**Huntington Hospital**

May 2016

***Medical Staff***

*General Staff Rules and Regulations*

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**Preamble**

**Authority:** *Chapter 14, of the Bylaws authorizes the Executive Committee to establish the Rules and Regulations.*

**Purpose:** *General Medical Staff Rules and Regulations shall supplement the Bylaws and cover Medical Staff procedure in more detail than the Bylaws. They are more flexible than the Bylaws since the Executive Committee is authorized to amend the Regulations by majority vote and to publicize changes in the Medical Staff Newsletter and other communications, without the formality of a change in the Bylaws. The Executive Committees, departments, staff meeting participation and directly to the Executive Committee. If there is a conflict between the Bylaws and the General Medical Staff Rules and Regulations, the Bylaws shall prevail.*

# CHAPTER 1: STAFF ORGANIZATION AND STAFF REQUIREMENTS

## 1.1 Orientation of New Staff Members

There shall be an orientation for new staff members organized by and initiated by the Department of Medical Staff Services.

## Staff Meetings

The staff meetings are designed to improve staff communications and hospital standards. Programs and attendance should conform to the recommendations of The Joint Commission.

## 1.3 Language Requirement

Applicants for staff membership must be proficient in the use of the English language, in order to reduce the risk of compromising patient care because of misunderstanding attributable to language problems.

## 1.4 Malpractice Insurance

Mandatory malpractice insurance will be a requirement for Medical Staff membership. A minimum insurance of $1 million/$3 million is required. Evidence of continuous coverage is to be submitted to the Department of Medical Staff Services on initial application, reappointment and upon request. Any changes occurring during the term of the coverage must be reported to the Department of Medical Staff Services; failure to do so may result in termination of Medical Staff privileges.

## 1.5 Medical Staff Dues

Medical Staff dues in the amount determined by the Executive Committee will be collected for a two year period at the time of reappointment. Proration of dues will only be granted for one year increments. Reappointment applications submitted without payment of dues are considered incomplete and are processed in accordance with Section 7.5-6 of the Bylaws Failure to File Pay Dues/Assessment.

## 1.6 Substitute/covering physician

1. Application for staff membership must include provision for coverage when the physician is not available. (back-up coverage)
2. Each staff member shall provide for a substitute staff physician in the event of non-availability with the exception of consulting staff. Such substitute physician shall be a member of the same department or section and have comparable privileges or hold comparable privileges in another specialty, section or department. If a substitute physician withdraws from this capacity, the attending physician must arrange for a replacement staff member and notify the Department of Medical Staff Services within two (2) weeks.
3. Each staff member shall have a record indicating his/her designee for back-up coverage in his/her absence maintained in his/her credentials file in the Department of Medical Staff Services. Coverage information is verified at least every two years at the time of reappointment. Confirmation of coverage must be signed by the substitute physician.
4. In the event of an emergency and the attending and/or substitute physician is unavailable; the chair of a section or department shall appoint a physicians to assume interim responsibility and a lapse in availability shall be referred as a quality of care event to the appropriate Department Quality Management Committee.
5. The physician or his/her designated substitute must be available to the Hospital 24 hours daily.

## Criteria for New Medical Staff appointments

1. The Medical Staff at Huntington Hospital has adopted the following protocol to assess new applicants to the staff:
2. Applicants must fulfill at the requirements set forth in the Medical Staff Bylaws, General Medical Staff Rules and Regulations, fulfill department and section rules and regulations and conform to the professional criteria and standards of Huntington Hospital. A personal interview maybe necessary prior to appointment.
3. All questions on the application form must be answered by the applicant. Failure to do so will result in non-acceptance of the application form. The required application-processing fee must accompany the application. Falsification of any statement shall immediately disqualify an applicant.
4. Details of the appointment process are described in the Bylaws, Chapter 5.

## 1.8 Department Policies and procedures

These are appended to these Rules and Regulations (See detailed policies in appropriate departments. Periodic review will be reported to the Executive Committee as needed.)

1. Medicine Department: See also Della Martin Center Rules and Regulations
2. Ob/Gyn Department: Ob/Gyn Department Rules and Regulations
3. Surgery Department: See Surgery Department Rules and Regulations, Surgical standards manual and Anesthesia policies and procedures
4. Pediatric Department: See Pediatric Department Rules and Regulations, polices and procedure manual
5. Miscellaneous Hospital Policies and Procedures including (but not limited to) Patient Rights, Organ and Tissue Donation, Restraints, Patient Care Orders

## 1.9 Appropriate Professional Conduct

The purpose is to define disruptive behaviors involving Huntington Hospital attending Medical Staff members and delineate the approach which will be taken regarding such behaviors. Disruptive behavior by members of the Medical Staff may result in corrective action.

For the purpose of this policy, “disruptive behaviors” means any conduct or behaviors including without limitation, sexual harassment or other forms of improper behavior, which:

When a physician’s conduct disrupts the operation of the hospital, affects the ability of others to get their jobs done, creates a “hostile work environment” for hospital employees or other physicians on the Medical Staff, or appears to interfere with the physician’s own ability to practice competently, action must be taken when behaviors:

1. Interfere or are inconsistent with a safe working environment
2. Jeopardize or are inconsistent with quality patient care or inhibit the ability of others to provide such care
3. are unethical or otherwise falls below professional standards, or
4. constitute the physical or verbal abuse of others involved with the patient or the care being provided

Disruptive behaviors occur in varying degrees which are classified into three levels (or classes) of severity. Class I behaviors are considered the most severe violations. Class II and Class III are progressively less severe. Any corrective action will be commensurate with the nature and severity of the disruptive behaviors. Repeated instances of disruptive behaviors will be considered cumulatively and action taken accordingly.

### 1.9-1 Classification of severity of three levels and procedure to resolve:

**A. Class I**

Physical violence or abuse, which is directed at human beings. Sexual harassment involving physical contact.

**Procedure**: The President-elect or Secretary/Treasurer shall replace the Medical Staff President in his/her absence. The Executive Committee may, at any point in the investigation, refer the matter to the Board without a recommendation. Any further action, including any hearing or appeal, shall then be conducted under the direction of the Board.

1. Medical Staff President must receive complaint in writing.
2. Medical Staff President or designee will interview complainant and/or witnesses promptly within five (5) days from receipt of written complaint.
3. Medical Staff President and another Executive Committee member will interview the Medical Staff member promptly. (Failure of the Medical Staff member to attend interview may result in corrective action according to Section 7.6 of the Bylaws)

After (1-3) the Medical Staff President may do any or all of the following:

1. Take no action (occurrence doubted)
2. Warning
3. Request written apology to complainant
4. Refer member to Physician Well-Being Committee
5. Initiate corrective action per the Medical Staff Bylaws, Chapter 7
6. Summary suspension by the Medical Staff President if necessary to prevent imminent danger to the health or safety of an individual

A summary with written justification of the procedure and action taken will be created by the Medical Staff President, with the original in the member’s credential file, and a copy to the member. The member may submit a written rebuttal to be placed in his/her credential file along with the summary created by the Medical Staff President.

**B. Class II**

Verbal abuse (e.g., unwarranted yelling, swearing, cursing or making humiliating, demeaning, or otherwise inappropriate comments), which is directed at human beings or physical violence or abuse directed in anger at an inanimate object.

**Procedure:** The President-Elect or Secretary/Treasurer shall replace the Medical Staff President in his/her absence.

1. Medical Staff President must receive complaint in writing.
2. Medical Staff President or Designee will interview complainant and/or witnesses promptly within fourteen (14) days from receipt of written complaint.
3. Department Chair or Designee and another Executive Committee member will interview the Medical Staff member promptly. (If Medical Staff member fails to attend interview, options in (d) may be invoked without Medical Staff member input). A copy of the complaint will be provided to member.

After (1-3) the Medical Staff President may do any or all of the following:

1. Determine no action is warranted
2. Warning
3. Request written apology to complainant
4. Refer to Physician Well Being Committee
5. Initiate corrective action

A summary with written justification of the procedure and action taken created by the Medical Staff President with the original in the member’s file and a copy to the member. The member may submit a written rebuttal to be placed in his or her credential file along with the summary created by the Medical Staff President.

**C. Class III**

Verbal abuse, which is directed at large, but is perceived by a witness to be disruptive behavior.

**Procedure:** The President-Elect or Secretary/Treasurer shall replace the Medical Staff President in his/her absence.

1. Medical Staff President must receive complaint in writing.
2. Department Chair or Designee will interview complainant and/or witnesses promptly within fourteen (14) days from receipt of written complaint.
3. If Medical Staff President or Designee receives second complaint within one (1) year of the first, the Medical Staff President will interview the member and provide a copy of the complaint to member.

After the above, the Medical Staff President may:

1. Determine no action is warranted
2. Counsel
3. Warn
4. Refer to Physician Well Being Committee

The Medical Staff President places the complaint in the Department of Medical Staff Services in the member’s credential file for the greater of two (2) years or until the next reappointment, and then discarded if no further complaints occur in any class. The Medical Staff President creates a summary and places it in the member’s credential file with a copy to the member. The member may submit a written rebuttal to be placed in his or her credential file along with the summary created by the Medical Staff President. Member shall be advised in writing, should the complaint be filed in their credential file.

Complaints about a member of the Medical Staff regarding alleged disruptive behavior must be investigated and verified prior to any corrective action being taken.

