Ventura County Medical Center
Medical Staff Rules

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Medical Staff Rules

Rule 1 Appointment and Reappointment

1.1 Overview of Process

The following charts summarize the application processes for appointment, temporary privileges and reappointment to the Medical Staff. Details of each step are described in Rule 1.2 through Rule 1.9.

APPOINTMENT		
Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify application information	Credentials Committee
Credentials Committee	Review applicant's qualifications vis-à-vis the criteria and standards for membership and clinical privileges set forth in the Medical Staff Bylaws (the Bylaws); make recommendation on appointment and privileges	Department
Department	Review applicant's qualifications vis-à-vis standards developed by the Department; make recommendation on appointment and privileges	Medical Executive Committee
Medical Executive Committee	Review recommendations of Credentials Committee and the Department; make recommendation on appointment and privileges; terminate credentialing process if applicant failed to complete application after reasonable opportunity	Governing Body (through the Oversight Committee)
Governing Body (through the Oversight Committee)	Review recommendations of the Medical Executive Committee; make decision	Final Action

TEMPORARY PRIVILEGES		
Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify application for temporary privileges	Department Chief
Department Chief or designee	Review applicant's qualifications vis-à-vis standards developed by the Department; make recommendation on temporary privileges	Chief of Staff or designee, Chief Medical Officer or designee)
Chief of Staff or designee, or Chief Medical Officer or designee	Review recommendations of the Department Chief; make recommendation on temporary privileges	Chief Executive Officer
Chief Executive Officer	Review recommendations of the Department and Chief of Staff or Chief Medical Officer or designee; make decision	Final Action

REAPPOINTMENT		
Person or Body	***Function***	***Report to***
Medical Staff Coordinator	Verify application reappointment information	Department
Department	Review applicant's performance vis-à-vis standards developed by the Department; make recommendation on reappointment and privileges	Medical Executive Committee
Medical Executive Committee	Review recommendations of the Department; request additional information if necessary; make recommendation on reappointment and privileges	Governing Body (through the Oversight Committee)
Governing Body (through the Oversight Committee)	Review recommendations of the Medical Executive Committee; make decision	Final Action

1.2 Application

1.2-1 The application shall be subject to approval by the Medical Executive Committee and the Oversight Committee and, once approved, shall be considered part of these rules. The application shall include:

a. An agreement by the applicant to abide by the Bylaws, the Rules, and applicable Medical Staff and hospital policies;

b. The application shall request information pertinent to the applicant's qualifications, including information to establish the applicant's basic qualifications as set forth in the Bylaws. The application shall also request any information pertinent to assessing the applicant, including but not limited to:

i. Education history (including participation in continuing medical education) and any specialty training;

ii. Experience, abilities and current competencies;

iii. Professional affiliations;

iv. Proffered references (including the names and contact information of professional peers when possible from the same professional discipline as the applicant who will be able to attest in writing to the applicant's relevant qualifications, character, conduct, experience, abilities and current clinical competencies);

v. Relevant health status (as further described below);

vi. Information regarding prior professional liability coverage history actions (including, but not limited to, all final judgments or settlements involving the applicant);

vii. Previously completed or currently pending challenges involving professional licensure, certification or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure, certification or registration;

viii. Voluntary or involuntary termination, limitation, reduction or loss of Medical Staff or medical group membership and/or clinical privileges at any other hospital or health facility or entity;

ix. Any formal investigation or disciplinary action at another hospital or health facility that was taken or is pending; and information detailing any prior or pending government agency or third party payor investigation, proceeding or litigation challenging or sanctioning the practitioner's patient admission, treatment, discharge, charging, collection or utilization practices, including, but not limited to, Medicare or Medi-Cal fraud and abuse proceedings or convictions;

x. Allegations or adverse actions related to sexual harassment and/or sexual misconduct and/or assault; and

xi. Any convictions of, or guilty pleas to, a criminal offense (i.e., a felony or misdemeanor) and/or placement on deferred adjudication or probation for a criminal offense.

1.2-2 The application shall also release from liability to be signed by the applicant as to all claims against representatives of the hospital and Medical Staff for their acts performed in evaluating the applicant's qualifications as well as against all individuals and organizations who provide information to the hospital and/or Medical Staff concerning the applicant, including otherwise privileged or confidential information.

1.2-3 Each practitioner who expresses formal interest in a recognized and appropriate category of membership and privileges shall be provided an application for Medical Staff membership, unless otherwise ineligible pursuant to the Bylaws. The practitioner shall return the application to the Medical Staff office together with the required, nonrefundable application fee.

1.3 Physical and Mental Capabilities

1.3-1 Obtaining Information

a. The application shall further require the applicant to submit a statement attesting that no health problems exist that could affect his or her ability to perform the responsibilities of Medical Staff membership or exercise of requested clinical privileges. If the applicant does have a health condition and/or requires special accommodations with respect to a health condition, the applicant shall provide all relevant information pertaining to his/her physical and mental health.

b. When the Medical Staff office verifies information and obtains references regarding the applicant, it shall ask for any information

concerning physical or mental health status to be reported on a confidential form, which can be processed separately from the other information obtained regarding the applicant.

c. The Credentials Committee and Medical Executive Committee shall be responsible for assessing any practitioner who has or may have a physical or mental disability or condition that might affect the practitioner's ability to exercise his or her requested privileges in a competent manner that meets the level of quality established by the hospital and Medical Staff. This may include one or all of the following:

i. **Medical Examination:** To ascertain whether the practitioner has a physical or mental disability or condition that might interfere with his or her ability to provide care which meets the hospital and Medical Staff's quality of care standards. Such medical examination may include a request that the practitioner submit to drug and/or alcohol testing.

ii. **Interview:** To ascertain the condition of the practitioner and to assess if and how reasonable accommodations can be made.

d. Any practitioner who feels limited or challenged in any way by a qualified mental or physical disability or condition in exercising his or her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Chief of Staff or Chief Medical Officer. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff's peer review activities.

1.3-2 Review and Reasonable Accommodations

a. Any practitioner who discloses or manifests a qualified physical or mental disability or condition requiring accommodation will have his or her application processed in the usual manner without reference to the condition.

b. Once the determination is made that the practitioner is otherwise qualified, the Credentials Committee may disclose information it has regarding any physical or mental disabilities or conditions and the effect of those on the practitioner's application for membership and privileges. Any such disclosure shall be limited as necessary to protect the practitioner's right to confidentiality of health information, while at the same time communicating sufficient information to permit the Medical Executive Committee to evaluate what, if any,

accommodations may be necessary and feasible. The Well-Being Committee and any other appropriate committees may meet with the practitioner to discuss if and how reasonable accommodations can be made.

c. As required by law, the Medical Staff and hospital will attempt to provide reasonable accommodations to a practitioner with known physical or mental disabilities or conditions, if the practitioner is otherwise qualified and can demonstrate to the satisfaction of the Medical Executive Committee that they are competent to perform the essential functions of the staff appointment and privileges in a manner which meets the level of quality established by the hospital and Medical Staff. If reasonable accommodations are not possible under the standards set forth herein, it may be necessary to withdraw or modify a practitioner's privileges and the practitioner shall have the hearing and appellate review rights described in the Bylaws.

