

LAKWOOD REGIONAL MEDICAL CENTER

GENERAL RULES AND REGULATIONS

FOR THE MEDICAL STAFF

Approved and adopted by the Medical Staff and the Governing Board on September 15, 2009.

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Revised May 2009
Revised May 2006
Revised December 2005
Revised March 2005
Revised September 2004
Revised May 2004
Revised Nov 2003
Revised Sept 2003
Revised June 2003
Revised March 2003
Revised November 2002
Revised June 2002
Revised September 2001
Revised June 2001
Revised November 2000
Revised March 2000
Revised Dec 1998
Revised Sept 1998
Revised January 1997
Revised October 1996
Revised Dec 1995
Revised October 1994
Revised Feb 1992
Revised Apr 2007
Revised July 2009

LAKWOOD REGIONAL MEDICAL CENTER

GENERAL RULES AND REGULATIONS OF THE MEDICAL STAFF

General Rules and Regulations of the medical staff are established to provide a framework for the conduct of care by the medical staff as a whole. These will refer to the conduct of clinical activity within the hospital.

No rules or regulations or medical staff policy shall in conflict with the Medical Staff Bylaws and Rules Regulations shall be reviewed annually.

Categories of the Medical Staff

The medical staff shall be divided into the following categories: Active, Courtesy, Provisional and Honorary.

I. ACTIVE STAFF

A. QUALIFICATIONS

The Active Staff shall consist of Members who:

- 1) meet the general qualifications for membership set forth in Article 3.1 of the Medical Staff Bylaws,
- 2) has, except as otherwise specifically exempted, completed at least 6 months of satisfactory performance on the Provisional Staff,
- 3) is located closely enough (office and residence) to the hospital to provide continuous care to their patients as determined by medical staff policy, and

An Active Staff member is expected to conduct a major portion of his Hospital practice at the hospital. Following are the requirements to maintain Active Staff. For the purpose of reappointments, performed every 2 years, the definition of period is 2 years:

- a. Each member must attend 2 or 25% (whichever is less) of their department meetings each period.
- b. Each active member must admit or be regularly involved in the care of greater than 10 patients (consisting of admissions, consults, and/or surgeries) in the 2 year period. Performance of rounds on behalf of another medical staff member shall constitute being involved in the care of patients within the meaning of this subparagraph. For the specialties of dermatology and allergy/immunology, minimum case activity is not required.

B. PREROGATIVES

The prerogatives of an Active staff member shall be to:

- 1) Physician members may admit patients without limitation. Dentists or podiatrists are limited to co-admission with a physician member who has assumed responsibility for the basic medical appraisal of the patient and for the care of any medical problems that may be present or may arise during hospitalization.
- 2) Exercise such clinical privileges as are granted to them, to include but not be limited to, prescribing medications in accordance with their DEA certificate and licensure, to perform History and Physical Examinations within the scope of their licensure.

- 3) Vote on all matters presented at general and special meetings of the Medical Staff and of the department(s) and committee(s) of which they are a member, unless otherwise provided by resolution of the Medical Executive Committee and approval by the Governing Board.
- 4) Hold office in the staff organization and in the departments and committee(s) of which they are a member, unless otherwise provided by resolution of the Medical Executive Committee and approval by the Governing Board.

Dentists and podiatrists shall not assume or be elected or appointed to any position for which medical education, training and experience, beyond that which podiatrists, dentists can demonstrate, are prerequisite for carrying out the duties and exercising the authority thereof.

C. RESPONSIBILITIES AND OBLIGATIONS

Each member of the active staff must, in addition to meeting the basic obligations set forth in Article 3:

- 1) Contribute to the organizational and administrative affairs of the medical staff, including service in medical staff, departments and on hospital and medical staff committees, faithfully performing the duties of any office or position to which elected or appointed.
- 2) Participate in the quality improvement activities required of the medical staff.
- 3) Discharge the recognized functions of staff membership by engaging in the staff's teaching and continuing education programs, supervising practitioners during the provisional and observation period, and fulfilling such other staff functions that may reasonably be required of staff members.
- 4) Attend regular and special meetings of the medical staff and of the department, fulfilling attendance requirements pursuant Article 4.2-1 (d) of the Medical Staff Bylaws.
- 4) Active medical staff members shall also demonstrate an active, supportive interest in the facility and willingness to devote such time and energy may be necessary in its best interests.

II. COURTESY STAFF

A. QUALIFICATIONS

Meet the general qualifications for membership set forth in Article 3.1 of the Medical Staff Bylaws:

- 1) Has except as otherwise specifically exempted, completed at least 6 months of satisfactory performance in the Provisional category,
- 2) is located closely enough (office and residence) to the hospital to provide continuous care to their patients as determined by medical staff policy, and
- 3) regularly care for patients in this hospital and are regularly involved in medical staff functions, as determined by the medical staff.

The Courtesy staff shall consist of practitioners each of whom is located closely enough to the hospital to provide continuous care to their patients as determined by medical staff policy and meets the following criteria:

- 1) Physician must admit patients to or be otherwise involved in the care of patients in this hospital. For the purpose of this Section, this means the admission of care of at least two (2) patients every two (2) years.

B. PREROGATIVES

- 1) Admit patients to the hospital within the limitations and under the same conditions as specified for active staff members. At times of full hospital occupancy or of shortage of hospital beds or other facilities, as determined by the administrator, the elective patient admissions of courtesy members shall be subordinate to those of active and associate staff members.
- 2) Exercise such clinical privileges as are granted to them.
- 3) May attend meetings of the staff, department or committee(s) to which they are a member and any staff or hospital education program. Courtesy staff members shall not be eligible to vote nor hold office in this medical staff organization.

C. RESPONSIBILITIES AND OBLIGATIONS

Each member of the courtesy staff is required to discharge the basic obligations as specified in Article 3 and as set forth in Section 1, Subsection 4, Item B of this Article 4.

IV. HONORARY STAFF

A. QUALIFICATIONS

The Honorary staff shall consist of retired practitioners recognized for their outstanding reputations, their noteworthy contributions to the health and medical sciences, or their previous long standing service to the hospital.

Medical staff members granted honorary staff status shall not be required to request reappointment.

B. PREROGATIVES

Honorary staff members are not eligible to admit patients to the hospital or to exercise clinical privileges in the hospital. They may, however, attend any staff or hospital education meetings. Honorary staff members shall not be eligible to vote or to hold office in the medical staff organization.

V. PROVISIONAL STATUS

A. QUALIFICATIONS

- 1) Meet the general Medical Staff membership qualifications set forth in Article 3 and
- 2) Immediately prior to their application and appointment were not members (or were no longer members) in good standing of this medical staff.

B. PREOGATIVES

The Provisional Staff member shall be entitled to:

- 1) admit patients and exercise such clinical privileges as are granted pursuant to Article 7; and
- 2) attend meetings of the Medical Staff and the department of which that person is a member, including open committee meetings and educational programs, but may not vote at such meetings, except within committees when the right to vote is specified at the time of appointment. Provisional Staff members shall not be eligible to hold office in the Medical Staff organization, but may serve upon committees.

