission orders

b. Discharge summaries

3.2.2.2. Physician Assistants

a. Education

i. A Physician Assistant shall hold a current, unrevoked, unrestricted, unsuspended license to practice issued by the Physician Assistant Committee of the Medical Board of California.

b. Practice Prerogatives

i. A Physician Assistant may only provide those services which he or she is competent to perform and which are consistent with the Physician Assistant's education, training, and experience and so delegated in writing by a Supervising Physician who is responsible for a patient's care by a Physician Assistant and so documented on the approved delineation of practice prerogative form for a Physician Assistant. The Department to which the Physician Assistant is assigned shall require proof of documentation of competence from a Physician Assistant for any tasks, procedures, or management he or she is performing. A Physician Assistant shall consult with his or her Supervising Physician regarding any tasks, procedures, or diagnostic problem which the Physician Assistant determines exceeds his or her level of competence or shall refer cases directly to the Supervising Physician.

c. Supervision

i. A supervising Physician shall be available in person or by electronic communication at all times when the Physician Assistant is caring for patients. A supervising Physician shall delegate to a Physician Assistant only those tasks and procedures consistent with the approved practice prerogative request form. The supervising Physician shall observe or review evidence of the Physician Assistant's performance of all tasks and procedures delegated to the Physician Assistant until that time when the supervising Physician is assured of the Physician Assistant's competency.

ii. The Physician Assistant and the supervising Physician shall establish, in writing, back-up procedures for the immediate care of those patients in need of emergency care beyond the Physician Assistant's practice prerogatives for such times when a supervising Physician is not on the premises. Further, a Physician Assistant and supervising Physician shall establish, in writing, guidelines for the adequate supervising of the Physician Assistant, including one or more of the following mechanisms:

a. Examination of the patient by the supervising Physician.

b. Adoption of protocols to govern the performance of a Physician Assistant for some or all tasks. The minimum content for such a protocol as referenced in this section shall include the presence or absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate tests or studies to order, drugs to recommend to the patient, and education to be given the patient. The protocol shall state what information should be given to the patient, the nature of the consent to be given the patient, the preparation and techniques of the procedure and the follow-up care.

c. Other mechanism approved, in advance, by the Interdisciplinary Practices Committee.

iii. Except in life threatening situations, a Physician Assistant shall perform surgery requiring other than local anesthesia only under the direct and immediate supervision of an approved Physician.

d. Charting

i. Each Physician Assistant must operate pursuant to a Delegation of Services Agreement (DSA) which will specify the requirements for the review and countersignature of patient charts. The DSA shall require the supervising Physician to review and countersign within 30 days (with the date and time the chart was countersigned), at a minimum, a 10% sampling of medical records of patients treated by the Physician Assistant functioning under the DSA. The supervising Physician shall select for review those cases which, by problem, diagnosis, treatment or procedure, represent in his or her judgment, the most significant risk to the patient. The Supervising Physician need not countersign each entry in the chart; but may enter one note confirming the review of the services provided by the Physician Assistant for the patient.

ii. In those circumstances where a Physician Assistant, is operating under interim approval, the supervising Physician shall review, sign, and date the medical record of all patients care for by that Physician Assistant within 7 days if the supervising Physician was on the premises when the Physician Assistant diagnosed or treated the patient. If the supervising Physician was not on the premises at that time, he or she shall review, sign and date such medical records within 48 hours of the time care was provided.

3.2.2.3. Nurse Practitioners

a. Education

i. A Nurse Practitioner shall hold a current, unrestricted, unrevoked, unchallenged license as a registered nurse in the State of California and have successfully completed a program of study as a Nurse Practitioner which conforms to the Board of Registered Nursing's standards, including:

a. Certification as a Nurse Practitioner by a national or state organization whose standards meet those standards of the State of California for the education of Nurse Practitioners; and

b. Educational background and documented experience confirmed by the California Board of Registered Nursing to conform with California standards for the education of a Nurse Practitioner.

b. Practice Prerogatives

i. The clinical functions which a Nurse Practitioner may perform shall be delineated by the clinical Department to which he or she may be assigned at the time of initial appointment.

c. Supervision

i. A physician meeting the criteria set forth below may apply for and assume responsibility for supervising a Nurse Practitioner's practice in the Hospital:

a. Be a member of the Active Staff category of the Medical Staff.

b. Be responsible for supervising no more than two Nurse Practitioners.

c. Be board certified or eligible in his or her primary specialty.

d. Have unrestricted Privileges to perform all of the procedures the Nurse Practitioner will perform under the physician's supervision.

ii. The approved supervising physician must review with the Nurse Practitioner, either in person or via telephone, the findings from a patient's history and physical examination; and, the performance by the Nurse Practitioner of the tasks and procedures he or she is allowed to perform at the Hospital. This review must occur on a continuing and timely basis depending upon the significance of the findings and the patient's clinical status.

Iii. The supervising physician and the Nurse Practitioner may establish in writing additional guidelines for timely supervision of the tasks or procedures the Nurse Practitioner will perform in the Hospital. These guidelines may be general or specific and may include standing orders or protocols, individual patient orders, immediate consultation guidelines and/or chart review mechanisms. The supervising physician and Nurse Practitioner cannot establish requirements less stringent than those set forth in this Rule. Any written guidelines prepared shall be submitted together with the Nurse Practitioner's application. Any revisions, amendments or additions to such guidelines shall be promptly submitted to the appropriate clinical Department Chief for review and approval.

iv. The supervising physician has continuing responsibility to follow the patient's progress and to assure that the Nurse Practitioner does not function autonomously.

e. Charting

i. Nurse Practitioners granted practice prerogatives may enter notes onto a patient's chart.

3.2.2.4. Research Nurse Coordinators

a. Education

i. A Research Nurse Coordinator must have a current, unrestricted, unrevoked, unsuspended State of California Registered Nurse license. The applicant must also have a minimum of two years documented experience as a Registered Nurse in his or her area of specialization.

b. Practice Prerogatives

i. The functions which a Registered Nurse Coordinator may perform shall be

delineated by the clinical Department to which he or she may be assigned at the time of initial appointment.

c. Supervision

i. A Registered Nurse Coordinator performs under the supervision of an identified Physician.

d. Charting

i. Registered Nurse Coordinator granted practice prerogatives may enter notes onto a patient's chart. The supervising Physician shall countersign all entries except routine progress notes. Unless otherwise specified in the Medical Staff Rules or specific supervision protocols, all chart entries which require countersignature must be signed by the supervising Physician within 24 hours of when the entry was made.

3.2.2.5. Acupuncturists

3.2.2.6 Certified Registered Nurse Anesthetists (CRNA)

a. Qualifications
A CRNA shall hold a current and unrestricted license as a registered nurse in the State of California, current certification from California as a certified registered nurse anesthetist, and current certification in Advanced Cardiac Life Support (ACLS) and Pediatric Advanced Life Support (PALS).

b. Practice Prerogatives

The clinical functions which a CRNA may perform shall be delineated on the approved CRNA privilege form.

c. Physician Supervision

CRNAs do not require physician supervision.

d. Charting

CRNA may enter notes in a patient's medical record (chart). No countersignatures are required from any Medical Staff member.

3.2.3 When an Allied Health Practitioner in a category that has not been approved as eligible to apply to practice at the Hospital requests to practice at the Hospital, the Medical Staff Management Department may begin to process an application at the same time the request for recognition of the profession is processed; however, no right to practice in the Hospital is thereby created or implied.

3.3 Prerogatives

The prerogatives which may be extended to an Allied Health Practitioner may include:

3.3.1 Provision of the specified patient care services under the supervision or direction of a Medical Staff Member and consistent with delineated practice privileges prerogatives approved for the Allied Health Practitioner and within the scope of the Allied Health Practitioner's license or certification.

3.3.2 Service on Medical Staff, Department, and Hospital committees.

3.3.3 Attendance at meetings of the Department to which the Allied Health Practitioner is assigned, as permitted by the Medical Staff or Department rules, and attendance at Hospital education programs in the Allied Health Practitioner's field of practice.

3.3.4 Allied Health Practitioners are not Members of the Good Samaritan Hospital Medical Staff, and hence are not entitled to vote on Medical Staff or Department or section matters.

3.4 Responsibilities

Each Allied Health Practitioner shall:

3.4.1 Meet those responsibilities required by the Rules and as specified for practitioners in the Bylaws or Rules, as modified to reflect the more limited practice of the Allied Health Practitioner.

3.4.2 Retain appropriate responsibility within the Allied Health Practitioner's area of professional competence for the care and supervision of each patient in the Hospital for whom the Allied Health Practitioner is providing services.

3.4.3 Consistent with the scope of practice approved for him or her, exercise independent judgment within his or her areas of competence, provided that a Medical Staff Member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

3.4.4 Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable Standardized Procedures, and by the scope of practice approved by the Board of Trustees.

3.4.5 Write orders to the extent established by any applicable Medical Staff, Department policies, rules or Standardized Procedures and consistent with the scope of practice approved for him or her.

3.4.6 Record reports and progress notes on patient charts to the extent determined by the appropriate Department, and in accordance with any applicable Standardized Procedures.

3.4.7 Assure that records are countersigned as required by the applicable Rules governing specific practice prerogatives granted to the Allied Health Practitioner, standardized procedures and Delegation of Services Agreements.

3.4.8 Consistent with the scope of practice approved for him or her, perform consultations as requested by a Medical Staff Member.

3.4.9 Comply with all Medical Staff and Hospital bylaws, rules, and policies.

3.4.10 Participate in peer review and quality improvement and in discharging such other functions as may be required from time to time.

3.5 Credentialing Criteria

3.5.1 Nature of Allied Health Practitioner Membership

3.5.1.1. Membership on the Allied Health Practitioner staff and practice prerogatives shall be extended only to those practitioners who are identified as being professionally competent and

who continuously meet the qualifications, standards, and requirements set forth in the Rules.

3.5.2 Basic Requirements:

3.5.2.1. Demonstrate compliance with all basic standards set forth in this Section

3.5.2.2. The applicant must belong to an Allied Health Practitioner category approved for practice in the Hospital by the Board of Trustees.

3.5.2.3. The applicant must meet the criteria for the scope of practice set forth in the scope of practice forms approved by the Interdisciplinary Practices Committee, relevant Department, the Medical Executive Committee and the Board of Trustees.

3.5.2.4. If required by law, the applicant must hold a current, unrestricted state license or certificate. If the Allied Health Practitioner is allowed to prescribe medications, hold a current, unrestricted Drug Enforcement Administration certificate.

3.5.2.5. Hospital independent contractors shall meet all conditions of their contract with the Hospital.

3.5.2.6. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment, current professional competence, adequate physical and mental health status (subject to any reasonable accommodation), and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the Hospital, and that he or she is qualified to exercise practice within the Hospital.

3.5.2.7. The applicant must maintain in force professional liability insurance or is equivalent covering the scope of practice requested or approved for him or her in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.

a. At the time of initial appointment and/or reappointment, the applicant / reapplicant must provide information on any professional liability claims filed against him or her, any malpractice claims reported to his or her insurance carrier, any letters of intent to sue he or she has received, any claims pending, any judgments entered against him or her, and any settlements made where there was a monetary payment. In addition, the applicant / reapplicant must state whether he or she was denied professional liability insurance, had his or her policy cancelled, had limitations placed on his or her practice prerogatives, or has been notified of any intent to deny, cancel, or limit coverage.

b. Reporting Changes

i. Each Allied Health Practitioner staff member shall report any reduction, restriction, cancellation or termination of the required professional liability insurance or change in insurance carrier as soon as reasonably possible to the Interdisciplinary Practices Committee via the Medical Staff Management department.

c. Failure to Maintain Professional Liability Insurance

i. The automatic suspension procedure set forth in the Medical Staff Rules shall be followed in the event an Allied Health Practitioner fails to maintain insurance in the required amount.

3.5.2.8. The applicant must submit a minimum of three references from either licensed physicians or adequately trained Practitioners in the appropriate field and who are familiar with his or her

professional work and demonstrated competency.

3.5.2.9. The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the Hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the Medical Staff.

3.5.2.10. The applicant must be determined (i) to adhere to the lawful ethics of his or her profession; (ii) to work cooperatively with others in the Hospital setting to as not to adversely affect patient care or Hospital operations; and (iii) to participate in and properly discharge Allied Health Practitioner staff responsibilities.

3.5.2.11. A practitioner who does not meet these basic standards is ineligible to apply / reapply for Allied Health Practitioner staff membership.

3.5.3 Specific Requirements

In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his/or her category of Allied Health Practitioner as set forth in the scope of practice for the category of Allied Health Practitioner.

3.5.4 Supervising Physician Responsibilities

3.5.4.1. Any supervising physician or group which employs or contracts with the Allied Health Practitioner agrees that the Allied Health Practitioner is solely his, her, or its employee or agent and not the Hospital's employee or agent. The supervising physician or group has full and sole responsibility for paying the Allied Health Practitioner and for complying with all relevant laws, including federal and state income tax withholding laws, overtime laws, and workers' compensation insurance coverage laws.

3.5.4.2. A supervising physician or group which employs or contracts with the Allied Health Practitioner agrees to indemnify the Hospital against any expense, loss, or adverse judgment it may incur as a result of allowing an Allied Health Practitioner to practice in the Hospital or as a result of denying or terminating the Allied Health Practitioner's practice prerogatives.

3.5.4.3. The supervision and assessment of an Allied Health Practitioner's care, treatment, and services provided, as well as accuracy of the medical record, will be documented by the supervising physicians' countersignature when such signatures are required by applicable Rules, standardized procedures, or Delegation of Services Agreements.

3.6 Processing the Application

3.6.1 Applications shall be submitted and processed in a manner parallel to that specified for Medical Staff applicants in Rule 3 (Appointment and Reappointment), except that the applications shall be submitted to the Interdisciplinary Practices Committee.

3.6.2 Once the application is determined to be complete, it will be forwarded to the Department Chief, who shall evaluate the Allied Health Practitioner based upon the standards set forth in Rules 3 and 5 (this Rule). The Department Chief or his or her designee may meet with the Allied Health Practitioner as well as the sponsoring or supervising practitioner (if applicable) to further investigate the Allied Health Practitioner's request for prerogatives. The Department Chief will make a recommendation to the Interdisciplinary Practices Committee regarding the applicant's qualifications to exercise the requested practice prerogatives.

3.6.3 Upon receipt of an Allied Health Practitioner's application from the Department Chief, the Interdisciplinary

Practices Committee shall consider the application. The Interdisciplinary Practices Committee may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The Interdisciplinary Practices Committee shall evaluate the Allied Health Practitioner based upon the standards set forth in Rules 3 and 5 (this Rule). The Interdisciplinary Practices Committee will also ascertain that appropriate monitoring mechanisms are in place (in the Department or through the Performance Improvement Council). Whenever possible, the Interdisciplinary Practices Committee shall include practitioners in the same Allied Health Practitioner category when conducting its evaluation. The Interdisciplinary Practices Committee shall forward its recommendations to the Medical Executive Committee.

3.6.4 Thereafter, the application shall be processed by the Medical Executive Committee and Board of Trustees in accordance with the procedures set forth in Bylaw Article 3.

3.7 Provisional Status

All Allied Health Practitioners shall be initially appointed to a Provisional status for at least 12 months. Advancement from the Provisional status will be based upon whether the professional's performance is satisfactory, as determined by the Department in which the Allied Health Practitioner is assigned, the Interdisciplinary Practice Committee, when its review is necessary for the practice prerogatives, the Medical Executive Committee and the Board of Trustees.

3.8 Duration of Appointment and Reappointment

3.8.1 Allied Health Practitioners shall be given an approved delineation of practice prerogatives for no more than 24 months. Reappointments to the Allied Health Practitioner Staff shall be processed every other year, in a parallel manner to that specified in Bylaw Article 3 for Medical Staff Members.

3.8.2 Applications for renewal of the Allied Health Practitioner's practice prerogatives and the supervising practitioner's approval must be completed by the Allied Health Practitioner and supervising practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in the Medical Staff Rules.

3.9 Procedural Rights of Allied Health Practitioners

3.9.1 Overview

Nothing contained in the Medical Staff Bylaws shall be interpreted to entitle an Allied health Practitioner to the procedural rights set froth in the Bylaws and Rules. However, an Allied Health Practitioner shall have the right to challenge any action that would constitute grounds for a hearing under the Bylaws or Rules by filing a written grievance with the Medical Executive Committee within 15 days of such action. Upon receipt of such a grievance, the Medical Executive Committee or its designee shall conduct an investigation that shall afford the Allied Health Practitioner an opportunity for an interview concerning the grievance. Any such interview shall not constitute a "hearing" as that term is used in the Bylaws and Rules and shall not be conducted according to the procedural rules applicable to such hearings. Before the interview, the Allied Health Practitioner shall be informed of the general nature and circumstances giving rise to the action, and the Allied Health Practitioner may present information relevant thereto at the interview. A record of the interview shall be made. The Medical Executive Committee or its designee shall make a decision based on the interview and all other information available to it.

3.10 Automatic Termination

An Allied Health Practitioner's practice prerogatives shall automatically terminate, without review pursuant to this Section or any other Rule, in the event:

3.10.1 The Medical Staff Membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;

3.10.2 The supervising Practitioner no longer agrees to act as the supervising Practitioner for any reason, or the relationship between the Allied Health Practitioner and the supervising practitioner is otherwise terminated,

regardless of the reason therefore;

3.10.3 The Allied Health Practitioner's certification or license expires, is revoked, or is suspended.

3.11 Review of Category Decisions

The rights afforded by this Section shall not apply to any decision regarding whether a category of Allied Health Practitioner shall or shall not be eligible for practice in the Hosp0ital and the scope of practice, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Board of Trustees, which has the discretion to decline to review the request or to review it using any procedure the Board of trustees deems appropriate.

RULE 4: COMMITTEES

4.1 General

4.1.1 Appointment of Members

4.1.1.1. Unless otherwise specified, the Chair and Members of all committees shall be appointed by and may be removed by the Medical Staff Chairman, subject to consultation with and approval by the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee.

4.1.1.2. A Medical Staff committee created by the Rules is composed as stated in the description of the committee in the Bylaws or Rules. Except as otherwise provided in the Bylaws or Rules, committees established to perform Medical Staff functions may include any category or Medical Staff Members, Allied Health Practitioners, representatives from Hospital departments such as Administration, Nursing Services or Health Information Management, representatives of the community and persons with special expertise, depending upon the function to be discharged. Each Medical Staff Member who serves on a committee participates with vote unless the statement of the committee composition designates the position as non-voting.

4.1.1.3. The Chief Executive Officer or his/or her designee shall appoint any non-Medical Staff member who serves in non ex-officio capacities.

4.1.1.4. The committee chair, after consulting with the Medical Staff Chairman and the Chief Executive Officer, may call on outside consultants or special advisors.

4.1.1.5. Each committee chair shall appoint a vice chair to fulfill the duties of the chair in his or her absence and to assist as requested by the chair. Each committee chair or other authorized person chairing a meeting has the right to discuss and vote on issues presented to the committee.

4.1.2 Representation on Hospital Committees and Participation in Hospital Deliberations

The Medical Staff may discharge its duties relating to accreditation, licensure, certification, disaster planning, facility / services planning, financial management, and physical plant safety by providing Medical Staff representation on Hospital committees established to perform such functions.

4.1.3 Ex-Officio Members

The Medical Staff Chairman, the Chief Executive Officer and the Vice President for Patient Care Services or their respective designees are ex-officio members of all standing and special committees of the Medical Staff and shall serve without vote unless otherwise noted in the provision or resolution creating the committee.

4.1.4 Action through Subcommittees

Any standing committee may use subcommittees to help carry out its duties. The Medical Executive Committee shall be informed when a subcommittee is appointed. The committee chair may appoint individuals in addition to or other than members of the standing committee to the subcommittee after consulting with the Medical Staff Chairman regarding the Medical Staff committee members and the Chief Executive Officer regarding Hospital committee members.

4.1.5 Terms and Removal of Committee Members

Unless otherwise specified, a committee member shall be appointed for a term of one year, subject to unlimited renewal, and shall serve until the end of this period and until his or her successor is appointed, unless he or she shall sooner resign or be removed from the committee. Any committee member who is appointed by the Medical Staff Chairman may be removed by a majority vote of the Medical Executive Committee. The removal of any committee member who is automatically assigned to a committee because he or she is a general Officer or other official shall be governed by the provisions pertaining to the removal of such Officer or official.

4.1.6 Vacancies

Unless otherwise specified, vacancies on any committee shall be filled in the same manner in which an original appointment to such a committee was made.

4.1.7 Conduct and Records of Meetings

Committee meetings shall be conducted and documented in the manner specified for such meetings in Article 8 of the Medical Staff Bylaws.

4.1.8 Attendance of Non-Members

Any Medical Staff member who is in good standing may ask the chair of any committee for permission to attend a portion of that committee's meeting dealing with a matter of importance to that practitioner. The committee chair shall have the discretion to grant or deny the request and shall grant the request of the member's attendance will reasonably aid the committee to perform its function. If the request is granted, the invited member shall abide by all Medical Staff Bylaws and Rules applicable to that committee.

4.1.9 Accountability

All committees shall be accountable to the Medical Executive Committee.

4.2 Bioethics Committee

4.2.1 Composition

The Committee shall be composed of at least the following: three Medical Staff Members and representatives from nursing, social services, and pastoral care. Whenever possible, it should include the risk manager, an

ethicist, and a community member. The Committee shall appoint members who shall be available to Medical Staff Members to consult on an as needed basis.

4.2.2 Duties

The Committee shall strive to contribute to the quality of healthcare provided by the Hospital by:

4.2.2.1. Providing assistance and resources for decisions having ethical implications. The Committee shall not, however, be a decision-maker in any case.

4.2.2.2. Educating members within the Hospital concerning ethical issues and dilemmas.

4.2.2.3. Facilitating communication regarding ethical issues and dilemmas among Hospital Staff and Medical Staff Members in general; and among participants involved in ethical dilemmas and decisions in particular.

4.2.2.4. Reviewing and providing recommendations concerning organizational ethical practices, issues and policies. Organizational ethical practices include, but are not necessarily limited to, patient rights, employee rights, billing, marketing, admission, discharge, transfers, relationships with other healthcare providers, educational institutions, payers and avoidance of conflict of interest. The Committee shall perform its duties in accordance with the Hospital's Code of Organizational Ethics.

4.2.2.5. Retrospectively review cases to evaluate ethical implications as well as providing policy and education guidance relating to such matters.

4.2.3 Meetings and Reporting

The Committee shall meet as often as necessary, but not less than annually. The Committee shall report to the Medical Executive Committee.

4.3 Bylaws Committee

4.3.1 Composition

The Committee shall include at least three Active Staff Members. The Chair shall be the Medical Staff Vice Chairman.