1.4 Effect of Application

By applying for or by accepting appointment or reappointment to the Medical Staff, the applicant:

1.4-1 Agrees to appear for interviews and provide additional information as requested by the Chief of Staff, Chief Medical Officer, Department Chief or Clinical Section, the Credentials Committee, the Medical Executive Committee or the Oversight Committee.

1.4-2 Authorizes Medical Staff and hospital representatives to consult with other hospitals, Medical Staffs, persons or entities who have been associated with him or her and/or who may have information bearing on his or her competence and qualifications or that is otherwise relevant to the pending review and authorizes such persons to provide all information that is requested orally and in writing.

1.4-3 Consents to the inspection and copying, by hospital and Medical Staff representatives, of all records and documents that may be relevant or lead to the discovery of information that is relevant to the pending review, regardless of who possesses these records, and directs individuals who have custody of such records and documents to permit inspection and/or copying.

1.4-4 Certifies that the applicant will report any changes in the information submitted on the application to the Medical Staff office and Chief of Staff or Chief Medical Officer as required by the Bylaws.

1.4-5 Releases from any and all liability representatives of the hospital and Medical Staff for acts performed in connection with evaluating the applicant's qualifications.

1.4-6 Releases from any and all liability all individuals and organizations who provide information concerning the applicant, including otherwise privileged or confidential information, to hospital or Medical Staff representatives.

1.4-7 Authorizes and consents to the release of all records and documents by hospital and Medical Staff representatives that, in the judgment of the Chief of Staff, Department Chair, the Credentials Committee, the Medical Executive Committee, or the Oversight Committee, may be material to an evaluation of the applicant's qualifications, performance, and quality of patient care, and releases the hospital and hospital representatives from liability for so doing.

1.4-8 Consents to undergo and to release the results of a physical or mental health examination by a practitioner acceptable to the Medical Executive Committee, at the applicant's expense, if deemed necessary by the Medical Executive Committee.

1.4-9 An acknowledgement that the applicant has received (or been given access to) a copy of the Bylaws and Rules, and agrees to be bound by the terms thereof, as they may be amended from time to time, if granted membership or clinical privileges, and to be bound by the terms thereof in all matters relating to consideration of the applicant's application, regardless of whether granted membership or clinical privileges.

1.4-10 For purposes of this Rule 1.4, the term "hospital representative" includes the Governing Body, or the Oversight Committee, as well as individual Directors and committee members of either; the Chief Executive Officer, the Medical Staff, all Medical Staff department officers and/or committee members having responsibility for collecting information regarding or evaluating the applicant's credentials; and any authorized representative or agent of any of the foregoing.

1.5 Verification of Information

The applicant shall fill out and deliver an application to the Medical Staff office, which shall seek to verify the information submitted. Verification shall encompass, but is not limited to, written verification of peer references, licensure status, training and education, current proficiency with respect to the Medical Staff's required general competencies (as applicable to the privileges requested), health status, other evidence submitted in support of the application, and confirmation that the practitioner is the same individual identified in the credentialing documents (by viewing a current, valid picture hospital ID card or a valid state or federal agency

picture ID card). The application will be deemed complete when all required information has been provided and all necessary verifications have been obtained, including, but not limited to, current California license, licensing board disciplinary records, specialty board certification status, Office of Inspector General, National Practitioner Data Bank information, Drug Enforcement Administration registration, if appropriate, verification of all practice from professional school through the present, current malpractice liability insurance and reference letters, verification of current proficiency in the Medical Staff's criteria for privileges and general competencies as set forth in the Bylaws, and other evidence that the applicant submitted in support of his/her application and/or requested by the Credentials Committee, Department Chief and/or Clinical Section, or the Medical Executive Committee. Additionally, the Medical Staff office may seek information from other relevant sources. The Medical Staff office shall then transmit the application and all supporting materials to the Credentials Committee and to the Department Chief of each department in which the applicant seeks privileges.

1.6 Incomplete Application

1.6-1 If the Medical Staff office is unable to verify the information, or if all necessary references have not been received, or if the application is otherwise incomplete, the Medical Staff office will contact the applicant to inform the applicant that processing will not begin until the application is deemed complete. To the extent the application is deemed incomplete, the applicant is responsible for providing the information to satisfy the process.

1.6-2 If the processing of the application is impacted for more than 60 days due to failure by the applicant to provide the requested information, and if the Medical Executive Committee deems the requested information relevant to a fair determination of the applicant's qualifications, the affected practitioner shall be so informed. The applicant shall then be given the opportunity to withdraw their application, or to request the continued processing of their application. If the applicant does not respond within 30 days, the credentialing process may be terminated at the discretion of the Medical Executive Committee, after giving the applicant an opportunity to be heard, either in writing or in person as determined by the Medical Executive Committee.

1.7 Action on the Application

1.7-1 Credentials Committee Action

Upon receipt, the Credentials Committee shall review the application and supporting documentation, may personally interview the applicant, and, based upon the criteria for appointment (as applicable) described in the

Bylaws, shall transmit to the Department on the prescribed form a written recommendation as to staff appointment and clinical privileges.

1.7-2 **Department Action**

The Department Chief shall review the application, the supporting documentation, the Credentials Committee's report and recommendations, and other such information available to it that may be relevant, subject to review of the Department Committee. The Department Chief, Department Committee, or a subcommittee thereof may personally interview the applicant. The Department shall then assess the applicant's health status, and determine whether the applicant is able to perform, with or without reasonable accommodation, the necessary functions of a member of the Medical Staff. The Department shall then transmit to the Medical Executive Committee a recommendation as to staff appointment, and Department affiliations and clinical privileges.

1.7-3 **Medical Executive Committee Action**

a. **Preliminary Recommendation:** At its next regular meeting after receipt of the Department recommendation, the Medical Executive Committee shall consider all relevant information available to it. The Medical Executive Committee may request additional information relevant to its assessment and shall then formulate a preliminary recommendation as to whether the applicant meets the relevant criteria specified in the Bylaws, with respect to membership and privileges.

b. **Final Recommendation:** Thereafter, a final recommendation shall be formulated, and the Medical Executive Committee shall forward to the Oversight Committee a written report and recommendations, as follows:

c. **Favorable Recommendation:** Favorable recommendations shall be promptly forwarded to the Oversight Committee together with the recommendation of the Department as to staff appointment, and department affiliations and any special conditions to be attached to the appointment.

d. **Adverse Recommendation:** When the recommendation is adverse in whole or in part, the Chief of Staff shall immediately inform the practitioner by special notice, and the practitioner may be entitled to procedural rights as provided in the Bylaws. The Oversight Committee shall be generally informed of, but shall not receive detailed information and shall not take action on, the pending adverse

recommendation until the applicant has exhausted or waived his or her available procedural rights. (For the purposes of this section, an adverse recommendation by the Medical Executive Committee is as defined in the Bylaws.)

e. **Deferral:** The Credentials Committee or Medical Executive Committee may defer its recommendation in order to obtain or clarify information, or in other special circumstances. A deferral must be followed up within 60 days of receipt of information with a subsequent recommendation for appointment and privileges, or for rejection of staff membership.