C. OBSERVATION/PROCTORING OF PROVISIONAL MEMBERS

The purpose of observation and proctoring shall be to evaluate the member's (1) proficiency in the exercise of clinical privileges initially granted and (2) overall eligibility for continued staff membership and

advancement within staff categories. An initial appointment shall remain provisional until the appointee has furnished to the Medical Executive Committee:

- 1) a statement signed by the Chair of each department in which he/she exercises privileges that the appointee satisfactorily meets most of the qualifications, responsibilities as described in Article 7 and has not exceeded or abuse the prerogatives of his/her provisional appointment; and
- 2) a statement signed by the Chair of his/her department that the appointee has demonstrated his/her ability to exercise the clinical privileges provisionally granted to him/her.

D. TERM OF PROVISIONAL STAFF STATUS

Provisional Staff status may not be renewed for more than one additional six (6) month period. If the provisional appointee fails within that time period to furnish the certification required in Article 7 of the Medical Staff Bylaws, the provisional member becomes ineligible for advancement to the permanent staff and will be deemed to have voluntarily resigned from the staff and his/her staff status or particular clinical privileges, as applicable, shall automatically terminate. The appointee so affected shall be given special notice of such termination and shall not be entitled to the procedural rights afforded in Article 9 of the Medical Staff Bylaws.

E. ACTION AT CONCLUSION OF PROVISIONAL STATUS

If the Provisional Staff member has satisfactorily demonstrated his/her ability to exercise the clinical privileges initially granted and otherwise appears qualified for continued Medical Staff membership, the member shall be eligible for placement in the Active or Courtesy Staff as appropriate, upon recommendation of the MEC. In all other cases the Credentials Committee shall advise the appropriate department which shall make its report to the MEC which in turn shall make its recommendations to the Board regarding a modification or termination of clinical privileges or termination of Medical Staff membership. Furthermore, a practitioner otherwise judged as qualified for advancement may be assigned to Active or Courtesy Staff category with a continuation of proctoring/observations where most of the proctoring has been satisfactorily met.

ORGANIZED HEALTH CARE ARRANGEMENT (OCHA) PROCEDURE

I. Commitment to Privacy Rule Compliance. The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information adopted by the US Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (the "Privacy Rule"). Medical Staff members shall protect the privacy of patients' health information as required by the Privacy Rule and applicable state law. Further, the Medical Staff is committed to complying with the Privacy Rule in a manner that reasonably minimizes disruption to quality patient care.

II. Organized Health Care Arrangement. The Privacy Rule permits multiple covered entities who provide care in a clinically integrated care setting, such as the hospital setting, to declare themselves an Organized Health Care Arrangement ("OCHA"). OCHA status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment, and health care operations of the arrangement. Such activities include peer review, credentialing, quality assurance and utilization review. As such, OCHA status protects patient privacy while minimizing disruption to quality patient care. Accordingly, by applying for and exercising clinical privileges at the Hospital, each Medical Staff and Allied Staff member agrees to participate in the Hospital's OCHA. As such, all members of the Medical Staff or Allied Staff shall abide by the Hospital's Privacy Policies and Procedures.

III. Joint Notice of Privacy Practices. The Privacy Rule requires a health care provider that is a Covered Entity (as defined in the Privacy Rule) to deliver a notice of privacy practices to a patient no later than the providers first date of service to the patient. Health care providers that participate in an OCHA may comply with this requirement by joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a Medical Staff or Allied Staff member in connection with his or her provision of services in the hospital, by applying for and exercising clinical privileges at the Hospital, each medical staff and allied staff members agrees to abide by the terms of the joint Notice of Privacy Practices of the Hospital and the Medical Staff then in effect.

II. Discipline. Whenever a medical staff or allied staff member uses or discloses health information in a manner inconsistent with the Hospital's Privacy Policies and Procedures or joint Notice of Privacy Practices, the member may be disciplined in accordance with the Medical Staff Bylaws.

ADMISSION & DISCHARGE

I. Admission of Patients

- A. A patient shall be admitted to the Hospital only by a practitioner with admitting privileges. A provisional diagnosis shall be stated or each patient upon admission to the hospital admission will be classed as an emergency, urgent or elective admission.
- B. Physicians admitting patients shall be held responsible to giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self harm.
- C. All patients admitted to the Hospital must be seen by a physician within twenty-four (24) hours of admission and thereafter on a daily basis with a progress note documented.
- D. Patients shall be admitted to the hospital in accordance with licensure of the hospital, subject to specific conditions as follows:

Any patient with a communicable disease, as specified by the Center for Disease Control, may be admitted to the hospital providing Health Department regulations for isolation are met. Refer to CDC Manual for diagnoses not recommended for admission.

II. Admission Laboratory Work

Pre-admit laboratory studies shall be performed at the discretion of the attending physician. It is the responsibility of the attending physician to assure that results of laboratory studies performed in the office are placed in the patients' medical record.

Miscarriage or Abortion - Patients who are Rh- and at risk will receive RhoGam.

III. Medical/Surgical Management

A member of the medical staff shall be responsible for the overall medical management and well being of the patient during hospital, including:

1. medical care and treatment of each patient
2. prompt completeness and accuracy of the medical record
3. formulate a plan of care for the patient that is comprehensive and meets the needs of the patient which is documented in his/her medical record before any procedure(s) are performed.
4. special instructions.
5. transmitting reports of the condition of the patient to the referring practitioner and to relatives or those persons responsible for the patient.
6. The responsible licensed independent practitioner or his or her designee clearly explains the outcome of any treatments or procedures to the patient and, when appropriate, the family, whenever those outcomes differ significantly from the anticipated outcomes.

IV. Continuity of Care

The attending physician has responsibility for complete and continuing care of his patients.

1. To assure continuity of care, each member of the medical staff shall be available or make available through their office, an eligible alternate practitioner who shall assure that all their patients receive optimal professional care.

2. If the patient is under the care of a single physician and the transfer or responsibility will be for a period of time greater than 72 hours, appropriate documentation that the patient has been informed of this transfer should appear in the medical record.
3. This alternate must be a member of the medical staff.

V. Continued Stay

The attending practitioner is required to document the need for continued hospitalization after specific period of stay as identified by the monitoring committee of the hospital. Documentation must contain at least the following:

1. An adequate written record of the reason for continued hospitalization.
2. The estimated period of time the patient will need to remain in the hospital.
3. Discharge plans.

VI. Discharge of Patients

A. Patients shall be discharged or transferred only on written order of the attending physician.

1. It is the responsibility of the attending practitioner to discharge patients in a timely manner.
2. At the time of discharge, the attending physician shall see that the record is complete, make his final diagnosis and sign the record.

B. AMA Discharges

Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

1. The patient should sign the appropriate release.
 - a. If this release is not obtainable, the circumstances shall be documented in the medical record.