4.3.2 Duties

The Committee's duties are to assure that the Medical Staff Bylaws and Rules adequately and accurately describe the Medical Staff structure, including the mechanism used to review credentials and to delineate individual clinical privileges, the organization of quality improvement activities including the procedures for conducting, evaluating, and revising such activities, the mechanism for terminating Medical Staff Membership, fair hearing procedures, and regulatory changes. The Committee shall assure that the Bylaws and Rules are reviewed as necessary.

4.3.3 Meetings and Reporting

The Committee will meet as requested by the committee chair or the Medical Staff Chairman. The Committee shall report to the Medical Executive Committee.

4.4 Cancer Committee

4.4.1 Composition

The Committee shall be multidisciplinary and include, when feasible, members from the specialties of Medical

Oncology, Radiation Oncology, Surgery, Diagnostic and Therapeutic Radiology, and Pathology. The Committee must also include the Cancer Liaison Physician and representatives of Hospital Administration, Nursing, Social Services, Quality Improvement, and Cancer Registry. Whenever possible, Nursing should be representative by a certified oncology nurse. Other specialties may be represented such as Pharmacy, Nutrition, Clergy, and Rehabilitation.

4.4.2 Duties

The duties of the Committee are to:

4.4.2.1. Develop and evaluate the annual goals and objectives for the clinical, educational, and program activities related to cancer.

4.4.2.2. Promote a coordinated, multidisciplinary approach to patient management.

4.4.2.3. Ensure that educational and consultative cancer conferences cover all major sites and related issues.

4.4.2.4. Ensure that there is an active supportive care program in place for patients, families, and staff.

4.4.2.5. Monitor quality improvement through completion of studies that focus on quality, access to care, and outcomes.

4.4.2.6. Promote clinical research.

4.4.2.7. Supervise the Cancer Registry and ensure accurate and timely abstracting, staging, and follow-up reporting.

4.4.2.8. Perform quality control of registry data.

4.4.2.9. Encourage data usage and regular reporting.

4.4.2.10. Ensure that an annual report is prepared that contains the required information and is published by the required deadline.

4.4.2.11. Uphold medical ethical standards.

4.4.2.12. Assure the Hospital is meeting cancer accreditation standards.

4.4.3 Meetings and Reporting

The Committee shall meet as often as necessary, but not less than quarterly. The Committee shall report to the Medical Executive Committee.

4.5 Continuing Medical Education Planning / Graduate Medical Education / Health Sciences Library Committee

4.5.1 Composition

The Committee shall consist of preceptors and representatives of fellowship, residency, and training programs that meet American College of Graduate Medical Education (ACGME) standards, the Medical Librarian, and representatives from Hospital Administration, Cancer Center, Clinical Services, Continuing Medical Education, Nursing, and Pharmacy.

4.5.2 Duties

The duties of the Committee are to:

4.5.2.1. Review and approval all physician education activities offered for Category I CME credit by the accredited Continuing Medical Education Program of Good Samaritan Hospital. This process shall comply with the Accreditation Council for Continuing Medical Education.

4.5.2.2. Develop, plan, and participate in programs of continuing medical education which are designed to keep the Medical Staff and regional physicians informed of significant new developments and new skills in medicine; and, which are responsible to evaluation findings.

4.5.2.3. Develop, plan, participate in, and accredit continuing medical education programs for physicians within the Hospital referral area.

4.5.2.4. Act upon continuing medical education recommendations from the Medical Executive Committee, other committees, and the Department Chiefs.

4.5.2.5. Cooperate, when appropriate, with universities and other institutions in continuing medical education efforts.

4.5.2.6. Review fellowship, residency, and clerkship programs proposed by Medical Staff Members.

4.5.2.7. Review all new programs and candidates; and, evaluate all existing programs on an annual basis.

4.5.2.8. Recommend policies for graduate medical education and act in an advisory capacity to the committee chair.

4.5.2.9. Ensure that any citations from residency review committees are addressed to ensure compliance.

4.5.2.10. Determine and approve the policies governing the Health Sciences Library, acting upon the advice of the Medical Librarian or his or her designee.

4.5.2.11. Interpret Health Sciences Library policies and procedures to respective Medical Staff and Hospital groups.

4.5.2.12. Serve as an advisory group to the Medical Librarian or his or her designee to solve Health Sciences Library administrative problems.

4.5.2.13. Work toward securing adequate funding to carry out progressively expanding Health Sciences Library programs that will meet the needs of the total Good Samaritan Hospital community.

4.5.2.14. Foster and develop the resources for and interests in the Health Sciences Library; and, encourage the use of its facilities by those entitled to the privilege.

4.5.2.15. Assist the Medical Librarian or his or her designee in establishing criteria for selecting materials and evaluating the effectiveness of the Health Sciences Library in meeting the informational and educational needs of its users.

4.5.3 Meetings and Reporting

The Committee shall meet as often as necessary, but not less than quarterly. The Committee shall report to the Medical Executive Committee.

4.6 Credentials and Privileging Committee

4.6.1 Composition

The Committee shall include the Chiefs of the Medical Staff Departments, i.e., Anesthesiology, Medicine, Obstetrics and Gynecology, Pathology, Pediatrics, Radiology, and Surgery. The Chair shall be the Medical Staff Vice Chairman.

4.6.2 Duties

4.6.2.1. The Committee shall evaluate or coordinate the evaluation of the qualifications of all applicants for Medical Staff initial appointment, reappointment, or changes in Staff category or privileges. The Committee shall develop recommendations based on its evaluation(s) or that of the Department Chief of the applicants.

4.6.2.2. The Committee may also initiate, investigate, review, and report on matters involving the clinical, ethical, or professional performance of any Medical Staff Member. The Committee may act on its own initiation or the referral of a matter by any Medical Staff Officer, Department Chief or other committee chair.

4.6.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.7 Health Information Management Committee

4.7.1 Composition

The Committee shall include members from the Medical Staff and the Health Information Management Director. Representatives from Hospital Administrative and Nursing shall be ex-officio members.

4.7.2 Duties

The Committee shall:

4.7.2.1. Provide for an ongoing review of medical records for clinical pertinence and timely completion from which a quarterly report on the findings of this review shall be presented. The review by a multidisciplinary team (including members of the Medical Staff, Nursing, Health Information Management department personnel, and other relevant clinical personnel) will focus on information available at the point of care and administration. The Committee will review a sample of records to determine whether they reflect the diagnosis, results of diagnostic tests, therapy rendered, condition and in-hospital progress of the patient and the condition of the patient at discharge.

4.7.2.2. Review summary reports concerning timely completion of medical records.

4.7.2.3. Approve a standardized medical record format and forms used in the records as well as electronic data process and storage in the Hospital.

4.7.2.4. Recommend solutions for problems identified during review and monitor effectiveness of these interventions.

4.7.2.5. Review and make recommendations for Medical Staff and Hospital policies and rules relating to medical record completion and enforcement of associated policies and rules.

4.7.2.6. Serve as a liaison to Hospital Administration and Health Information Management Department personnel on matters relating to health information.

4.7.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.8 Infection Prevention Committee

4.8.1 Composition

The Committee shall be include at least one physician whose primary clinical specialty is infectious disease, a nurse whose responsibilities include infectious disease and the director of the Pharmacy. The Employee Health Nurse, a representative from Nursing, the Operating Room supervisor, the Director of Central Supply, and a representative from Hospital Administration shall be ex-officio members. Representatives from Housekeeping, Laundry, Dietetic Services, Engineering and Maintenance shall be available to the Committee on an as-needed basis.

4.8.2 Duties

The Committee shall develop and monitor the infection control program. The Committee shall also review and approve action(s) to reduce risks of acquiring and transmitting infections in patients, healthcare workers, and visitors. At least every three years, the Committee shall review and approve all policies relating to the infection control program. The Committee chair or his or her designee shall be available for on-the-spot interpretation of applicable policies and rules.

4.8.3 Meetings and Reporting

The Committee shall meet at least quarterly and more often if necessary. It shall report to the Medical Executive Committee.

4.9 Interdisciplinary Practices Committee

4.9.1 Composition

The Committee shall include the Director of Nursing (or his or her designee), a representative from Hospital Administration, an equal number of physicians and nurses, and licensed or certified Allied Health Practitioners (other than Nursing) who perform standardized procedures. The Chair shall be the Medical Staff Vice Chairman.

4.9.2 Duties

The Committee shall be responsible for:

4.9.2.1. Recommending policies and procedures for the granting of expanded role privileges and practice prerogatives to registered nurses and other Allied Health Practitioners, whether or not employed by the Hospital, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of patients in the Hospital. These policies and procedures will be administered by the Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges and/or practice prerogatives.

4.9.2.2. Identifying the functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the California Business and Professions Code in order for them to be performed by registered nurses in the Hospital; and, initiating the preparations of such standardized procedures in accordance with this Section.

4.9.2.3. The review and approval of standardized procedures covering the practice by registered nurses in the Hospital. The Committee shall submit standardized procedures it has approved to the Medical Executive Committee for review and approval. The standardized procedures shall take effect following Medical Executive Committee approval.

4.9.2.4. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the4 Committee or by delegation to the Vice President of Patient Care Services.

4.9.2.5. Review and evaluate the qualifications of each Allied Health Practitioner who applies for practice prerogatives; and, in connection therewith, obtain and consider the appropriate recommendation.

4.9.2.6. Ensure that each standardized procedure approved by the Committee meets Hospital licensure regulation standards; they shall be designed to maintain clear lines of authority from the nursing service for the nursing care of patients and from the Medical Staff for medical services.

4.9.2.7. Secure recommendations from Medical Staff Members in the medical specialty or clinical field of practice under review; and, from persons in the appropriate non-clinical category who practice in the clinical field or specialty under review before taking action.

4.9.3 Meetings and Reporting

The Committee shall meet at least quarterly and more often if necessary. It shall report to the Medical Executive Committee.

4.10 Multidisciplinary Peer Review Committee

4.10.1 Composition

The committee shall consist of two to four members, in good standing, from each major medical department (or subsection) and a minimum one representative from Anesthesiology, Radiology, Pathology and Emergency Medicine, approved by the chairman of each hospital department, with the final approval from the Medical Executive Committee. The Chair shall be the Medical Staff Vice Chairman.

4.10.2 Duties

4.10.2.1. To develop a Multidisciplinary Peer Review policy and procedure that includes activities to measure, assess, and improve performance on an organization-wide basis by conducting peer review that includes the following:

a. Definition of those circumstances requiring peer review.

b. Specification of the participants in the review process, including a definition of "peer."

c. Method for selecting peer review panel physicians for specialty case review.

d. Time frames for initiating peer review, conducting the process and obtaining the result and reporting of the finding to the Medical Executive Committee and Board of Trustees.

e. Circumstances in which external peer review is required / requested.

f. Identifying when the reviewee (the physician being reviewed) participated in the peer review process.

g. The following characteristics:

i. Peer review is consistent, utilizes peer review screening criteria approved by the Medical Executive Committee and is conducted according to the process outlined in the Peer Review policy and procedure.

ii. Time frames are reasonably adhered to unless additional time is requested and approved by the Medical Executive Committee.

iii. All conclusions reached through the peer review process are supported by relevant clinical practice guidelines, references to literature and community standards.

iv. The findings and outcomes shall be balanced, minority opinion and views of the physician reviewer are considered and recorded on the peer review logs.

v. Peer review findings / activities shall be used during the credentialing and privileging process (performance improvement physician reappointment profiles) and by the Quality Management Department who will track peer review conclusions over time. Monitoring for ongoing effectiveness and improvement of patient care, practices, and outcomes.

4.10.3 Meetings and Reporting

The Committee shall meet at least quarterly and more often if necessary. All peer review findings, conclusions, recommendations, and actions will be communicated to the appropriate Medical Staff Department and the affected Medical Staff Member.

4.11 Patient Safety Committee

4.11.1 Composition

The Patient Safety Committee will include members of the Medical Staff, the Patient Safety Officer, Vice President of Patient Care Services or designee, Director of Pharmacy Services, Director of Quality Management, and Director of Risk Management. Other individuals from either the Medical or Hospital staffs may participate in committee meetings as deemed appropriate by the physician Chairman.

4.11.2 Duties

The Patient Safety Committee shall:

4.11.2.1. Plan, design, and direct patient safety activities and services

4.11.2.2. Integrate and coordinate effective patient safety practices

4.11.2.3. Review and evaluate the Patient Safety Plan and related policies and make recommendations, corrective measures, and submit reports and findings to the Medical Executive Committee and Governing Board, via the Performance Improvement Council

4.11.2.4. Effectively reduce medical errors and other factors that contribute to unintended adverse outcomes

4.11.2.5. Involve the patient, family, or significant other in preventing medical errors and maintaining a patient safe environment

4.11.2.6. Complete an annual evaluation of the effectiveness of the Patient Safety Program

4.11.2.7 Develop a process for conducting Sentinel Events to ensure a patient safety system that will notify the patient / family / significant other of an adverse outcome that affected their care

4.11.2.8. Review at least one high-risk patient safety process (FMEA) and conduct a proactive review making changes or a redesign as required by the process and/or underlying systems to minimize risk

4.11.2.9. Develop a Quality and Patient Safety culture that provides adequate patient safety education to patients, physicians, nurses, contract staff, and other hospital staff based on PI findings and recommendations

4.11.2.10. Ensure that the hospital Medical Staff and hospital staff are willing to report medical errors, make appropriate notification to the patients of errors, and provide comments to the Patient Safety Committee on ways to improve patient safety

4.11.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.12 Performance Improvement Council

4.12.1 Composition

The Council shall consist of the Chiefs of the Departments of Surgery, Anesthesiology, Obstetrics and Gynecology, Pediatrics, and Medicine; the Chairs of the Infection Prevention, Pharmacy and Therapeutics, and Cancer Committees, and representatives from Hospital Administration, Quality Management, the Board of Trustees, and other departments as needed. The Chair shall be the Secretary-Treasurer.

4.12.2 Duties

The Council shall be responsible for quality improvement, patient safety, review of operative procedures and other procedures that could put patients at risk, infection control, medical administration and usage review, blood usage review, and medical records review. Subcommittees that report to the Council may be appointed when necessary to carry out those functions with members assigned review and monitoring duties to carry out on behalf of the Council.

4.12.2.1. Quality Improvement

a. Provide leadership and oversight of the measurement, assessment, and improvement of the processes that depend primarily upon Members of the Medical and Allied Health Practitioner Staffs. These include:

i. medical assessment and treatment of patients;

ii. use of blood and blood components;

iii. use of operative and other procedures;

iv. efficacy of clinical practice patterns; and

v. significant departures from established patterns of clinical practice.

b. Provide leadership and oversight of the measurement, assessment, and improvement of other patient care processes, including:

i. education of patients and families;

ii. coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient;

iii. accurate, timely, and legible completion of patient's medical records.

c. Assure that findings relating to the performance of an individual are considered, when appropriate, for peer review and granting / renewal of privileges.

d. Review and act upon factors affecting the quality, appropriateness, and efficiency of patient care provided in the Hospital.

e. Coordinate the findings and results of department, committee, and staff patient care review activities; cost quality activities; reviews of medical record completeness, timeliness, and clinical pertinence; reviews of quality of medical histories and physical examinations; and other staff activities designed to monitor patient care practices.

f. Provide oversight of the intensive analysis of undesirable patterns or trends in sentinel events.

g. Submit regular reports to the Medical Executive Committee on the overall quality, appropriateness, and efficiency of medical care provided in the Hospital, and on department, and staff patient care review, safety, patient education, resource management, and other quality review, evaluation, improvement and, monitoring activities.

h. Make recommendations to the CME/GME/Library Committee for continuing medical education for the development of appropriate education programs.

i. At least once a year, evaluate the quality improvement program to assess the effectiveness of the monitoring and evaluation activities and to recommend improvement.

4.12.2.2. Performance Improvement

a. Identify the key strategic objectives that have been established for the Hospital (by the Medical Staff, Hospital Administration, and the Board of Trustees) and help design the processes for communicating those objectives throughout the organization.

b. Use key strategic objectives as a base for prioritizing performance improvement activities based upon recommendations from Medical Staff Committees and leadership.

c. Identify key outcome indicators of performance with appropriate benchmarks for measuring strategic and financial performance.

d. Receive and review reports from all performance improvement activities.

e. Reinforce a multidisciplinary approach to the review of care by identifying an appropriate interdisciplinary team activity(ies) to continually measure, assess, and, improve patient care and services.

f. Be actively involved in planning and coordinating performance improvement activities to ensure review activities are well-coordinated, communicated, and completed as recommended, and that follow-up is done to ensure appropriate action is taken.

g. Review and provide recommendations on what resources are required for performance improvement activities, including personnel and information systems.

h. Analyze and evaluate the effectiveness of the performance improvement activities in meeting the objectives of the organization.

i. Provide the framework for planning, initiating, and improving healthcare services that are responsive to community and patient needs, as identified in the policy for planning new processes or services.

j. Recommend performance improvement priorities, giving priority consideration to processes that affect a large percentage of patients, place patients at risk if not performed well, and/or that have been problem-prone.

k. Provide oversight of the systematic aggregation and analysis of data to monitor improvements in performance, and assure the Hospital compares its performance over time and with other sources of information.

l. Provide oversight of the intensive analysis of undesirable patterns or trends in performance.

4.12.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.13 Pharmacy and Therapeutics Committee

4.13.1 Composition

The Committee will include the Medical Director of the Blood Bank, the Pharmacy Director, the Manager of the Blood Bank, and representatives of Hospital Administration and Nursing Services.

4.13.2 Duties

The Committee shall:

4.3.12.1. Develop, implement, and monitor professional policies regarding evaluating, selecting, and procuring medications comprising the Hospital Formulary; preparing and dispensing medications; distribution, administration, safety, and effect (including reactions and interactions) of medication usage; patient education; and other matters pertinent to medication use in the Hospital.

4.3.12.2. Be responsible for monitoring and evaluating the processes related to the use of blood and blood components;

4.3.12.3. Coordinate and critically assess the activities related to the ordering, distributing, handling, dispensing, administering, and monitoring of blood and blood products.

4.3.12.4. Establish a mechanism for systematically measuring and documenting, on an ongoing basis, the processes related to the use of blood and blood components.

4.3.12.5. Evaluate each actual or suspected transfusion reaction referred to the Committee and make a report of its findings for review by other Medical Staff committees as appropriate.

4.13.3 Meetings and Reporting

The Committee shall meet at least quarterly and more often if necessary. It shall report to the Medical Executive Committee.

4.14 Rehabilitation Committee

4.14.1 Composition

4.14.1.1. The Committee shall be composed of all physicians supervising formal and approve Hospital rehabilitation programs. A Hospital Administrative representative, Nursing Services representative, director of Rehabilitation Services, Quality Management representative, and department of Occupational Therapy representative shall serve as ex-officio members.

4.14.2 Duties

The Committee will be responsible for:

4.14.2.1. Conducting quality assurance studies and program evaluations as required by the Commission on Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, and any other applicable regulatory accrediting body.

4.14.2.2. Reviewing quality and services of the Hospital's therapy departments, including Physical Therapy, Occupational Therapy, Cardiac Rehabilitation, and Speech Therapy.

4.14.3 Meetings and Reporting

The Committee shall meet as often as necessary. It shall report to the Medical Executive Committee.

4.15 The Well-being Committee

4.15.1 Composition

4.15.1.1. The Committee shall include two or more Active Staff Category Members of the Medical Staff. Whenever feasible, this will include the immediate-past Medical Staff Chairman, an addition medicine specialist, an anesthesiologist, a neurologist, a primary care physician, a psychiatrist, and a graduate of a monitoring program (especially from the former California Diversion Program). The terms shall be staggered to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or performance improvement committees while serving on this committee.

4.15.2 Duties

4.15.2.1. In accordance with Medical Staff Rule 3.4 (Physical and Mental Capabilities), the Committee shall review applicable responses from applicants concerning physical or mental disabilities and recommend what, if any, reasonable accommodations may be indicated in order to assure that the practitioner will provide care in accordance with the Hospital and Medical Staff standard of care.

4.15.2.2. With respect to matters involving individual Practitioners, the Committee may upon request of the involved practitioner, or upon request of the Credentials and Privileging Committee, the Medical Executive Committee, or the Medical Staff Chairman, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential, however, if the Committee receives information that demonstrates that the health or impairment of a Practitioner may pose a risk of harm to Hospital patients (or prospective patients), that information shall be referred to the Medical Staff Chairman, who will determine if the matter shall be referred for a corrective action investigation.

4.15.2.3. The Committee will also:

a. Plan one annual Medical Grand Rounds activity related to the Committee's scope of expertise.

b. Review all related policies on a triennial basis.

c. Review lessons learned and to-dos from conferences attended.

d. Develop an annual report to be distributed at the Annual Medical Staff Business Meeting.

e. Continually discuss potential recruits.

4.15.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.15.4 Impaired Practitioners

4.15.4.1 Purpose

This Rule addresses referral of Practitioners who possibly suffer mental or physical impairment, for evaluation and initiation of treatment for the purposes of assisting the Practitioner and protecting patients.

4.15.4.2 Assisting Impaired Practitioners

a. All Medical Staff Members should share in confidence with the Committee their concerns about mental or physical impairment, in themselves or other Members.

b. The Committee is dedicated to helping Members identify mental and physical impairments, and helping Members obtain. Even though the Committee's mission is to assist Medical Staff Members, patient safety must be primary. Thus, if the Committee finds a risk of harm or danger to patients, and the Practitioner does not willingly withdraw from clinical practice, the Committee will ask the Medical Staff Chairman to initiate a corrective action review.

c. The Committee will only address Axis I psychiatric disorders, Axis III organic disease, chemical dependency, and/or geriatric decline issues.

d. When initial evaluation, treatment, and fitness for duty evaluations are deemed necessary, different professional services will be used as much as possible to prevent potential conflicts of interest.

4.15.4.3 Confidentiality

a. The Committee shall maintain strict confidentiality. It will release information only with the express agreement of the Member, as needed to carry out Medical Staff duties, or as required by law. Releases to carry out Medical Staff duties shall be limited, insofar as possible, to protecting patients and carrying out Committee activities.

b. The Committee shall provide periodic updates on monitored practitioners to the Credentials and Privileging Committee and Medical Executive Committee, without identifying individuals.