1.7-4 **Oversight Committee Action**

a. **On Favorable Medical Executive Committee Recommendation:** The Oversight Committee shall adopt, reject or modify a favorable recommendation of the Medical Executive Committee, or shall refer the recommendation back to the Medical Executive Committee for further consideration, stating the reasons for the referral and setting a time limit within which the Medical Executive Committee shall respond.

b. **Without Benefit of Medical Executive Committee Recommendation:** If the Oversight Committee does not receive a Medical Executive Committee recommendation within the time specified in these Rules, it may, after giving the Medical Executive Committee written notice and a reasonable time to act, take action on its own initiative. If such recommendation is favorable, it shall become effective as the final decision of the Oversight Committee.

c. **Final Action:** In the case of an adverse Medical Executive Committee recommendation or an adverse Oversight Committee decision pursuant to these Rules, the Oversight Committee shall take final action in the matter only after the applicant has exhausted or has waived any procedural rights provided by the Bylaws.

d. **Expedited Review:** The Oversight Committee may use an expedited process for appointment, reappointment or when granting privileges when criteria for that process are met. The Oversight Committee may delegate this authority to any other committee of at least two voting members of the Oversight Committee; the decision regarding reappointment or privileging will then be reviewed by the Oversight Committee at its next regularly scheduled meeting. Expedited processing is generally not available if:

i. The practitioner or member submits an incomplete application;

ii. The Medical Executive Committee's final recommendation is adverse in any respect or has any limitations;

iii. There is a current challenge or a previously successful challenge to the practitioner's licensure or registration;

iv. The practitioner has received an involuntary termination of Medical Staff membership or some or all privileges at another organization;

v. The practitioner has received involuntary limitation, reduction, denial, or loss of medical privileges;

vi. There has been a final judgment adverse to the practitioner in a professional liability action.

1.7-5 Notice of Final Decision

A decision and notice to appoint shall include:

a. The staff category to which the applicant is appointed;

b. The department to which the practitioner is assigned;

c. The clinical privileges the practitioner may exercise; and

d. Any special conditions attached to the appointment.

If the decision is adverse, the notice to the applicant shall be by special notice, as further described in the Bylaws.

1.7-6 Application Processing

All individuals and groups shall act on applications in a timely and good faith manner. Applications shall be submitted to the Medical Staff office within 30 days from when the applicant has been provided access to the electronic application. It is the obligation and responsibility of the applicant to provide information requested in connection with the application, including responding in a timely manner. Failure, without good cause, to respond to requests for information may result in a determination that the application is incomplete.

1.8 Duration of Appointment.

All appointments to the Medical Staff shall be for a period not to exceed two (2) years, as specified in the Bylaws, and shall be staggered throughout the year so as to enable a thorough review of each member. Changes in staff category may be requested at any time during the reappointment period.

1.9 Reappointment Process

1.9-1 Schedule for Reappointment

At least 180 days prior to the expiration date of each staff member's term of appointment, the Medical Staff office will provide the member with a reappointment application. Completed reappointment applications shall be submitted to the Medical Staff office within 30 days from when the applicant has been provided access to the electronic reappointment application. Failure to do so may subject the applicant to a late fee. Notwithstanding this provision, it is the obligation and responsibility of the practitioner to maintain current appointment, including submitting applications for reappointment in a timely manner. Failure, without good cause, to return the form may result in a determination that the application for reappointment is incomplete.

1.9-2 Content of Reappointment Application

a. The reappointment application shall be approved by the Medical Executive Committee and the Oversight Committee and, once approved, shall be considered part of these Rules. The form shall seek information concerning the changes in the member's qualifications since his or her last review.

b. If the staff member's level of clinical activity at this hospital is not sufficient to permit the staff and board to evaluate competency to exercise the clinical privileges requested, the staff member shall have the burden of providing evidence of clinical performance at his or her principal institution in whatever form as the Medical Executive Committee may require.

c. In addition to completing the information requested on the reappointment application, the staff member shall submit his or her biennial dues.

1.9-3 Verification and Collection of Information

The Medical Staff office shall, in timely fashion, seek to verify the additional information made available on each reappointment application and to collect any other materials or information deemed pertinent by the Medical

Executive Committee, the Credentials Committee, and/or Department Chief. The information shall address, without limitation:

a. Reasonable evidence of current ability to perform privileges that may be requested including, but not limited to, consideration of the member's professional performance, judgment, clinical or technical skills and patterns of care and utilization as demonstrated in the findings of quality improvement, risk management and utilization management activities.

b. Participation in relevant continuing education activities.

c. Level/amount of clinical activity (patient care contacts) at the hospital.

d. Sanctions imposed or pending including, but not limited to, previously successful or currently pending challenges to any licensure or registration (state or district, Drug Enforcement Administration) or the voluntary relinquishment of such licensure or registration.

e. Health status including completion of a physical examination or psychiatric evaluation by a physician who is mutually accepted by the affected practitioner and staff, when requested by the Credentials Committee, Department Chief or Medical Executive Committee and subject to the standards set forth above pertaining to physical and mental health disabilities or conditions.

f. Attendance at required Medical Staff department and committee meetings.

g. Participation as a staff officer and Medical Staff committee member/Chair.

h. Timely and accurate completion and preparation of medical records.

i. Cooperativeness and general demeanor in relationships with other practitioners, hospital personnel and patients.

j. Professional liability claim experience, including being named as a party in any professional liability claims and the disposition of any pending claims.

k. Compliance with the Bylaws, these Rules, and all applicable Medical Staff and hospital policies.

l. Professional references from at least one practitioner who is familiar with the member's current qualifications by virtue of having recently worked with the member or having recently reviewed the member's cases.

m. Information concerning the staff member's activities at other hospitals and his or her medical practice outside the hospital, as applicable.

n. Information concerning the member from the state licensing board and the federal National Practitioner Data Bank.

o. Information from other relevant sources.

p. Any other information deemed pertinent by the Chief of Staff, Medical Executive Committee, Credentials Committee, or Department.

q. The Medical Staff office shall transmit the completed reappointment application and supporting materials to the Chief of the department to which the staff member belongs and to the Chief of any other department in which the staff member has or requests privileges.

1.9-4 Department Action

The Department Chief shall review the application and all other relevant available information. The Chief may confer with the Department and/or Clinical Section, or the whole Department, if there is neither Department. The Department Chief shall transmit written recommendations to the Medical Executive Committee, which are prepared in accordance with these Rules.

1.9-5 Medical Executive Committee Action

The Medical Executive Committee shall review the Department Chief's recommendations and all other relevant information available to it and shall forward to the Oversight Committee its recommendations for appointment, which are prepared in accordance with these Rules. The Medical Executive Committee may request additional information relevant to its assessment.

1.9-6 Reappointment Recommendations

Reappointment recommendations shall be written and shall specify whether the staff member's appointment should be (i) renewed; (ii) renewed with modified membership category, department affiliation and/or clinical privileges, or (iii) terminated. The reason for any adverse recommendation shall be described. The Medical Staff may require additional proctoring of

any clinical privileges that are used so infrequently as to make it difficult or unreliable to assess current competency without additional proctoring, and such proctoring requirements imposed for lack of activity shall not result in any hearing rights.