Disruptive behavior, as defined in Class I and II may result in corrective action being taken against the Medical Staff member in accordance with Medical Staff Bylaws Chapter 7. This policy shall not preclude the application of necessary actions to ensure a safe working environment or prevent unlawful conduct in the Hospital.

Involved parties shall be informed of the nature of all complaints lodged against them. The Medical Staff of Huntington Hospital is committed to educating members of the Medical Staff about disruptive behavior as follows:

The Officers of the Medical Staff and the Physician Well-Being Committee of the Medical Staff will be prepared to assist a member of the Medical Staff exhibiting disruptive behavior (especially repetitive Class I and II) to obtain education, behavior modification, or other treatment to modify future behavior, except in the case of conflict of interest.

## 1.10 Physician Reporting Laws

In compliance with California law that became effective in 2012, Business and Professions Code Section 805.01, the Executive Committee (EC) will submit a report to the Medical Board of California (MBC), the Osteopathic Medical Board or the Board of Podiatric Medicine within 15 days after any final decision or recommendation to take disciplinary action against a Medical Staff member following a formal investigation based upon any one of the following--regardless of whether a hearing will be held:

1. incompetence or gross or repeated deviation from the standard of care involving death or serious bodily injury to one or more patients, to the extent or in such a manner as to be dangerous or injurious to any person or to the public;
2. using, prescribing or administering controlled substances to himself/ herself, or using any dangerous drug or alcoholic beverages to the extent or in such a manner as to be dangerous or injurious to the member, any other person, or the public, or to the extent that such use impairs the ability of the member to practice safely;
3. repeated acts of clearly excessive prescribing, furnishing, or administering of controlled substances or repeated acts of prescribing, dispensing, or furnishing controlled substances without both (i) a good-faith prior examination of the patient, and (ii) a medical reason for use of the controlled substance; or
4. sexual misconduct with one or more patients during the course of examination or treatment.

Matters referred to the Executive Committee as informational do not constitute formal investigations. The term “formal investigation” is defined in Section 7.1-6 of the Medical Staff Bylaws, which also describes the formal investigation process.

In addition to any report required by California Business and Professions Code Section 805.01 following a formal investigation, a separate report may be required under California Business and Professions Code Section 805 after the effective date of an action taken under medical disciplinary circumstances. Examples of the type of action reportable under Section 805 include (but are not limited to) a restriction, suspension, or revocation of clinical privileges for a medical disciplinary cause or reason, and a resignation or leave of absence that occurs after notice a pending investigation for medical disciplinary cause or reason. Federal law (the Health Care Quality Improvement Act of 1986) establishes similar requirements for reporting medical staff professional review actions to the National Practitioner Data Bank, when the actions are related to competence or professional conduct.

The criteria and processes for formal investigations and corrective actions that may lead to such reports, and the procedural rights associated with such investigations and actions, are set forth in Chapters 7 and 8 of the Medical Staff Bylaws, and Section 1.9 of these Rules and Regulations (concerning disruptive behavior).

## 1.11 Access and Use of Computer Information

Security and confidentiality is a matter of concern for all persons who have access to information owned by or in the custody of Huntington Hospital. Each person accessing Huntington Hospital data and resources holds a position of trust relative to this information and must recognize the responsibilities entrusted in preserving the security and confidentiality of this information. Therefore, physicians who are authorized to access data and resources, through enterprise information systems, individual department local area network and databases, and paper documents, must read and comply with HMH policy 402, Access and Use of Computer Information.

Any violations of inappropriate use of date or HIPAA will be investigated as outlined in the HMH policy CO-004. Following an investigation, if it is determined that the physician was in violation, the following fines will be assessed after the physician has been warned:

* First violation - $1,000 fine will be assessed
* Second violation - $3,000 fine will be assessed and physician will be suspended until the assessment is paid
* Third violation - $5,000 fine will be assessed and the physician will be required to pay the assessment AND appear before the Medical Executive Committee to lift the suspension

## 1.12 Physician caring for member of Ones Own Family

The Medical Staff as a whole discourages medical staff members from providing patient care to members of ones own family. However, the medical Staff recognizes that each circumstance is unique and the desires and cultural needs of each patient must be considered individually. Therefore, providing patient care to a member of ones own family is not prohibited. When providing patient care for a member of ones own family the physician must adhere to the following conditions:

* If the physician is the attending of a family member, the physician must manage that care in accordance to all hospital and medical staff policy, procedure and requirements governing patient care and medical staff behavior.
* If the family member physician is not the attending of record, the attending physician must document in the medical record that he/she agrees to the family member physician providing patient care services to the patient. All care provided to the family member must be documented and noted in the medical record.

## CHAPTER 2: Patient Care

The following Patient Care provision applies to all patients registered and treated at Huntington Hospital.

### 2.1 Consent

A competent adult has the right to participate in his/her own medical care, to exercise control over his/her own body, and to determine whether or not he/she will submit to prescribed medical care. Except in an emergency, patients shall not be treated until consent for treatment has been obtained. Consent to treat may be obtained by a licensed or non-licensed agent of the hospital.

### 2.2 Informed Consent

It is the responsibility of the physician to obtain an additional informed consent for complex procedures and treatment as defined in Policy 113 “Consent, Obtaining and Documenting:” of the Administrative manual. Obtaining informed consent is an active process in which each physician participating in the treatment of a patient provides all material information to enable the patient to make an informed decision in regard to any proposed treatment or procedures. Material information is defined as:

* The nature of the procedure or treatment
* The risks, complications and expected benefits or effects of the procedure including potential problems related to recuperation
* Any alternatives to the treatment and their risks and benefits
* Likelihood of achieving treatment or care goals
* Any limitations on confidentiality of information learned from or about the patient.
* Name of practitioners performing the procedure(s) or important aspects of the procedures.
* The patient’s physician is encouraged, but not required to inform the patient who will be performing significant surgical tasks during the patient’s operation and what each person will be doing.

### 2.3 Documenting Informed Consent

The physician shall document in the patient’s medical record that a discussion was held that included discussion of all material information as described above, that the patient indicated understanding of the material information and informed consent was obtained. Informed consent may be documented in any of the following areas of the medical record:

* + - History and physical/Consultation
    - Progress Note
    - Pre-printed and approved informed consent formats
    - Faxed copy from a physician’s office

Special Circumstances in which a physician is not required to fully inform the patient:

When the patient has requested that he/she not be so informed. (Thoroughly document this request in the medical record).

Therapeutic Privilege – Defined as whenever such disclosure would likely result in serious harm rather than benefit the patient. In these instances the physician shall fully document in the medical record the facts that resulted in invoking therapeutic privileges. See Policy #113 “Consent, Obtaining and Documenting”.

When an emergency procedure or operation is required, the physician must sign the “Physician Certificate of Emergency” on the consent form and state in the progress notes the reason for the emergency procedures when consent cannot be obtained.

### 2.4 Physician orders

The staff physician is responsible for orders for care prior to or promptly after admission. Verbal orders are discouraged. Telephone and/or verbal orders must be authenticated by the ordering physician within 48 hours. All entries in the medical record must be dated, timed and authenticated.

### 2.5 Pre-Admission Procedure

Physicians are responsible to obtain or provide all necessary pre-authorizations in a timely fashion prior to admissions.

### 2.6 Admitting and Provisional Diagnosis

Except in emergencies, no patient shall be admitted to Huntington Hospital without a provisional diagnosis. The provisional diagnosis shall be entered into the record at the time of admission.

### 2.7 Transfer and Discharge

Patients who cannot be treated at this institution shall be transferred to an appropriate facility. No patient shall be transferred or discharged to another facility unless arrangements have been made in advance for admission to such facility and the person legally responsible for the patient has been notified, and such transfer is not medical contraindicated or inconsistent with legal requirements. The attending or primary physician shall be responsible for contacting consulting physicians when more than one physician’s approval is required to discharge the patient.

### 2.8 Requirements for Patient Examination

Every patient admitted to an acute care area of Huntington Hospital shall be seen by a physician at least once every 24 hours. These visits shall be documented at the time of service. All patients admitted to the critical care areas shall have been seen or will be seen within a reasonable time as indicated by the patient’s condition by the attending physician or a qualified representative. The qualified representative can be either the physician taking call for the attending physician, a consulting physician, or licensed resident physician whom the attending has contacted personally. This does not include the Emergency Department physician.

### 2.9 Consultation

All requests for physician consultation must be on a physician to physician basis, rather than by written order only.

Consultations must be requested for any patient when the problem is outside the area of the practitioner’s expertise. The physician of records is required to document, in the medical record, when a consult has been requested.

Consultation must be recorded on the patient’s medical record.

**Consultant**: Any physician who is not responsible for all overall care of the patient. He/she may be providing a second opinion.

**Consultations**: Consultation shall show evidence of a review of the patient’s medical record, pertinent findings on the examination of the patient, and the consultant’s opinion and recommendations

**Components of a Consultation report**

* + History of present illness/reason for consultation
  + Past Medical History
  + Review of systems
  + Findings/Recommendations/Treatment
  + Follow-up

In those cases where the necessity for consultation is brought to the attention of the chair for that section, the chair may, after discussion with the attending physician, request appropriate consultation.

Qualified physicians who are not members of the staff may be called into consultation in accordance with the Bylaws (Temporary Privileges 6.7). Orders may be written only by a member of the Medical Staff.