C. Transfers

1. If the attending physician concludes that the patient is suffering from a problem for which the hospital facilities and personnel are not adequately equipped, he or she shall make arrangements for transfer of the patient to a suitable facility, per current Administrative policy. This includes, but is not limited to the following patient populations:
 - a. Neo-natal intensive care
 - b. Patients requiring hyperbaric treatment
 - c. Psychiatric patients (emotionally ill, suicidal)
 - d. Burn victims
 - e. Patients requiring organ transplantation
 - f. Evidentiary Examination for alleged sexual assault
 - g. Pediatric Intensive Care
2. Patient shall be transferred to another facility only when such transfer is authorized by the attending physician as being in the interest of the patient, and after the transfer has been agreed upon by the receiving facility and the patient.

D. Deaths

In the event of a death in the hospital the deceased may be pronounced dead by the registered nurse.

1. The body shall not be released until an entry has been made and signed in the medical record of the deceased.
2. Policies with respect to release of the body shall conform to local law.

E. Autopsies

1. An autopsy shall be performed only with written consent, signed in accordance with state law.
2. All autopsies shall be performed by a hospital pathologist. In cases within the jurisdiction of the coroner, his or her authorization shall be obtained first, as dictated by applicable statutes.

CARE OF THE PATIENT**I. Orders for Care**

- A. All orders for drugs shall be in writing, and must be made by a person lawfully authorized to prescribe. An order shall be considered to be in writing if dictated to a licensed nurse (LVN or RN) or licensed pharmacist and signed within 48 hours by the prescribing physician. Verbal and telephone orders shall be written by the person to whom dictated, followed by the name of the prescribing physician, date and time, and then by the name of the writer. The attending physician responsible for the patient's care at the time the drugs are given to the patient may sign the order for a covering/ordering physician. The "attending physician" will be designated as the physician in charge of the patient care, to include admitting and discharge. The "covering physician is the physician who has been designated to be in charge of the patient care during the absence of the attending physician." Laboratory technologists, respiratory therapists and cardiopulmonary or pulmonary technologists may take verbal orders for administration of medication for limited use in their specialty as approved by the medical staff.
- B. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to a licensed nurse (LVN or RN), licensed physiotherapist, occupational therapist, speech therapist, licensed pharmacist, or clinical dietician. Verbal and telephone orders shall be written by the person to whom dictated, followed by the name of the writer. The attending physician responsible for the patient's care at the time the orders are given to the patient may sign the order for a covering/ordering physician during the patient's hospitalization. The "attending physician" will be designated as the physician in charge of the patient care, to include admitting and discharge. The "covering physician is the physician who has been designated to be in charge of the patient care during the absence of the attending physician."
- C. Orders for narcotics, hypnotics, antibiotics, anticoagulants and treatment ordered without time limit may automatically be canceled after 72 hours, but should not be discontinued without notifying the attending physician.
- D. House staff personnel, i.e., residents, fellows, etc. may write patient care orders.
- E. The attending practitioner shall be required to countersign the following medical record entries if made by house staff personnel:
 1. operative reports
 2. consultations
 3. discharge summaries
 4. physical examination reports

F. The attending practitioner shall be responsible for review and any necessary correction of medical record entries made by house staff personnel who are not medical staff members and shall either countersign such entries or sign a statement in the chart that he or she has conducted such review.

G. Outside Medications

Drugs brought into the hospital by patients will not be administered by hospital employees except on written order of the attending practitioner. These drugs must be properly labeled showing the name of the medication, issuing pharmacy with prescription number and is verified by the hospital pharmacist.

H. Investigational Drugs

No investigational drugs shall be administered in Lakewood Regional Medical Center without the signed consent of the patient and specific individual approval by the committee responsible for the pharmacy and therapeutics function, the Institutional Review Committee when applicable, and the Medical Executive Committee. Requests for use of investigational drugs shall be submitted in writing and shall be considered in accordance with State and Federal laws and regulations. Policies as set down in the California Hospital Association Consent Manual shall serve as guidelines for action by the medical staff.

II. Consultations

A. Except in an emergency, consultation with a proper member of the clinical staff is strongly recommended in all surgical cases in which the patient is not a good risk. For other required consultations refer to clinical service protocol.

B. Consultation by a qualified specialist is recommended whenever the attending physician determines that meeting the patient's needs can be enhanced through collaboration with a particular field.

Consultation is suggested on cases in which, according to the judgement of the attending physicians:

1. The diagnosis is obscure.
2. There is doubt as to the best therapeutic measures.
3. The patient is not exhibiting expected response to treatment.

C. Consultation by a medical staff member with obstetrical privileges is mandatory on all obstetrical patients.

D. Each service shall provide a list of qualified and responsible consultants who will be available for necessary consultations in emergency cases. All requests for consultation, where feasible, should be on a doctor-to-doctor basis. Whenever Nursing is requested to call a consultant, there must be a note on the chart regarding the reason for consultation.

1. The Chief of Staff or Chief of Service may call in a consultant on any patient if deemed necessary.

E. Psychiatric consultation and treatment should be requested for, and offered to all patients (whether admitted or treated in the Emergency Room) who have attempted suicide or have taken a Chemical overdose. That such services were offered should be documented in the patient's medical record. If such consultation is refused, the refusal of treatment form shall be completed by the nurse, signed by the patient and/or a member of the patient's family (if the patient is unable to sign). This form will then become part of the patient's medical record.

CONSENTSI. Physician Responsibility

- A. The competent patient is entitled to be informed about the nature of the proposed diagnostic and therapeutic procedures, possible benefits, risks, potential complications and alternative approaches available; the need for and risk of blood transfusion and available alternatives; and the anesthesia options with attendant risks.
- B. It is the physician's responsibility to convey the necessary information appropriate to the patient and the circumstances, in language which the patient is likely to understand, and to document this discussion in a separate entry in the medical record.
- C. No elective invasive procedure is to begin until documentation that informed consent was given to the patient is on the chart, except in cases of extreme life threatening emergencies where the physician feels such a delay would be detrimental to the patient's well being.

II. Emergency Situations

- A. Except in emergencies, or as noted below, no patients shall be subjected to any surgical, diagnostic, or therapeutic procedure that involves a significant risk of bodily harm unless an informed consent is obtained from the patient or his or her legally recognized representative and all other persons, if any, from whom consent is required by law. Said consent shall be in accordance with applicable standards identified in the CAHHS Manual.
- B. The medical record should indicate the emergent reason for not obtaining consent.
- C. In cases where a patient is unconscious or is an unaccompanied, unemancipated minor and requires emergency care, such condition will be documented in the medical record.

III. Patient Refusal

- A. In exceptional cases where the patient asks not to be informed, and/or where discussion of the risks or complications might, in the opinion of the attending physician, cause greater harm to the patient than is warranted, an informed consent may not be required. Such a situation should be noted in the patient's medical record.