1.9-7 No Extension of Appointment

Except as provided in the Bylaws, if the reappointment application has not been fully processed before the staff member's appointment expires, the staff member shall not exercise his or her current membership status and clinical privileges until the reappointment review is complete.

1.9-8 Failure to Timely File Reappointment Application

If the application for reappointment process is terminated due to failure to timely file a reappointment application, the practitioner may subsequently submit an application for membership and will be processed as a new applicant to the Medical Staff.

1.9-9 Relinquishment of Privileges

A staff member who wishes to relinquish or limit particular privileges shall send written notice to the appropriate Department Chief, as well as the Chief of Staff or the Medical Staff Office, identifying the particular privileges to be relinquished or limited. A copy of this notice shall be included in the staff member's credentials file.

Rule 2 Committees

2.1 Committees

In addition to those committees established by the Bylaws, the standing committees of the Medical Staff shall also include the following, with rules applicable to each committee set forth in the corresponding appendix:

See Appendix

❑ Blood Usage Committee	2A
❑ Bylaws Committee	2B
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❑ Department Committees	2D
❑ Infection Control Committee	2E
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Appendix 2A Blood Usage Committee

1. Composition

The Blood Usage Committee shall consist of those medical staff members and ancillary support personnel as appointed by the Chief of Staff.

2. Duties

The duties of the Blood Usage Committee shall include:

a. Conducting a review of the use of each category of blood and blood components to identify single cases or patterns of cases that require more intensive evaluation; and/or through evaluation of a single case or of a group of cases. Screening criteria are utilized. An adequate number of cases is used in the process. Consideration shall be given to high volume, substantial risk to patients, and/or are thought or known to be problem prone usage;

b. the evaluation of confirmed transfusion reactions;

c. the development or approval of policies and procedures relating to the distribution, handling, use, and administration of blood and blood components;

d. the review of ordering practices for blood and blood components; and

e. the review of the adequacy of the Blood Bank to meet the needs of patients.

3. Meetings

The Blood Usage Committee shall meet as often as necessary,. Reports of activities and recommendations relating to the Blood Usage Committee's functions shall be made to the Medical Executive Committee and the Oversight Committee as frequently as necessary.

Appendix 2B Bylaws Committee

1. Composition

The Bylaws Committee may include the Chief of Staff, the Chief of Staff Elect, Immediate Past-Chief, the CMO, or other members as may be appointed by the Medical Executive Committee.

2. Duties

The duties of the Bylaws Committee shall include:

a. Conducting a review of the Bylaws, as well as the Rules at least every two years;

b. Receiving and evaluating suggestions for modification of the Bylaws, as well as the Rules and Medical Staff policies;

c. Assuring that the Bylaws, Rules, and Medical Staff policies comply with applicable laws, regulations, and accreditation standards, and that they adequately and accurately describe the current structure of the Medical Staff, including, but not limited to:

1. Establishing and enforcing criteria and standards for Medical Staff membership and clinical privileges, as well as the mechanisms for doing so;
2. Establishing and enforcing clinical criteria and standards to oversee and manage quality improvement and assessment, utilization review, and other Medical Staff activities, including procedures for meetings of the Medical Staff and its committees and departments and review and analysis of patient medical records; as well as procedures for evaluating and revising such activities;
3. The mechanism for terminating Medical Staff membership;
4. The fair hearing and appeal procedures;
5. Provisions for assessing Medical Staff dues and utilizing the Medical Staff dues as appropriate for the purposes of the Medical Staff;
6. Provisions respecting the Medical Staff's ability to retain and be represented by independent legal counsel at the expense of the Medical Staff; and

7. Provisions requiring a physical examination and medical history to be completed within the time frames established by state hospital licensing regulations and federal Medicare law; and

d. Submitting recommendations to the Medical Executive Committee for changes in the Bylaws, these Rules, and Medical Staff policies as necessary to reflect current Medical Staff practices and requirements.

3. Meetings

The Bylaws Committee will meet as requested by the Bylaws Committee Chair or Chief of Staff.

Appendix 2C Cancer Committee

1. Composition

The Cancer Committee shall be multi-disciplinary, including members from the specialties of surgery, internal medicine, gynecology, pediatrics, diagnostic and therapeutic radiology, pathology, and family practice. The committee must also include representatives of hospital administration, nursing, social services, rehabilitation and the cancer registry.

2. Duties

The duties of the Cancer Committee are to:

a. Make certain that educational programs address major cancer issues.

b. Evaluate the quality of care given patients with cancer and report as necessary to assure that the results of such evaluations are incorporated into the hospital-wide quality assessment and improvement systems.

c. Supervise the cancer data system.

d. Appoint Cancer Committee members to act as registry physician advisors.

e. Educate hospital and Medical Staff members and patients about cancer prevention, detection and treatment.

3. Meetings

The Cancer Committee will meet as requested by the Cancer Committee Chair or Chief of Staff.

Appendix 2D Department Committees

1. Composition

Each department shall have a committee consisting of the Departmental Chief, the Chief-elect and others as established in the Rules developed by each department.

2. Duties

The Department Committees shall assist their respective Department Chief to carry out the responsibilities assigned to the Department Chief, including the duties to recommend professional criteria for clinical privileges within the department, review applicants for appointment, reappointment, and clinical privileges, and to fulfill the responsibility for peer review. The Department Committees shall also fulfill the medical assessment and treatment, use of medications, use of blood and blood components, operative and other procedures, efficiency of clinical practice patterns, monitoring of departures from established clinical patterns, patients' and families' education, coordination of care, and medical records and functions.

3. Meetings

Each Department Committee shall meet as often as necessary, but no less than annually.

Appendix 2E Infection Control Committee

1. Composition

a. The Infection Control Committee shall be composed of at least five (5) members of the Medical Staff (to assure representation of Medicine, Family Medicine, OB/GYN, Pediatrics and Surgery Departments), an infectious disease practitioner, an infection control specialist, a Pathologist, a representative from Administration, and a representative from Nursing Service.

b. Representatives from the following areas shall be available on a consultative basis and invited to participate as needed or others as deemed necessary by the Chairman: Central Supply, Operating Room, Dietary, Maintenance, Housekeeping and Pharmacy. The chairman of the Infection Control Committee shall be a physician qualified by training or experience to carry out his/her responsibilities.

2. Duties

The Infection Control Committee shall develop and monitor the hospital's infection control program and the staff's treatment of infectious disease, including review of the clinical use of antimicrobials. The committee shall approve action to prevent or control infections and the infection potential among patients and hospital personnel. The committee shall ensure that the hospital's infection control plan links with external support systems and with communitywide agencies as they relate to reduction of risk from the environment. The committee shall ensure that appropriate resources are available for infection control activities. The committee shall also assure that the results of infection control studies and reviews are incorporated into the hospital's educational programs and into the hospital's quality assessment and improvement activities. At least every two years, the committee shall review and approve all policies relating to the infection control program. The Chair or his or her designee shall be available for on-the-spot interpretation of applicable rules.

3. Meetings

The Infection Control Committee shall meet as often as necessary, but not less than quarterly. Reports of activities and recommendations relating to the Infection Control Committee's functions shall be made to the Medical Executive Committee and the Oversight Committee as frequently as necessary and at least quarterly.