Psychiatric consultation must be requested for all cases of attempted suicide.

Psychiatric consultation is strongly encouraged whenever signs and symptoms of emotional or psychiatric instability are exhibited and are of a severity that the patient’s well being and/or response to medical treatment is affected.

Consultation with an addiction specialist or psychiatrist is strongly encouraged whenever signs and symptoms of chemical or substance abuse are identified.

**Consultations used as an H&P**

A consultation can be used in lieu of a H&P if it meets all of the requirements of; who may perform, content of an H&P, timing and expiration, and documentation as stated in 3.5 and 3.5-1.

### 2.10 Intensivist Consultation Requirements in the Critical Care Unit (CCU)

An Intensivist consultation is required in the following circumstances:

1. When a patient is admitted to the CCU from the ER or transferred to the CCU from the Floor (this excludes post-anesthesia care unit and Cath Lab) with the diagnosis of: Sepsis, Shock or Respiratory Failure; or if the patient requires any of the following: Pressors, Mechanical Ventilation or Therapeutic Hypothermia.
2. When a patient is going directly to the CCU from the Operating Room (no recovery in post-anesthesia care unit) and they did not come directly from CCU preoperatively, a consultation is required if the patient requires any of the following: Pressors, Mechanical Ventilation or Therapeutic Hypothermia

### Critical Care Unit (CCU) Intensivist Consultation Requirements for Code Patients

1. Code Blue patients (an Intensivist Consult is required after arrival in the Critical Care Unit)
2. Code Rapid Response patients (an Intensivist Consult is required after arrival in the Critical Care Unit)
3. Code AMI (an Intensivist Consult is required after arrival in Critical Care Unit if the patient requires mechanical ventilation or therapeutic hypothermia)
4. Code Stroke (an Intensivist Consult is required after arrival in Critical Care Unit if the patient requires pressors, mechanical ventilation or therapeutic hypothermia)
5. Code Trauma (If the Trauma Attending is not an Intensivist) an Intensivist will be consulted.

Consultation by an Intensivist will not be required for the following patients:

1. Cardiothoracic surgery patients
2. Postoperative patients being recovered in PACU
3. Neurosurgery patients

### 2.12 Privileges

Medical Staff privileges granted pursuant to the Bylaws and Rules and Regulations shall be consistent with the applicant’s training and experience. It is expected that staff members will only care for those patients with medical problems that are within the scope of that staff member’s specialty. If a member of the Medical Staff wishes to admit a patient for a medical problem outside that member’s specialty and delineated privileges, then the member shall seek consultation or make arrangements to transfer the care of the patient to a member of the Medical Staff in the appropriate specialty.

### 2.13 Teaching Program

The resident physicians are selected through the National Matching Program and are only from accredited training institutions. Medical Staff members who choose not to participate in the teaching programs are not subject to denial or limitation of privileges for this reason alone.

### 2.14 House Service

A house service or teaching service case is a patient who is approved by the appropriate physicians on the Medical Education Service for care by the teaching service physicians. Emergency cases without an attending physician may be admitted to the appropriate teaching or house service. However, the patient or those in the family responsible may select some other staff member as the physician at any time (if the staff member accepts the case).

Only members of the Surgery Teaching Faculty are allowed to supervise and train residents (including fellows) in this institution in those disciplines within the definition as put forth by the American Board of Surgery.

Only members of the Internal Medicine Teaching Faculty are allowed to supervise and train residents (including fellows) in this institution in those disciplines within the definition as put forth by the American Board of Internal Medicine.

Any resident/fellow participating in patient care at this hospital must be credentialed and approved. A letter is required from the program director describing the resident or fellow’s functions while at Huntington. The training/utilization of any outside resident/fellow, which may impact the Internal Medicine or General Surgery program, must be approved by the relevant Resident Training Program.

### 2.15 Hospitalist Service

In collaboration with the house Teaching Service the hospital sponsored hospitalist service will provide admission and ongoing in-hospital care to unassigned patients (no primary care on staff) or those patients who need admission and whom the primary/referring physician on staff would prefer to have admitted by the hospitalist service. The hospitalist service contracted by the hospital will adhere to the following principles in its organization and operations:

* + 1. Hospital sponsored hospitalist physicians must be members of the provisional or active staff with all privileges appropriate to their responsibilities as reviewed by the Credentials Committee and the physician’s appropriate Department and/or Section Chair.
    2. Use of hospitalists is voluntary for members of the medical staff.
    3. All unassigned patients presenting to the ED will be admitted through the Hospitalist Service regardless of insurance status.
    4. First 10 unassigned patients to be admitted will be assigned to the house staff. After Resident Cap is met unassigned patients will be assigned to the hospitalist service.
    5. Patient may be switched from house staff to hospitalist based on teaching/learning potential.
    6. Participation on the Teaching Faculty is encouraged but not required to participate in the Hospitalist Program.
    7. Hospitalists will not have a competing private practice.
    8. A formalized process will be developed to refer patients to a primary care physician for post hospitalization care that will include the following:
    - Referral to Primary Care will be made first day of admission
    - Referrals will be made on a rotational basis.
    - New Medical Staff members will have the opportunity to have their name added to the referral list.
    - Participation on the referral list is voluntary.
    - Sub-specialty preference of Primary Care will be honored.
    - Primary Care must be able to see patient within 48 hours of discharge from the hospital.

### 2.16 Restraint Policy

Use of patient restraints by members of this Medical Staff is governed by Huntington Hospital Clinical Policy “Restraints and Seclusion”. The policy is reviewed and approved by the Medical Staff in accordance with the Medical Staff governing documents and Title XXII of the California Department of Health and Human Services.

#### Restraint

Acute Care and Emergency Department: There are two categories of restraints: Medical and Behavior. Category of restraint is determined by the situation not diagnosis or treatment setting. Restraint methods are either physical or chemical. Physical Restraints is defined as any manual method physical or mechanical device material or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body or head freely, or prevent the patient from voluntarily exiting the bed. Chemical Restraint is defined, as a drug or medication when it is used as a restriction to manage the patient’s behavior or restrict the patient’s freedom of movement and is not a standard treatment or dosage for the patient’s condition.

#### Seclusion

The involuntary confinement of a person alone in a room or an area from which the patient is physically prevented from leaving. May only be used for the management of violent or self-destructive behavior.

#### Policy

Restraint may only be used to ensure the immediate physical safety of the patient, staff or others and must be discontinued at the earliest possible time. Alternative and nonphysical interventions are attempted prior to use of restraints.

#### Patient Rights

When restraints are deemed necessary, such activity will be undertaken in a manner that protects the patient’s health and safety and preserves his/her dignity, rights and well being.

Restraints will be used for medical necessity only and not as a means of coercion, discipline, convenience or retaliation.

1. Each patient will be respected as an individual
2. Staff will monitor and meet the patients needs while in restraints
3. Staff will reassess and encourage release from restraints
4. The patient and family will be encouraged to participate in care and receive education as appropriate
5. Provide for safe application and removal of restraint by qualified staff authorized to do so and whose competencies have been validated

#### Procedure

Alternatives and nonphysical interventions are less restrictive interventions and must be attempted and determined to be ineffective to protect the patient and/or others from harm prior to the application of restraints.

1. A patient assessment is completed by the Licensed Independent Practitioner or qualified Registered Nurse (RN) proper to restraint application to determine the justification for the restraint and to select the appropriate restraint.
2. Restraint(s) is/are applied when alternative strategies or less restrictive interventions have been determined to be ineffective to protect the patient or others from harm.
3. Assessment of the patient is required prior to administering a chemical restraint. The assessment must be documented in the medical record and contain:
   1. Rationale for use
   2. What alternative, less restrictive interventions were attempted

#### Orders

1. Restraint(s) is/are used in accordance with the order of a physician or other licensed independent practitioner who is responsible for the care of the patient and is authorized to order restraint or seclusion in accordance with state law.
   1. If the attending physician did not order the restraint, the attending physician (or treating physician) must be consulted as soon as possible.
2. Orders for restraints are documented on the Restraint Order Set in the patient’s medical record.
3. All orders are time limited and restraints must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
4. Orders will not be accepted as a standing order or on as-needed (PRN) basis.
5. Chemical intervention orders include the following:
   1. Patient name, medication name, dose, route and that it is STAT or NOW order.

#### Medical Restraint Orders:

A RN may initiate medical restraint but must notify the LIP and obtain orders within 12 hours of initiation. If the medical restraint initiation is based upon significant change in condition the RN must notify the physician immediately. The LIP must perform a face to face examination and document within 24 hours of the initiation of restraint.

A new Restraint Order Set must be completed at least once each calendar day AND based upon an examination for the patient by the LIP.