IV. Special Consents

Special consents may be required, such as for patient photographs, or for observation or a surgical procedure or delivery, or for education and will be identified by the Executive Committee consistent with legal requirements. All such consents shall become part of the medical record.

V. Incompetent Patients

- A. Any patient over the age of 18 who, in the opinion of the attending physician, is unable to understand the nature of a procedure and/or the consequences of having the procedure done versus not having it done, shall be considered incompetent to give or refuse consent for that procedure.
- B. If two (2) members of the medical staff believe that the procedure is needed to preserve life or health of such a patient, and if the patient has no legal guardian and if the physicians believe that delaying the procedure for the time required to have a legal guardian appointed would jeopardize the patient's life or health, then the physicians will so indicate by signing a consent for emergency treatment, which will serve in place of the usual informed consent. The procedure also be discussed with the patient's family and/or close friends when appropriate.

- C. This mechanism shall also be used for patients under age 18 who have no parent or legal guardian.

SURGERY PATIENTS

I. Requirements Prior to Surgery

- A. All surgeries must have a history and physical, and consultation, if required, written or dictated prior to the patient leaving the floor for surgery.
- B. No surgery is to begin until a completed history and physical is on the chart or the surgeon has written an interim note indicating that the history and physical has been dictated, except in cases of extreme life threatening emergency where the surgeon feels such a delay to be detrimental to the patient's well being. In such cases, history and physical must be dictated immediately following the termination of the surgery and stabilization of the patient and so noted on the chart.
- C. All laboratory work to be performed must be specific as ordered by the individual physician.

II. Scheduling of Surgeries

- A. Surgery may be scheduled only by a member of the medical staff or by their designee. Scheduled surgery must be in accordance with procedures listed on the surgeon's surgery control card.
- B. Operating Room Reservations
Reservations for operations are made at the surgical desk by operating room personnel from 7 a.m. to 11 p.m., Monday through Friday. Elective cases may be scheduled at any time after 11 p.m. or on the weekends with the Nursing Supervisor or designated personnel.
- C. Elective Surgery Admission
All patients scheduled for elective surgery, when feasible, are admitted the day of surgery, unless medically indicated.
- D. Day Care Patients
Patients undergoing surgery under general anesthesia- Requires pre-operative studies completed the day prior to surgery with results on the patient's chart and a brief history and physical be admitted two (2) hours or more prior to scheduled procedure.
- E. Outpatients
Patients admitted for a surgery under local anesthesia. History and physical exam is required by a physician as well as the operating practitioner. Laboratory workup is at discretion of surgeon. An operative note is required and must include: Indications for surgery, condition of patient, operative findings and procedure performed. Outpatients must arrive at the hospital approximately two (2) hours prior to surgery.
- F. Invasive Procedures
Invasive procedures are those involving puncture or incision of the skin or insertion of an instrument or foreign material into the body, including but not limited to, percutaneous aspirations and biopsies, cardiac and vascular catheterization, endoscopies, angioplasties, and implantations, and excluding venipuncture, intravenous therapy, and IM, subcutaneous or intradermal injections.

III. Emergency Surgery Cases

- A. Surgical emergency is defined as any instance where the operating surgeon feels that the delay might

be detrimental to the future health and welfare of the patient and so documents nature of the emergency in the medical record.

- B. In the case of genuine emergency, the emergency may take precedence over the scheduled operation.
- C. The surgeon requesting emergency status over a scheduled case should contact the surgeon whose case is being delayed and explain the circumstances requiring the change.
- D. After the emergency the cases are to be resumed in the previous order.
- E. If emergency status is questioned, it will be reported to and resolved by the chief of surgery.

IV. Pre-operative/Procedure Anesthesia Evaluation

Anesthesia is defined as the administration (in any setting, for any purpose, by any route) of general, spinal or other major regional anesthesia; or sedation (with or without analgesia) for which there is a reasonable expectation that in the manner used, the sedation/analgesia will result in the loss of protective reflexes.

- A. A pre-operative procedure evaluation shall be conducted by an anesthesiologist prior to the scheduled surgery/procedure. At that time there shall be a disclosure of the plan for anesthesia, the inherent risks and possible complications and completion of the pre-anesthesia evaluation. If sedation is administered by someone other than an anesthesiologist the patient is made aware of anesthesia options with attendant risks.
- B. Except in emergency cases this pre-anesthesia evaluation should be recorded prior to the patient's transfer to the anesthesia and operating area and before pre-operative medication has been administered. The choice of specific anesthetic agent or technique shall be left to the discretion of the anesthesiologist. The pre-operative evaluation shall be documented in the patient's medical record and shall include at least the following information:
 - History & Physical (shall be available at time of preanesthesia visit)
 - Choice of anesthesia
 - Previous drug history
 - Previous anesthesia experience/potential problems
 - Date and time of visit
 - Pre-operative condition of the patient
- C. There shall be an appraisal of the patient's condition immediately prior to induction of anesthesia to determine any changes in the patient's condition as compared with that noted on previous visits. Physical status of patient should be noted.
- D. No anesthesia shall be started before the surgeon is dressed in the scrub room preparing for the operation.

V. Post-Operative/Invasive Procedure Anesthesia Care

The postprocedure status of the patient shall be measured, assessed and documented including: the patient's physiologic and psychological status, pathologic findings (when indicated); intravenous fluids and drugs administered, including blood and blood components; and any unusual events or postoperative complications and their management.

- A. Following the procedure for which anesthesia was administered the anesthesiologist or his/her qualified designee(s) shall remain with the patient as long as required for the patient's anesthesia status, and until responsibility for the proper patient care has been assumed by other qualified individuals. Personnel responsible for post-anesthetic care shall be advised of specific problems presented by the patient's condition

- B. After the patient has been returned to the general care area, the anesthesiologist shall visit the patient within twenty-four (24) hours, and shall note the presence or absence of any anesthesia related complications. Each post-anesthesia note shall specify the date and time of visit and must be signed by the anesthesiologist. When the post anesthesia visit and record entry is not feasible because of early patient release from the hospital, the physician who discharges the patient from the hospital must assume the responsibility.

VI. Surgeon's Responsibilities

- A. The surgeon performing the surgery on any patient shall in all instances be known to the patient.
- B. The operative report shall reveal in all actual operating surgeon on the case.
- C. It shall be the responsibility of the operating surgeon to secure an appropriate surgical assistant on cases in which an assistant is indicated.
- D. The assisting physician in the surgical procedures must be a medical staff member or have temporary privileges granted to him/her.
- E. Appropriate x-rays will be taken of all surgical patients when there is an incorrect count of all surgical materials, such as needles (size 6-0 or larger), sponges, etc.

VII. Emergency Procedures

The attending physician may declare that an emergency has arisen and perform a procedure for which he/she has not received approval. He/she must accept full responsibility for his/her acts and adequately state his/her reason for performing them on the progress notes.