Appendix 2F Interdisciplinary Practice Committee

1. Composition

The Interdisciplinary Practice Committee (IPC) shall have an equal number of Medical Staff members appointed by the Medical Executive Committee and nursing staff members appointed by the hospital's director of nursing. It shall include a representative from the nursing administration and the director of nursing. In addition, representatives of the categories of Allied Health Professionals (AHPs) granted privileges in the hospital should serve as consultants on an as-needed basis and shall participate, when available, in the committee proceedings when a member of the same specialty is applying for privileges.

2. Duties

a. Standardized Procedures and Practice Agreements

1. The IPC shall develop and review standardized procedures and practice agreements that apply to nurses or AHPs; identify functions that are appropriate for standardized procedures and practice agreements and initiate such procedures; and review and approve standardized procedures and practice agreements.
2. Standardized procedures and practice agreements can be approved only after consultation with the Medical Staff department involved, the IPC, and the Medical Executive Committee, by affirmative vote of the administrative representatives, a majority of physician members, and a majority of nurse and any AHP members.

b. Credentialing Allied Health Professionals

1. The IPC shall recommend policies and procedures for expanded role privileges for assessing, planning and directing the patients' diagnostic and therapeutic care.
2. The IPC shall review AHPs' applications and requests for privileges and forward its recommendations and the applications on to the appropriate clinical department.
3. The IPC may participate in AHP peer review and quality improvement. It shall initiate corrective action when indicated against AHPs in accordance with the Medical Staff Bylaws, these Rules or guidelines governing AHPs.
4. The IPC shall serve as liaison between AHPs and the Medical Staff.

c. Education

1. The IPC shall have responsibility to assess and provide input with respect to appropriate ongoing educational programs addressing issues relevant to AHP staff.

3. Meetings

The IPC shall meet as often as needed, but no less than annually. Reports of activities and recommendations relating to the IPC's functions shall be made to the Medical Executive Committee as frequently as necessary.

Appendix 2G Health Information Management Committee

1. Composition

The Health Information Management Committee shall consist of at least three (3) members of the Medical Staff (one of whom shall be a representative of the Graduate Medical Education Committee), and representatives from the Hospital's Health Information Management Department, nursing staff, administration, and others as deemed necessary.

2. Duties

The duties of the Health Information Management Committee are to:

a. Review the quality of medical records for clinical pertinence or quality of documentation and timely completion.

b. Assess that medical records reflect the diagnosis, results of diagnostic tests, therapy rendered, condition of in-hospital progress of the patient, and condition of the patient at discharge; and

c. Review the summary information regarding the timely completion of all medical records.

3. Meetings

The Health Information Management Committee shall meet as often as necessary, but no less than quarterly. Reports of activities and recommendations relating to the Health Information Management Committee's functions shall be made to the Medical Executive Committee and the Oversight Committee as frequently as necessary and at least quarterly.

Appendix 2H Pharmacy & Therapeutics Committee

1. Composition

The Pharmacy and Therapeutics Committee function shall consist of at least five (5) members of the Medical Staff as well as the chief pharmacist, or designee, a representative of the hospital administration as an ex-officio member, and a member of the Nursing Department as a consultant.

2. Duties

a. the development or approval of policies and procedures relating to the selection, distribution, handling, use and administration of drugs and diagnostic testing materials, including nursing floors, the emergency department, radiology, anesthesiology, operating room, etc.;

b. the development and maintenance of drug formulary or drug list;

c. the definition and review of drug reactions; and

d. drug usage review, which shall include the routine collection and assessment of information in order to identify opportunities to improve the use of drugs and to resolve problems in their use. Review may include the use of objective criteria to identify, for more intensive evaluation, problems in or opportunities to improve the use of a specific drug or category of drugs.

e. Specific drugs for review shall include:

1. high volume;
2. those that pose a substantial risk to patients;
3. are thought or known to be problem prone; and/or
4. are a critical component of the care provided for a specific diagnosis, condition or procedure.

3. Meetings

The Pharmacy and Therapeutics Committee shall meet as often as necessary, but no less than quarterly. Reports of activities and recommendations relating to the Pharmacy and Therapeutics Committee's functions shall be made to the Medical Executive Committee and the Oversight Committee as frequently as necessary and at least quarterly.

Appendix 2I Utilization Review Committee

1. Composition

The Utilization Review Committee shall consist of at least two (2) members of the active staff, and representatives from utilization review, medical records, nursing, and a resident.

2. Duties

The Utilization Review Committee shall perform the following functions:

a. General Duties

Oversees the review of the medical necessity for admissions, extended stays and services rendered. The committee addresses over-utilization, under-utilization, and inefficient scheduling and use of resources. Patterns of care will be followed, and focused review may be undertaken as deemed necessary. They shall also work toward maintaining continuity of care upon discharge. The committee shall communicate pertinent data and results of review to the Medical Executive Committee and shall make recommendations for the utilization of resources and facilities commen-surate with quality patient care and safety.

b. Utilization Review Plan

The committees shall establish and follow a Utilization Review Plan which shall be approved by the Medical Executive Committee and Oversight Committee, and shall comply with applicable federal and state regulations.

c. Continuity of Care

The committee shall promote continuity of care upon discharge and supervise the accumulation of data on the availability of health care resources outside the hospital.

d. Education

The committee shall assure that the overall results of quality improvement activities are used to guide educational programs throughout the hospital.

3. Meetings

The Utilization Review Committee shall meet as often as necessary, but no less than quarterly. Reports of activities and recommendations relating to the Utilization Review Committee's functions shall be made to the Medical Executive Committee and the Oversight Committee as frequently as necessary and at least quarterly.

Appendix 2J Well-Being Committee

1. Composition

a. The Well-Being Committee shall be composed of no fewer than three (3) active Medical Staff members, a majority of whom shall be physicians and one of whom should be a psychiatrist or psychologist whenever possible.

b. Except for initial appointments, each member shall serve a term of three years. Insofar as possible, members of this committee shall not actively participate on other peer review or Quality Improvement Committees while serving on this committee. There is no limit to the number of terms that one may serve.

2. Duties

a. The Well-Being Committee is charged with developing a process that provides education about physician health, addresses prevention of physical, psychiatric or emotional illness, and facilitates confidential diagnosis, treatment and rehabilitation of practitioners who suffer from a potentially impairing condition. These processes should include mechanisms for the following:

1. Self-referral by a practitioner, and referral by other Medical Staff and hospital staff.
2. Upon its own initiative, upon request of the involved practitioner, or upon request of a Medical Staff or Department or officer, providing such advice, counseling or referrals to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern.
3. Assisting the Chief of Staff or Chief Medical Officer in evaluating the credibility of a complaint, allegation or concern, including such assessment as reasonably deemed necessary.
4. Monitoring the affected practitioner and the safety of patients until the rehabilitation or any corrective action process is complete; and in the event the member fails to complete a required rehabilitation program, informing the Medical Executive Committee so that need for other appropriate actions may be assessed.
5. If the committee receives information that demonstrates that the health or impairment of a Medical Staff member may pose a risk of harm to any individual, including but not limited to hospital patients (or prospective patients), that information shall be referred to the

Chief of Staff, who will determine whether corrective action is necessary to protect the individual.