#### Behavioral Restraint Orders:

In an emergent situation where the patient can reasonably be expected to immediately bring harm upon him/herself or others:

* A qualified RN may apply the restraints then call the LIP or the DMC RN supervisor or appropriately trained designee to request a face-to-face patient evaluation.
* The face-to-face evaluation must occur within one (1) hour of restraint application.
* If a DMC RN supervisor or designee performs the 1 hour patient evaluation, the attending must be consulted as soon as possible and an order obtained.
* If the ED physician orders the restraint, the attending LIP must be consulted as soon as possible.
* The initial LIP evaluation includes:
  + the patient’s immediate situation
  + the patient’s reaction to the intervention
  + The patient’s medical and behavioral condition and the need to continue or terminate the restraint or seclusion
  + Documentation that DMC RN supervisor or designee or the physician worked with the patient and staff to identify ways to help the patient regain control
  + Revises the patients plan of care for treatment and services as needed
* The initial Violent/Self Destructive Restraint Order will be signed by the LIP by
  + Eight hours for 18 years of age and older
  + Four hours for 17 years and younger
  + Two hours for 9 years and younger
* Continuation
  + Restraint usage beyond time may be renewed by alternating LIP face to face evaluation with a written renewal order and DMC RN supervisor or designee patient assessment and LIP notification for telephone order.
  + Orders are time limited as follows:
    - Four (4) hours for adults 18 years of age and older with face to face patient re-evaluation and written order renewal every eight (8) hours
    - Two (2) hours for children and adolescents age 9 to 17 years of age with face to face patient re-evaluation and written order renewal every four (4) hours
    - One (1) hour for children under 9 years of age with face to face patient re-evaluation and written order renewal four (4) hours

#### Patient and Family Education

To the extent feasible, depending on the emergent nature of the use of a restraint, the reasons for such use will be explained to the patient and/or to an appropriate family member acting on behalf of the patient.

1. If unable to notify family prior to initiation of restraints, the family will be notified as soon as possible of the initiation of restraints, as appropriate.
2. Education will be documented in the medical record.

#### Documentation

Documentation will be completed for every patient restraint episode upon initial and as defined in policy/procedure and will be maintained in the medical record.

Documentation should provide clinical justification for use and document clinical oversight, including documentation of alternative/nonphysical interventions that were attempted.

The following elements will be included:

* + 1. Relevant orders for restraint use
    2. Results of patient monitoring
    3. Reassessment
    4. Significant changes in the patient’s condition

#### Performance Improvement Monitoring

Pertinent findings of PI monitoring will be communicated through the Medical Staff Governance Structure as appropriate.

#### Restraint: Psychiatric Services

Order, continuation, patient assessment and documentation of restraint in the Della Martin Center is governed by the Huntington Hospital Policy, “Restraints and Seclusion”.

### 2.17 Autopsies:

The Pathology Department shall attempt to notify the physician(s) involved in the patient’s care that an autopsy is being performed and that the autopsy results will be forwarded to them.

Deaths in which an autopsy would be especially encouraged are:

1. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician
2. All deaths in which the cause of death or a major diagnosis is unknown with reasonable certainty on clinical grounds
3. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding the same
4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies
5. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
6. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction
7. Natural deaths which are subject to, but waived by a forensic medical jurisdiction such as (a) persons dead on arrival at hospitals (b) deaths occurring in hospitals within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
8. Deaths resulting from high-risk infectious and contagious diseases.
9. All obstetric deaths.
10. All prenatal and pediatric deaths.
11. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
12. Deaths known or suspected to have resulted from environmental or occupational hazards. (Source, The College of American Pathologists)

#### Organ Donation

Each staff member is encouraged to seek written permission for organ tissue donation.

### 2.18 Admission and Prescribing Privileges

Practitioners in the Active, Provisional and Courtesy staff categories, when appropriately credentialed, may admit patients to the hospital. Active, Provisional, Courtesy and consulting staff practitioners may medically manage or treat patients, including the prescription of medication.

### 2.19 No Smoking Policy

The only exception to the Hospital’s No Smoking Policy will be a physician’s written authorization to allow a specific patient to smoke. The authorization is intended only for such conditions as terminal disease, patients who cannot be with a patient with the same smoking status.

### 2.20 Emergency Medical Services

#### Non-Discrimination

Emergency services and care shall be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care shall be provided without regard to the patient’s race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical mental handicap, insurance status, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, pre-existing condition or mental or physical handicap is medically significant to the provision of appropriate care to the patient.

#### Medical Screening Examination

Medical screening examinations, within the capability of this Huntington Hospital will be performed on all individuals who come to Huntington Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified medical personnel who can perform medical screening examinations within applicable Huntington Hospital policies and procedures are defined as:

**Emergency Department**

1. Physician members of the Professional Staff with privileges in the Emergency Department.
2. Crisis Intervention Specialists as qualified by the Department of Mental Health may perform the initial medical screening examination for psychiatric patients in accordance with the Department of Mental Health policies and procedures.

**Labor and Delivery Department**

1. Physician members of the Professional Staff with privileges in the Labor and Delivery Department.
2. Registered Nurses who have completed the Labor and Delivery departmental orientation and competency assessment may perform the initial medical screening in accordance with Labor and Delivery Policies and Procedures.

#### On-Call Coverage

Each Section shall establish policies and duty rosters of physicians who serve on an “on-call” basis for in-hospital coverage for emergency cases, in accordance with the policies of the Medical Staff. The duty roster shall list the physician on call until appropriately relieved from duty. On-call roster shall be prepared in advance to ensure that that the Emergency Department staff is prospectively aware of the physician’s on-call. If the on-call physician is taking call simultaneously at another facility and is unable to respond, it is the responsibility of the on-call physician to notify the Emergency Department and to indicate who his/her back up person is. The Executive Committee retains the ability to alter arrangements or require participation of any Medical Staff member as needed to assure coverage.

#### On-Call Responsibilities

The failure or refusal of an on-call physician to respond to a request by the Emergency Department or other treating physician to see an emergency patient, either by not answering pages or not responding to the Emergency Department, is a violation of the Medical Staff Rules, State licensing laws and EMTALA, unless the on-call physician is unavailable due to his/her treating another critically ill patient or due to other circumstances beyond the control of the on-call physician. The following responsibilities are outlined for further clarification:

1. Panel members must go and evaluate the patient when called.
2. If you evaluate the patient and the patient requires care within the scope of an area that you are uncomfortable performing, you are responsible to obtain a physician that can provide the required care after seeing the patient.
3. If the ED physician agrees the patient can be managed by them and referred to your office for outpatient care, this is acceptable. However, if the ED physician indicates that you need to come in, you must reach a mutually agreeable resolution.
4. If you are called in for something outside the scope of your practice, you may advise the ED physician that the patient requires care outside your scope. However, if the ED physician indicates that they want you to evaluate the patient; you are required to evaluate the patient. Your consultation should document that the care required is outside your scope.
5. An Emergency Room transfer from another Emergency Room hospital falls under EMTALA and all EMTALA rules apply.
6. Once the Emergency Department is required to contact a back-up (whether the on-call surgeon has failed to respond or refuses to respond) and that back-up surgeon verbally accepts the responsibility to come in and evaluate the patient, the patient shall immediately become the responsibility of the back-up physician. If the on-call physician subsequently responds, it is at the discretion of the back-up physician if a transfer of care to the former shall occur.

Additionally, see HMH policy #020, Failure to Respond to On-Call; HMH policy regarding E telemergency Department Patient Transfer policy and HMH policy regarding Emergency Department Triage; HMH policy regarding Medical Screening Examinations; and HMH policy #7400.700 Labor and Delivery Medical Screening Examinations.

#### Response time

For adult patient requiring a medical admission, the admitting physician or any physician acting as the patient’s admitting physician, is required to call back the emergency Department within thirty (30) minutes of being called/paged by the Emergency Room physician. Failure to respond within thirty (30) minutes will result in the patient being admitted to the academic Hospitalist for the duration of the admission or a specific time agreed upon by the Academic Hospitalist and the admitting physician.

It is the physician’s responsibility to notify the Emergency Department in writing of any groups or the name of the physician admitting on their behalf. It is also the responsibility of the primary care physician to inform the Emergency Department immediately of any changes to these practices. Failure to do so may result in admitting the patient to the Academic Hospitalist by default.

#### Transfers

A patient shall be transferred to another facility only when the transfer is authorized by the treating physician and has been agreed upon by the receiving physician and facility. The patient or the patient’s legal representative, when he/she is reasonably available shall consent and be notified of the transfer and the reasons for the transfer. Prior to transferring a patient with an emergency medical condition within the meaning of the EMTALA regulations, a physician shall examine the patient to determine whether the patient has an emergency medical condition and provide such emergency services and care as may be necessary to prevent a material deterioration of, or jeopardy to the patient’s medical condition or expected chances of recovery. Patients who are not stable may be transferred only if the physician determines, based upon reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks of posed by the transfer, or the patient or legal representative requests the transfer, after risks and benefits of the transfer have been explained to the patient.

#### Dispensary

In general, each section or department may make such arrangements as it sees fit to assure adequate Medical Staff attendance at Dispensary Clinics, this may include the option of arranging to see dispensary patients at their private offices as long as the financial restraints of the patients are observed. The Executive Committee retains the ability to alter arrangements or require participation of any Medical Staff member as needed to assure coverage.

#### Event Review Process

The Medical Staff has adopted HMH Policy 114 which defines the intense review and analysis requirements for unusual events and “near misses” with attention focused on the identification of system issues that negatively affect the processes of care or could potentially impact the care of other patients.

#### Telemedicine

Telemedicine services at Huntington Hospital consist of diagnostics utilized by Hospital staff as approved by the Medical Executive Committee and the Board of Directors, for the following specialties:

* Teleneurology
* Teleradiology

### *Sedation Analgesia*

Anesthesia Services Oversight: The Anesthesia Services Medical Director, as reported through the Anesthesia Section, will have oversight of all privileging criteria and competency assessment tools used by hospital staff and by non-Anesthesiologists requesting anesthesia/sedation privileges throughout the organization.