4.15.4.4 Reporting and Review Procedure

The Committee will review all reports of impairments. This protocol applies to Members who have impairments, as well as applicants who have a history of impairment.

a. The review process may include evaluation of written reports; interviews of associates, relatives, and others at the Hospital, office or home (when authorized by the practitioner); and chart review of records at this or other hospitals for the purpose of identifying impairment, rather than assessing quality of care.

b. If an impairment is validated, the Practitioner in question will be invited to meet with the Committee to discuss the findings from the review process. The interview will be informal.

c. The Committee may encourage the practitioner to obtain a professional evaluation. The Committee will outline what it feels is negotiable and non-negotiable, such as maintenance of clinical privileges, immediate assignment of a worksite monitor, etc. The Committee will ask the Practitioner to sign a form authorizing disclosure of the results of the evaluation to the Committee. The Committee may pay for the evaluation, although that is discretionary. The report should address the diagnoses, prognosis, and treatment program recommendation.

d. If the professional evaluation deems treatment is necessary, the Practitioner may be encouraged to take a medical leave of absence. The treatment program chosen must be approved by the Committee.

e. The Committee will draw up a monitoring agreement between it and the Practitioner delineating the Committee's expectations for treatment and monitoring. The monitoring agreement, at a minimum, will require the Practitioner to agree to the following conditions, depending upon the nature of the impairment:

i. To provide documentation from the evaluating or treating professional that initial treatment has been provided and that the Practitioner may safely return to work.

ii. To abstain from using any drugs or alcohol, except as approved by the treatment program and the Committee.

iii. To participate in an ongoing treatment program. Any specific terms, such as continuing psychiatric counseling, securing medical treatment or attending Practitioner recover groups two nights a week or Alcoholics Anonymous or Narcotics Anonymous tow nights a week should be stated.

iv. To agree to any indicated random testing of bodily fluids, by the treatment program or as directed by the Committee.

v. To meet regularly, and at least quarterly, with a monitor approved by the Committee.

vi. To allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the monitoring agreement, and the Committee.

vii. To request a medical leave of absence in the event the Committee finds that the impairment or failure to comply with the monitoring agreement presents a risk to patients.

viii. To sign whatever forms are needed to authorize release of information from the treatment programs to the Committee, and request that reports shall be made regularly, at defined time intervals, such as quarterly.

ix. To acknowledge that any failure to comply with the conditions will result in immediate referral to the Medical Executive Committee for corrective action.

x. To provide for post-treatment monitoring of a sufficient duration (usually five years).

xi. To participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.

f. If the treating program or the Committee concludes that the Practitioner cannot practice safely, the Practitioner shall request a leave of absence. Discontinuance of the leave shall be contingent upon the Practitioner satisfying the Committee's requirements so that he or she can return safely to work (if the Member still chooses to comply voluntarily with the support program).

g. When indicated based upon the severity and duration of the mental or physical impairment, the Practitioner may be required to (1) pass an oral or written test administered by an appointed panel of Department Members and/or (2) be proctored on at least 20 cases and for at least 3 months, and have reports of satisfactory performance on the cases.

4.15.4.5 If the Practitioner refuses to cooperate at any stage and the Committee agrees that the preponderance of evidence merits professional evaluation or treatment, the issue will be referred to the Medical Executive Committee, with a recommendation as to public safety. If the Medical Executive Committee agrees that the Practitioner is a threat to public safety, it will determine the immediacy of the threat, and recommend any appropriate corrective action, including investigation (per California Business and Professionals Code 821.5), blood or body fluid testing, or hair analysis, and/or summary suspension or termination (per Medical Staff Rule 11).

4.15.4.6 After successful completion of the treatment program the Practitioner will undergo a Fitness for Duty Evaluation. Upon positive evaluation, the Practitioner may return to work.

4.15.4.7 New Applicants Who Were (or Are Being) Monitored by the California Diversion Program

a. Applicants recently (or currently) monitored by the California Diversion Program will be required to provide copies of all documents applying to their monitoring activities, including correspondence from the Diversion Program, reports from monitors, and copies of body fluid testing.

4.15.5 Suspicion of Chemical Dependency

4.15.5.1 If a practitioner appears to be impaired due to chemical dependency and presents an immediate patient safety risk, the Chief of the Department will be called. If the Chief is unavailable, the Medical Staff Chairman or Vice Chairman will then be called.

4.15.5.2 In addition, the House Physician or any other available physician can be called to make an immediate assessment so that if needed, a scheduled procedure can be aborted.

4.15.5.3 In cases where the practitioner suspected of impairment due to chemical dependency is belligerent, a Code Gray (disruptive person) may be called.

4.16 Professional Standards Committee

4.16.1 Composition

The Professional Standards Committee shall be composed of the Medical Staff Chairman, Medical Staff Vice Chairman, Secretary-Treasurer, and Immediate-Past Medical Staff Chairman. Other attendees include the Director of Medical Staff Management and the Director of Quality Management.

4.16.2 Duties

4.16.2.1. The Professional Standards Committee shall review, evaluate, and process all complaints of (1) disruptive physician behavior and (2) medical staff policy violations, as follows:

a. Any Hospital employee (caregiver) who believes that he or she is being subjected to disruptive or discriminatory behavior or sexual harassment is authorized to report this to Administration and the Medical Staff Chairman.

b. Any report of disruptive or discriminatory behavior or sexual harassment shall be forwarded to the Medical Staff Management Office and shall be reviewed by the Professional Standards Committee as soon as practicable.

c. All reports reviewed by the Professional Standards Committee shall be masked to preserve the anonymity of the reporter.

d. The Professional Standards Committee will, at its discretion, determine how to process the complaint. Options include:

i. Appoint ad-hoc fact-finding team to conduct interviews and formulate recommendations for the Professional Standards Committee's consideration.

ii. One or more members of the Professional Standards Committee to meet with the reporter and/or reportee.

iii. Send letter addressing issues

iv. Refer the issue to the Physician Well-Being Committee.

Only wellness issues, such as Axis I psychiatric disorder, Axis III organic disease, chemical dependency, and geriatric decline issues will be addressed by the Physician Well-Being Committee.

e. In all cases, the Professional Standards Committee shall send a "thank you" letter to the reporter.

4.16.2.2. The Professional Standards Committee shall maintain a log of all complaints through the Medical Staff Management Office for tracking and trending purposes.

4.16.2.3. The Professional Standards Committee shall develop and maintain a "Code of Conduct" that will delineate expected behaviors from members of the Medical Staff.

4.16.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.17 Research Advisory Committee

4.17.1 Composition

The Committee will be composed of five members, including three Medical Staff Members, and representatives from Nursing, Pharmacy, and Finance.

4.17.2 Duties

4.17.2.1. The Committee shall evaluate the research proposed to be conducted in the Hospital involving human subjects and provide advisory recommendations on any issues it identifies, including any concerns regarding protection of human subjects, use of limited Hospital resources, or the effect on the Hospital's reputation.

4.17.2.2. It shall periodically assess ongoing studies and reports from the Institutional Review Board regarding ongoing protection of human subjects.

4.17.2.3. It shall be responsible for investigating any issues referred by the Institutional Review Board and recommending to the investigators and Hospital any necessary plans for correction.

4.17.3 Meetings and Reporting

The Committee shall meet as often as necessary. The Committee shall report to the Medical Executive Committee.

4.18 Utilization Management Committee

4.18.1 Composition

The Committee shall be composed of at least two Medical Staff Members and representatives from Quality and Resource Management. Other members may be appointed to carry out the Resource Management Plan.

4.18.2 Duties

The Committee shall perform the following functions:

4.18.2.1. General Duties

The Committee shall oversee the review of the medical necessity for admissions, extended stays, and services rendered. The Committee shall address over-utilization, underutilization, and inefficient scheduling and use of resources. Patterns of care will be followed and focused review may be undertaken as deemed necessary. The Committee shall communicate pertinent data and results of review and shall make recommendations for the utilization of resources and facilities with quality patient care and safety.

4.18.2.2. Resource Management Plan

The Committee shall establish and follow a Resource Management Plan which shall be approved by the Medical Executive Committee and the Board of Trustees, and shall comply with applicable Federal and State regulations.

4.18.2.3. Evaluation

The Committee shall evaluate the medical necessity of continued services for particular patients, when appropriate. In making such evaluations, the Committee shall be guided by the following criteria:

a. No practitioner shall have review responsibility for any extended stay cases in which he or she was professionally involved.

b. Each decision that further inpatient stay is not medically necessary shall be made by the Medical Staff members of the Committee; and, only after opportunity for consultation has been given to the Attending Physician and full consideration has been given to the availability of Hospital facilities and resources.

c. All decisions that further inpatient care is not medically necessary shall be given by written notice in accordance with the written Resource Management Plan.

4.18.2.4. Liaison

The Committee will act only upon the direct instruction of the Medical Executive Committee as the liaison committee for governmental agencies and third party providers.

4.18.2.5. Continuity of Care

The Committee shall promote continuity of care upon discharge and oversee the accumulation of data by the Case Management Services Department on the availability of healthcare resources outside the Hospital.

4.18.3 Meetings and Reporting

The Committee shall meet at least quarterly and more often if necessary. The Committee shall report to the Medical Executive Committee.

RULE 5: DEPARTMENTS

5.1 Current Designation of Departments

The current Departments are:

5.1.1 Anesthesia

5.1.2 Emergency / Family Medicine

5.1.3 Medicine

5.1.4 Obstetrics and Gynecology

5.1.5 Pathology

5.1.6 Pediatrics

5.1.7 Radiology

5.1.8 Surgery

5.2 Department Functions

5.2.1 Each Department, through its officers and any established and any established committees, is responsible for the quality of care within the Department and for the effective performance of the following as it relates to the members of the Department and Allied Health Practitioners practicing within the Department:

5.2.1.1. Patient care and evaluation, observation, and monitoring (including periodic demonstration of ability) consistent with guidelines developed by the committee(s) responsible for quality improvement, utilization review, education, medical records, and by the Medical Executive Committee.

5.2.1.2. Credentials review, consistent with guidelines developed by the Credentials and Privileging Committee and the Medical Executive Committee.

5.2.1.3. Corrective action, when indicated, in accordance with the Bylaws and the Rules.

5.2.1.4. Continuing education consistent with guidelines developed by the CME / GME / Library Committee and the Medical Executive Committee.

5.2.1.5. Planning and budget review consistent with guidelines developed by the Medical Executive Committee.

5.2.2 When the Department or any Department committee meets to carry out the duties described above, the meeting body shall constitute a peer review committee, which is subject to the standards and entitled to the protections and immunities afforded by Federal and State law for peer review committees. Each Department and Department committee shall meet when and if necessary to carry out its duties at the request of the chair.

RULE 6: CORECTIVE ACTION, HEARINGS, AND APPEALS

6.1 Automatic Suspension or Limitation

6.1.1 Automatic Suspension or Limitation

In the following instances, the Member's Clinical Privileges or Membership may be suspended or limited as described:

6.1.1.1 Failure to Pay Dues

Members will be billed for dues in December and will be required the dues promptly. A second notice will be sent 30 days after the initial billing to remind anyone who is delinquent. Practitioners who fail to pay their dues within 15 days after the date the second notice was mailed will be automatically suspended. Such suspension shall apply to the Medical Staff Member's right to admit, treat, or provide services to any patients in the Hospital. The suspension shall remain in effect until the dues are paid.

Practitioners who are suspended for failure to pay dues will, in addition to suspension, automatically be assessed the following fines for each day the dues remain unpaid:

Fines for days 1-9: $25 per day
Fines for days 10-30: $10 per day

Dues and applicable fines shall be payable no later than 90 days after the date of suspension.

A lack of payment after 90 days shall be deemed a voluntary resignation of Medical Staff Membership and Privileges.

Thereafter, reinstatement to the Medical Staff shall require payment of the dues, accumulated fines, and an application with processing fee, per the appointment procedures for applicants.

6.1.1.2 Failure to Timely See Patients

When a Practitioner fails to see patients within the time frames set forth in the Medical Staff Bylaws and Rules, the following penalties may be assessed by the Medical Executive Committee based upon incidents validated from incident reports or the patient's record:

First Incident in a calendar year	$100 Fine
Second incident in a calendar year	$200 Fine, and a mandatory appearance at the Medical Executive Committee
Third incident in a calendar year	$500 Fine plus appropriate

Written notice will be given when a penalty has been assessed and the Practitioner shall have thirty days to pay any fine that is due and to meet any conditions imposed by the Medical Executive Committee. Failure to pay any fine by the deadline will result in suspension of dining and parking privileges until the fine is paid.

RULE 7: GENERAL PROVISIONS

7.1 Credentials Files

7.1.1 General

7.1.1.1 The credentials files of Medical Staff applicants and Members shall contain all relevant information regarding the practitioner that is needed to evaluate the professional competency and performance.

7.1.1.2 The credentials files shall be retained in strict confidence in the Medical Staff Management Department or other designated areas.

7.1.1.3 It is expressly understood that the contents of the credentials file constitute records and proceedings of Medical Staff Committees that are responsible for evaluating and improving the quality of care provided in the Hospital.

7.1.2 Contents

Each credentials file shall include the practitioner's application forms and all correspondence and other documents pertaining to the practitioner and his or her professional qualifications, performance, and Medical Staff activities and responsibilities.

7.1.3 Disclosure to Applicant or Medical Staff Member

7.1.3.1 A Medical Staff applicant or Member who wishes to review any portion of his or her credentials file shall submit a written request that specifies the item(s) he or she wishes to see. Requests to review any portion of the credentials file that conform to the restrictions set forth below may generally be granted, but may be denied in unusual circumstances by the Medical Staff Chairman or Chief Executive Officer or either's designee.

7.1.3.2 An applicant or Member may inspect only his or her own credentials file (unless he or she is authorized to review other applicants' or Members' files in accordance with the provision set forth in Section 7.1.4 below) and may review only the following credentials file items:

a. documents or correspondence the applicant or member personally prepared and submitted, e.g., his or her application and letters;

b. documents or correspondence addressed and sent directly to the applicant or member; and,

c. public documents, such as copies of the applicant's or Member's license to practice medicine.

7.1.3.3 Photocopies or any other copy of any item contained in the credentials file shall not be made for an applicant or Member unless:

a. pursuant to Section 7.1.3.2 above, the applicant may inspect the item; and

b. approval for such copy(ies) to be made has been secured from the Medical Staff Chairman, the Medical Staff Vice Chairman; and/or either's designees; and

c. the applicant or Member has reimbursed the Hospital for the costs it incurred in making such copies.

Except as provided in Section 7.1.3.2 and 7.1.3.3 above, applicants and Members may not

have access to any item or document contained in the credentials file except as approved by the Medical Staff Chairman or the Chief Executive Officer.

Disclosures shall be made in connection with any hearing, as provided by the Medical Staff Bylaws and Rules.

7.1.4 Disclosure to Medical Staff Officers and Medical Staff Committees, or Their Designee

7.1.4.1 Credentials files may be disclosed, as appropriate, to Medical Staff Officers, Department Chiefs, Medical Staff Committees and their chairs, or to their designees. Disclosure to such persons or entities shall occur whenever necessary to enable them to carry out their responsibilities or evaluating and improving the quality of care rendered in the Hospital. For example, the contents of the credentials files may be disclosed to persons or committees that are responsible for recommending appointment or reappointment to the Medical Staff and what, if any, clinical privileges or practice prerogatives shall be granted; for investigating and requests for corrective action; or recommending what, if any, corrective action should be taken; and, for quality improvement and peer review committee activities.

7.1.4.2 Disclosure to Medical Staff Officers and Medical Staff Committees shall occur in the Committee meeting or Medical Staff Management Department except in the rate exception authorized by the Medial Staff Chairman or the Chief Executive Officer. Copies of all or a portion of a credentials file shall not be made for Medical Staff Members or Medical Staff Committees except as directed by the Medical Staff Chairman, Chef Executive Officer or Committee chair.

7.1.5 Disclosure to the Hospital Board of Trustees

7.1.5.1 The contents of the credentials files may be disclosed to the Hospital Board of Trustees, or any individual Board member, insofar as is necessary to enable the Board of Trustees to properly fulfill its legal responsibilities.

7.1.5.2 Disclosure should be limited to Board members or subcommittees that are responsible for evaluating and analyzing such information.

a. Generally, any portion of a credentials file that is reviewed by Board of Trustees members should not be included in or maintained as part of the Board of Trustees records or minutes.

b. Board of Trustees actions shall refer, as appropriate, in summary fashion and by reference to any credentials file material.

c. All portion(s) of credentials files reviewed by the Board of Trustees shall be returned to and maintained by the Medical Staff Management Department or designated area.

7.2 Call Panel

7.2.1 Call Panel List

7.2.1.1 A Call Panel has been established for referring patients who need inpatient care or immediate specialized care to qualified Practitioners.

7.2.1.2 All Active, Courtesy, and Provisional Members must serve on the Call Panel when requested by the Medical Executive Committee. If coverage of a service is not feasible given the limitations on available resources, transfer agreements should be sought with other hospitals.

a. Generally only Active Staff Members may serve unless there is a crisis or a need for a particular specialty that cannot be fully met by Active Staff Members. Provisional members may also serve but they first must complete proctoring except when no other coverage is available for the call panel and the services of the Provisional member are needed, in which case the Provisional member should inform the proctors of cases and concurrent proctoring should be completed whenever feasible of the call panel cases.

b. Members age 65 and over may request and be exempted from serving on call.

c. Members of the Department of Medicine must have admitted, consulted on, or otherwise cared for at least 24 patients in a 12 month period (not including patients who are assigned through the Call Panel) in order to qualify for service. Doctors assigned to serve as the house physicians and provide continuous coverage automatically qualify based upon their consultative and coverage assignments.

d. Since patients who seek care from the Hospital generally reside close to the Hospital, the location of a Member's office will be taken into account.

e. Practitioners whose privileges are suspended or restricted may not serve on call.

7.2.1.3 Emergency Call schedules are created on a monthly basis.

a. The Medical Staff Management Department shall be responsible for preparing the Call Panel schedules.

b. The House Physicians shall serve on call as required by their contract with the Hospital.

c. Surgical specialties will commence and end call at 06:00 a.m. All other specialties will commence and end call at 08:00 a.m.

7.2.1.4 Denial or Termination from the Panel

a. A member may be denied participation on or terminated from the Call Panel by the Department Chief to which the member is assigned, the Medical Staff Chairman, the Emergency Department Medical Director, or the Medical Director of Case Management. The Medical Director of Case Management may deny or restrict Call Panel participation only in instances of over-utilization that adversely impacts patient care and then only after the member was warned and given a reasonable opportunity to improve his/her performance. The action may be made effective at any time and remain in effect until such time as a final decision is reached by the Medical Executive Committee or its appointed subcommittee.

b. The decision to deny or terminate a Practitioner's participation will be final, subject only to review by the Medical Executive Committee or a subcommittee comprised of at least three Medical Executive Committee members appointed by the Medical Executive Committee to conduct the review ("MEC Subcommittee").

c. Prior to a final adverse decision, a Practitioner whose participation on the Call Panel may be denied or terminated will be given a statement of the reasons for the proposed action and an opportunity to appear before the Medical Executive Committee, or MEC Subcommittee, to explain why it should not take the proposed action.

d. The fact that the Medical Executive Committee denied a Practitioner's request to serve, or terminated a Practitioner's participation, on the Call Panel shall not affect the Practitioner's Medical Staff Privileges nor shall it be used as evidence in any disciplinary action. However, the facts which the Committee reviewed in reaching its decision may be used for any and all purposes.

e. Service on the Call Panel is not a Privilege, but is an obligation of Staff Membership. No Medical Staff Member has a right to serve on any Call Panel. A decision to remove a Member from the Call Panel shall not constitute a denial or restriction of Clinical Privileges and gives rise to only the hearing rights set forth in this Rule.

7.2.2 Conduct of Call Panel Members

7.2.2.1 Practitioners on call must respond promptly when requested to see a patient and at least call within 20 minutes after they are first called. The response time must be reasonable in view of the patient's clinical circumstances. Each panelist must let the Hospital know how to reach him or her immediately and remain close enough to the Hospital to be able to arrive within 30 minutes.

7.2.2.2 A Panelist who is unable to provide panel coverage during his or her scheduled time (including when he or she is detained due to another medical commitment) is responsible for arranging for coverage by a Practitioner who meets the criteria for panel eligibility. The Panelist shall inform the Hospital of the name of the Practitioner who will provide back-up coverage. The Emergency Department will assist the Panelist when the Panelist is unavailable because he or she is in surgery or a delivery.

7.2.2.3 When scheduled on call, each Practitioner shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion, pre-existing medical condition (except to the extent it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay.

7.2.2.4 All transfers shall be carried out in accordance with the Hospital policy on transfers. In summary, it requires:

a. The Emergency Department Physician, the patient's Attending Practitioner, or a Call Panelist must personally examine the patient prior to transfer and fins that the patient is stable. Patients who are not stable may be transferred only if the Practitioner finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient, or his/her authorized decision maker, requests transfer, after the Practitioner has explained the medial risks and benefits of transfer.

b. In addition:

i. The receiving facility must consent to the transfer and confirm it has the staff and facilities needed to provide the care the patient needs;

ii. Staff and equipment necessary for a safe transfer must be arranged;

iii. Copies of pertinent medical records must be provided, including a copy of the consent for transfer; and

iv. The "Transfer Summary Form" must be completed and a copy sent with the patient.

7.2.2.5 A patient can be admitted in the name of the Call Panel Practitioner by the Emergency Physician if both parties concur, but if the Emergency Physician so specifies, the Panelist must see the patient prior to admission. The Call Panel Practitioner must be notified about each admission prior to the patient leaving the Emergency Department.

7.2.2.6 A Panelist shall cooperate with and assist the Emergency Department, Emergency Physicians, and all Department Chiefs who may call a Panelist for assistance. The Panelist shall act in the best interests of patient care and in accordance with the Hospital's philosophy and Rules.

7.2.2.7 Panelists will see unassigned patients in the Emergency Department on a person physician, private-pay basis. The Panelist retains responsibility for billing and collecting his/her fees. The Hospital has no responsibility for this physician/patient relationship, and each Panelist agrees to release the Hospital from any obligation in this regard.

7.2.2.8 Any dispute between a Panelist and the patient or the patient's family or authorized decision-maker shall be referred to the Emergency Physician. No Panelist shall presume that his/her services have been refused unless the patient or his/her authorized decision-maker has been fully informed of the benefits of the treatment offered and the risks of refusing such treatment and has given an informed refusal of treatment in writing. The Emergency Physician shall be informed of any such refusal of treatment.

7.3 Research

7.3.1 Practitioners who desire to conduct research should be encouraged to conduct reasonable research projects. The Practitioners should be given, whenever possible, access to appropriate equipment and resources necessary for the research project.

7.3.2 Researchers may review and have access to confidential patient information for research purposes only if the patient has authorized the disclosure, or the Western Institutional Review Board, has approved the research protocol, including the disclosure.

7.3.3 All research undertaken by Medial Staff Members or others involving Hospital patients must be approved by the Research Advisory Committee, and when appropriate, the Western Institutional Review Board. All research must be conducted in accordance with the rules and policies governing research approved by the Research Advisory Committee and Medical Executive Committee.

See Rule 4.16 Research Advisory Committee for further details about this committee.