3. Meetings

The Well-Being Committee shall meet as often as necessary, but no less than quarterly. It shall maintain only such records of its proceedings as it deems advisable, and shall routinely report on its activities to the Chief of Staff. Reports of activities and recommendations relating to the Well-Being Committee's functions shall also be made to the Medical Executive Committee and the Oversight Committee as frequently as necessary and at least quarterly.

Rule 3 Allied Health Professionals

3.1 Overview

3.1-1 The credentialing process for Allied Health Professionals (AHPs) is similar to that for credentialing Medical Staff members. However, the Interdisciplinary Practices Committee (IPC), rather than the Credentials Committee, is responsible for overseeing the credentialing of AHPs. The credentialing process for AHPs is summarized in these Rules.

3.1-2 This Rule sets forth the basic requirements that all AHPs must meet.

3.1-3 Also, the clinical department in which the AHP will exercise privileges has a role in establishing criteria for the exercise of specific privileges in that department, and in evaluating whether the particular applicant meets the established criteria. The departments also have the responsibility for generally supervising AHPs in their department, through their proctoring and peer review mechanisms.

3.1-4 Until the AHP has been granted privileges and assigned to a department, an AHP should not be practicing within the hospital.

3.1-5 This Rule applies to AHPs who are subject to the credentialing and privileging requirements of the Hospital, including all AHPs providing care within the HCA.

3.2 Categories of AHPs Eligible to Apply for Practice Privileges

3.2-1 The types of AHPs allowed to practice in the hospital will be ultimately determined by the Oversight Committee, based upon the recommendations of the Medical Executive Committee and such other information as may be available to the Oversight Committee.

3.2-2 The types of AHPs currently eligible to apply for practice privileges are:

- Nurse Practitioners
- Optometrist
- Physician Assistants
- Certified Nurse Midwives

The following categories may practice in the hospital only pursuant to an employment or independent contractor agreement with the hospital:

- Perfusionists
- Speech Pathologists
- Orthotist/Prosthetist

3.2-3 When an AHP in a category that has not been approved as eligible to apply for clinical privileges under the Bylaws requests privileges, the IPC 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 Processing the Application

3.3-1 Applications shall be submitted and processed in a manner parallel to that specified for Medical Staff applicants in these Rules, except that the applications shall be submitted to the IPC rather than the Credentials Committee.

3.3-2 Once the application is determined to be complete, it will be forwarded to the IPC for consideration. The IPC may meet with the applicant and the sponsoring or supervising practitioner (if applicable). The IPC shall evaluate the AHP based upon the standards set forth in these Rules. The IPC will also ascertain that appropriate monitoring mechanisms are in place. Whenever possible, the IPC shall include practitioners in the same AHP category when conducting its evaluation. The IPC shall forward its recommendations to the department to which the AHP would be assigned.

3.3-3 Upon receipt of an AHP application from the IPC, the Department Chief or Department Committee shall evaluate the AHP based upon the standards set forth in these Rules. The Department Chief or his or her designee or Department Committee may meet with the AHP as well as the sponsoring or supervising practitioner (if applicable) to further assess the AHP's request for privileges. The Department Chief, Department Committee will make a recommendation to the Medical Executive Committee regarding the applicant's qualifications to exercise the requested privileges.

3.3-4 Thereafter, the application shall be processed by the Medical Executive Committee and Oversight Committee in accordance with the procedures set forth in Rule 1.

3.4 Credentialing Criteria

3.4-1 Basic Requirements

a. The applicant must belong to an AHP category approved for practice in the hospital by the Oversight Committee.

b. If required by law, the applicant must hold a current, unrestricted state license or certificate.

c. In addition, hospital independent contractors shall meet all conditions of their contract with the hospital.

d. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment and physical and mental health status with sufficient adequacy to demonstrate that any patient treated will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the hospital, and that the applicant is qualified to exercise clinical privileges within the hospital.

e. The applicant must maintain in force professional liability insurance or its equivalent for the privileges exercised in the amounts of at least $1,000,000/occurrence and $3,000,000/aggregate.

f. The applicant must submit a minimum of two references from either licensed physicians or adequately trained professionals in the appropriate field and who are familiar with his or her professional work and have demonstrated competency.

g. 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.

h. The applicant must certify that that they will report any changes in the information submitted on the application to the Medical Staff office.

3.4-2 Specific Requirements

In addition to meeting the general requirements outlined above, AHP applicants must meet any specific licensure and certification and/or practice

requirements established for his or her category of AHP, as set forth by applicable policies developed and enacted by the IPC, consistent with applicable federal and state law.

3.5 Duration of Appointment and Reappointment

3.5-1 AHPs shall be granted practice privileges for no more than twenty-four (24) months. Reappointments to the AHP staff shall be processed every other year, in a parallel manner to that specified in Rule 1.

3.5-2 Applications for renewal of the AHP's privilege and the supervising practitioner's approval must be completed by the AHP and supervising practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in these Rules.

3.6 Observation

3.6-1 All new AHPs shall be subject to a performance evaluation and monitoring, consistent with the provisions of the Bylaws,, as adapted to the scope of practice and privileges of the AHP.

3.6-2 Each department shall be responsible for establishing performance evaluation and monitoring programs appropriate to each category of AHP granted privileges within that department. The department shall determine the appropriate frequency and methods of initial Focused Professional Practice Evaluation, which may include proctoring, concurrent or retrospective chart review or consultations. AHPs exercising surgery or anesthesia practice privileges shall be observed during surgery.

3.6-3 The proctor or evaluator should be a member in good standing of the Medical Staff who exercises appropriate clinical privileges; however, in appropriate circumstances, the department chief may assign an appropriately credentialed AHP to serve as the proctor/evaluator. Whenever possible, the proctor/evaluator should not be the sponsoring or supervising practitioner of the AHP being observed.

3.6-4 The Oversight Committee may approve alternative observation procedures for employee or Contract AHPs.

3.7 General

3.7-1 Duties

Upon appointment, each AHP shall be expected to:

a. Consistent with the privileges granted to the AHP, exercise independent judgment within the AHP's areas of competence and, if applicable, within the limits of an approved standardized procedure or practice agreement.

b. Participate directly in the management of patients to the extent authorized by the AHP's license, certificate, other legal credentials, any applicable standardized procedure or practice agreement, and by the privileges granted by the Oversight Committee.

c. Write orders to the extent established by any applicable Medical Staff or department policies, rules or standardized procedure or practice agreement and consistent with privileges granted to the AHP.

d. Record reports and progress notes on patient charts to the extent determined by the appropriate department, and in accordance with any applicable standardized procedure or practice agreement.

e. Consistent with the privileges granted to the AHP, perform consultations as requested by a Medical Staff member.

f. Comply with the Bylaws, these Rules, and all applicable Medical Staff and hospital policies.

3.7-2 **Prerogatives and Status**

AHPs are not members of the Medical Staff, and hence shall not be entitled to vote on Medical Staff or department matters, unless otherwise permitted pursuant to the Bylaws, these Rules, or applicable policies. AHPs shall not be required to pay membership dues. They are expected to attend and actively participate in the clinical meetings of their respective departments, to the extent consistent with applicable department rules. The prerogatives which may be extended to an AHP shall be defined in policy developed and enacted by the IPC.