# CHAPTER 3: Clinical Record

All entries in the medical record must be dated and timed.

## 3.1 Property

Medical Records are the property of the Hospital and are not to be removed from the Hospital, except under subpoena or court order to the Custodian of Records.

X-ray and pathology specimens are the property of the Hospital and may not be removed from the Hospital except after proper authorization.

## 3.2 Legibility

Dictated notations or a combination of dictated and handwritten notes maybe required when the practitioner’s handwriting is illegible.

## 3.3 Documentation Requirements

Per Federal and State regulations and Huntington Medical Executive Committee requirements, physicians are responsible for the following:

## 3.4 Authentication

All entries in the medical record require authentication, to include date and time authentication is performed.

1. All physicians’ orders and Progress Notes must be authenticated by the responsible practitioner at the time the order/note is written.
2. Telephone orders will be electronically authenticated within 48 hours. A physician involved in the case may sign the order(s). Such physicians are delineated on each practitioner’s registration form.
3. Verbal orders issued during an emergency will be authenticated as soon as the emergent situation is controlled.
4. All history and physical examination reports, consultative reports and operative reports must be authenticated in a timely manner.
5. All dictated reports shall be electronically authenticated.

## 3.5 History and Physical Examinations

Who may perform: A history and physical (H&P) examination may be performed by the following:

1. A qualified physician who is a member of the Huntington Hospital professional staff; who, by virtue of education, training and demonstrated competence, is granted clinical privileges to perform specific diagnostic and therapeutic procedures and who is fully licensed to practice medicine in the State of California.
2. An H&P submitted by a referring physician not on the Huntington Medical Staff may be utilized if the Huntington Hospital attending physician attests to the validity of the content of the H&P and countersigns the document within 24 hours of admission or prior to the performance of any invasive procedure.
3. Oral and maxillofacial surgeons if they possess the clinical privileges to assess the medical/surgical/anesthetic risks of the proposed operative/other procedure.
4. Dentists and podiatrists are responsible for those parts of the H&P examination that relate respectively to dentistry and podiatry. Dentists and Podiatrists are required to obtain Medical Consultation to complete the history and physical examination.
5. Allied Health Professionals may perform part or all of the H&P examination if granted clinical privileges to so, provided the findings, conclusions and assessment of risk are endorsed by a qualified physician within 24 hours of completion of the H&P.
6. Attending physician will document his or her involvement with the supervision of residents by reviewing and correcting medical record entries when appropriate and countersigning H&Ps.

### 3.5-1 Content of the H&P Examination

The H&P must contain sufficient information to support the diagnosis or differential diagnosis, justify the treatment plan and facilitate the care after discharge.

Patients requiring an H&P will receive an H&P examination or an interval note as set forth in this provision of the Rules and Regulations.

An H&P shall include the following minimal elements:

1. History – identifying data (e.g. name, age, sex); chief complaint, history of present illness; medications; allergies; habits (e.g. tobacco, alcohol, other as appropriate); past medical and surgical history; relevant past social and family history.
2. Physical – heart, lungs, area of the body, as appropriate to the chief complaint.
3. Review of – laboratory and diagnostic studies as appropriate.
4. Documentation of diagnosis and treatment plan.
5. For Children – evaluation of developmental age.
6. For Psychiatric Patients – Neurological assessment including assessment of Cranial Nerves.
7. Other relevant elements including but not limited to advance directive, informed consent.

Interval Note – If the H&P is older than 24 hours but was completed fewer than 30 days ago, an interval note will be entered into the medical record. The interval note will contain a statement that the H&P has been reviewed and that there are

1. No significant changes to the findings contained in the H&P since the time it was performed; or
2. Significant changes and such changes are subsequently documented in the medical record.

### 3.5-2 Timing and Expiration of the H&P

An H&P must be performed and documented in the medical record for all patients undergoing outpatient surgery within 24 hours of admission or prior to undergoing invasive complex procedure.

* Pertinent relevant history and physical

The H&P remains valid during the entire hospitalization or procedure. If complications occur requiring either an unanticipated hospitalization or a hospital stay longer than initially intended, a note must be included in the medical record detailing the reason for the extended hospitalization, including a focused physical examination and a revised assessment and plan.

The H&P may be completed in advance, but no more than 30 days before the planned admission or procedure. If the H&P has been performed within 30 days before admission a copy of this report must be used as the H&P provided that any changes are recorded in the medical record at the time of admission (i.e. an interval note).

Prior to an operative or invasive procedure an interval note must be completed within 24 hours prior to the procedure. In all cases a copy of the H&P and the interval note must be present in the medical record.

If a patient is readmitted for the same or related condition and has pertinent H&P performed within the preceding 30 days, the H&P requirement may be satisfied by documenting an interval note and including a copy of the prior H&P in the current hospital record.

### 3.5-3 Documentation

Dictation is strongly recommended; however, hand written H&Ps are acceptable if legible. Restricted abbreviations may not be used.

## Operative and Other High Risk Procedure Reports

An immediate post op note (operative progress note) is entered into the Medical Record immediately after any procedure. The note shall be dated, timed, signed and shall include the following:

1. Name(s) of the primary surgeon(s),
2. Name(s) of his or her assistant(s),
3. Procedure performed and a description of each procedure finding,
4. Estimated blood loss,
5. Specimens removed, and
6. Postoperative diagnosis

Postoperative diagnosis Operative and Procedure Reports shall be dictated or written immediately following the procedure. The completed operative report shall be authenticated and made available in the medical record as soon as possible after the procedure. Per Section 4.42 if the Rules and Regulations Operative Records are considered delinquent at 24 hours post procedure. The comprehensive procedure report shall contain the following:

1. Name of Surgeon
2. Preoperative diagnosis
3. Procedure performed
4. Description and findings of the procedure
5. Complications if any
6. Specimen/tissue removed
7. Disposition of each specimen removed
8. Post operative diagnosis
9. Post operative plan
10. Discharge considerations if outpatient or same day surgery

## 3.7 Discharge Summary

A completed discharge summary is required on all patients. A discharge summary shall include:

1. Reason for admission
2. Information relative to pertinent findings
3. Procedures performed and treatment rendered,
4. The condition of the patient on discharge and
5. Instructions given to the patient and/or family, particularly in regard to physical activity limitations, medications, diet and follow-up visits.

Discharge summary reports may be handwritten (if legible) for non-expired patients with a seven (7) day or less admission stay. All others must be dictated. A hospital approved Discharge Summary form shall be used.

## 3.8 Completion Requirements

### 3.8-1 Post Discharge

Medical records shall be completed within 14 days from the date of discharge.

### 3.8-2 Chart deficiencies

Charts are defined as deficient if the following are incomplete or unsigned:

1. H&P
2. Consultation
3. Operative report
4. Discharge summary
5. Discharge order
6. Newborn nursery record
7. Progress notes
8. Orders

Those records, which are incomplete according to this definition, will be returned to the responsible physician(s) for completion.

### 3.8-3 Operative and Procedure Reports

Operative and Procedure Reports are considered delinquent if the report is not on the medical record within 24 hours of the procedure.

Medical Records shall endeavor to provide a courtesy call to physician’ offices by 11 a.m. the day following a surgery or procedure, to remind them that the Operative/Procedure Report remains undictated. In the event that an Operative/Procedure Report remains undictated at 9 a.m. the morning following the courtesy notification, the physician will be suspended.

Medical Records staff will notify Surgery, Cath Lab, GI Lab and Radiology’s scheduling personnel of suspension.

Suspension due to undictated Operative/Procedure Report(s) will result in the following:

1. Admitting privileges are suspended
2. ER-Call Coverage is suspended and
3. Physician will not be able to schedule a new surgery/procedure

It will be the responsibility of the suspended physician to make arrangements for ER-call coverage during their suspension.

It will be the responsibility of the suspended physician to notify medical records upon completion of the Operative/Procedure Report dictation(s).

## 3.9 Visits to the Medical Record Department

Physicians are expected to visit the Medical Records Department regularly and as necessary to complete all records as they are made available.

### 3.9-1 Hospital Based Physicians:

Hospital based physicians will schedule a regular time each week to complete records within the Medical Records Department.

### 3.9-2 Residents

Residents will schedule a regular time each week to complete records within the Medical Records Department.

## 3.10 Suspension and Other Disciplinary Action

Failure to meet the completion requirements as delineated in Chapter 3.8 of this document will result in suspension of admission privileges and suspension of procedural privileges for patients not yet admitted. Criteria for suspension is applied and enforced daily.

### 3.10-1 Accumulation of 15 Days of Suspension

Physicians who accumulate 15 or more days of suspension in a rolling three month period will be referred to the department chair. At the discretion of the Chair the physician may be required to submit a plan for improvement or appear before the department. Those who fail to improve may be referred to the Medical Executive Committee for action.

### 3.10-2 Accumulation of 30 Days of Suspension

Physicians who accumulate 30 or more days of suspension in a calendar year will be placed on suspension and a $500 fine will be assessed. The Medical Executive Committee has the option to report delinquency to the Medical Board of California.

### 3.10-3 Accumulation of 45 Days of Suspension

Physicians who accumulate 45 or more days of suspension in a calendar year will be placed on suspension and a $750 fine will be assessed and the physician remains on suspension until the assessment is paid.