IX. Podiatric Patients

Patients admitted for podiatric procedures whether inpatient or outpatient shall be admitted to the Podiatric Service and shall be the joint responsibility of the podiatrist and a physician. The admitting podiatrist shall perform the podiatric admission history, podiatric examination and podiatric treatment plan. The physician staff member shall perform the general medical admission history, physical examination and medical treatment plan, if any. Consultations shall be requested, as indicated, for complicated cases.

X. Dental Patients

- A. Patients are admitted for dental procedures only when they require the support of a general hospital for a coexisting medical condition. Patients admitted for dental procedures shall be the joint responsibility of the attending dentist and physician staff member.
- B. Except as specified in this Section B, a patient admitted for dental treatment shall have an admission history, physical examination and medical treatment plan performed by a physician who is a member of the medical staff or a physician approved by the medical staff. The dental history, dental examination and dental treatment plan are performed by the admitting dentist. Consultations shall be requested as indicated for complicated cases. Oral and maxillofacial surgeons who have met the criteria set forth in the Bylaws and have been determined by the medical staff competent to do so, may perform a history and physical examination and determine the ability of their patient to undergo surgical procedures the maxillofacial surgeons proposes to perform on ASA 1 classified patients. Patients must be evaluated by anesthesia prior to the surgery to determine the patient's ASA status and have enough time remaining to obtain a medical evaluation if it is determined the patient is not an ASA 1 classified patient. For patients with existing medical conditions or abnormal findings beyond the surgical indications, a physician member or physician approved by the medical staff must conduct or supervise the portion of the patient's medical problems present at the time of the admission or which may arise during the hospitalization which are outside the scope of the oral and maxillofacial

surgeon's lawful scope of practice.

XI. Therapeutic Abortions

Therapeutic Abortions up to fourteen (14) weeks gestation may be done by D&C and/or Vacuum curettage at Lakewood Regional Medical Center.

XII. Prompt Attendance of Surgeons

- A. Surgeons must be in the Operating Room and ready to commence operation at the time scheduled.
- B. Any physician having surgery scheduled and finding himself detained is expected to notify surgery.
- C. Surgery will be held for thirty (30) minutes.
- D. If the surgeon cannot be in the hospital in that length of time, his case may be dropped to the end of the schedule.

XIII. Pathological Examinations

- A. It is the responsibility of the surgeon to be sure that all tissue and foreign objects removed by operation shall be delivered to the hospital pathologist and a report of their findings be filed in the patient's medical record except as approved by waiver.
- B. Such tissue shall become the property of the hospital.
- C. Slides of tissue blocks may be made available to outside medical facilities on the surgeon's request for review on a loan basis.

XIV. Autopsies

- A. It shall be the duty of all staff members to secure autopsies whenever possible. Autopsies should be requested in those cases where the findings may reveal causes or mechanism of death which would not otherwise be known or to determine the status of a surgical procedure or cases that meet the medical staff's current criteria.
- B. Autopsies will be performed only upon the written consent of a legally authorized person in a form consistent with applicable statutes. In cases within the jurisdiction of the coroner, his/her authorization shall be obtained first.

MEDICAL RECORD SECTION OF RULES AND REGULATIONS

MEDICAL RECORDS

I. Medical Records

- A. The attending physician shall be held responsible for the preparation of a complete medical record for each patient. The record shall include identification data, completed medical history and report of physical examination, special reports such as consultations, autopsies, and operative reports, laboratory and x-ray data, other provisional diagnosis, progress notes, clinical resume, appropriate consents and final diagnosis. The minimum medical record requirements shall be as follows:

1. HISTORY AND PHYSICAL EXAMS

A. History - Chief complaint, present illness, past history (relevant emotional, behavioral, past, social and family histories) system review, HEENT, pulmonary cardiovascular, gastrointestinal, genitourinary, gynecological status and pregnancy status.

B. Physical Examination - Vital signs, general appearance, HEENT, admitting diagnosis, lungs, heart, abdomen, extremities. Documentation of examination of Pelvic, Rectal, Breast, Genitalia should be included in the History and Physical when clinically indicated or at the discretion of the physician. Documentation must be included as to the reason why the exam of pelvic, rectal, breast or genitalia is not done. A report of vaginal examinations (rectal in virgins) must be recorded on the chart before any pelvic surgery.

C. Outpatient Requirements: All non-inpatients undergoing invasive procedures requiring moderate sedation, general, spinal and regional anesthesia, except those procedures performed under a local skin infiltration or biopsy procedures of skin and subcutaneous tissue, require at a minimum, a legible Short Stay H&P documented prior to the procedure which contains the following: relevant history of illness or injury, past medical history, current medications/allergies, pertinent physical exam, diagnosis, planned procedure and pre-anesthesia assessment and plan.

D. Timeliness Requirements: An H&P must be on the medical record within 24 hours of admission or outpatient surgery.

1. An H&P must be done prior to surgery; and updated if done more than 24 hours prior to surgery.
2. The H&P cannot be completed more than 30 days prior to the admission or outpatient procedure. If completed more than 30 days prior to the admission or procedure, a new H&P must be done.
3. If the H&P is completed less than 30 days prior to the admission or outpatient procedure, an update to the H&P must be documented. If there are no changes to the H&P, the update can be "no changes." This can be documented in the progress notes, or on the existing H&P, or on an H&P update form.

E. Requirements for Performing H&Ps: H&Ps must be performed by physicians with appropriate privileges. If the practitioner providing the history and physical is not a member of the medical staff, it may be accepted as long as the attending or surgeon co-signs the report and documents he/she agrees or writes in changes.

4. **Operative Report** - Pre-operative and post-operative diagnosis, operation/procedure performed, description of the findings, technical procedure, and tissue/specimen removed.
5. **Clinical Resume (Discharge Summary)** - Dates of admission and discharge, reason for admission (pertinent history and physical findings), significant findings, (lab tests, x-rays, etc.) procedures performed/treatment rendered (course in hospital, operations, complications), condition of the patient on discharge, instructions for home care (discharge medications, physical activity, diet, and followup-care), final diagnosis. A final progress note may be substituted for the resume in the case of patients with problems of a minor nature who require LESS THAN 48 hour hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any and all instructions given to the patient and/or family.
6. Late entries in the medical record must be identified as a "late entry", must be dated the date the entry was made, and authenticated by the author.

Patients coming to the hospital for chemotherapy or transfusion for two to three days consecutively or on a regular schedule within a month do not need a history and physical or discharge summary completed.