3.8 Procedural Rights

3.8-1 **Fair Hearing and Appeal**. Denial, revocation, or modification of AHPs' privileges shall be the prerogative of the IPC, subject to approval by the Chief of Staff, the Medical Executive Committee, and the Oversight Committee.

3.8-2 **Automatic Termination.** Notwithstanding the provisions of the Bylaws, an AHP's privileges shall automatically terminate, without review pursuant to the Bylaws in the event:

a. The Medical Staff membership of the supervising practitioner is terminated, whether such termination is voluntary or involuntary;

b. The supervising practitioner no longer agrees to act as the supervising practitioner for any reason, or the relationship between the AHP and the supervising practitioner is otherwise terminated, regardless of the reason therefore;

c. The AHP's certification or license expires, is revoked, or is suspended; or

d. Loss of professional liability insurance, exclusion from participation in federally funded programs such as Medicare and Medi-Cal, and failure to pay dues and assessments, if present.

e. Where the AHP's privileges are automatically terminated for reasons specified in the Bylaws, the AHP may apply for reinstatement as soon as the AHP has found another supervising practitioner who agrees to supervise the AHP and receives privileges to do so. In this case, the Medical Executive Committee may, in its discretion, expedite the reapplication process.

3.8-3 **Review of Category Decisions**. The rights afforded by this Section shall not apply to any decision regarding whether a category of AHP shall or shall not be eligible for practice privileges and the terms, prerogatives, or conditions of such decision. Those questions shall be submitted for consideration to the Oversight Committee, which has the discretion to decline to review the request or to review it using any procedure the Oversight Committee deems appropriate.

3.9 Standardized Procedures and Practice Agreements

Standardized procedures and practice agreements refer to the written policies and protocols for the performance of standardized procedure or practice agreement functions, and which have been developed in accordance with standards of practice and applicable law. The IPC is responsible for assuring that standardized procedures and practice agreements are a collaborative effort among administrators and health professionals, including physicians, AHPs, and nurses. AHPs are responsible for complying with the requirements of the standardized procedures or practice agreements.

Rule 4 Admissions

4.1 **General** - The hospital shall accept patients for care and treatment, subject to the limitations of the hospital's facility, personnel and the medical services it offers. A patient may be admitted to the hospital only by a practitioner who has been granted appropriate privileges to admit patients to the hospital or order procedures in accordance with state and federal law, and applicable Hospital policies. Members of the Medical Staff must maintain responsibility for the overall care of patients whom they admit, including appropriate supervision of AHPs to the extent applicable.

4.2 **Provisional Diagnosis -** Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

4.3 **Responsible Physician -** A physician with appropriate privileges shall be responsible for the medical aspects of admission, hospital care, and discharge of each patient.

4.4 **Sufficient Information -** The admitting practitioner shall be held responsible for giving such information as may be necessary to the protection of the patient from self-harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.

4.5 **Transfer of Patient Responsibilities -** Whenever the attending physician transfers the patient responsibilities to another staff member, the physician will be responsible for notifying the physician to whom they are referring the patient, who must verbally accept the transfer. A note covering the transfer of responsibilities shall be entered on the order sheet of the medical record.

Rule 5 Consultations

5.1-1 **Psychiatric Consultations –** All suicide attempt and overdose patients should be offered psychiatric consultations.

5.1-2 **Consultation Recommended -** Except in an emergency, consultation is recommended in the following situations:

a. Where the patient's condition is deteriorating for unknown reasons;

b. Where diagnosis is obscure;

c. For continued and/or multiple therapeutic choices of unusual complexity;

d. For situations of unusual risk;

e. For disease processes or procedures with which practitioner is not fully current or familiar;

f. Where consultation is requested by the patient or family;

g. When declaration of brain death is required; or

h. When withdrawal of life support is being considered in non-brain dead patients.

The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Requests for consultation must be made by direct personal communication from the requesting practitioner to the consulting member of the Medical Staff or other qualified individual as permitted by California law. The use of hospital nurses or other employees to request the consultation is not allowed, except in cases of emergency or if consultation is part of routine, pre-printed orders. When requesting a consultation, the practitioner must enter an appropriate order, if applicable to the type of consultation being requested, and is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation. Upon completion of the consulting practitioner's duties the consulting practitioner may remove themselves by direct computer entry. The attending practitioner's responsibility for his or her patient does not end with a request for a consultation.

5.1-3 **Required Consultations -** The Department Chief, Chief of Staff, the Chief Medical Officer, Medical Director or the Service Director may recommend or require consultation where it appears advisable in the interest of patient care.

5.1-4 Notwithstanding the Recommended and Required Consultation set forth above, this Rule shall not preclude consultations on any patient when the attending physician determines a patient will benefit from such consultation.

Rule 6 Discharges

6.1-1 **Discharges -** Patients shall be discharged on order of a physician in compliance with applicable Hospital and Medical Staff policies and practices. At the time of discharge, the responsible physician will see that the record is complete, including final diagnoses, procedure reports, complications, discharge disposition and summary, and record signatures. All records must be completed within fourteen (14) days following the patient's discharge

from the Hospital. If the patient leaves the Hospital against medical advice, this must be documented in the patient's medical record and the patient should be asked to sign the appropriate release form.

6.1-2 **Discharge Summary -** Conclusions at the termination of hospitalization shall be recorded in the discharge summary. The summary shall concisely recapitulate the reason for the hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or the family. Instructions shall relate to the physical activity, medication, diet, and follow-up care of the patient.

Rule 7 Medical Records

7.1-1 **Responsible/Attending Physician -** The responsible/attending physician is responsible for ensuring that a complete and legible medical record for each hospital patient is prepared; other practitioners involved in the patient's care shall be responsible for proper documentation in the record of the involvement. The medical record shall contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. Its contents shall be pertinent and current and in compliance with applicable Hospital and Medical Staff policies.

7.1-2 **Attending Staff Documentation -** Every medical record shall contain written evidence of patient care and critical review of the patient by a member of the attending staff.

7.1-3 **Entries –** All medical record entries will be legible, dated, timed and signed.

7.1-4 **Medical Record Content –** The medical record shall contain the following information:

a. Identification data;

b. Appropriate comprehensive medical history and physical examination (the History & Physical);

c. Provisional diagnosis;

d. Diagnostic & Therapeutic orders;

e. Informed consent, where applicable;

f. Reports of procedures, tests, findings, and results;

g. Operative notes;

h. Progress notes;

i. Consultation reports;

j. Anesthesiology records;

k. Discharge summary;

l. Any other pertinent information (such as patient's advance directives).

7.1-5 **Components of History & Physical** – The History & Physical shall include:

a. Chief complaint;

b. Details of present illness, including when appropriate, assessment of patient's emotional, behavioral, and social status;

c. Relevant past, social and family history appropriate to the age of the patient;

d. Review of body systems and pain evaluation;

e. Physical examination;

f. Statement of conclusions or impression drawn;

g. Statement of course of action planned.

7.1-6 **Pediatric History and Physical Components –** In regard to children and adolescents, the History & Physical shall also include:

a. An evaluation of patient's developmental age;

b. Consideration of educational needs and daily activities, as appropriate;

c. The patient's report or other documentation of patient's immunization status;

d. The family's and/or guardian's expectations for, and involvement in, assessment, treatment and continuous care of the patient.