### 3.10-4 Accumulation of 60 Days of Suspension

Physicians who accumulate 60 or more days of suspension in a calendar year will be placed on suspension and a $1,000 fine will be assessed. The physician is required to pay the assessment AND to appear before the Medical Executive Committee to lift the suspension.

### 3.10-5 Notification

1. Medical Records personnel concurrently notify physician as they are put on suspension.
2. Each month a list of physicians who have accumulated 10 or more suspension days in a rolling quarter is forwarded to the Medical Staff Office.
3. Physician who have accumulated 10 or more but less than 15 days suspension are sent a letter of warning. The letter is generated from the Medical Staff Office, signed by the Chief of Staff and sent via certified mail.
4. Physicians who have accumulated 15 or more days of suspension are referred to the appropriate Department Chair for action.
5. Physicians who have accumulated 30 or more days of suspension in a calendar year are immediately referred to the Chief of Staff.
6. The data is verified and once verified the physician is suspended for Medical Record non-compliance.
7. Notification and invoice is sent via certified mail and under the direction of the Chief of Staff.

## 3.11 Reporting

Aggregated Medical Record performance data stratified by physician, section and department will be reported to the sections, department, the Quality Management Committee and the Medical Executive Committee. These reports will be prepared by the Medical Records Department and reported at least quarterly.

## 3.12 Clinical Research and Publication

Medical Records of the Hospital may be used for the preparation of scientific papers or reports only with approval of the Executive Committee. If Huntington Hospital is identified in the report, these papers that identify Huntington Hospital shall be submitted to and cleared by the Institutional Review Board and approved by the Executive Committee and Chief Executive Officer of the Hospital, or designee.

## 3.13 Clinical Pertinence Review

Medical Records shall be reviewed for completeness and clinical pertinence and the findings of this review will be considered in the reappointment process.

# CHAPTER 4: Duties of Medical Director

Physician with demonstrated competence may be appointed as Medical Directors, paid or “voluntary” to oversee hospital department or care units. Functions of these directors, in addition to administrative duties, shall specifically include:

1. Clinical direction
2. Continuous surveillance of performance by individuals with clinical privileges in the area
3. Recommending criteria for clinical privileges

# CHAPTER 5: Provisions for Committees

## 5.1 General Provisions

The chair of any committee should have previous experience on that Committee. The President of the Medical Staff incoming for the calendar year in questions appoints the Chair and in conjunction with the chair, selects members of each committee. Administration shall be responsible for the appointment of Hospital representatives to standing and ad hoc Medical Staff committees. Medical Staff committees shall meet as often as necessary at the call of their chair. They shall maintain a record of findings, proceedings and recommended action and shall make a report of these to the Executive Committee, and when appropriate, to the Quality Management Committee. All recommendations of Medical Staff committees shall be approved by the Executive Committee before implementation.

The committees described in Chapter 7.0 shall be the standing committees of the Medical Staff. Special or ad hoc committees may be created by the Executive Committee, department chairs or committee chairs to perform specified tasks. Unless otherwise specified, the Chair and members of all committees shall be appointed by and may be removed by the President of the Medical Staff, who may consult the Executive Committee. These subcommittees shall keep minutes and report to the parent Committee.

## 5.2 Terms of Committee Members

Committee members shall be appointed for a term of two (2) years and shall serve until the end of this period or until the member’s successor is appointed, unless the member shall sooner resign or be removed from the committee.

## 5.3 Removal

If a member of a committee ceases to be a member in good standing of the Medical Staff, or loses employment or a contract relationship with the Hospital, suffers a loss or significant limitation of practice privileges, or if any other good cause exists, that member may be removed by the Executive Committee.

## 5.4 Vacancies

Unless otherwise specifically provided, vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

## 5.5 Committee Member Prerogative

All committee members are eligible to present agenda items and participate fully in discussion of issues. Members of the Medical Staff are eligible to make and second motions as well as vote. Where appropriate, nursing, administration and other hospital representative shall be appointed to committees as consultants with the consent of the committee chair and President of the Medical Staff.

## 5.6 Executive Session

Executive session is a meeting of a Medical Staff committee which only voting Medical Staff committee members may attend, unless others are expressly requested by the committee to attend. Executive session may be called by the presiding officer at the request of any Medical Staff committee member, and shall be called by the presiding officer pursuant to a duly adopted motion. Executive session may be called to discuss peer review issues, personnel issues or any other sensitive issues requiring confidentiality.

# CHAPTER 6: Committee Descriptions

## 6.1 Bioethics Committee

**Composition**

The Bioethics Committee shall consist of physicians and such other staff members as the Executive Committee may deem appropriate. It may include nurses, community representatives, social workers, clergy, ethicists, attorneys, administrators and representatives from the Governing Board.

**Duties**

The committee shall:

1. The purpose of the Committee is to facilitate communications between patients, families, physicians and other care givers regarding treatment decisions and to assist in the decision making process when ethical conflicts occur. The committee is advisory only in function.
2. The Bioethics Committee may participate in:
3. Development of guidelines for consideration of cases having bio-ethical implications.
4. Implementation of procedures for the review of such cases.
5. Retrospective review of cases for the evaluation of bio-ethical policies.
6. Education of the Hospital Staff on bio-medical matters.
7. When asked to consult, the Committee will be available to patients, family members and other members of the health care team to facilitate communication and aid conflict resolution. Care shall be taken to ensure confidentiality.

**Meetings**

The Committee meets once a month.

## 6.2 Bylaws committee:

**Composition**

The committee shall consist of senior members of the Active Staff. As feasible, members shall include past Presidents of the Medical Staff, past chairs of the department and/or other past committee chairs and the Bylaws chair shall be a past President of the Medical Staff.

**Duties**

The committee shall:

1. Conduct a periodic review of the Medical Staff Bylaws, as well as the Rules and Regulations promulgated by the Medical Staff, its department and sections.
2. Submit recommendations to the Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices.
3. Receive and evaluate for recommendation to the Executive Committee suggestions for modification of these items specified in subdivision (a).

**Meetings**

The Bylaws Committee shall meet at least annually. It shall maintain a record of its proceedings and shall report its activities and recommendations to the Executive Committee.

## 6.3 Cancer Committee

**Purpose**

The Cancer Committee is a standing Medical Staff committee which provides program leadership for the Cancer Program, as described in the Guidelines of the Commission on Cancer. The Chair is appointed by the Chief of Staff.

**Composition**

The membership composition shall be multidisciplinary and shall include representatives of all specialties involved in the care of patients with cancer. Voting membership include the American College of Surgeons physician liaison and physicians representing surgery and surgery sub-specialties, medical, oncology, diagnostic radiology, radiation oncology and pathology. Also voting are representatives from administration and nursing, including pain control. Non voting members include social services, the cancer registry and quality management.

**Duties**

1. Develops and evaluates annual goals and objectives for the clinical, educational and programmatic endeavors related to cancer.
2. Promotes a coordinated, multidisciplinary approach to patient management.
3. Establishes, monitors, and evaluates the cancer conference frequency, format, care presentation and multidisciplinary attendance requirements.
4. Ensures that an active education supportive care system is in place for patients, families and staff.
5. Promotes clinical research.
6. Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis. The plan include procedures to monitor case finding, accuracy of data collections, abstracting timeliness, follow-up and data reporting.
7. Monitors quality management and improvement through completion of quality management studies that focus on quality, access to care, and outcomes.
8. Upholds medical ethical standards.

**Meetings**

The committee meets quarterly.

**Reporting Process**

The committee shall maintain a record of its proceedings and actions and shall report to the Quality Management Committee.

## 6.4 Continuing Medical Education Committee

**Composition**

The Medical Staff shall have a committee, which deals with continuing medical education. This committee shall be composed of physician members and other appropriate health professionals. The number shall be appropriate to the size of the hospital and number of program activities produced annually. The composition shall include a chairperson, Manager of Health Science Library, Pharmacy Representative and a Representative from Graduate Medical Education. The Director of Medical Education shall be a voting member of the Committee.

**Duties**

The Continuing Medical Education Committee shall:

1. Plan, implement, coordinate and promote ongoing special clinical and scientific programs for the Medical Staff. This includes:
   1. Identifying educational needs of the Medical Staff.
   2. Formulating clear statements of objectives for each program.
   3. Assessing the effectiveness of each program.
   4. Choosing appropriate teaching methods and knowledgeable faculty for each program.
   5. Documenting staff attendance at each program.
2. Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.
3. Establish liaison with the various quality improvement programs of the Hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.
4. Maintain close liaison with the Hospital Medical Staff, department and committees concerned with patient care.
5. Advise Administration of the financial needs of the continuing medical education program.

**Meetings**

The Committee shall meet as often as necessary, but at least quarterly. It shall maintain minutes of the program planning discussions and report to the Executive Committee.

## 6.5 Credentials Committee

**Composition**

The credentials committee shall consist of 12 members from representative specialties (5 surgical, 5 medical, 1 pediatric and 1 Ob/Gyn). Members shall serve two-year rotational terms (renewable – with no term limits) – half of the initial members to be appointed for a 3 year term to establish the rotation. At the discretion of the chair, appropriate consultants may be invited to attend the meeting.