- B. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record. The record shall include:
1. Adequate patient identification.
 2. Information concerning the time of patient's arrival, means of arrival and by whom transported.
 3. Pertinent history of injury or illness including details relative to first aid or emergency care given the patient prior to his/her arrival at the hospital.
 4. Description of significant clinical laboratory, radiological, and other diagnostic findings.
 5. Diagnosis and impression.
 6. Treatment given.
 7. Condition of the patient on discharge or transfer, this shall be stated in terms permitting specific measurable comparison, not "improved", "good", etc.
 8. Final disposition, including instructions given to the patient and/or his family, relative to necessary follow-up care.
 9. Paramedics reports must be attached to the medical record.
 10. Signature of the attending practitioner who is responsible for the clinical accuracy of the records.
- C. The complete history and physical examination shall, in all cases, be available on the chart or dictated through the hospital system within twenty-four (24) hours after admission of the patient.
- D. Operative Notes/Report
1. On return of the patient from surgery to the recovery room or his/her hospital room, the surgeon shall complete an operative note. The operative note must contain the following: the date, preoperative diagnosis, operation performed, findings, surgeons, anesthesia, drains, estimated blood loss and condition. This operative note is to be such that another physician can sufficiently follow the patient's post-operative course in the interim before the dictated operative report returns to the chart. Dictated operative reports should be back on the chart within 72 hours.
 2. An operative report must be dictated or written in the medical record immediately following the surgery. It must contain a description of the findings, the technical procedures used, the specimens removed, the pre and post-operative diagnosis, type of anesthetic used, estimated blood loss, condition of the patient and the name of the primary physician, surgeon and any assistants.
 3. When completed, the operative report must be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.
- E. Special procedure reports must be dictated or written at the conclusion of the procedure by the operating surgeon or performing surgeon.
- F. Dated progress notes must adequately reflect the condition of the patient and course of therapy, as the patient's condition warrants.
- G. Final or provisional final diagnosis must be provided at the time of discharge.
- H. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated by written signature, or computer key. The practitioner shall be the only individual to use the computer key and all applicable administrative policies and procedures will apply for their use.
- I. The patient's medical record shall be completed at the time of discharge, including final diagnosis, progress notes, and discharge summary. An incomplete medical record will be considered delinquent under the following circumstances:
1. After fourteen (14) days from the date of discharge.
 2. History and Physical not dictated or written on the chart within 24 hours after admission.
 3. Operative Report not dictated immediately following the procedure.

If the record is delinquent, the Director of Health Information Services will notify the practitioner that

his/her privileges to admit, consult, schedule elective operations and assist at elective operations and deliveries have been suspended per the following:

1. Via **fax and/or** mail if the record is not completed after 14 days following discharge;
2. Via telephone and faxed letter if the H&P and Operative Reports are not dictated or written as noted above.

The practitioner shall remain suspended until the records have been completed. All appropriate hospital departments, including Admitting, Nursing and Administration shall be notified of this action. **After ninety (90)** consecutive or cumulative days of suspension in a calendar year for delinquent medical records, the Medical Staff Office will notify the practitioner of his/her voluntary resignation from the medical staff. No medical record shall be filed until it is completed except upon the order of the Medical Executive Committee and approved by the Governing Board.

- K. All records are the property of the Hospital and shall not be removed from the hospital except by subpoena, statute or court order under the direction of the Administrator.
- L. In case of readmission of the patient, previous records shall be available for use by the attending physician. This shall apply-whether the patient is attended by the same physician or another.

EMERGENCY SERVICES

- A. Emergency care will be rendered to any patient presenting to the Emergency Room regardless of age, sex, ethnicity, social or financial status. Every patient will be examined by a physician and will receive at least first aid treatment. In the following cases, emergency care will be given and the patient transferred when stable:
 - a. Severe and extensive burns.
 - b. Psychiatric patients with no chemical dependency problems.
 - c. Violent or severe psychiatric disordered patients in need of locked/secured environment.
- B. The following procedures will not be performed in the Emergency Room:
 - a. Surgery requiring general anesthetic.
 - b. Procedures requiring the use of flammable agents.

C. Each physician serving on a call panel shall fulfill the following general criteria:

1. Any physician who serves on the E.R. Call Panels shall see all patients he/she is called in to see by the E.R. physician, if the E.R. physician deems it to be an emergency.
2. It is the physician's responsibility to make arrangements for any change in the Call Panel schedule. All changes must be reported to the E.D. and the Medical Staff Office.
3. Any patients admitted will be under the service of the physician on call to the E.D. unless the patient has a private attending physician who is a member of the medical staff.
4. Physicians who serve on the Call Panels must be members of the hospital medical staff with full privileges in their specialty.
5. Each clinical department shall develop criteria regarding staff membership category, rotation time, and specific criteria relating to an individual panel under that department.
6. Service on any Call Panel shall be deemed a courtesy and not a privilege. Final discretion relative to a physician serving on a panel shall be that of the Executive Committee and Governing Board.

Individual Call Panel criteria shall not be inconsistent with the general criteria for Call Panels, the Medical Staff Bylaws, and the Rules and Regulations of the Medical Staff.

It is the physician's responsibility to make arrangements for any change in the Call Panel schedule. All changes must be reported to the E.D. and the Medical Staff Office.

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4. Physicians who serve on the Call Panels must be members of the hospital medical staff with full privileges in their specialty.
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6. Service on any Call Panel shall be deemed a courtesy and not a privilege. Final discretion relative to a physician serving on a panel shall be that of the Executive Committee and Governing Board.

Individual Call Panel criteria shall not be inconsistent with the general criteria for Call Panels, the Medical Staff Bylaws, and the Rules and Regulations of the Medical Staff.

MEDICAL STAFF STANDING COMMITTEES

A. Bioethics Committee

1. Composition and Meetings

The Committee membership shall be composed of a Chairperson, Vice Chairperson and a minimum of five (5) members of the Active Medical Staff who represent the major patient care services. Non-physician, non-voting members and shall include the hospital's Administrator, Director of Nursing, and Director of Social Services, and may include an attorney, a child advocate, and a pastoral care representative from the community. The consensus of the committee shall be recorded for each case reviewed.

The Committee shall meet a minimum of twice a year for organizational purposes and shall also meet on call. The Committee shall report directly to the Medical Staff Executive Committee.

2. Duties and Responsibilities

The Committee shall evaluate and strive to improve the quality of care delivered in the hospital to cases having ethical implications.

The Bioethics Committee shall advise and assist the responsible physician, patient, and the patient's family on ethical issues referred to the committee relating to hospitalization and treatment. The committee should not make binding decisions regarding the patient's care.

The Committee should ensure there has been adequate communication between all concerned parties and the decision they reach is within the range of ethically and legally acceptable alternatives.

The Committee shall also be responsible for adopting, reviewing, and revising its policies and procedures for treatment in cases having ethical implications.

B. Committee on Interdisciplinary Practice

1. Composition

The Committee on Interdisciplinary Practice shall consist of, at a minimum, the Director of Nursing, the Administrator or designee, and an equal number of physicians appointed by the Medical Executive Committee and registered nurses appointed by the Director of Nursing. Licensed or

certified health professionals other than registered nurses who perform functions requiring standardized procedures shall be included in the committee. The chair of the committee shall be a physician member of the active medical staff appointed by the Medical Executive Committee.

2. Duties and Responsibilities

The Interdisciplinary Practice Committee shall perform functions consistent with the requirements of law and regulation. The Interdisciplinary Practice Committee shall routinely report to the Governing Board through the Medical Executive Committee, and, in addition, shall submit an annual report directly to the Governing Board and the Medical Executive Committee.