7.3.4 Patient care shall be rendered according to approved protocols.

7.3.5 A Medical Staff Member may use or allow the use of the Hospital's name in published works only with the permission of the Medical Executive Committee, via the Research Advisory Committee. However, Members may identify themselves as Members of the Hospital's Medical Staff within the limits of accepted professional ethics and practices.

7.4 Routine Monitoring, Education, and Focused Review

7.4.1 Routine Monitoring and Education

7.4.1.1 The Departments and Committees of the Medical Staff are responsible for carrying out delegated review and quality improvement functions. They may be assisted by the Medical Directors, Medical Staff Management Department, and Department Chiefs.

7.4.1.2 They may counsel, education, issue letters of warning or censure, or institute retrospective or concurrent monitoring (so long as the Practitioner is only required to provide reasonable notice of admissions and procedures) in the course of carrying out their duties without initiating formal corrective action. Comments, suggestions, and warnings may be issued orally or in writing.

7.4.1.3 The Practitioner shall be given an opportunity to respond in writing and may be given an opportunity to meet with the Department or Committee.

7.4.1.4 Any information actions, monitoring, or counseling shall be documented in the Member's file.

7.4.1.5 Neither Credentials and Privileging Committee nor Medical Executive Committee approval is required for such actions, although the actions shall be reported to the Credentials and Privileging Committee.

7.4.1.6 The actions shall not constitute a restriction of Privileges or grounds for any formal hearing or appeal rights under the Bylaws or Rules.

7.4.2 Focused Review

7.4.2.1 A Focused Review shall generally be initiated in the following instances:

a. Unexpected deaths, deaths within 24 hours of hospital admission, deaths during an operation and within 12 hours post-operatively, and all unexpected deaths of full term babies.

b. Unexpected complications in patient condition and/or care or treatment, including those that result in major permanent loss of function, not related to the natural course of the patient's illness or underlying condition.

c. Postoperative complications identified for special study by the Departments of Surgery, Obstetrics and Gynecology, or Family Medicine.

d. Severe drug reactions.

e. Severe transfusion reactions (hemolytic, febrile, allergic)

f. Sentinel Events

g. Potentially compensable events identifies by the Risk Manager and all cases in which a letter of intent has been filed.

h. Written patient complaints concerning a Medical Staff Member or Allied Health Practitioner, including complaints about the care the Member or Allied Health Practitioner provided and/or about the Member's or Allied Health Practitioner's conduct.

i. Staff reports of concerns about a Medial Staff Member or Allied Health Practitioner, including reports of concerns about the care the Member or Allied Health Practitioner provided and/or about the Member's or Allied Health Practitioner's conduct.

j. Utilization issues (e.g., excessive delays in discharge, prolonged length of stay, unsafe transfer or discharge of patient related to clinical stability).

k. Iatrogenic events.

l. Cases for a specific Medical Staff Member or Allied Health Practitioner, when indicators suggest there have been a pattern of problems or a particular need for the review that is documented by the Department or a Committee that will review the cases (e.g., a specific study may be warranted if a Member has had problems elsewhere or if a few problems suggest there may be more that are not being picked up by the screening criteria).

m. Service-specific defined performance indicators, which have been established and approved by the Departments and/or the Performance Improvement Council.

n. Criteria set by the Performance Improvement Council for selecting cases for focused review to assess:

i. Appropriate use of blood or blood components

ii. Appropriate use of medications

iii. Appropriate use of nutritional products

iv. Appropriate medical record documentation, including assessment of whether the documentation is timely, complete, and legible

7.4.2.2 Reviewers

a. Generally cases involving medical management and clinical care issues will be referred initially to the Department for review, and other cases will be referred to the Performance Improvement Committee or Credentials Committee for review. The Director of Quality Improvement shall be responsible for determining where to refer a case for review, and he/she may confer with Department and Committee chairs when it is not clear where a case should be referred.

b. The Department Chair or the Committee Chair will delegate the initial review to a member who is licensed in the same medical specialty (when possible) as the individual whose case is under review, or when the care involves an Allied Health Practitioner to an Allied Health Practitioner form the same or related medical specialties whenever possible. Opinions from Medical Staff members and Allied Health Practitioners who are not licensed or certified in the same specialty as the individual whose case is under review may also be offered and considered.

c. A person who participated in care for a patient should not serve as a Peer Reviewer regarding the case, although opinions and information may be obtained from such a person.

d. Ad Hoc Peer Review Panels may also be set up when additional expertise may be necessary to adequately review a specific case. Panelists may be selected for their expertise in a given subject of medicine or in a specific medical specialty.

e. External peer review can be helpful and should be considered in the following circumstances:

i. When no other Medical Staff Members provide the services that are under review.

ii. A peer review committee cannot make a determination and requests external review or would like a second opinion from an external reviewer.

iii. The individual whose case is under review requests external peer review, although in such cases the individual who requests the outside review must be solely responsible for paying the cost of the external review.

7.4.2.3 Participation in the Peer Review Process by the Practitioner Whose Performance Is Under Review

a. If there are questions or concerns regarding a case that will be presented at a Department or Committee meeting, the Medical Staff members and Allied Health Practitioners who were involved in caring for the patient, whose care is under review, should be invited to the meeting. They should be given a notice, preferably two weeks before the meeting, noting the date, time and place of the meeting, and the medical record number and date of service of the case(s) that will be discussed. The Member and Allied Health Practitioner should be given a chance at the meeting to present information and opinions regarding the case to the Peer Reviewers.

b. Every effort will be made to have the Member or Allied Health Practitioner present when his or her cases are being reviewed. However, if a Member or Allied Health Practitioner fails to attend the meeting following notification, the committee may proceed with its review.

7.4.2.4 Time Frame for Review

a. Cases forwarded to Medical Staff committees for peer review should be reviewed within 90 days of referral.

b. Cases requiring immediate action in the opinion of the Director of Quality Management will be referred to the Department Chief or the appropriate committee chair, for immediate attention. When necessary, the review will be completed without waiting for the medical record to be completed. Such review should be completed and a preliminary assessment prepared within 30 days after the receipt of the referral.

7.5 Medical Staff Funds

7.5.1 Sources of Medical Staff Funds

7.5.1.1 Applicants for appointment will be expected to pay application fees as provided in Rule 3.

7.5.1.2 Members will be expected to pay dues as provided in Rule 3.

7.5.1.3 The Medical Staff Funds will be invested in a manner that provides for prudent returns, which shall be added to the funds.

7.5.2 Use of Medical Staff Funds

11.5.2.1 The Medical Executive Committee shall be responsible for authorizing the expenditure of the Medical Staff Funds.

11.5.2.2 Medical Staff Funds shall be used as appropriate for purposes of the Medical Staff. All expenditures shall be consistent with the requirements that apply to the use of the funds of a not-for-profit entity, which, for example, forbid distributing funds for the private benefit of any individual or entity.

RULE 8: CLINICAL RULES

8.1 Admission of Patients

8.1.1 General

8.1.1.1 Good Samaritan Hospital shall accept patients for diagnostic and therapeutic care, except patients who suffer from serious burns; primarily need psychiatric or substance abuse treatment; have major psychiatric problems requiring close supervision or restraint which the Hospital cannot provide; or have virulent infectious diseases for which suitable isolation cannot be maintained or adequate care given. Exceptions may be made with special permission from the Chief Executive Officer.

8.1.1.2 The Clinical Department may contact the Attending Physician when questions arise as to whether a patient should be admitted, retained, or transferred.

8.1.2 Procedure

8.1.2.1 A patient may be admitted to the Hospital only by Members of the Medical Staff who have admitting privileges. All Practitioners shall be governed by the Hospital's official admitting policy.

8.1.3 Responsibility

8.1.3.1 The patient's Attending Physician shall be responsible for directing and supervising the patient's overall medical care, for completing or arranging for the completion of the medical history and physical examination within 24 hours after the patient is admitted or before surgery (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient' status to the patient, the referring Practitioner, if any, and to the patient's family.

8.1.3.2 Whenever these responsibilities are transferred to another Medical Staff Member, a note covering the transfer of responsibility shall be entered on the order sheet in the medical record. It shall state the date responsibility is transferred. Alternatively, arrangements may be made in advance to designate that a particular Medical Staff Member shall have attending staff responsibility for patients depending upon their scheduled coverage time.

8.1.3.3 Any Medical Staff Member who cannot or will not assume all of the responsibilities of the Attending Physician shall admit patients only with another Medical Staff Member who can and will assume such responsibilities.

8.1.3.4 All nursing calls to physicians, physicians' assistants or nurse practitioners must be returned within 20 minutes.

8.1.3.5 Failures to meet all elements of these rules will be reported and corrective action taken as outlined in the Rules.

8.1.4 Provisional Diagnosis

8.1.4.1 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In case of an emergency, such statement shall be recorded as soon as possible, no later than 24 hours after admission.

8.1.5 Psychiatric Precautions and Infection Admission Precautions

8.1.5.1 The Attending Physician, at the time the patient is admitted, shall inform the admitting staff and nursing staff if he or she suspects that the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The Attending Physician shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall note in the patient's record the reason for his or her suspicions, and the precautions taken to protect the patient and others.

8.1.5.2 In the event the patient or others cannot be appropriately protected in the general acute care service, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed. When indicated, individual nursing care shall be arranged in accordance with Hospital policy.

8.1.5.3 The Attending Physician should also seek assistance from a psychiatrist for any patient who suffers from an incapacitating emotional illness or substance abuse.

8.1.6 Emergency Admission

8.1.6.1 When a patient who is not in the Emergency Department (or another part of the Hospital) requires admission to the Hospital for non-elective medical treatment, the Attending Physician shall, whenever possible, contact the Admitting Department and determine whether there is an available bed.

8.1.6.2 In all cases involving emergency admissions, the Attending Physician must be able to demonstrate to the Medical Executive Committee and the Chief Executive Officer that the admission was due to a bona fide emergency. The history and physical examination report must clearly justify the emergency admission.

8.1.6.3 Patients who require emergency admission and do not have an Admitting Physician shall be assigned an Attending Physician in accordance with the Rule 8.2.

8.1.6.4 Admissions to Non Critical Care Units

When a patient is admitted to a Non-Critical Care Unit, the Admitting Doctor must respond in person or by telephone within twenty minutes and provide admitting orders within one hour after being notified of the patient's admission. The Admitting Doctor or Attending Physician must see the patient within fifteen hours after the patient was admitted. The admitting Doctor or Attending Physician will be expected to respond faster when the reports given on the patient's condition suggest admitting orders should be given sooner or the patient should be seen sooner. Failure to meet these requirements will be reported and corrective action taken as outlined in the Rules.

8.1.7 Admission to the Intensive Care Unit

8.1.7.1 Practitioners admitting patients to the Intensive Care Unit (ICU) shall automatically accept, in addition to their own, the routine standing orders of the Unit, and abide by the Unit's special rules (see Intensive Care Unit policies).

8.1.7.2 A Practitioner who is the Managing Physician for a patient who is admitted to a Critical Care Unit must respond in person or by telephone within twenty minutes after receiving notice that the patient has been admitted and must give admitting orders with one hour after being notified of the patient's admission. The Managing Physician must see the patient within two hours after being notified of the patient's admission to the Critical Care Unit. There after the Managing Physician must see and evaluate that patient at least once a day no later than 2:00 p.m. The managing Physician will be expected to respond faster when the reports given on the patient's condition suggest admitting orders should be given sooner or the patient should be seen sooner. Failure to meet these requirements will be reported and corrective action taken as outlined in the Rules. The Critical Care Units include

the Intensive Care Unit (ICU), Coronary Care Unit (CCU), Cardiac Surgery Unit (CSU), and Cardiac Post-Operative/Procedure Recovery Unit (CPPU). The Managing Physician is responsible for providing the level of care necessitating the CCU admission, and can be the Attending or his designee as documented in the Medical Record. The Managing Physician has the responsibility to determine whether the patient should remain in the CCU or be transferred and must notify all physicians on the case of any transfer orders.

8.1.7.3 Questions regarding the discharge or admission of a patient to a Critical Care Unit shall be resolved by the Attending Physician consulting with the Unit Medical Director or the Medical Staff Chairman.

8.1.7.4 If there is a dispute regarding a patient's medical care in a Critical Care Unit or the admission, transfer or discharge from the Critical Care Unit, the Unit Medical Director has the ultimate authority to decide what shall be done. Before making any decisions contrary to the Attending

Physician, the Unit Medical Director shall confer with the Attending Physician and may examine the patient and the patient's records. Patients and patients' surrogate decision- makers shall be consulted when consent is required. The Chief of the Department of Medicine shall review all instances when the Unit Medical Director and Attending Physician disagreed on the proper course of treatment.

8.1.8 Admission to the Short Stay Observation Unit

8.1.8.1 When admitting a patient to the Short Stay Observation Unit, the physician must provide a set of physician orders which clinically justify a patient's stay on the unit.

8.1.9 Priority of Admissions and Transfers

8.1.9.1 When the Chief Executive Officer, after consulting with the Medical Staff Chairman, determines that bed space is not available, he or she may limit admissions to emergency cases. In such an event, patients will be admitted using the following order of priority:

a. First Priority Emergency Admissions

Patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four hours.

b. Second Priority Urgent Admissions

Patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within 24 hours.

c. Third Priority Preoperative Admissions

Patients who are already scheduled for surgery.

d. Fourth Priority Routine Admissions

Patients who will be admitted on an elective basis to any service.

8.1.9.2 Priority shall be given for the transfer of patients in the following order:

a. Emergency admissions to an appropriate bed

b. Intensive Care Unit to a telemetry or general care bed

c. Temporary placement in an inappropriate area for that patient to an appropriate area

8.1.9.3 The Medical Staff Chairman shall be consulted to help prioritize admissions and transfers.

8.2 Consent for Medical and Surgical Procedures

8.2.1 Policy

8.2.1.1 Patients have the right to participate actively in decisions regarding their medical care and to decide whether to authorize or refuse procedures recommended by their Practitioners. Practitioners must give patients the information they need to make their decisions. Accordingly, diagnostic and therapeutic procedures may be performed only when the patient, or his or her surrogate decision-maker, has been given information about the procedure and has given consent. When the recommended procedure is complex (i.e., involves risks or complications that are not commonly understood), "informed consent" must be secured (see Rule 12.2.2 below) Decisions to discontinue life-sustaining treatment raise special concerns, which are discussed in Rule 12.7 "Discontinuing Life-Sustaining Treatment."

8.2.1.2 Surgical, special diagnostic, or therapeutic procedures require consent by the patient or his or her surrogate decision-maker. This Rule outlines the basic requirements. Further information and forms are provided in the Consent Manual prepared by the California Healthcare Association.

8.2.2 Informed Consent Defined

8.2.2.1 Informed consent is a process whereby the patient, or his or her surrogate decision-maker, is given information which will enable him or her to reach a meaningful, informed decision regarding whether to give consent.

8.2.2.2 The information that must be provided includes a description of:

a. The nature of the recommended treatment.

b. Its expected benefits or effects.

c. The associated risks and possible complications.

d. Any alternative procedures and their expected benefits or effects and associated risks and possible complications and the alternative of not providing any curative treatment.

e. Any independent economic interests a Practitioner may have that influence his or her treatment recommendations.

8.2.3 Who May Give Consent

8.2.3.1 Informed consent must be secured from competent patients. If a patient is incompetent by reason of age or condition, consent must be secured from a surrogate decision-maker (i.e., parents or guardians of minors who may not consent, conservators, attorneys-in-fact, the patient's closest available relatives, or the court). (The persons who may give consent are identified in the California Healthcare Association Consent Manual.)

8.2.4 Responsibility for Securing Informed Consent

8.2.4.1 The patient's Attending Physician generally is responsible for giving the patient, or his or her surrogate decision-maker, the requisite information and securing consent.

8.2.4.2 Practitioners other than the patient's Attending Physician may have a duty to secure consent when they will provide specialized services at the request of or together with the patient's attending. (Examples include special diagnostic or therapeutic radiology, nephrology, gastroenterology, pulmonary, or anesthesia services.)

a. The consent process is shared when two or more Practitioners will provide specialized services. In this Hospital, responsibility is divided as follows:

i. The patient's Attending Physician who recommended the procedure shall explain why he or she has advised performance of the special procedure and describe any alternative procedures and their expected benefits and associated risks and the alternative of not providing any curative treatment.

ii. The Practitioner who will provide the specialized service (e.g., the radiology study or anesthesia) shall describe the nature of the procedure and its risks and associated complications.

iii. After both Practitioners have discussed the proposed procedure, the patient or the surrogate decision-maker shall be asked for consent.

iv. The referring Practitioner must tell the specialist who should give consent when a patient is incompetent and help arrange contact with a suitable surrogate decision-maker.

8.2.4.3 When surgery or other procedures are performed on an outpatient basis or on the same day as admission, the Practitioner who will perform the procedure must either meet the patient (or surrogate decision-maker) prior to the procedure and discuss it or verify that another Practitioner has fully explained the procedure and secured consent.

8.2.5 Emergencies

8.2.5.1 Consent may be implied in an emergency. An emergency occurs when treatment is immediately necessary to prevent the patient's death, severe impairment or deterioration, or to alleviate severe pain, and the patient is incompetent to give consent, or there is insufficient time to secure consent from the patient, or his or her surrogate decision-maker.

8.2.5.2 The emergency exception applies only to the treatment which is immediately necessary and for which consent cannot be secured.

8.2.5.3 In the case of an emergency (as defined above), treatment may proceed without the patient's consent, if the patient or his or her legal representative is unable to give consent.

8.2.5.4 Consent should be secured for all further, non-emergency treatment that may be necessary.

8.2.6 Particular Legal Requirements

8.2.6.1 Consent for blood transfusions, HIV blood tests, elective sterilization procedures, hysterectomies, use of investigational drugs or devices, participation in human experimentation, reuse of hemodialysis filters, treatment for breast cancer, use of psychotropic medications, and involuntary commitment for psychiatric disorders must be secured in the manner specified in the laws applicable to these particular procedures. The laws are described in the California Healthcare Associated Consent Manual.

a. Psychotropic medications raise special concerns, even in hospitals that have no licensed psychiatric beds.

b. Practitioners must secure informed consent for anti-psychotic medications, and document that the patient gave consent in writing. Preferably, the patient shall sign the form acknowledging informed consent was given, but a physician note documenting the discussion may suffice since Good Samaritan Hospital does not have licensed psychiatric beds.

8.2.6.2 Special requirements for consent also apply to discontinuing life-sustaining treatment. (See Rule 8.7 "Discontinuing Life-Sustaining Treatment.")

8.2.6.3 The Attending Physician shall assure that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

8.2.7 Documentation

8.2.7.1 The Practitioners involved in securing informed consent should document, in the patient's medical record, their discussions regarding the proposed procedure and whether they secured consent.

a. The Practitioner is required to sign the Consent to Treatment form to verify informed consent was obtained. A signed facsimile of this form may be accepted as the Hospital's consent form.

b. Such documentation should describe any special or unique concerns of or related to the patient.

c. The documentation should indicate why a person was selected as a surrogate decision-maker for a patient who is incompetent.

8.2.7.2 The Practitioner's documentation for emergencies (see 8.2.5 above), which should be entered in a progress note, must describe:

a. The nature of the emergency.

b. The reasons consent could not be secured from the patient or a surrogate decision-maker.

c. The probably result if treatment would have been delayed or not provided.

8.2.7.3 Hospital employees are responsible for verifying that consent has been given. This will be done for all operations using general anesthesia and all major invasive procedures, for inpatients and outpatients. This is done one of four ways:

a. Asking the patient or a surrogate decision-maker to sign the general consent form entitled "Informed Consent to Surgery or Special Diagnostic or Therapeutic Procedures." The Medical Staff Member acts as a witness, which means that he or she assesses whether the patient (or a surrogate decision-maker) is competent and understands what he or she is signing, and did in fact, sign the form.

b. Verifying that the special forms required for blood transfusion, HIV blood tests, elective sterilization, hysterectomies, investigational devices, human experimentation, reuse of hemodialysis filters, treatment for breast cancer or antipsychotic drugs have been signed as required by law.

c. Verifying that the patient, or a surrogate decision-maker, has signed an informed consent form which contains not only the general provisions set form in the standard consent form, but also medical information regarding the procedure, and that this form is included in the patient's medical record. Hospital employees may not distribute forms containing medical information except for the general consent form that describes the common risks or surgery and information forms for radiology procedures. All other forms containing medical information must be given to the patient by the Practitioner.

d. Verifying that the "emergency exception" applies.

8.2.8 Hospital Employee Role in Providing Information

8.2.8.1 Hospital employees may not provide patients or surrogate decision-makers with medical information regarding any proposed procedure except as noted in Section 13.2.7.3 above. If a patient or surrogate decision-maker expresses doubt or confusion about a procedure, the patient's Attending Physician or the Practitioner who is responsible for securing consent shall be contacted and asked top provide the necessary information.

8.2.8.2 If the Practitioner responsible for securing consent is not available, the Good Samaritan Hospital employee(s) shall determine whether the patient's doubt or confusion warrants delaying the procedure until the Practitioner is available to respond to the questions or concerns.

8.2.8.3 Surgical or other special diagnostic or therapeutic procedures generally need not be delayed unless the procedure involves substantial risks that the patient, or his or her surrogate decision-maker, clearly does not understand. In all cases, the Practitioner shall be informed of the doubts, concerns, or questions before the procedure is performed and allowed to determine whether effective consent has been secured.

8.2.9 Consent by Telephone

8.2.9.1 Consent by telephone may be acceptable in certain situations. The Hospital's Risk Manager should be contacted if there is a question about using the phone to discuss the case and secure consent.

8.2.9.2 When the telephone is used to obtain consent from a surrogate decision-maker, the information normally given to secure informed consent must be given. Thus, the condition of the patient and the proposed medical and/or surgical treatment must be explained. Inquiries concerning the procedure should be answered only by the Practitioner, or his or her designee.

8.2.9.3 When consent by telephone, a Hospital employee should join the conversation to listen and act as a witness. All persons joining the call must be informed that a Hospital employee will be listening to the discussion.

8.2.9.4 The Practitioner shall note the exact time, nature, and any limitation of the consent in the medical record. The witness shall countersign and date this note.

8.2.9.5 The Practitioner should instruct the surrogate decision-maker immediately to send a facsimile or letter confirming the telephone consent. If possible, a copy of the consent form should be sent and returned (signed), by facsimile. At a minimum, the written documentation should name the person giving the consent, describe his or her relationship to the patient and confirm that consent was given for treatment. The facsimile or letter should be placed in the medical record.

8.2.10 Refusal of Treatment

8.2.10.1 A patient or the patient's surrogate decision-maker has the right to refuse treatment. If the patient is a minor who is not legally authorized to consent to treatment and his or her parent or guardian refuses consent, it may be desirable and possible to secure court authorization.