7.1-7 **Orders: Diagnostic & Therapeutic** – All orders for treatment shall be in writing, dated, timed & signed with physician's last name, and must include appropriate information about the patient's diagnosis as necessary to justify the treatment.

7.1-8 **Telephone/Verbal Orders -** A telephone order shall be considered to be in writing from a licensed independent practitioner when received by telephone, by nurses and by technicians of specific departments who have been authorized to receive.

a. Verbal orders will be allowed in emergency situations only.

b. All orders given over the telephone shall be reviewed and signed by a physician responsible for the patient's care or the ordering physician, noting date and time and practitioner's name. The covering or attending physician shall authenticate such orders within 48 hours.

c. All staff receiving a telephone order shall write the order in the medical record and read back the complete order for verification from the ordering physician.

d. Telephone orders are to be used infrequently and not primarily for the convenience of the ordering practitioner.

e. Do Not Resuscitate orders may not be documented as telephone/verbal orders.

7.1-9 **Telephone orders for administration of medications -** Telephone orders for drugs shall be given only by a person lawfully authorized to prescribe or furnish in the State of California and shall be recorded promptly in the patients' medical record, noting the name of the person giving the verbal order and the signature of the person receiving the order. Telephone orders may be given to the R.N., L.V.N., Nurse Practitioner, Licensed Psychiatric Technician; Pharmacist, Physician and Physician's Assistant (P.A. from Supervising Physician only), Physical Therapists (for certain topical drugs only), and Respiratory Therapists when the orders relate specifically to respiratory therapy.

7.1-10 **Telephone orders for other than drugs –** Telephone orders for other than drugs shall be given only by a licensed, registered or certified health professional provided that the orders given are within the professional's area of competence of the individual: Audiologists, Cardiopulmonary/Pulmonary Technologists/Technicians, Dietitians (except parenteral nutrition), Laboratory Technologists, Occupational Therapists, Physical Therapists, Radiological Technologists, Respiratory Therapists, and Speech Pathologist.

7.1-11 **Progress Notes –** Progress notes reflect the course of hospitalization and significant changes in patient status. Abnormal test results are discussed. Progress notes must be timed, dated and signed with physician's last name.

7.1-12 **Non-Removal of Records –** Medical records may not be removed from the hospital except under court order, subpoena or state statute. There are no exceptions to this rule. Remote access to the hospital's electronic health records system must be in compliance with applicable hospital policies and confidentiality protections provided under federal and state law.

7.1-13 **File Complete –** No medical record shall be filed until it is complete, except on order of the Medical Records Committee.

Rule 8 Surgery

8.1-1 **Surgical Informed Consent -**Written, signed informed consent shall be obtained prior to any operative procedure in accordance with the hospital's informed consent policies, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained. In emergencies involving a minor or unconscious patient, in which consent for surgery cannot be obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient medical record.

8.1-2 **Labs and Pre-Op Tests -** The ordering of labs and other pre-operative tests will be left to the discretion of the Surgeon and Anesthesiologist based on the individual needs of the patient.

8.1-3 **Commence Operation -** Surgeons must be in the operating room and ready to commence operation at the time of the scheduled surgery. In no case will the operating room be held longer than fifteen (15) minutes after scheduled time of operation.

8.1-4 **Operative Report -** The Operative Report shall include the pre-operative diagnosis, description of findings, technique used, and tissue removed or altered.

a. An immediate operative report shall be entered in the medical record immediately after the completion of any invasive procedure. This note must include: Name of primary surgeon and assistants, Findings, Technical Procedure used; Specimens removed, Post-Operative Diagnosis, Estimated Blood Loss.

b. A dictated, detailed, operative/procedure report shall be completed, authenticated, and filed in the medical record as soon as reasonably

possible after any invasive procedure requiring more than simple local anesthesia.

8.1-5 **Specimen Removed During Surgery -** All tissue removed at operation, with the following exceptions, shall be sent to the hospital Pathologist, who shall make such examinations as may be considered necessary to arrive at a diagnosis and who shall sign such report.

8.1-6 **List of Specimens -** The following list of specimens removed during surgery may, at the discretion of the surgeon, be exempt from the requirement for pathology examination:

a. Specimens by nature or condition do not permit fruitful examination, such as a cataract, orthopedic appliance, foreign body or removed only to enhance operative exposure;

b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements;

c. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

d. Foreign bodies (e.g. bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives;

e. Specimens known to rarely, if ever, show pathological change and removal of which is highly visible post-op, such as the foreskin from the circumcision of a newborn infant;

f. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;

g. Teeth, provided the number, including fragments, is recorded in the medical record;

h. Tissues debrided from areas of trauma;

i. Cartilage or bone removed in the course of septoplasty/rhinoplasty;

j. Ventilation tubes removed from the tympanic membrane or external auditory canal;

k. Arch bars;

l. Dentures and intra-oral prosthetic splints;

m. Toenails and fingernails;

n. Burn debridement specimens;

o. K-wires and Steinmann pins;

p. Breast implants;

q. Normal bone, muscle tissue, adipose tissue, skin or cartilage removed incidental to the primary procedure;

r. Scribner shunt parts, Hickman catheter parts;

s. Unused donor site skin removed for application as a skin graft;

t. Orthopedic hardware, i.e., screws, nails, etc.

u. Meniscus fragments removed at arthroscopy;

v. Phalanges removed for hammer toe;

w. Sutures removed at surgery.

8.1-7 **Oral/Dental/Podiatric Surgery -** Patients admitted for oral or dental surgery or podiatric surgery shall be under the joint responsibility of a doctor of dental surgery or podiatrist and a physician. The doctor of dental surgery or podiatrist shall be responsible for documenting treatment including the surgical reports. A physician shall be responsible for the general care of the patient, including the general medical history and physical.

8.1-8 **Cancel Surgery -** When the history and physical examination is not recorded before the time slated for surgery, the surgery shall be canceled unless the attending surgeon states in writing that such a delay would be detrimental to the patient.

Rule 9 Autopsies

9.1-1 **Securing Autopsies –** Unless otherwise required by the County Coroner, an autopsy may be performed only with written consent of a relative or legally authorized agent.

9.1-2 **Autopsy as Part of Record -** When an autopsy is performed, provisional anatomic diagnosis shall be recorded in the medical record within three (3) days, and the complete protocol shall be made part of the medical record

within ninety (90) days. An exception for special studies may be established by the Medical Records Committee.

9.1-3 **Autopsy Criteria –** The following criteria shall be used to identify deaths in which an autopsy should be performed:

a. Unanticipated death;

b. Death occurring while the patient is being treated under an experimental regimen;

c. Intra-operative or intra-procedural death;

d. Death occurring within 48 hours after surgery or an invasive diagnostic procedure;

e. Death incident to pregnancy within seven (7) days following delivery;

f. All deaths on the psychiatric inpatient service;

g. Death where the cause is sufficiently obscure to delay completion of the death certificate;

h. Death in infants/children with unexplained congenital malformations;

i. Deaths reportable to the County Coroner referenced in the Hospital administrative policy.