3. Meetings

The Interdisciplinary Practice Committee shall meet such intervals as the chair or the Medical Executive Committee may deem appropriate or at least quarterly.

C. Credentials Committee

1. Composition and Meetings

The Credentials Committee shall be composed of a Chair whose selection and tenure shall be in accordance with the Bylaws of the Medical Staff. The Chair who is appointed by the Chief of Staff, shall appoint the Vice-chair of the Committee following consultation with the Chief of Staff. There shall be representation from Hospital Administration. The Chair shall have overall responsibility for coordinating the credentialing process for all new applicants to the medical staff.

There shall be at least five (5) members of the Active Staff. The Credentials Committee shall meet as needed.

2. Duties and Responsibilities

Initial applicants to the medical staff and their responsibilities are as outlined in these Bylaws.

The Committee shall conduct a thorough investigation as to the qualifications of all applicants to the medical staff and for AHPs.

The Committee shall thoroughly review and assure completion of the application for medical staff membership and privilege control card, consistent with these Bylaws requirements, specified in Article 7, Section 2.

The Committee shall investigate all disciplinary action reports, and any other action taken against a physician by another medical facility or medical organization.

The Committee shall review all applications for reappointment, supporting documentation required by Bylaws Article 6, Section 5, Subsections 1-3, and Departmental recommendations for continuance of staff membership and privileges.

The Committee shall also submit recommendations to the Executive Committee and Governing Board relative to new applicants and other medical staff members for reappointment.

The committee shall review the credentialing process on an annual basis to assure that it is current and complete.

D. Critical Care Committee

1. Composition and Meetings

The Critical Care Committee shall be a multidisciplinary committee composed of representatives of each major

clinical department of the medical staff. There shall be representation from nursing, laboratory, radiology, respiratory therapy, pharmacy, and Administration.

The Committee shall meet regularly and at least four (4) times per year, and report directly to the Medical Executive Committee.

The Chair of the Critical Care Committee shall be appointed by the Chief of Staff. The Vice Chair shall be appointed by the Chair.

2. Duties and Responsibilities

The Critical Care Committee shall review and evaluate the quality of patient care rendered in the Units. Written reports shall be presented to the Medical Executive Committee and appropriate clinical departments. It shall evaluate the Units for equipment and space utilized and the nursing service, making recommendations where appropriate. It shall make recommendations regard policies related to the Units and ensure the reinforcement of these policies. It shall make plan for the growth and development of the Units. It shall be responsible for conducting quality improvement activities to evaluate the quality of care rendered in the Units.

The Chair of the committee, the Vice Chair and members of the committee shall be available to discuss any patient care problems with the Nursing Director of the Units.

E. Infection Control/Pharmacy and Therapeutics Committee

1. Composition and Meetings

The Committee shall be a multi-disciplinary committee, composed of a Chair, Vice Chair and a minimum of five (5) members of the medical staff, including the Director of Pathology. Non-physician, non-voting members shall include representation from Administration, Nursing, Quality Assessment, Medical Records, Pharmacy, Housekeeping, Central Services, Maintenance, Dietary, Operating Room, Laboratory and the Infection Control Nurse. These ancillary services shall participate and attend on an as-needed basis.

California statutory requirements (SB 158, Chapter 294, Statutes of 2008) mandate that all physicians with responsibility for infection control or designated as a hospital epidemiologist in their hospitals receive specialized training in infection surveillance, prevention and control by January 1, 2010. The training program must be offered by the federal Centers for Disease Control and Prevention and the Society for Healthcare Epidemiology of America (SHEA) or other recognized professional organization.

Therefore, the Chairman of the Infection Control / Pharmacy & Therapeutics Committee shall successfully complete the specialized training in infection surveillance, prevention and control offered by the federal Centers for Disease Control and Prevention and the Society for Healthcare Epidemiology of America (SHEA) or other recognized professional organization.

The Committee shall meet periodically (a minimum of at least once in each quarter) and report directly to the Medical Staff Executive Committee.

2. Duties and Responsibilities

The Committee shall:

- a) Develop a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.
- b) Develop and implement a preventive and corrective infection control program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques.

- c) Develop and review written policies defining special indications for isolation requirements in relation to the medical condition involved; review and/or act upon findings from such review of clinical use of antibiotics.
- d) Be responsible for the development and surveillance of the drug therapy and utilization policies and practices in the hospital in order to promote satisfactory clinical results while minimizing the potential for hazards.
- e) Review significant untoward drug reactions and medication errors.
- f) Assist in the formulation of broad professional policies regarding the evaluation, selection, storage, distribution, use, safety procedures, administration and other matters relating to drugs and diagnostic testing materials in the Hospital.
- g) Advise the Professional Staff on matters pertaining to the choice of available drugs; evaluate clinical data concerning new drugs; make recommendations concerning drugs to be stocked throughout the hospital.
- h) Develop and maintain a current formulary for use in the hospital and establish standards concerning the use and control of investigational drugs and of research in the use of approved drugs.

F. Medical Education Committee

1. Composition and Meetings

The Medical Education Committee shall be a multidisciplinary committee composed of a Chair who shall be appointed by the Medical Executive Committee for a period of two (2) years and members who shall serve staggered terms. The Vice Chair shall be selected from the appointed committee members by the Chair.

The Chair shall also serve as a member of the Process Improvement Committee.

The Committee shall meet at least quarterly and submit reports to the Medical Executive Committee.

2. Duties and Responsibilities

Continuing Medical Education: The Medical Education Committee shall organize and monitor a continuing medical education program coordinated with the Process Improvement Program, designed to keep the Professional Staff informed of significant new developments in medicine and based on presumed, expressed or demonstrated needs.

The monitoring process shall include opinions and experience of the program planners, consideration of needs identified by the medical staff and demonstrated needs identified by but not limited to Process Improvement activities and feedback from patient satisfaction surveys.

Clear statements of objectives for educational activities shall be formulated. Programs shall be evaluated to determine if objectives were met.

The Committee shall be responsible for documentation of all Committee meetings and activities as well as documentation of all educational activity designated as Category 1, including but not limited to attendance records, evaluations, etc.

Medical Library: The Medical Education Committee shall be responsible for maintaining the Medical Library.

It shall review library policies and procedures, evaluate the effectiveness of the Library in meeting the informational, educational and research needs of its users; assist in establishing priorities in the selection of new texts, the selection or renewal of journals and the acquisition of other library materials.

Other Medical Staff Committees: The Medical Education Committee shall maintain a liaison relationship with other committees responsible for assessing educational needs.

G. Medical Staff Advisory

1. Composition and Meetings

The Committee membership shall be composed of a minimum of four (4) members of the Medical Staff, including the Chair and Vice Chair. Representation from Psychiatry, one representative from primary care, one representative from Anesthesiology.