**Duties**

The Credentials Committee shall:

1. Review all new applications
2. Interview new applicants, when determined necessary.
3. Oversee the departmental recommendations for all staff reappointments.
4. Conduct a review of reappointments based upon predetermined “trigger” criteria.
5. Review core privileges criteria and specialty privilege criteria.
6. Coordinate (arbitrate) the development of criteria for procedures that cross specialty lines.
7. Review departmental recommendations for all new or additional provisional requests.
8. Review all requests for Temporary Privileges.
9. Review all provisional upgrades.
10. Oversee recommendations pertaining to proctoring.
11. Establish, review and approve all policies/procedures and forms utilized in the Credentialing process.
12. Set policy related to:
    1. Qualifications for Medical Staff membership.
    2. Proctoring requirements.
    3. Restriction of privileges.
    4. Requirements for continued membership.
13. Make final recommendations to the Medical Executive Committee.

**Meetings**

The Credentials Committee shall meet as often as necessary at the call of its chair, but not less than 10 times per year. The committee shall maintain a recommend of its proceedings and actions and shall report to the Medical Executive Committee.

## 6.6 Department Committees

Each Department Committee will be comprised of the Chairs of the Department’s sections and additional members at the discretion of the Chair and when applicable, and appropriate personnel from other hospital services, i.e., Quality Management and Nursing. In the event that a Section Chair cannot attend a meeting, a designee who will attend to represent the Section.

Review of credentialing issues, quality management activities and policy and procedure issues will occur in the individual sections and will be forwarded to the applicable Department Committee for ratification. If there are issues that cannot be resolved at the Section level, they will be forwarded to the Department Committee for review and assistance in resolution.

**Duties**

1. Serve as a policy-making body relative to departmental issues including credentialing matters contained within the Departmental Rules and Regulations avoiding conflict with the Medical Staff Bylaws and Rules and Regulations.
2. Make recommendations for equipment and patient care standards.
3. Provide support to Sections Chairs in resolving difficult or unusual physician related credentialing issues.
4. Investigate, review and report on matters discovered through the credentialing or peer review, process or referred by the President or the Executive Committee regarding the qualifications, conduct professional character or competence of any applicant for Medical Staff membership or any member of the department.
5. Review, prioritize and approve all capital equipment requests and recommend purchase or non purchase to Administration through the Executive Committee.

**Meetings**

Each Department Committee shall meet as often as necessary at the call of the Chair but at least quarterly.

## 6.7 Endovascular Committee

**Composition**

The Endovascular Committee shall consist of Vascular Surgeons, Interventional Radiologists, Interventional Cardiologists, Interventional Neuroradiologists, and representation from Quality Management Services and Administration.

**Duties shall include:**

1. Development and evaluation for privileging criteria for endovascular procedures.
2. Retrospective patient care reviews.
3. Evaluation of patient care practices.

**Meetings**

The Endovascular Committee shall meet as often as necessary at the call of its Chair.

**Record and Keeping and Reporting**

The Endovascular Committee shall maintain records of meetings. The reporting structure will be as follows:

1. Peer review actions shall be reported directly to the Quality Management Committee.
2. Credentialing and privileging issues shall be reported to the Credentials Committee.
3. All other actions will be reported directly to the Medical Executive Committee.

## 6.8 Graduate Medical Education Committee

**Composition**

This Committee shall be composed of the following: a Chair appointed by the President of the Medical Staff, the Education Program Directors, Coordinators of post-graduate training, Director of Graduate Medical Education, one resident from each program that is elected for service by his/her peers, the Chief Resident of each service, (if the Chief Resident is not elected to represent the residents) representation from hospital operations and representation from the faculty as well as other knowledgeable and interested Medical Staff members. Al members serving on this committee, that is physicians, faculty and residents will serve as voting members.

**Duties**

The Committee shall

1. Review and approve all medical training programs at the Huntington Hospital.
2. Establish and implement policies and procedures that affect the residency programs regarding the quality of education and the work environment of the residents for each program.
3. Provide oversight of and liaison with program directors and appropriate personnel of other institutions participating in programs sponsored by the institutions.
4. Perform regular review of all residency programs to assess compliance with both the institutional requirements and program requirements of the relevant ACGME RRC’s
   1. Educational objectives of each program
   2. Adequacy of available educational and financial resources to meet the objectives
   3. Effectiveness of each program in meeting its objectives.
   4. Effectiveness of corrective action plans in regard to citations and recommendations from previous internal and external reviews.
   5. Documentation of the review shall include mechanisms to correct identified deficiencies.
5. Assure that each residency program establishes and implements written criteria and processes for the selection, evaluation, promotion and dismissal of residents in compliance with both the institutional and relevant program requirements.
6. Assure an educational environment in which residents may raise and resolve issues without fear of intimidation and retaliation.
7. Collect and analyze intra-institutional information as well as make recommendation on the funding for resident positions, including benefits and support services.
8. Monitor duty hours of the residents
9. Assure that the curricula include review of all ethical, socioeconomic, medical/legal, and cost containment issues that affect GME and medical practice.
10. Assure that the curricula provide for introduction to communication skills, research design, statistical process and critical review of the literature as well as other skills necessary for lifelong learning.
11. Assure that there is adequate resident participation in departmental scholarly activity as outlined in the relevant program requirements.
12. Review all relationships between the Hospital and other affiliated programs.

**Hospital Monitoring of Supervision**

1. The Senior Vice President for Medical Education and Research is responsible for ensuring that the institution fulfills all responsibilities identified within this section.
2. Along with the Director of Medical Education, each program director is responsible for monitoring resident supervision, identifying problems, and devising plans of action for their remedy.
3. As a minimum, the monitoring process will include:
   1. A review of compliance with inpatient and outpatient documentation requirements, as part of medical records review.
   2. A review of all incidents and risk events with complications to ensure that the appropriate level of supervision occurred.
   3. A review of all accrediting and certifying bodies; concerns and follow-up actions.
   4. A review of resident evaluations of their faculty and rotation.
   5. An analysis of events where violations of graduated levels of responsibility may have occurred.
   6. A review of all tort claims involving residents, to determine if there was an appropriate level of supervision. (Chief Resident/Attending) Review pertaining to monitoring of resident supervision will be communicated, at a minimum, on a yearly basis, to the GMEC.

**Meetings**

Reports to the Governing Board through the Executive Committee.

## 6.9 Institutional Review Board

This committee is under the Bylaws of the Governing Body.

## 6.10 Infection Control Committee

**Composition**

This is a multidisciplinary committee comprised of at least five Active Medical Staff Members (one serving as chair), including one representative from each Medical Staff Department (surgery, medicine, OB/GYN, pediatrics), and one physician whose primary specialty is infectious disease. In addition, a nurse whose responsibilities primarily involve infection control.

The Employee Health Nurse, a representative from nursing, the operating room supervisor, and a representative of Hospital administration, Pulmonary Lab and Respiratory shall be members and the City of Pasadena Department of Health Services shall be represented by a liaison member. All members shall be voting members. Representatives from all other hospital departments shall be available on a consultative and ad-hoc basis.

**Duties**

The Committee shall:

1. Develop and monitor the hospital’s infection control program.
2. Approve action to prevent or control infections and the infection potential among patients and hospital personnel.
3. At least every three years or as often as needed, review and approve all policies relating to the infection control program.
4. The chair or his/her designee shall be available for on-the-spot interpretation of applicable Rules.
5. Evaluate and approve reports from the Nurse Epidemiologist

**Meetings**

The Committee shall meet at least quarterly.

**Records and Reporting**

Appropriate records of meetings and proceedings will be kept. The Committee will report to the Board of Directors trough the Quality Management Committee and Executive Committee.

## 6.11 Medical Staff Newsletter Committee

**Composition**

The Medical Staff Newsletter Committee shall consist of an editor, at least three (3) members of the Medical Staff and a representative from Medical Staff Services.

**Duties**

The Committee shall receive, editor and approve articles from physicians, Medical Staff Departments and Hospital department for publishing a monthly Medical Staff Newsletter.

**Meetings**

The Committee shall meet as often as necessary at the call of its Editor. It shall maintain a copy of each Medical Staff Newsletter published.

## 6.12 Pharmacy, Therapeutics and Diet Committee

**Composition**

This is a multidisciplinary committee consisting of the chair, appointed the President of the Medical Staff representatives from each clinical Medical Staff Department, Clinical Pharmacy, Nursing Clinical Practice, Dietary and Quality Management.

**Duties**

The Committee shall

1. Assist in the formulation of professional practices and policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Hospital.
2. Develop and review Drug Usage Evaluations.
3. Advise the Medical Staff and the Pharmaceutical Service on matters pertaining to the choice of available drugs.
4. Make recommendations concerning drugs to be stocked by Pharmacy.
5. Develop and periodically review the Hospital formulary.
6. Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.
7. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.
8. Maintain a record of all activities relating to pharmacy and therapeutics functions and submitting periodic reports and recommendations to the Medical Executive Committee concerning those activities.
9. Review untoward drug reactions.
10. Conduct yearly review and approval of all standing orders.
11. Review all policies and procedures for Pharmacy.
12. Make recommendations regarding nutritional assessment and therapy.
13. Receive and approve reports from IV services and nutrition support services.

**Meetings**

The Pharmacy, Therapeutics and Diet Committee shall meet as often as necessary at the call of the chair but at least quarterly.

**Records and Reporting**

Appropriate records of meetings will be kept. The Committee will report to the Board of directors through the Quality Management Committee and Executive Committee.