8.2.10.2 If a patient or the patient's surrogate decision-maker refuses treatment, the Attending Physician shall be contacted immediately and shall explain the reason for the treatment and the possible ill effects of refusal. The Attending Physician shall enter a brief note in the patient's chart regarding the initial refusal and whether the outcome was consent or continued refusal.

8.2.10.3 The Refusal of Treatment form should be presented to the patient or the surrogate decision-maker for signature. If the patient or surrogate decision-maker refuses to sign, the notation "refuses to sign" shall be made at the place for the signature.

8.2.10.4 If treatment is ultimately refused, an Event Report shall be completed and forwarded to the Quality Management Department along with a copy of the Refusal of Treatment form.

8.2.10.5 See also Rule 8.6.2 "Leaving Against Medical Advice" and Rule 8.7 "Discontinuing Life-Sustaining Treatment."

8.3 Consultations

8.3.1 General

8.3.1.1 The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the seriousness of the illness and the resolution of any doubt regarding the diagnosis or treatment rests with the Practitioner responsible for the care of the patient. The organized Medical Staff, through the Department Chiefs and the Medical Executive Committee, have oversight responsibility for assuring that consultations are called as needed.

8.3.1.2 Any qualified Practitioner with Clinical Privileges can be called for consultation within his or her area of expertise and within the limits of Clinical Privileges which have been granted to him or her.

8.3.1.3 An Attending Physician's responsibility for his or her patient does not end with a request for consultation.

8.3.1.4 The consultation and specific diagnostic and therapeutic procedures will be done at Good Samaritan Hospital unless specific diagnostic or therapeutic facilities are not provided within the confines of Good Samaritan Hospital. Any outside sources used for inpatients must be approved by the Medical Staff and must meet accreditation standards.

8.3.2 Requests for Consultation

8.3.2.1 Requests for consultation should be made by direct personal communication from the Attending Physician to the consulting Practitioner. The Attending Physician must document the consultation request.

8.3.3 Recommended Consultations

8.3.3.1 Except in an emergency, consultation is recommended in the following instances:

a. When the patient is not a good risk for an operation or treatment.

b. When the diagnosis is obscure after ordinary diagnostic procedures have been completed

c. When there is doubt as to the choice of therapeutic measures to be used.

d. In unusually complicated situations when specific skills of other Practitioners may be needed.

e. In instances when the patient exhibits severe psychiatric symptoms.

f. In the case of a deliberate drug or chemical overdose or attempted suicide.

g. When pelvic surgery is contemplated in the presence of a confirmed pregnancy.

h. When requested by the patient or a surrogate decision-maker.

8.3.4 Requested or Required Consultations

8.3.4.1 A consultation may be requested when the Department Chief or Medical Staff Chairman determines that a patient will benefit from such consultation.

8.3.4.2 If a nurse has any reason to doubt or question the care provided to any patient or believes that consultation is needed and has not been obtained, the nurse may call this to the attention of his or her supervisor, who in turn may refer the matter to the Department Chief. The Department Chief may then, in appropriate circumstances, request a consultation after conferring with the patient's Attending Physician.

8.3.4.3 A Medical Staff Member may be required to have consultations on all or some of his or her cases. In such situations, the Member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultations.

8.3.5 Performance of and Reporting of Consultations

8.3.5.1 A satisfactory consultation includes examination of the patient and the record. The Attending Physician is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for consultation.

8.3.5.2 A written opinion signed by the consultant must be included in the patient's medical record. A limited statement, such as "I concur," is not sufficient. When operative procedures are involved, consultations performed before surgery shall be reported before the operation, except in emergency cases. Consultation reports shall be prepared in accordance with Rule 7.8 Medical Records.

8.4 Coverage

8.4.1 General

8.4.1.1 Each Practitioner shall arrange coverage for each of his or her patients in the Hospital. The Attending Physician is responsible for informing the Practitioner who will provide coverage about his or her schedule and for assuring that the Practitioner will be available and qualified to assume responsibility for the patients during the Attending Physician's absence and is aware of the status and condition of each patient he or she is to cover.

8.4.1.2 A failure to arrange appropriate coverage shall be grounds for corrective action.

8.4.2 Leadership Role in Arranging Interim Coverage

8.4.2.1 If the Attending Physician's alternate is not available, the Department Chief or Medical Staff Chairman must be contacted, and assume responsibility for caring for the patient or appoint an appropriate Good Samaritan Hospital Medical Staff Member who will assume responsibility until the Attending Physician can be reached.

8.5 Deaths and Autopsies

8.5.1 Pronouncement of Death

8.5.1.1 If a patient arrives at the Hospital dead or dies in the Hospital, a physician shall pronounce the patient dead within a reasonable period of time. The patient's remains may not be released until the physician has made an authenticated entry of the pronouncement of death in the patient's medical record. Nurses may pronounce death pursuant to standardized procedures.

8.5.1.2 If the patient has suffered "brain death" (i.e., the total and irreversible cessation of all functions of the entire brain, including the brain stem), death may be pronounced only in accordance with the Good Samaritan Hospital Administrative Policy governing "brain death."

8.5.2 Autopsies

8.5.2.1 It shall be the duty of all Good Samaritan Hospital Medical Staff Members to attempt to secure consent to meaningful autopsies. Autopsies should be encouraged in the situations identified by the College of American Pathologists:

a. Deaths in which an autopsy would explain unknown or unanticipated medical complications.

b. All deaths in which the cause is not known with certainty on clinical grounds.

c. Unexplained or unexpected deaths from dental, medical, or surgical procedures.

d. Deaths of patients participating in clinical investigations.

e. All obstetric deaths.

f. Death of an infant or child who had a congenital malformation.

g. Deaths wherever an autopsy might reveal information that could affect survivors or recipients of transplant organs.

8.5.2.2 An autopsy is a consultation. It requires consent and requires the concurrence of the Good Samaritan Hospital's pathologist that it would offer meaningful information. An autopsy may be performed only if authorized in accordance with law. (The persons who may consent to autopsies are identified in the California Healthcare Association Consent Manual.) The Attending Physician should provide a brief clinical summary and delineate the questions to be answered by the autopsy.

8.5.2.3 Except in coroner cases, all autopsies shall be performed by the Hospital pathologist or his or her designee. Provisional anatomic diagnoses shall be recorded on the medical record by the pathologist within 72 hours after completion of the autopsy. The complete protocol should be made a part of the record within 60 days.

8.5.3 Coroner's Cases

8.5.3.1 The law requires death to be reported to the coroner in the following circumstances:

a. Violent, sudden, or unusual deaths.

b. Unattended deaths.

c. Deaths related to or following known or suspected self-induced or criminal abortions.

d. Known or suspected homicide, suicide, or accidental poisoning.

e. Deaths known or suspected as resulting in part form or related to an accident or injury, either or recent.

f. Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration.

g. When the suspected cause of death is sudden infant death syndrome.

h. Death in whole or in part occasioned by criminal means or associated with a known or alleged sexual crime.

i. Deaths suspected to be due to a contagious disease that has not been reported to the Department of Health Services.

j. Deaths due to occupational diseases or hazards.

8.5.3.2 The coroner also asks for reports of deaths due to drug addition, pneumoconiosis and therapeutic misadventures as well as deaths during or within 24 hours after operation.

8.5.4 Notifying the Next of Kin

8.5.4.1 The Attending Physician or his or her representative is responsible for notifying the next of kin in all cases of death.

8.5.5 Disposition of Remains and Contributions of Anatomical Gifts

8.5.5.1 The patient's remains shall be disposed of in accordance with the instructions of the patient, the patient's legal representative, or his or her next of kin. The order in which the next of kin shall be consulted is set forth in the California Healthcare Association Consent Manual.

8.5.5.2 If the patient or his or her family indicates that the patient has or will contribute anatomical gifts, consent shall be secured in accordance with the relevant law, which is described in the California Healthcare Association Consent Manual. The patient's Attending Physician shall comply with the Hospital protocol for identifying potential organ and tissue donors, and, whenever possible, confer with the patient or family about donations.

8.5.6 Death Certificate

8.5.6.1 The Attending Physician or other physician last in attendance is responsible for signing the death certificate or ensuring its completion.

8.6 Discharge of Patients

8.6.1 General

8.6.1.1 Patients shall be discharged only on the order of the Attending Physician or his or her designee, or by a Member acting pursuant to an approved standardized procedure.

8.6.1.2 Minors shall be discharged only to their parents or legal guardians or a person designated in writing by the parent or legal guardian. The "Health Facility Minor Release report" in the California Healthcare Association Consent Manual must be completed whenever a minor is discharged to anyone except a parent, relative by blood or marriage, or legal guardian.

8.6.1.3 The Attending Physician should inform the Hospital's Nursing Service of possible discharges as early as possible and enlist the aid of Case Management when appropriate.

8.6.1.4 At the time of discharge, the Attending Physician or his or her designee acting pursuant to an approved standardized procedure who is discharging the patient must complete the discharge instruction sheet. The discharge summary must be completed within 14 days after the patient's discharge.

8.6.1.5 Under usual circumstances, the Attending Physician shall discharge the patient by 11:00 a.m. on the day of discharge. According to Hospital Administrative policy, patients may be charged for any later discharge time.

8.6.2 Leaving Against Medical Advice

8.6.2.1 If a patient indicates that he or she will leave the Hospital without a discharge order from the Attending Physician, the Nursing Staff shall attempt to arrange for the patient to discuss his or her plan with the Attending Physician before the patient leaves.

8.6.2.2 Whenever possible, the Attending Physician shall discuss with the patient the implications of leaving the Hospital against medical advice.

8.6.2.3 The patient who insists on leaving against medical advice shall be asked to sign the form "Leaving Against Medical Advice." If the patient refuses to sign the form, or cannot be located, the Nursing Staff shall document in the patient's record the facts surrounding the patient's departure.

8.6.3 Refusal to Leave

8.6.3.1 Hospital Administration shall be contacted for assistance whenever a patient refuses to leave the Hospital.

8.7 Discontinuing Life-Sustaining Treatment
Withholding and Withdrawing Medical Care; Issuing No Cardiopulmonary Resuscitation Code Orders

8.7.1 General

8.7.1.1 Decisions to withhold or withdraw medical care must be handled carefully. The effect upon the patient, and the patient's family, friends, significant others, and members of the healthcare team should be kept in mind.

8.7.1.2 Decisions are to be made by the patient or his or her surrogate decision-maker, after consulting with the patient's physician. The physician is responsible for providing advice about when medical care should be withheld or withdrawn.

8.7.2 Guidelines for Decision

8.7.2.1 Whether life-sustaining care should be continued or started depends upon whether the treatment is "proportionate" or "disproportionate." This framework applies to all patient conditions and all possible treatments and interventions.

8.7.2.2 Whether a treatment is proportionate or disproportionate depends on an assessment of the treatment's expected benefits versus the burdens it may cause. The unique facts of each case must be considered. The relevant considerations include:

a. How long the treatment is likely to extend life and whether it can improve the patient's prognosis for recovery.

b. What the nature of the patient's extended life may be, and specifically what are the possibilities of a return to a cognitive life and of a remission of symptoms enabling a return towards a normal, functioning integrated existence.

c. What is the degree of intrusiveness, risk, and discomfort associated with the treatment.

8.7.2.3 There is no legal distinction between withholding and withdrawing medical care. Clinical conditions and perspectives may change and it may become proper to withdraw care that was previously initiated. Time should be taken to confirm the medical diagnosis and prognosis and for review prior to making the irrevocable decisions to terminate life-sustaining treatment.

8.7.2.4 All medical treatment may be withheld or withdrawn, except any medical procedure deemed necessary to alleviate pain. Further guidance is provided in the Hospital policy for special considerations pertaining to artificial feeding, irreversible comas, persistent vegetative states and cardiopulmonary resuscitation.

8.7.2.5 No Cardiopulmonary Resuscitation Orders (to stop the otherwise automatic initiation of cardiopulmonary resuscitation [CPR]) may be proper when the patient has an underlying incurable medical condition, does not have any reasonably conceivable possibility of recovering or long term survival, and there is no medical justification or purpose which would be achieved by applying CPR should the natural course of a patient's medical condition cause vital functions to fail. CPR may also be found disproportionate if the patient has a serious, life-threatening illness; but such decisions should usually be reserved to the patient rather than surrogate decision-makers.

8.7.3 Procedure for Issuing Orders

8.7.3.1 Who Must Be Consulted

a. The treating physician and consulting physicians (if any) shall be responsible for determining the patient's prognosis and diagnoses. The physicians must identify, to the extent possible, the patient's clinical and physiological / neurological diagnosis, the expected course of the patient's condition, and the risks and possible complications of treatments that can be provided, as well as their potential benefits.

b. The Attending Physician is responsible for providing this information to the patient, or the patient's surrogate decision-maker, to enable him or her to evaluate a treatment's benefits and burdens. Confirmation of a treating physician's determinations is not required, although a physician may choose to secure a second opinion or to consult with the Bioethics Committee Chair.

c. With children, almost always parents or another proper surrogate decision-maker must make the decision. The patient may decide, however, if he or she is competent (i.e., 18 years or older or a minor otherwise entitled to make decisions, and able to understand the decision). Hospital policy provides further guidance regarding who may make the decisions when questions or disputes arise.

d. Unless the patient has directed otherwise, the patient's immediate family and significant others shall be consulted, and their wishes should be given very great weight in arriving at the decision. The patient's desires, if known, should guide the decision.

e. Orders to withhold or withdraw CPR and other forms of life-sustaining treatment when there are no surrogate decision-makers who can act on behalf of the patient may be proper in some cases. The patient's Attending Physician must notify Hospital Administration of the proposed order, and consult with any designated persons or entity, such as the Bioethics Committee, an ethicist or the Hospital attorney.

8.7.3.2 Issuing the Order

a. All orders to withhold or withdraw life-sustaining treatment must be written and signed by a physician on the physician order sheet in the patient's medical record. The physician also must orally inform the Nursing Staff that such an order has been given to assure that the order is known and understood at the time it is written.

8.7.3.3 Oral Orders

a. Oral telephone orders will be accepted only if the physician is familiar with the patient and the medical record already includes documentation supporting the order.

8.7.3.4 No-CPR or Partial No-CPR Orders

a. CPR will be initiated when cardiac or respiratory arrest is recognized, unless a No-CPR Order is given. No resuscitative measures will be taken if the physician writes "No-CPR," "No Code," or "Do Not Resuscitate."

b. A "Partial No-CPR" or "Partial Do Not Resuscitate" order may be warranted in limited situations, such as when aggressive medical intervention is not indicated when a patient cannot survive the basic intervention. If a "Partial No-CPR" order is issued, the physician must specify precisely which modalities shall be used and which shall not.

8.7.3.5 Reviewing Other Treatments

a. The physician should assess whether to continue other treatments the patient is receiving, such as routine laboratory testing, antibiotics, use of a ventilator, and other treatments. It can be proper to discontinue some, but not all life-sustaining medical treatment.

8.7.3.6 Documentation

a. The orders to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the progress notes of all the circumstances surrounding the decision. The notes should summarize the medical situation and the patient's diagnosis and prognosis; the outcome of any consultations which other physicians; identify who are the decision-makers and describe the information they wee given and state their decision.

8.7.3.7 Disconnecting Equipment

a. The patient's physician shall be responsible for disconnecting medical devices (e.g., ventilators or IVs).

8.7.3.8 Maintaining Comfort

a. Every necessary procedure should be performed to relieve the patient's suffering and to maintain the patients comfort, hygiene, and intrinsic human dignity.

8.7.4 Dispute Resolution

8.7.4.1 In the event a dispute arises concerning the issuance of an order to withhold or withdraw treatment, the matter may be referred to the Bioethics Committee Chair via the Medical Staff Management Department, Administration, or any Nursing Director. Until the dispute is resolved, life-sustaining treatment should be provided and disputed No-CPR orders, if any, suspended.

8.7.4.2 Further guidance is provided in Hospital operational policies.

8.8 Medical Records

8.8.1 General

8.8.1.1 The patient's medical record serves a multitude of purposes, including those relating to primary patient care, continuity of patient care, quality improvement, medical research, and business documentation. Although the primary purpose of the record is to serve the interests of the individual patient, it also serves as the basis for quality improvement and utilization review activities. In addition, it may be used in connection with lawsuits, and thus serves a medico-legal function.

8.8.1.2 Records must be maintained for all patients who receive treatment at the Hospital, including inpatients, outpatients, and emergency patients.

8.8.2 Responsibility for the Record

8.8.2.1 The patient's Attending Physician and each Practitioner involved in the care of the patient shall be responsible for preparing a complete and legible medical record for each patient.

8.8.3 Completion of the Record

8.8.3.1 Timely Completion

a. Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care. Verbal orders must be countersigned by the Practitioner who issued the order within the time periods established in Rule 8.10 Orders.

b. Medical records must be completed promptly and authenticated or signed by a Practitioner within 14 days following the patient's discharge.

c. If a patient's record remains incomplete 14 days after discharge, it will be considered delinquent. The Hospital policy on completion of Medical Records and suspension for failure to complete records will be followed.

d. When all efforts to complete a record have been exhausted, the Health Information Committee may administratively close the record. This will be documented in the chart and the Practitioner's credential file.

e. A medical record shall not be permanently filed until it is completed by the responsible Attending Physician or is administratively closed by the Health Information Committee. The Health Information Committee may authorize the administrative closure of records under the following circumstances:

i. When the Practitioner is deceased;

ii. When the Practitioner has moved from the area;

iii. When the Practitioner has resigned form the Good Samaritan Hospital Medical Staff; or

iv. When the Practitioner is on an extended leave of absence.

f. The Chair of the Health Information Committee must sign and date a cover letter for the chart, stating the reason for the administrative closure.

8.8.3.2 Authentication

Each entry made in the record shall be authenticated. All orders and other approved documentation that specifically requests a Physician identification number must include the Physician identification number or have the Physician's name legibly stamped. Further it is recommended that all other entries (i.e., Progress Notes) also include the Physician identification number. Medical record entries may be authenticated by a signature, signature sent by fax or computer key. Electronic will be accepted only when the Practitioner has placed a signed statement in the Health Information Management Department conforming he or she is the only person who has possession of or access to the password for the electronic signature or the stamp and will use it.

8.8.3.3 Correction of the Medical Record

If it is necessary to correct an entry in a medical record, the person shall line out the incorrect data with a single line in ink, leaving the original writing legible. The person shall note the reason for the change, the date of striking, and sign the note. Appropriate cross-referencing shall be placed in the record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating Practitioner at the time the report is authenticated. Any cross-outs with or without reentries in the report should be noted as "error," dated, and initialed.

8.8.3.4 Dating and Timing of Entries

Each entry that is made in the record shall be dated and, when appropriate the time shall be noted. The date and time (if any) shall be the date and time that the entry is made, regardless of whether the contents of the note related to a previous date or time.

8.8.4 Contents

8.8.4.1 General

a. Each record shall contain sufficient detail and be organized in a manner which will enable a subsequent treating Practitioner or other health care provider to understand the patient's history and to provide effective care. The contents of the record must be legible in order to be useful. The medical record must be accurate; consequently, only those who are familiar with the patient's case will be allowed to make entries in the record.

8.8.4.2 History and Physical Examination Report

a. Physicians must include the adult immunization status of their patients in either a "full" or "abbreviated" H&P.

b. Abbreviated H&P

An abbreviated H&P is defined as an H&P that contains the following data elements:

i. A chief complaint.

ii. Details of the present illness.

iii. Past medical and surgical history pertinent to the operative or invasive procedure being performed, including current medications and allergies.

iv. Relevant past psycho-social history pertinent to the operative or invasive procedure being performed.

v. A relevant physical examination of those body systems pertinent to the operative or invasive procedure performed, but including at a minimum an appropriate assessment of the patient's cardiopulmonary status.

vi. A statement on the conclusions or impressions drawn from the history and physical examination.

vii. A statement on the course of action planned for the patient for that episode of care.

c. Interval H&P (Update Note)

An interval H&P is defined as a statement entered into the patient's medical record that a valid full or abbreviated H&P has been reviewed and that:

i. There are no significant changes to the findings contained in the full or abbreviated H&P since the time such H&P was performed; or

ii. There are significant changes and such changes are subsequently documented in the patient's medical record.

iii. It is recommended that the interval H&P be documented on or appended to the full or abbreviated H&P.

d. The requirement as to which type of H&P must be performed, and required timeframes are noted in the following table:

Type of History and Physical

Patient Type	H&P Requirements
Inpatient Admission, Except OB Admissions for Vaginal Delivery	A full H&P is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an update note must be entered into the record within 24 hours after admission.
Inpatient Surgical Procedure	A full H&P is required. If the surgery is performed more than 24 hours after admission, the admission H&P is considered the surgical procedure H&P as well. No update is needed since the physician progress note constitutes an "updating" of the patient's condition. If surgery is to be performed within the first 24 hours of admission, but an admission H&P has not been done, and H&P must be completed on the day of surgery prior to the start of the procedure and after the patient is admitted. In an emergent situation, the H&P should be completed as soon as possible after surgery. If surgery is to be performed within the first 24 hours of admission, and an H&P was performed prior to admission, an "update note" must be entered into the record on the day of surgery prior to the start of the procedure and after the patient is admitted. In an emergent situation, the "update note" should be completed as soon as possible after surgery.
Outpatient Surgical Procedure	A full or abbreviated H&P is required. The H&P must be completed no more than 30 days prior to surgery or on the day of surgery prior to the start of the procedure and after the patient is admitted. If the H&P was performed within 30 days prior to surgery, an "update note" must be entered into the record on the day of surgery prior to the start of the procedure and after the patient is admitted.
Outpatient Complex Invasive Procedure	A full or abbreviated H&P is required. The H&P must be completed no more than 30 days prior to the procedure or on the day of the procedure prior to the start of the procedure and after the patient is admitted. If the H&P was performed within 30 days prior to the procedure, an "update note" must be entered into the record on the day of the procedure prior to the start of the procedure and after the patient is admitted.
Observation Patient (non-surgical)	A full or abbreviated H&P is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P was performed within 30 days prior to admission, an "update note" must be entered into the record within 24 hours after admission.

Type of History and Physical

Patient Type	H&P Requirements
OB Admissions for Vaginal Deliveries	A full H&P, abbreviated H&P, or the patient's prenatal record is required. The H&P must be completed no more than 30 days prior to admission or within 24 hours after admission. If the H&P is performed within 30 days prior to admission, an "update note" must be entered into the record within 24 hours after admission. If the patient's prenatal record is used in lieu of an H&P, the last entry on the prenatal record must be within 30 days of admission and an "update note" must be entered into the record within 24 hours after admission. The prenatal record must be legible and transferred to the hospital before admission. Otherwise, an H&P must be done. Completion of the newborn record shall constitute an adequate medical history and physical assessment for newborns.