Except for initial appointments, each member shall serve a term of two years, and the terms shall be staggered as deemed appropriate by the Medical Executive Committee to achieve continuity. Insofar as possible, members of this committee shall not serve as active participants on other peer review or quality improvement committees while serving on this Committee.

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain only such record on its activities so as to report on a routine basis to the Medical Executive Committee.

2. Duties and Responsibilities

The Committee shall receive reports related to the health, well-being, or impairment of medical staff members and, as it deems appropriate, may investigate such reports. With respect to matters involving individual medical staff members, the committee may, on a voluntary basis, provide such advice, counseling, or referrals as may seem appropriate. Such activities shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a medical staff member poses an unreasonable risk of harm to hospitalized patients, that information may be referred for corrective action.

The Committee will review and make recommendations, as necessary, to the Medical Executive Committee on progress reports of medical staff members participating in diversion programs administered by the California Medical Board or other regulatory agencies.

The Committee shall also consider general matters related to the health and well-being of the medical staff and, with the approval of the Medical Executive Committee, develop educational programs or related activities.

H. Medical Staff Bylaws Committee

1. Composition and Meetings

The Medical Staff Bylaws Committee shall be composed of a Chairperson, a Vice-Chairperson and at least five (5) members of the Active Medical Staff and shall include representation from hospital administration.

The Committee shall meet as often as necessary to fulfill their committee functions, but in no event shall this be less than annually.

2. Duties and Responsibilities

The Committee shall be responsible for:

- a) Reviewing and maintaining the Medical Staff Bylaws, Rules and Regulations.
- b) Conducting an annual review of the Bylaws.
- c) Submit written recommendations to the Executive Committee, Active Staff and Governing Board regarding revisions or amendments to the Bylaws, assuring compliance with Bylaws, Article 16,

Adoption and Amendment, etc.

The Committee shall assure that the Bylaws, Rules and Regulations meet all requirements as stated by all regulatory bodies.

I. Process Improvement Committee

1. Composition and Meetings

The Committee shall be composed of a Chairperson, Vice Chair and a representative from each Clinical Department of the medical staff, and the Continuing Education Committee Chair. Non-physician, non-voting members shall include the Administrator, or his designee, Director of Nursing, Director of Process Improvement, Director of Medical Records, and Laboratory Director. Ancillary department directors shall participate when appropriate.

The Committee shall meet periodically (a minimum of four (4) times a year and report directly to the Medical Executive Committee.

2. Duties and Responsibilities

a. Process Improvement Plan: The Process Improvement Committee shall be responsible for implementing the Process Improvement Program/Plan. The Committee shall identify and appraise all hospital process improvement activities, to identify problems in patient care and set priorities for their investigation and resolution, and to oversee the review functions set forth in the PI plan.

The Committee shall reappraise the PI Plan annually. The Committee shall provide a summary documenting activity and demonstrating relevant findings, actions taken and evidence of the program's impact on clinical performance, patient care and patient safety, on a bi-monthly basis. This report shall be presented to the Executive Committee, Governing Board and Administration.

The Process Improvement Committee shall work with the departments to implement quality of care and risk management activities for the Hospital which are comprehensive, integrated and which promote accountability.

The Process Improvement Committee is responsible for the following functions:

b. Health Information Services

The Committee shall assure that all medical record completion requirements are fulfilled as outlined in these Bylaws, Rules and Regulations.

The Committee shall assure that the medical record contains sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

The Committee shall assure that the medical record data and information are managed in a timely manner.

The Committee shall assure that medical records are reviewed at least quarterly for completeness, accuracy, and timely completion of information, and action is taken as necessary to improve this process.

The review is performed by, at a minimum, the medical staff in cooperation with nursing, the health information service, management and administrative services, and representatives of other departments as appropriate.

c. Process Improvement

The Process Improvement Committee is responsible to ensure that when the performance of a process is dependent primarily on the activities of one or more individuals with clinical privileges, the medical staff

provides leadership for the process measurement, assessment, and improvement. These processes include, but are not limited to:

Medical assessment and treatment of patients; use of medications; use of blood and blood components; use of operative and other procedures; efficiency of clinical practice patterns; significant departures from established patterns of clinical practice.

The Process Improvement Committee is responsible to ensure that the medical staff participates in the measurement, assessment, and improvement of other patient care processes. The processes include, but are not limited to:

Education of patients and families; coordination of care with other practitioners and hospital personnel, as relevant to the care of an individual patient; and accurate, timely and legible completion of patients' medical records.

Ensure that when the findings of the assessment process are relevant to an individual's performance, the medical staff is responsible for determining their use in peer review or the ongoing evaluations of a licensed independent practitioner's competence.

Ensure that the findings, conclusions, recommendations and actions taken to improve organization performance are communicated to appropriate medical staff members; and

Ensure that the medical staff, with other appropriate hospital staff, develops and uses criteria that identify deaths in which an autopsy should be performed.

J. Utilization Review Committee

1. Composition and Meetings

The Utilization Review Committee shall be composed of a Chair, Vice Chair and a minimum of five (5) members of the Active medical staff who represent the major patient care services. Non-physician, non-voting members shall include representation from administration, nursing, and quality improvement. Ancillary department personnel shall participate when appropriate.

The Committee shall meet at least four (4) times a year and report directly to the Medical Staff Executive Committee.

2. Duties and Responsibilities

The Utilization Review Committee shall endeavor to assure appropriate allocation of the hospital's resources in striving to provide high-quality patient care in the most cost-effective manner.

The Committee shall review the following areas:

- a) Utilization Review activities
- b) Social Services
- c) Discharge Planning

The Committee shall develop, implement, and routinely update a written plan that describes the utilization review program in total.

K. AD HOC Dispute Resolution Committee

All disputes between the Governing Board/Administration and the Medical Staff ("Parties"), relating to the medical Staff's rights of self-governance as set forth in California Business & Professions Code section 2282.5 ("Disputes"), which have not been resolved by informal meetings and discussions, shall be addressed and resolved in accordance with the meet and confer process of an Ad Hoc Dispute Resolution

Committee ("AHDRC"), as described in this section. In the event either Party determines that a Dispute exists, such Party shall give written notice to the other Party, stating the nature of the Dispute. Within three (3) business days following receipt of such notice, both Parties shall appoint representatives to an AHDRC, as provided below. Neither party shall initiate any legal action to resolve the Dispute until this Committee has completed its efforts to resolve this dispute.

1. COMPOSITION

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

2. DUTIES

When formed, an AHDRC shall promptly receive and review written requests for initiation of the meet and confer/dispute resolution process. The AHDRC, with such assistance and input as it may request, shall then meet to in good faith to recommend a resolution of the dispute. Such efforts shall continue, as necessary, for up to sixty (60) days. The AHDRC shall report the results of its efforts and its recommendations to both the Medical Executive Committee and the Governing Board. Unless requested by the Parties to continue its deliberations, the AHDRC shall dissolve thirty (30) business days following the reporting of its results and recommendations.