## 6.13 Quality Management Committee

The Quality Management Committee is a multidisciplinary committee with representation from Medical Staff, Executive Administration and Operations that is charged with the function of providing oversight to the quality and performance improvement activities of the organization as a whole. The goal of the Committee is to assure that the organization designs processes well and systematically monitors, analyzes, reduces risk and improves its performance to improve patient outcomes.

**Composition**

The Quality Management Committee shall be composed of a Chair elected by the Medical Staff membership for a two year term, a Physician Vice-Chair elected by the Medical Staff membership, a physician representative from each of the four clinical departments, Chair of Infection Control, Committee Chair of Pharmacy, Therapeutics and Dietary Committee, Executive Administration, Risk and Compliance Services, Utilization Review, Performance Improvement, Nursing Education, CALS Liaison and other members of the hospital and Medical Staff as appropriate to the Committee function. All members have equal voting rights during regular business. Only physician members have voting rights during the Executive Session.

**Medical Staff Peer Review**

In Executive Session the physician members of the Committee provide oversight to the Medical Staff Peer Review function across all departments and sections in order to assure that peer review activities are performed consistently, accurately and fairly especially where a standard of care was not met.

**Peer Review Policy:** Peer review is conducted in accordance with the Medical Staff Peer Review Process Policy and Procedure 8710.030.4.

**Peer Review Time-Line**

The Quality Management Committee Chairperson participates in evaluation of unexpected clinical outcomes to determine if the event meets the definition of a “never event”. Peer review for “never events” status. All routine peer review will be initiated within thirty (30) days of determination of “never event” status. All routine peer review will be initiated within one-hundred and twenty (120) days.

**Conflict of Interest/Chain of Command**

In the event there is a conflict of interest, such as the peer review is specific to a Section or Department’s Chair, the Section or Department’s Chair-Elect will lead the applicable peer review session.

**Duties**

The Quality Management Committee is responsible for the following functions:

1. The establishment of a planned, systematic organization wide approach to process design, and performance measurement, analysis and improvement.
2. Annual review and approval of the Performance Improvement Plan.
3. Assurance that data is collected to monitor the stability of existing processes, identify opportunities for improvement, identify changes that will lead to improvement and sustain improvement.
4. Assurance that data is systematically aggregated and analyzed on an ongoing basis.
5. Comparison of organization performance both internally and externally over time.
6. Intensive analysis of undesirable patterns or trends in performance and sentinel events.
7. Periodic review of performance of the following:
8. Patient safety
   1. Clinical and operational performance (service line and dashboard reports)
   2. Utilization management
   3. Risk management findings
   4. Quality management and peer review findings (Executive Session)
   5. Medication usage
   6. Blood and blood product usage
   7. Approval of Clinical and Administrative Policies that have both a clinical component and an organization wide scope

**Meetings**

The committee will meet 10 times per year.

**Reporting Structure**

The Quality Management Committee reports to the Executive Committee and through the Executive Committee to the Board.

## 6.14 Robotic Committee

**Composition**

The Robotic Committee shall consist of members from the Obstetrics and Gynecology Department and the Surgery Department involved in the performance of robotic surgery. The chair shall be appointed by the President of the Medical Staff and include representatives from Administration, Nursing and Quality Management.

**Duties**

The Committee shall be responsible for:

1) The evaluation of quality improvement data related to robotic surgery;

2) Making recommendations to the appropriate Medical Staff Sections or Departments regarding proposed privileging criteria and proctoring requirements for robotic surgery;

3) Review by the Committee Chair of all requests for robotic surgery privileges and

forwarding privileging recommendations to the appropriate Section or

Department Chair.

**Meetings**

The Robotic Committee shall meet as often as necessary at the call of the chair but at least quarterly.

**Records and Reporting**

Appropriate records of meetings will be kept. The Committee will report the quality improvement and peer review activities to the Quality Management Committee. The Committee will report privileging and proctoring recommendations to the appropriate Departmental Committee.

## 6.15 Transfusion Subcommittee

**Composition**

The Transfusion Subcommittee shall consist of Active Staff members and representatives from the Blood Bank and Quality Management Department. The Chairman is elected by the committee members for a term of two years. The primary focus of the Transfusion Subcommittee is the safe use of blood in the Hospital. The Transfusion Subcommittee shall develop, review and evaluate recommended policies and procedures concerning the administration of blood and blood components and shall take such action as may be necessary to maintain appropriate standards of quality transfusion practices.

**Duties and Responsibilities**

The duties of the Transfusion Subcommittee relating to the transfusion of blood and blood components include:

1. Evaluating the sources, adequacy, quality and safety of the supply of blood and blood components used in the Hospital.
2. Reviewing data regarding transfusions and the adequacy of transfusion services to meet patient needs, and reviewing/making recommendations concerning policies governing such practices.

3. Reviewing all confirmed transfusion reactions, and making recommendations to improve transfusion procedures and practices.

4. Conducting intensive evaluations of any known or suspected problems in the use of blood or blood components, according to clinically valid criteria.

5. Reviewing data from the Blood Bank and medical records in order to:

1. Identify unnecessary waste due to unreasonable “hold” order or excessive “outdating” of blood.
2. Identify questionable ordering practices and use of blood or blood components.

c. Study all instances of transfusion transmissible diseases.

**Meetings**

The Transfusion Subcommittee will meet quarterly.

**Records and Reporting**

Meeting minutes will be maintained. The Subcommittee reports to the Pharmacy, Therapeutics & Diet Committee.

## 6.16 Trauma Services Committee

**Composition**

The Trauma Service Committee shall consist of general surgeons, neurosurgeons, orthopedists, plastic surgeons, anesthesiologist, pathologist, radiologist, chief paramedic, chief surgical resident, the chief trauma surgeon or his/her representative, and representative from nursing and ancillary services department and quality management.

**Duties**

The Committee shall:

1. Develop and maintain the policies and procedures of the Trauma Services and oversee the quality of trauma care.
2. Ensure compliance with the requirements of the Los Angeles County Trauma Services Committee.
3. Keep statistics and evaluate and review all Code Yellow cases and other appropriate trauma cases.

**Meetings**

The Committee shall meet at least bimonthly.

**Record Keeping and Reporting**

Appropriate records of meetings will be kept. The Committee will report to the Board of Directors through the Surgery Committee, Quality Management Committee and the Executive Committee.

## 6.17 Well Being Committee

**Composition**

To promote the competence and well being of the Medical and Allied Health Staff, the Executive Committee shall establish a Well Being Committee, comprised of no fewer than three senior active members of the Medical Staff. Insofar as possible, members of this committee should not serve as active participants on other peer review or quality management committees while serving on this committee. Each member shall serve a term of not less than three years.

**Duties**

The Well Being Committee may receive self-referrals or referrals from other staff within the organization related to the health, well being, or impairment of a Medical Staff or Allied Health Staff member(s). The identity of individuals making referrals shall remain confidential unless the Well Being Committee is directed otherwise. The Committee as it deems appropriate, may evaluate the credibility of such reports. With respect to matters involving individual Medical Staff or Allied Health Staff members, the committee may on a voluntary basis, provide such advice, counseling or referrals to appropriate professional internal or external resources for diagnosis and treatment of the condition or concern. Monitoring of the affected physician and his/her care of patients will be conducted until the rehabilitation program, the Medical Executive Committee will be informed so that need for other appropriate actions may be assessed. All such activity shall be confidential; however, in the event information received by the committee clearly demonstrates that the health or known impairment of a Medical or Allied Health Staff member poses an unreasonable risk of harm to hospitalized patients, that information shall be referred to the medical staff leadership or in the case of Allied Health staff, hospital leadership for corrective action. The committee with the approval of the Executive Committee shall periodically provide education regarding illness and impairment recognition to the Medical, Allied Health Staff and Hospital Staff.

1. The Well Being Committee may, on request of Graduate Medical Education Program Director or a resident physician, become involved in matters regarding impairment of a resident physician. A peer resident physician will be appointed as a temporary member of this committee for resident physician matters.
2. Any Practitioner who feels limited or challenged in any way by a qualified mental or physical disability in exercising his or her clinical privileges and in meeting quality of care standards should make such limitation immediately known to the Well Being Committee. The Well Being Committee shall review the responses from applicants concerning physical or mental disabilities and recommend what, if any, reasonable accommodations may be indicated in order to assure that the practitioner will provide care in accordance with the hospital and medical staff’s standard of care. Any such disclosure will be treated with the high degree of confidentiality that attaches to the Medical Staff’s peer review activities.
3. The Well Being Committee shall recommend to the Executive Committee educational materials and/or educational activities for practitioners and other organization staff about illness and impairment recognition issues specific to licensed independent practitioners (e.g., at risk criteria).

**Meetings**

The Committee shall meet as often as necessary at the call of its Chair and shall provide reports of its activities to the Executive Committee and to the Governing Board. To preserve confidentiality, it shall maintain only such records of its proceedings, as it deems advisable.

# CHAPTER 7: Amendment to General Medical Staff Rules and Regulations

These rules and regulations may not be unilaterally amended or repealed by the Medical Staff or the Governing Board.

Last Revised: 3/25/2010; 2/22/2012; 5/28/2012; 9/27/2012; 09/26/13; 10/24/2013

Revised/Approved: 6/24/2010; 9/22/2011; 2/22/2012; 5/28/2012; 9/27/2012; 10/13/12; 09/26/13; 10/24/13; 09/25/14