8.8.4.3 Inpatient Records

The inpatient record shall include the following elements:

a. Identification Sheets

The identification sheets ("face sheets") shall include the patient's name, address, identification number, age, sex, marital status, religion, date of admission, date of discharge, name, address and telephone number of a person responsible for the patient, initial diagnostic impression, discharge or final diagnosis, discharge attestation, other diagnoses, complications, procedures and consultants. The principal diagnosis must be recorded on discharge. This is defined as the condition established, after study, to be chiefly responsible for occasioning the patient's admission. When a patient is transferred to a different service or Practitioner, the face sheet and patient identification care shall be updated.

b. Admitting Note

An admitting note must be written in the progress notes on admission. The only exceptions are a.m. surgeries, when the Practitioner already has a history and physical examination report on the chart. The Admitting Note shall include an initial diagnostic impression (i.e., a concise statement of the complaints which led the patient to consult with the Practitioner), and a provisional diagnosis (i.e., the impression reflecting the examining Practitioner's evaluation of the patient's condition based upon the physical findings and history).

c. Consultation Reports

Consultation requests should be documented in the chart. Consultants should provide a written opinion that they sign, including findings on physical examination of the patient or of other data and information. (Refer to Rule 12.3 Consultations for further information on consultations.)

d. Order Sheets

Medication, treatment, and diet orders shall be entered on the order sheet. (Refer to Rule 12.10 Orders for further information on orders.)

e. Progress Notes

Progress notes shall be entered at least daily (excluding Skilled Nursing Unit [which requires weekly rounding] and Acute Rehab Unit [which requires rounding every 48 hours]) and more often when warranted by the patient's condition. The progress notes shall give a chronological picture of the patient's progress, and be sufficient to permit continuity of care and transferability. The progress note shall delineate the course and results of treatment.

f. Operative Reports

i. Operative reports shall include pre-operative and post-operative diagnosis, a description of the techniques used, a description of the findings, and a notation of any tissue removed or altered.

ii. All operative reports must be dictated immediately following surgery. The surgeon shall also enter a post-operative note in the progress notes immediately following surgery. The reports shall be promptly signed and dated by the surgeon.

g. Cancer Staging

All newly diagnosed cancer malignancies must be staged according to the Tumor, Nodes, and Metastases (TNM) scheme of the American Joint Committee on Cancer. The managing or treating physician is responsible for the cancer staging and for completed the Hospital's cancer staging form.

h. Nursing and Ancillary Notes

Notes and reports from the nursing, ancillary, and support staff and services involved in the patient's care shall be included in the patient record.

i. Discharge Summary

The discharge summary shall briefly recapitulate the significant findings and events of the patient's hospitalization, describe his or her condition on discharge, justify the patient's admission and the treatment provided, and identify the recommendations and arrangements for follow-up care, including discharge medications, dietary and activities advice. The discharge summary shall be dictated by the responsible Practitioner and completed within 14 days after the patient's discharge. If the patient was hospitalized for less than 48 hours for minor ailments, the abbreviated clinical resume format may be used.

j. Final Diagnosis

The discharge summary shall include a final diagnosis. It shall be recorded in full without the use of symbols or abbreviations.

k. Consent Forms

(See Rule 8.2 Consent for Medical and Surgical Procedures.)

l. Restraints

Restraints shall be used only when alternative methods are not sufficient to protect the patient or other from injury. A Practitioner's order must be obtained for each use of restraints. The order may be given in writing or orally. It must be time-limited and should include the reason for restraint and the type of restraint to be used. If Nursing Services staff initiate the restraints, an order for the restraints must be obtained within the time required by Hospital policy. Any verbal orders given for restraints must be countersigned by the Practitioner (or his or her covering Practitioner) on the next visit. The time within which a physician must evaluate the patient is as established by Hospital policy. The maximum time restraints may be continuously used is established by Hospital policy, as are the requirements for periodic observation of the patient, including a maximum time between observations.

8.8.4.4 Outpatient Records

Each outpatient record (including outpatient surgery records) shall include the following elements:

a. Identification sheet.

b. A record of the patient's medical history, including immunization record, screening tests, allergy record, and a neonatal history for pediatric patients.

c. A physical examination report.

d. Consultation reports.

e. Clinical note, including the dates of visits.

f. A record of treatment and instructions, including notation of any prescriptions written, diet instructions, if applicable, and self-care instructions.

g. Reports of all ancillary services, including laboratory tests, pathology reports, if tissue or body fluid was removed, and X-ray examinations.

h. If an operation was performed, a dictated operative report on the outpatient surgery describing the techniques used, the findings, and tissue removed or altered, as appropriate; a written record of pre-operative and post-operative instructions; and an anesthesia record. The operative report must be dictated immediately following surgery.

i. Referral information from other providers.

j. Consent forms. (See Rule 8.2 Consent for Medical and Surgical Procedures.)

8.8.4.5 Emergency Records

A record shall be kept for each patient receiving emergency services, which shall be incorporated into the patient's Hospital and outpatient record, and shall include at least the following information:

a. Adequate patient identification.

b. Information concerning the patient's arrival, means of arrival, and by whom transported.

c. Pertinent history of the injury or illness, including details regarding first aid or emergency care given the patient prior to his or her arrival at the Hospital.

d. A description of significant clinical, laboratory, and radiology findings.

e. Diagnosis.

f. A description of the treatment provided.

g. The condition of the patient upon discharge or transfer.

h. Final disposition, including instructions given to the patient and/or his or her family, relative to follow-up care.

i. The signature of the Practitioner in attendance who is responsible for the patient's treatment and for the clinical accuracy of the record.

8.8.5 Availability of Records

8.8.5.1 Records shall be maintained safely by the Hospital. Each Practitioner shall respect the confidentiality of physician-patient communications, information obtained in the course of diagnosing and treatment patients, and in medical records.

8.8.5.2 Records may be removed from the Hospital only in accordance with a court order, subpoena, patient authorization, or other authorization as allowed by California and federal law. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer.

8.8.5.3 Unauthorized removal of charts from the Hospital is grounds for corrective action against the Practitioner.

8.8.5.4 Charts stored off-premises will be purged on an as-needed basis by Hospital personnel and maintained by a professional storage service to assure confidentiality and security of the records.

8.9 Medications

8.9.1 General

8.9.1.1 All medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia National Formulary, American Hospital Formulary Service, or the American Medical Association Drug Evaluations, or newly approved medications that are not listed but have been approved by the Pharmacy and Therapeutics Committee.

8.9.1.2 Medications for bona fide clinical investigations are exceptions. Investigational drugs may be used only if the physician complies with the policy governing use of investigational drugs. All uses must be in compliance with the federal Protection of Human Subjects regulations, which are described in the California Healthcare Association Consent Manual. Investigational drugs must be dispensed by the Hospital pharmacy according to established procedure for handling investigational drugs.

8.9.1.3 Any Medical Staff Member who prescribes or administers narcotics must be registered and have current certification with the Drug Enforcement Administration. The Pharmacy shall be advised of any practitioner whose DEA certificate has expired or been limited.

8.9.2 Review of Medication Orders

8.9.2.1 Each physician is expected to review all medications for patients regularly to ensure discontinuation of orders that are no longer needed.

8.9.2.2 All prescribed medications in the following categories shall be automatically discontinued after the specified time:

a. Antibiotics

i. Seven days based on criteria recommended by the Pharmacy and Therapeutics Committee.

b. Controlled Substances (Schedule 2, 3, and 4)

i. Seventy-two hours (3 days).

c. Large Volume Parenterals

i. Seventy-two hours (3 days).

ii. Large volume parenterals refer to all continuous infusions 500ml or greater intended for volume replacement.

iii. Drips (vasoactive, antiarrhythmic, analgesic, etc.), IV piggybacks (H2 antagonists, antibiotics, etc.), and volume expanders (Hespan) are excluded from this category.

8.9.2.3 An automatic stop order does not apply when the prescriber specifies the number of doses or an exact and reasonable period of time.

8.9.2.4 A sticker placed on front of the chart will be used for notifying the physician when the next-to-last dose of a medication is given. When this occurs between 10:00 p.m. and 7:00 a.m., the orders will be automatically continued until 9:00 a.m., when the expiration order is called to the attention of the physician.

8.9.2.5 Orders for medications must be rewritten when:

a. Patients return from surgery.

b. Medication is to be resumed after an automatic stop order has been employed.

c. Patients are transferred to or from the ICU or a telemetry bed.

8.9.2.6 Practitioners must respond to pharmacist inquiries concerning particular patients within 48 hours and preferably within 24 hours.

8.9.3 Procurement of Medications

8.9.3.1 All medications shall be procured from the Good Samaritan Hospital pharmacy.

8.9.3.2 All medications brought to the Hospital by patients will be turned over for safekeeping to the nurses in charge of the patient's care and may be administered to the patiently only if the medication is clearly identified by the Hospital's pharmacist and specifically ordered by the patient's Attending Physician.

8.9.3.3 Under no circumstances may narcotics, barbiturates, or hypnotic drugs be brought into the Hospital by the Practitioner or the patient for administration to the patient at any time.

8.9.4 Orders

8.9.4.1 Substitution of Generic Drugs

a. The Pharmacy may generically substitute medications prescribed by a practitioner unless the practitioner clearly writes after the order for a trade (proprietary) medication, "do not substitute," or "dispense as written." The Pharmacy and Therapeutics Committee may develop policies and procedures relating to the therapeutic substitution of medications.

8.9.4.2 Medication Orders

a. Medication orders must be given as provided in Rule 8.10 Orders.

8.9.5 Medications Prescribed for Release to Patients on Discharge

8.9.5.1 Each medication released to a patient on discharge shall be recorded in the medical record.

8.9.5.2 When discharge medications are ordered, the nurse discharging the patient shall review with the patient (or if the patient is incompetent, a competent caregiver) the use and storage of each medication, the precautions and relevant warnings, and the importance of compliance with directions. The nurse will document completion of the counseling on the nursing discharge form.

8.9.5.3 When pre-printed instructions for medication utilization are given to the patient or family, the medical record should so indicate and a copy of the instruction sheet be filed with the medical record.

8.10 Orders

8.10.1 Treatment Orders

8.10.1.1 All orders for treatment shall be in writing until June 1, 2014. On and after June, 2014, orders must be entered electronically by the Hospital's Computerized Provider Order Entry (CPOE) unless pursuant to Rule 8.10.1.6 the provider is not required to and has not completed CPOE training or the orders cannot be placed electronically.

8.10.1.2 All orders for drugs and biologicals, with the exception of influenza and pneumococcal polysaccharide vaccines, must be documented and signed by a practitioner who is authorized to write orders and who is responsible for the care of the patient. Practitioners who are authorized to provide care include:

a. A doctor of medicine (MD) or osteopathy (DO);

b. A doctor of dental surgery (DDS) or dental medicine (DMD);

c. A doctor of podiatric medicine (DPM), but only with respect to functions which he or she is legally authorized to perform;

d. A clinical psychologist (Ph.D. or Psy.D.), but only with respect to clinical psychologist services, and to the extent permitted by law;

e. Nurse Practitioners (NP); and

f. Physician Assistants (PA).

8.10.1.3 Influenza and pneumococcal polysaccharide vaccines may be administered per physician-approved Hospital policy after an assessment of contraindications.

8.10.1.4 In accordance with standard practice, elements that must be present in orders for all drugs and biologicals to ensure safe preparation and administration include:

a. Name of patient (present on order sheet or prescription);

b. Age and weight of patient, when applicable;

c. Date and time of order;

d. Drug name;

e. Exact strength or concentration, when applicable;

f. Dose, frequency, and route;

g. Quantity and/or duration, when applicable;

h. Specific instructions for use, when applicable; and

i. Name of prescriber.

8.10.1.5 The Hospital promotes a culture in which it is not only acceptable, but also strongly encouraged, for staff to bring to the attention of the prescribing practitioner questions or concerns they have regarding orders. Any questions about orders for drugs or biologicals are expected to be resolved prior to the preparation, or dispensing, or administration of the medication.

8.10.1.6 All providers who are granted privileges to issue orders must successfully complete CPOE training on or before June 1, 2014, with the following exceptions:

a. Providers who issued fewer than 50 orders in the prior calendar year.

b. Providers who applied and were granted by the HIM Committee or the Medical Executive Committee an extension of the deadline (with such extensions not to exceed 90 days) to complete training irrespective, of these provisions, the providers who belong to a group, and all covering for that group, are required to be trained.

8.10.2 Verbal Orders

8.10.2.1 Verbal orders, if used, must be used infrequently (i.e., not a common practice). Verbal orders pose an increased risk of miscommunication that could contribute to a medication or other error, resulting in a patient adverse event. Verbal orders should be used only to meet the care needs of the patient when it is impossible or impractical for the ordering practitioner to write the order. Verbal orders are not to be used for the convenience of the ordering practitioner.

8.10.2.2 The content of each verbal order must be clearly communicated, using the Hospital's read-back verification practice. Verbal orders should be recoded directly onto an order sheet in the patient's medical record, and promptly documented in the patient's medical record and signed by the individual receiving the order.

8.10.2.3 Verbal orders must be counter-signed by the physician who issued the order or his covering physician within 48 hours for the administration of medications, on the next visit for the restraint orders, or within the timeframe as specifically set for any other type of order

8.10.3 Legibility

8.10.3.1 The Practitioner's orders must be written clearly, legibly, and completely. Orders which are unclear, illegible or incomplete will not be carried out until rewritten or understood by Nursing.

8.10.4 Cancellation of Orders on Transfer; Automatic Stop Orders

8.10.4.1 All previous orders are cancelled when w patient goes to surgery or the patient is admitted to the Intensive Care Unit or a telemetry bed.

8.10.4.2 Stop Orders

a. In addition to the automatic stop orders for medications prescribed in Rule 8.9.2.2, the following automatic stop orders will be in effect:

i. Restraints

24 hours

ii. Occupational Therapy and Rehabilitation Orders

30 days

iii. Outpatient Physical Therapy and Rehabilitation Orders

30 days

iv. Daily X-rays

3 days

v. Daily Laboratory Tests

3 days

vi. Respiratory Therapy on the Floors

3 days

vii. Physical Therapy on the Floors

3 days

b. The automatic stop order will not take effect of the order gives a specific number of treatments or days.

8.10.5 Standing Orders

8.10.5.1 Standing orders may be used for specified patients when authorized by a person licensed and given Privileges to issue the orders. A copy of standing orders for a specific patient must be dated, promptly signed by the Practitioner, and included in the patient's medical record. These standing orders must:

a. Specify the circumstances under which the orders are to be carried out.

b. Specify the medical conditions to which the standing orders are intended to apply.

c. Be specific as to the orders which are to be carried out, including all of the relevant information which usually is given in the order.

d. Be initially approved by the Health Information Committee, the appropriate Department, and the Medical Executive Committee and be reviewed at least annually by those committees and whenever any changes are made in the standing orders.

8.11 Outpatient Services

8.11.1 Services

8.11.1.1 Outpatient services shall include cardiology, chemotherapy, clinical laboratory services, gamma knife, gastroenterology, lithotripsy, pathology, physical therapy, pulmonary function, radiation oncology, radiology, rehabilitation, respiratory therapy, and surgery.

8.11.2 Registration of Outpatients

8.11.2.1 Patients referred for outpatient services must be registered to the Hospital's outpatient service. A record shall be created in accordance with Rule 8 Medical Records.

8.11.3 Written Orders

8.11.3.1 Patients shall receive outpatient therapy only upon the written order of and pursuant to the continuing supervision of a Medical Staff Member.

8.11.4 Outpatient Surgery

8.11.4.1 Eligible Cases

a. Any surgical procedure may be performed on an outpatient basis, provided the patient may be safely cared for on an outpatient basis.

8.11.4.2 Anesthesia

a. All types of anesthesia may be used for patients undergoing outpatient surgery.

8.11.4.3 Pre-Operative Evaluation

a. Each patient shall be evaluated pre-operatively by the surgeon, who shall be responsible for determining what surgical intervention is necessary and for securing the patient's informed consent for the surgery. In addition, if anesthesia other than a

local anesthesia will be used and administered by an anesthesiologist, the anesthesiologist shall be responsible for evaluating the patient pre-operatively, using the same standards that apply when surgery is performed on an inpatient basis. A short form H&P may be used, although a full H&P is preferred.

8.11.4.4 Informed Consent

a. Prior to the performance of surgery on an outpatient basis, the surgeon shall be responsible for assuring that an informed consent is secured for the procedure or that it is an emergency situation and that the emergency circumstances are documented in the record. (See Rule 8.2 Consent for Medical and Surgical Procedures.)

8.11.4.5 Specimens

a. All anatomical parts, tissues and foreign objects that are removed during surgery (except those exempted from review in the Surgery or Pathology Department Rules) shall be submitted to the Hospital pathologist for examination. The pathologist shall prepare a report on the findings from an examination of the specimen and a copy of the report shall be filed in the patient's medical record.

8.11.4.6 Pre-Operative Instructions

a. Patient's admitted for outpatient surgery should be given written pre-operative instructions which address:

i. Any restrictions on food and drug ingestion prior to surgery;

ii. Any special preparations the patient should make;

iii. Any post-operative instructions;

iv. A statement that admission to the Hospital may be required in the event of unforeseen circumstances.

8.11.5 Discharge

8.11.5.1 Each patient shall be examined by a licensed practitioner whose scope of licensure permits such examination prior to discharge from the Hospital.

8.11.6 Ordering Outpatient Examinations by Non-Attending Licensed Independent Practitioners

8.11.6.1 Outpatient clinical laboratory tests may be ordered by any licensed independent practitioner who holds a current license to practice in the State of California, including but not limited to, Doctors of Allopathic Medicine (MD), Doctors of Osteopathic Medicine (DO), Dentists (DDS), Oral and Maxillofacial Surgeons (DMD), Chiropractors (DC), Podiatrists (DPM), Physician Assistants (PA), and Licensed Acupuncturists (LAc).

8.12 Utilization Review

8.12.1 General

8.12.1.1 The Medical Staff must support the Hospital's Case Management and Utilization Management programs. Medical Staff Members must promptly respond to and cooperate with requests from the Hospital's Case Management and/or Utilization Management staff. It is unacceptable to ignore or be unresponsive to Case Management and/or Utilization Management staff.

8.12.1.2 The Performance Improvement Council is responsible for overseeing the development of Clinical Pathways to be used to promote efficient quality care in the selected disease model. All Practitioners who practice in the Hospital, as well as the Hospital employees, are strongly encouraged to use those Clinical Pathways that have been approved by the Medical Executive Committee A Practitioner who does not utilize recognized pathways must document in the medical record his or her clinical rationale for deviating from the pathway when asked to do so by a Medical Staff Committee.

8.12.2 Documentation of Medical Necessity

8.12.2.1 Each Attending Physician must document the need for his or her patient's admission, for the use of intensive resources (such as critical care beds), and for continued hospitalization.

8.12.2.2 The documentation shall include:

a. An adequate written record of the reason for admission, use of intensive resources, and continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

b. Plans for post-Hospital care.

8.12.3 Justification for Continued Hospitalization

8.12.3.1 Upon appropriate request, each Medical Staff Member is required to report to the Utilization Management Committee, or Chair, the necessity for continued hospitalization for any patient, including an estimate of the number of additional days of stay and the reason therefore.

8.12.4 Utilization Compliance and Enforcement Policies

8.12.4.1 Denial Process

a. Payor denial for hospitalization is often reversed on appeal. As a result it is expected that the Medical Staff will work with the Hospital to facilitate the most effective appeals.

i. Participation on the Call Panel will be revoked when a physician does not comply with the Hospital's attempts to appeal denials.

ii. As the process is time sensitive, physicians are expected to respond to Utilization / Case Management within 10 days of notification.

iii. Failure to respond within the time frame will result in revocation of Call Panel participation for the next 30 days.

iv. Physicians who respond after 10 days, but before 30 days will be allowed to serve on the Call Panel in the month following their panel revocation.

v. Physicians failing to respond, or who respond in a less-than-sincere fashion, will be deemed a revocation of participation on the Call Panel. They will also receive a letter from the Utilization Management Committee, which will be placed in their credentials file. Reinstatement will only occur at the discretion of the Utilization Management Committee.

8.12.4.2 Utilization Compliance

a. The Utilization Management Committee meets regularly to discuss current Hospital

admissions, and evaluates them as to necessity and appropriateness. Physicians who have patients that fall out of accepted utilization standards will be notified of this via letter. This letter is designed both for notification and education. A copy of this letter will be placed in the Physician's credentials file. The physician may respond to the letter and a copy of the same will be placed in the credentials file.

b. Repetitive need to notify physicians will result in the following:

i. Three letters in a given quarter or any two letters with >/= 2 items of concern in a given quarter is considered excessive.

ii. Any Physician who has this quantity of letters (or items) will be asked to attend the Utilization Management Committee. The Committee will then decide whether to place the Physician on Focused Review, as defined below:

8.12.4.3 Focused Review

a. All patients admitted, or deemed to be co-managed by the Physician in question will be assigned a case manager upon admission for a Focused Review.

b. Focused Review of all admissions will last for 30 days.

c. Physicians are expected to work with the Case Manager for the designated 30-days. Areas for review are:

i. Necessity of admission.

ii. Procedures consistent with the admitting DRG / ICD-9.

iii. Timely discharge planning.

iv. Utilization of resources.

d. Formal referral of the Physician to the Medical Executive Committee will occur if there is:

i. Non-compliance with the Focused Review, or unwillingness to work with Case Management.

ii. Two Focused Reviews in any 12-month period.

e. The Medical Executive Committee may chose to recommend suspension, remedial course work, and/or voluntary withdrawal of Privileges.

8.13 Patient Safety

8.13.1 Communication Among Caregivers

8.13.1.1 All Practitioners shall provide accurate information regarding their patient's care, treatment, current condition, safety issues, etc. when transitioning (or handing off) care to a covering Practitioner.

8.13.2 Medication Safety

8.13.2.1 All Practitioners shall ensure that a list of their patient's medications upon discharge is reconciled with the medication list created at the time of admission.

8.13.2.2 All Practitioners in the perioperative and other procedural settings both on and off the sterile field shall label medications and solutions that are not immediately administered.

a. In perioperative and other procedural settings both on and off the sterile field, labeling occurs when any medication or solution is transferred from the original packaging to another container. Medication or solution labels shall include the following:

i. Medication name

ii. Strength

iii. Quantity

iv. Diluent and volume (if not apparent from the container)

v. Preparation date

vi. Expiration date when not used within 24 hours

vii. Expiration time when expiration occurs in less than 24 hours

b. All medication or solution labels shall be verified both verbally and visually.

8.13.3 Patient Identification

8.13.3.1 All Practitioners shall use two patient identifiers when administering medications, blood, blood products, or other treatments / procedures.

8.13.4 Prevention of Wrong Site, Wrong Procedure, Wrong Person Surgery

8.13.4.1 All Practitioners shall be actively involved in their patient's time-out, using active communication:

a. A preprocedure process to verify the correct procedure, for the correct patient, at the correct site.

b. Items that must be available for the procedure, including:

i. Relevant documentation (history and physical, signed procedure consent form, nursing assessment, and preanesthesia assessment)

ii. Labeled diagnostic and radiology test results that are properly displayed

iii. Any required blood products, implants, devices, and/or special equipment for the procedure

c. The time-out, conducted immediately before starting the invasive procedure or making the incision, shall include the individual performing the procedure, the anesthesia providers, the circulating nurse, and operating room technician, and other active participants who will be participating in the procedure form the beginning.

d. During the time-out, the team members agree, at a minimum, on the following:

i. Correct patient identity

ii. The correct site

iii. The procedure to be done

8.13.4.2 Practitioners shall mark the procedure site, before the procedure is performed, and if possible, with the patient involved.

a. The marking shall be done by the licensed independent practitioner who is ultimately accountable for the procedure and will be present when the procedure is performed.

b. The method for marking shall be unambiguous and consistent with Hospital practice.

8.13.5 Hand Hygiene

8.13.5.1 All Practitioners shall comply with either the current Centers for Disease Control and Prevention (CDC) hand hygiene guidelines or the current World Health Organization (WHO) hand hygiene guidelines.

RULE 9: DEPARTMENT RULES

9.1 Department of Anesthesiology

9.1.1 Membership

9.1.1.1 The Department of Anesthesiology shall be composed of those physicians who specialize in the administration of anesthesia as their principal medical specialty and full-time profession. These physicians shall adhere to the philosophy that administration of anesthesia is a distinct specialty, which requires specialized education and unique requirements of judgment.

9.1.1.2 Membership to the Department of Anesthesiology shall be limited to the specialties of Anesthesiology, Pain Medicine, and Acupuncture.

9.1.1.3 Membership within the Department of Anesthesiology shall be limited to partners or subcontractors of the group holding the exclusive services contract with by the Hospital.

9.1.1.4 Membership shall be dependent upon performing sufficient anesthesia procedures on a continuing basis at the Hospital to maintain optimum professional proficiency and upon satisfactory attainment of all other requirements of the Medical Staff Bylaws and Rules. Accordingly, active participation on the Daily Call Schedule as well as service on appropriate Hospital and Medical Staff committees may, at the discretion of the Department Chief, be required of all members. The privilege of practicing anesthesiology at the Hospital carries with it the willingness and ability to cooperate in a professional manner with other members of the Department and the Medical Staff.

9.1.2 Definition of Anesthesiology

9.1.2.1 Anesthesiology is the practice of medicine dealing with, but not limited to:

a. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures.

b. The support of life functions under the stress of anesthetic and surgical manipulations.

c. The clinical management of the patient unconscious from whatever cause.

d. The application of specific methods of respiratory therapy.

e. The clinical management of various fluid, electrolyte, and metabolic disorders.

9.1.3 Requests for Specific Personnel

9.1.3.1 The Chief of the Department of Anesthesiology will attempt to honor reasonable requests for specific personnel, utilizing the following guidelines:

a. Patient requests for a particular anesthesiologist will be honored whenever possible. In the event such requests cannot be honored, an attempt will be made to contact the patient and/or surgeon with an explanation.

b. Physician requests based on a perceived need to the medical skills of a specific anesthesiologist will be given consideration. However, the smooth and efficient functioning of the operating rooms will not be compromised to honor such requests. In the event these requests cannot be honored, an anesthesiologist with sufficient skills will be assigned. Should this be unacceptable to the surgeon, he or she will be afforded the option to reschedule the case.

c. Requests not to work with a specific anesthesiologist must be made in writing to the Chief of the Department of Anesthesiology, stating the grounds for the request an dif the request is relative or absolute. Other physicians shall not be inconvenienced to honor such requests. In the event no other anesthesiologist is available, the surgeon will be afforded the option to reschedule the case.

d. In all such matters of anesthesia case management, the decision of the Chief of the Department of Anesthesiology shall be final.

9.1.4 Practice of Anesthesia

9.1.4.1 Availability

a. All patients (inpatients / outpatients / A.M. admissions / obstetrical) shall be evaluated pre-anesthetically by an anesthesiologist.

b. Pre-anesthesia assessment shall include, when circumstances permit:

i. Review of the medical record.

ii. Interview with the patient to discuss medical, anesthetic, and drug history to determine that the patient is an appropriate candidate to undergo the planned anesthesia.

iii. Immediately prior to induction of anesthesia, the patient is reassessed to determine that he or she is an appropriate candidate to undergo the planned anesthesia.

iv. Performance of investigations which would reasonably assist in decision-making regarding anesthetic management:

(1) Suggested database requirements are:

a. Hemoglobin (Hb) or Hematocrit (Hct) within 7 days.

b. Chem 7 (also known as basic metabolic panel [blood urea nitrogen, carbon dioxide, creatinine, glucose, serum chloride, serum potassium, and serum sodium]) profile within 7 days on all patients over 50 years of age, and on all patients taking medications for cardiac disease, hypertension, diuretics, or who have renal disease, or diabetes.

c. EKG (electrocardiogram), within past 6 months, done on all patients over 50 years of age, or in whom there is historical or physical reason to suspect cardiac abnormality.

d. Chest x-ray, within past 6 months, on patients over 50 years of age, or as indicated by history.

(2) When these or other studies are performed in a physician's office, or other outside facility, copies of the results or a statement of the findings should be affixed to the patient's medical record early enough to be reviewed by the anesthesiologist prior to the procedure.

(3) Exceptions may be made at the discretion of the attending anesthesiologist for emergency cases. Documentation of the emergent nature of the situation shall be made in the pre-operative evaluation.

(4) A complete and legible History and Physical examination must be available in the patient's medical record at the time the anesthesiologist personally evaluates the patient (this stipulation supports Rule 12.8.4.2 b).

(5) The surgeon and/or attending Physician shall be responsible for communicating to the anesthesiologist, in such a manner as to be clearly understood, any unusual problems known to them which may affect the administration of anesthesia.

(6) Pre-op abnormalities, drugs, or other medical conditions that might reasonably affect the conduct or risk of anesthesia should be noted in the medical record.

(7) Except in an emergency, no surgery shall be performed until the patient has been carefully studied, and the findings records in the medical record.

(8) A statement by the patient denying current pregnancy or a negative pregnancy test should be considered in any female of childbearing age scheduled for elective surgery.

v. Disputes between Surgeon and Anesthesiologist

(1) Readiness for Surgery

a. Whenever a serious question is raised regarding the readiness of a patient for elective or emergency surgery, consultation shall be obtained with the operating surgeon as soon as possible. Any substantial differences between

the surgeon and anesthesiologist regarding the appropriate anesthetic to be administered should be resolved prior to selection and implementation of a plan and disclosed to the patient, if appropriate.

(2) The anesthesiologist, in consultation with the physician in charge, should avail him or herself of any consultations, laboratory determinations, or diagnostic examinations, reasonably necessary or desirable, consistent with current community standards of medical practice in anesthesia.

(3) Withdrawal from Case

a. Whenever an anesthesiologist believes it necessary to withdraw from a case, consistent with his or her best professional judgment and in the best interest of the patient, he or she shall state his or her reasons in writing in the medical record. It is the prerogative of the anesthesiologist to withdrawn from such a case with cause. It is the privilege of the operating surgeon to obtain another anesthesiologist and/or consult with another anesthesiologist, reschedule, or cancel the case, consistent with current community standards of medical practice.

(4) The proposed anesthetic plans, procedures, risks, benefits, and alternatives and complications are discussed with the patient, all questions are answered and verbal consent is obtained and documented within the medical record. A notation of the patient's acceptance of the proposed anesthetic plan(s) is documented within the medical record.

(5) Preoperative Medications

a. Preoperative medications need not be restricted to sedatives and hypnotics, but may include anti-hypertensives, cardiac medications, or others that the anesthesiologist feels are necessary, consistent with current standards of practice.

b. When necessary, consultation will be arranged between the anesthesiologist and the patient's surgeon or other attending physician(s).

(6) The ultimate choice of technique is the prerogative of the attending anesthesiologist after discussion with the patient.

(7) Cases scheduled under "local" anesthesia, with or without sedation but without Department of Anesthesiology personnel in attendance will not be seen preoperatively. In such cases, the surgeon is responsible for all the duties that would normally fall to the anesthesiologist.

(8) Cases scheduled under "local standby (also know as Monitored Anesthesia Care [MAC]) will be seen and evaluated by an anesthesiologist as usual.

9.1.4.2 Intra-Operative Care

a. The anesthesiologist shall have an anesthesia machine in the anesthetizing area when appropriate, and shall be proficient in its use for anesthesia and resuscitation. He or she shall have read and be familiar with the operating manuals of the machine itself, and all associated monitoring equipment provided by the Hospital for intra or perioperative use.

All anesthesia machines and other equipment must be inspected and tested before use in accordance with the manufacturer's instructions. Anesthesia machines shall be equipped with a fail-safe system, pin index system, gas scavenging system, oxygen interlock system, and oxygen analyzer.

b. Prior to commending surgery, the person responsible for administering anesthesia shall verify the patient's identify and ascertain that the following is in the patient's medical record:

i. A History and Physical examination performed per Medical Staff Rules.

ii. An informed consent for anesthesia and surgery, completed pre-anesthesia evaluation as described in this Rule.

ii. Screening test based on the patient's needs recorded within the appropriate interval (as previously defined).

c. The surgeon and the surgeon's assistant (if any) shall be present prior to the induction of anesthesia. The anesthesiologist shall be in constant attendance and monitor the patient during anesthesia (except when the patient is on full cardiopulmonary bypass). The methods of monitoring shall be recorded in the medical record, in keeping with current community standards of care.

d. During anesthesia / surgery, vital signs (heart rate, temperature [when indicated], blood pressure, oxygen saturation, method of respirations) shall be monitored (and contemporaneously charted whenever possible).

e. During anesthesia / surgery, drugs and dosages, and time of administration shall be recorded. Unusual or significant clinical occurrences shall be noted within the medical record.

f. At the discretion of the surgeon, anesthesia and surgery may be started provided the assistant surgeon is present (if applicable).

g. Authorized members of the operating team shall be present during anesthesia and surgery. Observers in the OR will be limited to those persons within the medical and nursing fields who will benefit professionally from the direct teaching experience the surgery performed can provide. Special permission may be authorized in the Obstetrical Suite for the presence of a "support person" for the mother-to-be while awaiting delivery. This "support person" shall assume full responsibility for his or her actions and all consequences related thereto.

h. The use of explosive or flammable anesthetic agents is forbidden.

i. It shall be the responsibility of the anesthesiologist to communicate to the surgeon any untoward event or adverse drug reaction known to him or her that occurs while the patient is under his or her care.

j. The anesthesiologist will take every reasonable precaution, consistent with

applicable community standards of practice, to guarantee the safety of the patient during the anesthetic period.

i. Pursuant to the statement above, the Department of Anesthesiology recognizes that there are cases where appropriate care dictates that more than one anesthesiologist may be necessary. Therefore, the policy of the Department of Anesthesiology shall be that if an anesthesiologist requests the assistances of a colleague to ensure the appropriate care of a patient, an effort will be made to obtain the necessary assistance, including calling in other on-call personnel. The second anesthesiologist may receive a reasonable charge for such service.

k. All anesthetic apparatus' and equipment must be inspected by the anesthesiologist prior to use. If a problem is encountered, the equipment shall not be re-used until the fault is repaired and the fault shall be closely monitored if it is discovered during a case and it is necessary to continue to use the equipment until the completion of the case.

l. The following methods and practices shall be employed when possible for all patients undergoing anesthesia with Department of Anesthesiology personnel in attendance (epidural analgesia for labor is considered an exception, see below):

i. IV for all adult patients.

ii. EKG.

iii. Blood pressure measured and recorded a minimum of every 5 minutes.

iv. Inspired oxygen concentration (for general anesthesia).

v. Airway management by endotracheal tube in all cases where appropriate.

vi. For the patient with a full stomach, cricoid pressure and rapid sequence. induction or awake intubation should be considered.

vii. Suction shall be available and ready in the anesthesia area.

viii. Pulse oximetry shall be available and utilized.

ix. Ambu bag, oxygen source (tank and central).

m. Standard dress code shall be adhered to, as determined by Hospital policies for the Operating Room.

n. For outpatients or A.M. admissions, the patient shall sign a Patient Authorization form which certifies that he or she has been NPO (nil per os [nothing by mouth]) for the 8 hours immediately prior to the scheduled surgery. In the case of outpatients, the form shall also indicate that he or she will have a responsible adult to drive him or her home and that admission to the Hospital may be necessary.

o. The following standards apply to epidural analgesia when administered for relief of labor pain:

i. Oxygen, suction, and a means of providing oxygen by positive pressure ventilation (including endotracheal intubation(will be immediately available prior to the administration of the block.

ii. Appropriate fluids and drugs for treatment of hypotension, seizures, drug reactions, and other complications, which could reasonably be expected to occur, shall be immediately available prior to the administration of the block. An intravenous catheter shall be in place prior to the block being performed.

iii. Following initial placement of the catheter and after each "top up" dose, the anesthesiologist will take and record the vital signs as often as he or she feels is clinically indicated (but not less than every 5 minutes x3 or longer) until he or she is satisfied that the patient is stable and probability of an adverse reaction to the block is minimal.

iv. Between "top up" doses, or throughout the duration of a continuous infusion epidural technique, the anesthesiologist will visit and examine the patient as often as is clinically indicated. Vital signs shall be recorded at a minimum, every 30 minutes.

9.1.4.3 Post-Operative Visits

a. Following the administration of anesthesia, the anesthesiologist, or his or her designee, shall remain with the patient as necessary according to his or her best medical judgment and consistent with community standards of medical practice. The anesthesiologist shall make a post-anesthetic visit and record his or her findings in the medical record. Complications of anesthesia, when recognized, shall be properly documented within the medical record.

9.1.4.4 Local Anesthesia

a. When a surgeon undertakes a case under local anesthesia without Department of Anesthesiology personnel in attendance, he or she assumes all of the responsibilities which would normally be undertaken by the anesthesiologist. The Department of Anesthesiology considers each surgeon to be a licensed independent practitioner and has no obligation to provide backup assistance in the vent of an untoward reaction.

9.1.4.5 Post-Operative Care

a. Responsibility

i. The Chief of the Department of Anesthesiology shall be responsible for the medical administration of the Recovery Room. In general, physicians shall be responsible for the patient's medical care and Nursing shall be responsible for the patient's nursing care in the Recovery Room or other Post Anesthesia Recovery area (PAR).

ii. The Department of Anesthesiology and Nursing Administration shall jointly formulate policies and procedures for patient care by PAR personnel.

b. A patient shall not be removed from the Operating Room until the practitioner administering anesthesia is satisfied with the patient's stability.

c. All patients having undergone anesthesia with Department of Anesthesia personnel in attendance shall be taken to the PAR.

d. Patients entering the recovery room shall be accompanied by the attending anesthesiologist.

e. The care of the post-anesthetic patient shall not be delegated by the anesthesiologist to PAR personnel until the anesthesiologist has ascertained that the patient's condition is such that the patient may safely be transferred from the immediate supervision of a physician to that of a PAR facility.

f. The status of the patient at the time of supervision is transferred to the PAR facility shall be recorded.

g. The anesthesiologist is required to discuss, and document where appropriate, the care of the patient with PAR personnel at the time the general care of the patient is passed to the nurse. Such discussion should include anesthetic technique used, surgery performed, untoward reactions or unusual incidents, special orders of precautions if indicated, and any special therapy.

h. In addition to specific orders, routine PAR care shall be given to each patient and is to include:

i. Vital signs (blood pressure, heart rate, respiratory rate) taken every 5 minutes x3 or longer until stable, then every 15 minutes until discharge from the PAR. Continuous pulse oximetry monitoring is to be done on all patients until the patient is fully awake. Further monitoring of oxygen saturation will be done if clinically indicated.

ii. IVs are to be kept running during transport to the ward or related care facility. IVs may be discontinued upon order of the attending physician.

iii. Restraints are to be used when necessary to prevent patients from falling or otherwise injuring themselves or others. The anesthesiologist in charge shall be informed immediately when they are utilized.

iv. Unless otherwise ordered, all patients shall receive supplemental oxygen, which shall continue, until the patient is fully awake.

v. Suction shall be immediately available at each recovery station. Tonsil (yankaur) and tracheal suction catheters shall also be immediately available.

vi. Consultation with the anesthesiologist and/or surgeon should be obtained and recorded as necessary.

vii. Orders for PAR care (analgesics, fluids, medications, etc.) may be written by the surgeon, anesthesiologist, or other attending physician. When a non-anesthesiologist requests the nurse to discontinue or alter an order previously written by the attending anesthesiologist, the nurse will (when time permits) inform the anesthesiologist of the requested change. If appropriate, the anesthesiologist and surgeon shall confer and jointly decide upon an appropriate course of action.

i. When patients have received anesthesia services, an anesthesiologist who is familiar with the patient is responsible for the decision to discharge the patient from the recovery room when the patient is being discharged home directly (refer to "n" below).

j. A discharge order is not necessary if the patient is being transferred to the ICU or another unit / ward in the Hospital. However, criteria according to Hospital PAR policies must be met for discharge to another unit / ward (refer to "m" below).

k. The anesthesiologist shall remain available to PAR personnel for consultation or further care of his or her patient as may be required until the patient is discharged from the recover room, or in the case of ambulatory patients, from the Hospital. In the event the anesthesiologist cannot be available for such consult, another member of the Department of Anesthesiology who is familiar with the patient's treatment and progress may be designated for this function. This may be the anesthesiologist on-call.

l. The responsibility for patients in the PAR is a joint one shared by the surgeon and the anesthesiologist. Requests for assistance by PAR personnel shall evoke immediate and appropriate response on the part of all physicians involved.

m. Anesthesiologists shall require the following criteria in all patients prior to discharge from the PAR:

i. An Aldrete post anesthesia score of at least 8.

ii. Vital signs stable.

iii. Swallow, cough, and gag reflex present.

iv. Minimal nausea and vomiting.

v. Appropriately responsive and oriented.

vi. Dressing checked and showing minimal postoperative bleeding or drainage.

vii. Evaluation for transfer shall be not less than 45 minutes following administration of any narcotics or sedatives (except where patient is receiving Patient-Controlled Analgesia).

n. In addition, the following apply to patients discharged home from PAR:

i. Ability to ambulate or manage appropriate aids for ambulation within the level of assistance available at home.

ii. Minimal dizziness.

iii. Ability to void (or patient is instructed to contact physician if he or she does not void within the next 8 hours).

iv. Ability to tolerate liquids and/or light nourishment.

v. Patient has been examined by the appropriate physician(s) and shall be discharged by a physician.

vi. Take home medications and prescriptions given to the patient.

vii. Responsible adult present to accompany the patient home.

viii. Discharge instruction sheet given to the patient and information reviewed with the patient and responsible adult accompanying the patient.

o. The PAR is not to be used as a substitute for routine postoperative floor care (i.e., outpatients undergoing prolonged surgical procedures and requiring prolonged observation are to be admitted).

p. If no anesthesiologist is involved in the care of the patient, the surgeon shall perform those duties in the recovery room for which an anesthesiologist would normally have been responsible.

q. All incidents and untoward reactions shall be recorded in the PAR record by recovery room personnel. In addition, the appropriate quality improvement procedures will be followed by PAR personnel.

r. The responsible physician shall be notified immediately of any deterioration of the patient's condition.

s. If PAR personnel are absent, patients are to recover in an intensive care area. In such cases, the above shall apply as if the patient were in a recovery room.

9.1.4.6 Complications

a. In addition to routine quality improvement activities, the Department of Anesthesiology will thoroughly investigate all allegations of improper anesthetic management by its members in accordance with the Medical Staff Bylaws and Rules.

9.1.4.7 Equipment and Safety

a. Anesthetic devices shall be inspected per appropriate schedule as established by the vendor, other technological expert used, or by Biomedical Engineering, and a log of such inspection dates shall be maintained.

b. Prior to administration of anesthesia, the anesthesiologist shall check the readiness, availability, cleanliness, sterility (where required), and working condition of all equipment utilized in the administration of anesthetic agents.

c. Laryngoscopes, airways, breathing bags, masks, tubes, and all reusable equipment in direct contact with the patient shall be cleaned after each use in accordance with established Hospital policies and procedures.

d. All equipment in the surgical suite, which requires grounding, shall be fitted with grounding devices to maintain a constant conductive path to the floor. The electrical equipment and various electronic devices shall be inspected regularly by the appropriate engineer and a log of such inspection dates shall be maintained.

e. Humidity levels of Operating Rooms shall be maintained between 50% and 60%. A humidifier shall be in each room and a humidity gauge with a daily record shall be maintained.

f. Patients shall be attached to the operating table only via a conductive strap. A pad of conductive material will cover the operating table.

g. Should the isolation monitor (ground contact indicator) indicate a hazard during an operative procedure, use of electrical gear shall be discontinued as soon as possible.

h. With the exception of certain radiology equipment and of fixed lighting more than 5 feet above the floor, all electrical equipment in areas with conductive flooring must be on a floating electrical circuit with a ground contact indicator. When a line isolation monitor indicates a hazard, the use of any electrical gear is prohibited. Following completion of the procedure, the operating room from which the signal emanated should not be utilized until the defect is corrected. Line isolation monitors are to be tested and recorded per Biomedical Engineering policies and procedures.

i. The condition of the operating room electrical equipment such as cords, plugs, switches, and various electronic devices shall be inspected regularly by qualified Hospital personnel. Written records of the results of such tests shall be kept per established Hospital policies and procedures.

j. All anesthetic machines shall be checked and serviced by their respective manufacturers or a qualified maintenance service at least every 4 months or sooner if necessary. Written records of such maintenance shall be kept per established Hospital policies and procedures.

k. An independent agency shall evaluate waste gas concentrations in all anesthetizing areas, the PAR, and tank storage areas at least every 6 months to ensure compliance with State and federal safety mandates. When problems are identified, prompt correction action(s) shall be taken. Written records of such evaluations shall be kept established Hospital policies and procedures.

9.1.4.8 Additional Recommendations

a. The following standards and methods of practice are recommended for all anesthesia cases, subject to the professional judgment of the individual anesthesiologist and consistent with appropriate community standards of medical practice:

i. Personnel

(1) All personnel shall comply with established Operating Room and Hospital-wide policies and procedures.

ii. Anesthesiologists shall take appropriate precautions to ensure that physician-to-patient as well as patient-to-physician cross-contamination does not occur.

iii. Equipment

(1) Use and care of equipment (i.e., regional trays, disposables, circuits, filters, anesthesia machines, etc.) shall be per established Hospital policies and procedures.

9.1.5 Administrative Responsibilities

9.1.5.1 The Chief of the Department of Anesthesiology shall be responsible for the performance of the members of the Department, as specified by the Medical Staff Bylaws and Rules.

9.1.6 Obstetrical Anesthesia

9.1.6.1 General Anesthesia

a. Prior to administration of a general anesthetic, the following shall be checked:

i. Resuscitation equipment

(1) Ambu bag / mask.

(2) Oxygen tank adequately filled.

(3) Oxygen from central source (availability of Crash Cart, per Hospital policy).

ii. Suction connected and working.

iii. Anesthesia machine.

iv. Appropriate patient monitors to include, at least:

(1) EKG.

(2) Pulse oximeter.

(3) Automated blood pressure machine.

(4) Pericardial stethoscope.

v. Appropriate airway equipment include, at least:

(1) Laryngoscope.

(2) Endotracheal tube.

(3) Mask.

(4) Oral and nasal airways.

vi. Functioning IV.

vii. Appropriate drugs / expiration dates.

9.1.6.2 Regional Anesthesia

a. Prior to the institution of block for labor epidural

i. An obstetrician must be on the Hospital grounds.

ii. For cesarean section, the obstetrician or an assistant capable of performing the procedure must be in the Labor and Delivery suite.

9.1.6.3 Labor Epidural

a. Prior to the administration of a labor epidural, the following shall be checked:

i. Resuscitation equipment:

(1) Ambu bag / mask.

(2) Oxygen tank adequately filled.

(3) Oxygen from central source (availability of Crash Cart, per Hospital policy).

ii. Suction connected and working.

iii. Appropriate patient monitors to include, at least:

(1) EKG.

(2) Automated blood pressure machine.

(3) Pericardial stethoscope.

iv. Appropriate airway equipment include, at least:

(1) Laryngoscope.

(2) Endotracheal tube.

(3) Mask.

(4) Oral and nasal airways.

v. Functioning IV.

vi. Appropriate drugs / expiration dates.

b. Analgesia can be provided with either:

i. Intermittent injection.

ii. Continuous infusion.

ii. All patients shall be attended by a physician or licensed nurse when in active labor, during delivery, and in the immediate postpartum period.

c. For continuous infusion and intermittent injection

i. The following vital signs will be monitored regularly, every 5 minutes x3, then every 30 minutes. Rate of infusion will be changes by the anesthesiologist only:

(1) Blood pressure.

(2) Respiration rate.

(3) Heart rate.

ii. Between "top up" doses, or throughout the duration of a continuous infusion epidural technique, the anesthesiologist will visit and examine the patient as often as is clinically indicated. Vital signs shall be recorded at a minimum of every 30 minutes.

iii. Nursing will

(1) Ensure supine position is avoided if clinically indicated.

(2) Turn the patient one side to the other every 30 minutes if clinically indicated.

(3) Instruct the patient to move legs every 30 minutes and notify the anesthesiologist if the patient is unable to do so.

(4) Assess the degree of pain relief and notify the anesthesiologist if it is inadequate.

9.1.6.4 Recovery Room

a. The anesthesiologist on call for the Perinatal Unit will supervise the immediate post-anesthesia recovery of the obstetrical patient who received general or regional anesthesia.

b. Length of initial recovery period for the postpartum patient is dependent upon the type of anesthesia used during delivery and the patient's recovery from the anesthetic agent. All patients who receive anesthesia will remain in the recovery phase for a sufficient amount of time (as defined by Hospital obstetrics policies and procedures) to meet discharge or transfer criteria. The patient may be discharged or transferred when vital signs are deemed stable. (For spinal or epidural anesthesia see the applicable section below.)

9.1.6.5 Anesthesia Coverage and Equipment

a. An anesthesiologist from the Department of Anesthesiology will be assigned in-house to cover the 24-hour obstetrical needs. If a second anesthesiologist is required, either the obstetrician, anesthesiologist, or OB charge nurse must contact the O.R. first call anesthesiologist.

b. The obstetrical anesthesiologist must keep Labor and Delivery advised at all times as to where he or she can be located and/or carry a pager.

c. The Chief of the Department of Anesthesiology must be notified of irregularities specific to anesthesia coverage.

d. First and second call will do their assigned line-ups. The appropriate call person will perform all add-ons.

e. All anesthesia equipment in Labor and Delivery shall be checked on a regular basis by anesthesiologists and/or an anesthesia technician. Maintenance shall be provided in the same manner that all other anesthesia equipment at Good Samaritan Hospital is maintained.

9.1.6.6 Types of Anesthesia That May Be Performed on the Obstetrics Unit

a. General Anesthesia

i. Endotracheal

(1) Direct laryngoscopy.

(2) Fiberoptic laryngoscopy.

ii. Monitored Anesthesia Care (MAC)

(1) Administration of drugs by any route for moderate sedation.

(2) Straight local without sedation.

iii. Regional Techniques

(1) Epidural (with local anesthetic, narcotic or blood injection).

(2) Spinal (with local anesthetic or narcotic injection).

iv. Special Techniques

(1) Arterial line.

(2) Central venous line.

(3) Patient-controlled analgesia (PCA).

(4) Pulmonary artery catheter (PAC) placement with or without pacing capability.

9.1.7 Aldrete Post Anesthesia Scoring System

		Score
Activity		
	Able to move 4 extremities voluntarily on command	2
	Able to move 2 extremities voluntarily on command	1
	Able to move 0 extremities voluntarily on command	0
Respiration		
	Able to deep breathe and cough freely	2
	Dyspnea or limited breathing	1
	Apnea (or requiring mechanical ventilation)	0
Circulation		
	Blood pressure +/- 20% of preanesthetic level	2
	Blood pressure +/- 20%-50% of preanesthetic level	1
	Blood pressure +/- 50% of preanesthetic level	0
Consciousness		
	Fully awake	2
	Arousable upon command	1
	Not responding	0
Color		
	Pink	2
	Pale, dusky, blotchy, jaundiced	1
	Cyanotic	0

9.1.8 Spinal or Epidural Anesthesia

9.1.8.1 The following standard information is given to Nursing upon admission to the recovery room (note: these standards also apply to the recovery of all patients – post general and/or regional anesthesia):

a. Patient's name and age.

b. Surgical procedure.

c. Preoperative medication and type of medication used.

d. Intraoperative drugs used (sedatives, vasopressors, cardiac dysrhythmics, antiemetics, etc.).

e. Preoperative vital signs.

f. Co-existing medical disease and associated defects.

g. Preoperative drug therapy.

h. Allergies.

i. Intraoperative estimated blood loss and measure urine output.

j. Intraoperative fluid and blood replacement.

k. Anesthetic and surgical complication.

l. Special medications or procedures that will be necessary in the recovery room.

m. The current dermatomal level of sensory blockade (regional anesthesia only).

9.1.8.2 The following will be used on all patients:

a. EKG.

b. Pulse oximeter.

c. Blood pressure monitoring.

9.1.8.3 In addition to routine recording of vital signs, the patient will be assessed a minimum of once every 30 minutes for return of motor function and sensation.

9.1.8.4 When sensation has returned to baseline, and the patient is able to dorsiflex the feet and raise the legs, the patient may be discharged from the PAR only if vital signs are stable and there ahs been a minimum of 1 hour recovery time.

9.1.9 Neonatal Anesthesiology

9.1.9.1 All neonatal anesthesia cases will require the presence of a neonatologist.

9.2 Department of Emergency / Family Medicine

9.2.1 Membership

9.2.1.1 Membership to the Department of Emergency / Family Medicine shall be limited to the following specialties:

a. Emergency Medicine.

i. Fast Track.

b. Family Medicine.

c. House Physician (Internal Medicine).

d. Primary Care Physician (Internal Medicine).

9.3 Department of Medicine

9.3.1 Membership

9.3.1.1 Membership to the Department of Medicine shall be limited to the following specialties:

a. Allergy and Immunology.

b. Dermatology.

c. Internal Medicine.

i. Cardiovascular Disease.

(1) Clinical Cardiac Electrophysiology.

(2) Interventional Cardiology.

ii. Critical Care Medicine.

iii. Endocrinology, Diabetes, and Metabolism.

iv. Gastroenterology.

v. Geriatric Medicine.

vi. Hematology.

vii. Hospice and Palliative Medicine.

viii. Infectious Disease.

ix. Medical Oncology.

x. Nephrology.

xi. Pulmonary Disease.

xii. Rheumatology.

xiii. Sleep Medicine.

xiv. Sports Medicine.

d. Neurology.

e. Physical Medicine and Rehabilitation.

f. Preventative Medicine.

i. Aerospace Medicine.

ii. Occupational Medicine.

iii. Preventive Medicine.

iv. Undersea and Hyperbaric Medicine.

g. Psychiatry.

i. Child and Adolescent Psychiatry.

ii. Geriatric Psychiatry.

9.4 Department of Obstetrics and Gynecology

9.4.1 Membership

9.4.1.1 Membership to the Department of Obstetrics and Gynecology shall be limited to the following specialties:

a. Medical Genetics

i. Clinical Genetics.

b. Obstetrics and Gynecology

i. Gynecologic Oncology.

ii. Gynecology only.

iii. Maternal and Fetal Medicine (Perinatology).

iv. Obstetrics only.

v. Reproductive Endocrinology and Infertility.

9.4.2 Assistants

9.4.2.1 All gynecologists performing major surgery are responsible for having a qualified assistant surgeon present. An assistant surgeon must be a licensed physician or otherwise qualified Allied Health Practitioner.

9.4.3 Family Practitioners

9.4.3.1 In all maternity cases admitted to the Hospital by a Family Practitioner not specializing in obstetrics, consultation is required for the following conditions:

a. All prolonged labors or patients who have not delivered within 24 hours of admission for labor.

b. All cases for induction or augmentation of labor.

c. All forceps or vacuum extraction deliveries.

d. Any malpresentations, e.g., breech, face, shoulder.

e. Any complicated or high risk case, such as:

i. Pregnancy-induced hypertension.

ii. Eclampsia.

iii. Placenta previa or unexplained vaginal bleeding.

iv. Suspected abruption placentae.

v. Pre-term labor.

vi. Multiple gestation.

vii. Vaginal birth after Cesarean section.

viii. Fetal distress or abnormal fetal heart rate pattern.

ix. Medical complications concurrent with pregnancy.

x. Fourth degree or any cervical or vaginal laceration.

9.4.4 Care of Unregistered Patients Admitted from the Emergency Department

9.4.4.1 A schedule of physicians taking emergency call will be available in the Emergency Department and on the Perinatal Unit. These physicians must be members of the Active or Courtesy staff.

9.4.4.2 The Emergency Department physician will evaluate and, if possible, transfer the patient. If conditions do not permit transfer, or in any uncertain situation, the on-call physicians, or his or her designee, shall be notified. No patient should be admitted to the Perinatal Unit without prior authorization from the on-call physician or his or her designee, and from the Perinatal charge nurse. If the Emergency Department physician requests the consultation of the attending physician or his or her designee, such consultation must be performed or the Chief of the Department of Obstetrics and Gynecology shall be notified.

9.4.5 On-Call House Physician Duties and Responsibilities

9.4.5.1 The duties and responsibilities of on-call physicians are as follows:

a. First call for walk-in obstetric patients:

i. Complete management.

b. First call for walk-in gynecologic patients:

i. Complete management.

c. Cover any emergency on the Perinatal Unit.

d. Provide general obstetrics and gynecology ultrasound or limited consultation to private physicians upon request under supervision of the staff maternal-fetal medicine specialist on-call.

e. Weekend morning rounds on walk-on obstetric patients.

f. Assist private physician at Cesarean section or other instrumented vaginal delivery upon request.

9.4.6 Certified Nurse Midwives

9.4.6.1 All Certified Nurse Midwives must be certified by the American College of Nurse Midwives and meet the credentialing criteria outlined for Allied Health Practitioners.

9.4.6.2 A Certified Nurse Midwife is authorized, under his or her supervising physician, to attend cases of normal childbirth and to provide prenatal, intrapartum, and postpartum care. All complications must be referred to his or her supervising physician immediately. The practice of midwifery does not include the assisting of childbirth by an artificial, forcible, or mechanical means, nor the performance of antepartum version. Supervision shall not be construed to require the physical presence of a supervising physician, but a supervising physician must be immediately available.

9.4.6.3 In all cases below, the supervising physician should be consulted:

a. All prolonged labors or patients who have not delivered within 24 hours of admission for labor.

b. All cases for induction or augmentation of labor.

c. All forceps or vacuum extraction deliveries.

d. Any malpresentations, e.g., breech, face, shoulder.

e. Any complicated or high risk case, such as:

i. Pregnancy-induced hypertension.

ii. Eclampsia.

iii. Placenta previa or unexplained vaginal bleeding.

iv. Suspected abruption placentae.

v. Pre-term labor.

vi. Multiple gestation.

vii. Vaginal birth after Cesarean section.

viii. Fetal distress or abnormal fetal heart rate pattern.

ix. Medical complications concurrent with pregnancy.

x. Fourth degree or any cervical or vaginal laceration requiring repair.

9.4.6.4 Certified Nurse Midwives may assist in a Cesarean section only in an emergency, only after the following emergency priority sequence has been exhausted by Nursing:

a. On-call house physician.

b. Any available physician on the floor.

c. Any Certified Nurse Midwife.

9.4.7 Physician Response

9.4.7.1 The attending physician should make every effort to respond to Labor and Delivery calls in an expedient manner. The attending physician or his or her designee should also make every effort to be available for delivery of his or her patient. Repetitive infractions of this policy will be brought to the attention of the Chief of the Department of Obstetrics and Gynecology.

9.4.8 Nursery

9.4.8.1 Infants may be admitted to the Nursery by a board certified or qualified Pediatrician or Family Practitioner.

9. 5 Department of Pathology

9.5.1 Membership

9.5.1.1 The Department of Pathology shall be composed of those physicians who specialize in pathology as their principal medical specialty and full-time profession. These physicians shall adhere to the philosophy that pathology is a distinct specialty, which requires specialized education and unique requirements of judgment.

9.5.1.2 Membership to the Department of Pathology shall be limited to the following specialties:

a. Anatomic Pathology.

b. Blood Banking Medicine / Transfusion Medicine.

c. Chemical Pathology.

d. Clinical Pathology.

e. Cytopathology.

f. Dermatopathology.

g. Hematology.

h. Surgical Pathology.

9.5.1.3 Membership within the Department of Pathology shall be limited to partners or subcontractors of the group holding the exclusive services contract with by the Hospital.

9.6 Department of Pediatrics

9.6.1 Membership

9.6.1.1 Membership to the Department of Pediatrics shall be limited to the following specialties:

a. Pediatrics

i. Neonatal-Perinatal Medicine.

ii. Neonatology Fellow.

iii. Pediatric Cardiology.

9.6.2 Neonatology Fellows

9.6.2.1 Duties

a. Cover any emergency on the Perinatal Unit for newborn babies in the normal nursery.

b. Admit and manage neonatal patients in the Neonatal Intensive Care Unit under the direction of the attending neonatologist.

c. Attend Cesarean sections and high-risk deliveries when request by obstetric staff.

d. Respond to Emergency Department staff when requested to attend to a newborn patient.

9.7 Department of Radiology

9.7.1 Membership

9.7.1.1 The Department of Radiology shall be composed of those physicians who specialize in radiology as their principal medical specialty and full-time profession. These physicians shall adhere to the philosophy that radiology is a distinct specialty, which requires specialized education and unique requirements of judgment.

9.7.1.2 Membership to the Department of Radiology shall be limited to the following specialties:

a. Radiology.

i. Diagnostic Radiology.

ii. Neuroradiology.

iii. Radiation Oncology.

iv. Vascular and Interventional Radiology.

b. Nuclear Medicine.

9.7.1.3 Membership within the Department of Radiology shall be limited to partners or subcontractors of the group holding the exclusive services contract with by the Hospital.

9.8 Department of Surgery

9.8.1 Membership

9.8.1.1 Membership to the Department of Surgery shall be limited to the following specialties:

a. Colon and Rectal Surgery.

b. Neurological Surgery.

1. Spine Surgery.

c. Ophthalmology.

d. Orthopaedic Surgery.

i. Hand Surgery.

ii. Podiatry.

iii. Spine Surgery.

e. Otolaryngology.

i. Dentistry.

ii. Neurotology.

iii. Oral and Maxillofacial Surgery.

f. Plastic Surgery.

g. Surgery.

i. General Surgery.

ii. Vascular Surgery.

h. Thoracic Surgery.

i. Cardiothoracic Surgery.

i. Urology.

9.8.2 Surgeon's Responsibility

9.8.2.1 No surgery shall be performed until the patient has been appropriately studied preoperatively, the History and Physical examination (H&P) has been written and/or dictated and appropriate laboratory examinations have been completed. The preoperative diagnosis and the H&P should be recorded and signed by the operating surgeon or by his or her designee prior to surgery.

9.8.2.2 The patient may not be brought into the Operating Room until:

a. The surgeon and assistant (if required) are on Hospital premises.

b. The H&P is on the medical record.

c. The appropriate laboratory studies are on the medical record.

d. The appropriate consent has been signed, dated, and witnessed, and on the medical record.

e. The only exception to this rule is a life-threatening emergency.

9.8.2.3 Preoperative medications are to be prescribed only by a licensed physician who has seen and evaluated the patient.

9.8.2.4 Surgeons must be in the Operating Room and ready to commence the operation at the scheduled time.

a. Practitioners who are late and not ready to proceed with the case within 15 minutes of the scheduled time may have their case delayed. This will be at the discretion of the next scheduled surgeon in that room.

b. Practitioners arriving late (more than 15 minutes) twice within a six-month period may be barred from scheduling a 07:30 case for 6 months.

9.8.2.5 The surgeon must satisfy him- or herself as to the identity of the patient and the site and side of the body to be operated on prior to the administration of anesthesia.

9.8.2.6 Operations performed at the Hospital will be done by physicians, dentists, and podiatrists that have been granted surgical privileges. A non-surgeon may assist in these operations after he or she has been granted assisting privileges by the Department of Surgery. A non-surgeon will not be the responsible surgeon.

9.8.2.7 It is the responsibility of each attending physician to be available to his hospitalized patients. In his or her absence, the physician must arrange coverage for his or her practice. The name and telephone number of the covering physician must be available through the attending physician's answering service on a 24-hour-a-day, 7-day-a-week basis and/or should be recorded on the physician's order sheet for each patient. The covering surgeon shall have the same privileges as the attending surgeon.

9.8.2.8 The surgeon is responsible for the proper preoperative preparation of the patient. Minimizing the risk of the operation, while providing maximal opportunity for a satisfactory outcome requires a full appreciation by the surgeon for the patient's condition. Achieving optimal preoperative preparation of the patient will frequently require consultation with other physicians; however, the responsibility for attaining this goal rests with the surgeon.

9.8.2.9 The surgeon is responsible for postoperative care of the patient. This responsibility includes personal participation in the direction of the postoperative care, including the management of postoperative complications. The best interest of the patient is therefore optimally serviced because of the surgeon's comprehensive knowledge of the patient's disease and surgical management. Even when some aspects of postoperative care may be best delegated to others, the surgeon must maintain an essential coordination role. Should complications from the operation develop, the surgeon is best able to detect them and to provide or coordinate timely and appropriate therapy. This responsibility extends through the period of convalescence until the residual effects of the surgical procedure are minimal, and the risk of complications from the operation is predictably small. The surgeon is responsible for determining when the patient should be discharged from the hospital.

9.8.3 Surgical Assistants

9.8.3.1 The need for a surgical assistant is to be determined by the primary surgeon.

9.8.3.2 An assistant may be:

a. A surgeon or a surgery resident or fellow in an approved training program.

b. A non-surgeon (physician, nurse assistant, or physician assistant) who has been granted surgical assistant privileges.

9.8.3.3 It is the responsibility of the surgeon to arrange for a surgical assistant.

9.8.3.4 This policy does not alter any State-mandated laws or requirements and/or prior restrictions imposed on a surgeon.

9.8.3.5 Approval of surgery residents or fellows is required from the Medical Staff Management Department (Graduate Medical Education).

9.8.4 Emergency and Weekend Add-Ons

9.8.4.1 Agreeing to the following case classifications and related care requirements is the first step to smoothing demand, easing communication, and establishing clear service expectations across Hospital departments:

a. Emergency Cases

i. Emergency occurs when treatment is immediately necessary to prevent patient death, severe impairment, or deterioration, or to alleviate severe pain, and any delay in performing a procedure would add to that danger.

(1) The case will start immediately in the first available room.

(2) The surgeon will schedule this with the Operating Room for the next available room and team that can be made available.

(3) If another case must be bumped, the emergency case surgeon should personally notify the surgeon whose case is going to be displaced, if feasible.

b. Elective Cases

i. Elective cases are scheduled prior to 17:00 (for inpatients) and 15:00 (for outpatients) the day before the surgery. They are performed as scheduled within normal operating hours (07:30 – 15:30).

(1) Elective cases are scheduled Saturdays from 07:00 – 15:00 on a first-come, first-serve basis and performed by regularly scheduled staff (only 1 elective operating room).

(2) Emergency or Urgent cases are the only surgeries that can be performed on Sundays or holidays.

c. Urgent Cases

i. Urgent is defined as a procedure to be done within 2-4 hours; delay of the case beyond 2-4 hours will result in permanent damage to life, limb, or tissue.

(1) The urgent case will be scheduled into the next open time.

(2) Other cases will be bumped only if necessary. If it is necessary to bump a case, the urgent case surgeon must personally notify the surgeon whose case is going to be displaced.

d. Add-On Cases

i. Add-On is defined as a procedure scheduled after 15:00 the day before surgery.

(1) An add-on becomes urgent only if the patient's condition deteriorates.

(2) The add-on is scheduled on a first-come, first-serve basis as the surgeon's and the Operating Room schedules permit until close of normal operating hours.

(3) For add-on cases to be done on Monday, the surgeon must call the Nursing Office on the weekend. The Nursing Office will call the on-call Operating Room nurse to communicate with the surgeon to add on the case.

e. On Call Teams

i. On Saturdays, there is one room fully staffed for scheduled cases. There is an additional on-call team for general cases and an on-call team for cardiovascular cases. Both teams may be utilized for urgent and emergency cases. If one on-call team is already working, and there is no need to the other on-call team to save life or limb, it will be utilized for any emergency until the appropriate on-call team can relieve them.

GLOSSARY

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APPROVAL

Approved by the Medical Executive Committee of April 18,2019 and the Board of Trustees meeting of April 25, 2019

Charles Munger
Chairman, Board of Trustees

Allison Hill, M.D.
Medical Staff Chair

Supersedes: Rules November 16, 2017

Amendments:

Rule New: 3.2.2.6 Addition of CRNAs to the categories of AHPs