VALLEY PRESBYTERIAN HOSPITAL

Excellence in All We Do

MEDICAL STAFF

RULES AND REGULATIONS

2017

Medical Staff Services
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GENERAL RULES AND REGULATIONS
TABLE OF CONTENTS

RULE 1 ADMISSION AND DISCHARGE OF PATIENTS

1.1 Only a member of the Valley Presbyterian Hospital Medical Staff (the Medical Staff) with appropriate and approved privileges may admit a patient to Valley Presbyterian Hospital (the Hospital, VPH). The *Admission of a Patient* policy of the Hospital will be followed by all practitioners. Patients must be seen by the attending physician or designee on a daily basis and appropriate documentation is to be recorded in the medical record. Patients must be seen within 24 hours of admission to the Hospital or sooner depending on the acuity of the patient's condition.

1.2 When a patient is admitted to the intensive care unit the primary care physician or designee must contact the ICU staff and present a plan for evaluation, supportive care and treatment immediately upon admission or transfer. All patients admitted to the ICU shall be seen and evaluated by a physician either prior to or within four (4) hours of admission, except in the NICU and PICU, where *NICU Admission Protocol* and *Pediatrics/PICU Admission Protocols* define this requirement for those areas.

1.3 A dentist or podiatrist with clinical privileges may admit patients to the Hospital so long as an appropriate physician member of the Medical Staff assumes responsibility for the overall aspect of the patient's care throughout the hospital stay, including the medical history and physical examination. However, a podiatrist may perform the medical history and physical examination if granted such privileges by the Medical Staff. Consultations with a physician member of the Medical Staff shall be required when medical or surgical complications are present for Podiatry or Dental patients.

1.4 The patient's attending physician shall be responsible for directing and supervising the patient's overall medical care, for coordinating all consultations, for completing and recording in the medical record a medical history and physical examination within twenty-four (24) hours of admission, for the prompt and accurate completion of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring physician, if any, and to the patient's family. The history and physical examination must be completed and authenticated in the medical record prior to any surgery or invasive procedure.

1.5 Whenever responsibilities are transferred from the attending physician to another Medical Staff member, a note covering the transfer of responsibility shall be reflected on the orders in the medical record by the current attending physician, and the transferring physician shall personally notify the receiving physician. The documentation shall state to whom care is being transferred and the date and time responsibility is transferred. Should the patient be transferred to another level of care within the Hospital, the responsible Medical Staff member for coordinating care should likewise be identified to assist with reconciling medications and other treatments.

1.6 Except in an emergency, no patient shall be admitted to the Hospital until provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible, but no later than twenty-four (24) hours after admission. Patients should be admitted with appropriate orders consistent with the diagnosis. Bed assignment and appropriate level of care is determined based on intensity of service and severity of illness obtained from the admitting physician prior to admission whenever possible.

1.7 Each member of the Medical Staff shall name a member of the Medical Staff who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such associate, the Emergency Department or patient care unit staff shall have authority to call any member of the Medical Staff in such event utilizing the Chain of Command.

1.8 A practitioner who will be out of town or unavailable for a significant period of time shall notify the Hospital, in writing, of the name of the practitioner who will be assuming responsibility for the care of patients during this absence.

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

All patients with infectious disease will be admitted in accordance with the *Hospital Infection Prevention Policy and Procedure Manual*.

The attending physician shall seek assistance from a psychiatrist for any patient who suffers from an incapacitating emotional or psychiatric illness.

In the event that a patient cannot be appropriately treated in the general acute care service, arrangements shall be made to transfer the patient to a facility where his or her care can be appropriately managed, once the patient is medically stable.

1.10 When a physician requests to admit a patient to the Hospital for medical treatment, the attending physician shall, whenever possible, contact the Operations Supervisor to determine whether there is an available bed. Any patient admitted through the Emergency Department shall be seen and evaluated by their attending physician or designee either immediately prior to or within twenty-four (24) hours of admission except as otherwise required in Rule 1.2.

1.11 Patients who require emergency admission through the Emergency Department and do not have an attending physician shall be assigned an

attending physician in accordance with the Medical Staff Emergency Department Call Panel Procedure.

1.12 If a physician is on suspension due to medical record delinquencies or any other cause and must admit a patient in an emergent situation because the patient could not be admitted or cared for by another physician with appropriate clinical privileges, then the physician on suspension must follow the procedures as identified in Rule 2.6.

1.13 All patients admitted to the Hospital shall be seen by an attending physician on a daily basis following the initial History and Physical, and an appropriate notation shall be recorded in the medical record in the form of a daily progress note or discharge summary. The frequency of visits by consultants should be commensurate with the needs of the patient with regard to their medical condition and in accordance with Departmental Rules and Regulations and Hospital policies.

1.14 Patients should be discharged from the Hospital only on the order of the attending physician or appropriate designee. A final diagnosis, appropriate discharge instructions, necessary medications or prescriptions, and specific recommendations for follow-up care will be completed by the attending physician or designee to be provided to the patient prior to discharge.

RULE 2 MEDICAL RECORDS

2.1 Valley Presbyterian Hospital Medical Staff recognizes use of the Hospital's electronic medical record as the standard of practice at Valley Presbyterian Hospital. Guidelines for electronic medical record appropriate use are provided through various supporting hospital policies. All providers shall adhere to policy to promote the creation of an accurate and concise medical record that facilitates patient safety, quality of care, communication between providers and appropriate billing. All entries in the medical record, including orders, shall be clear and complete and shall comply with relevant hospital policies.

When within patient care areas (inpatient, outpatient, and Emergency Department) that are supported by the use of the electronic medical record, Medical Staff members will be subject to the regulations described in Rules 2.2 – 2.6. Patient care areas that are not supported by the electronic medical record are excluded from Rules 2.2 - 2.6.

2.2 Providers must either attend a mandatory education session that will provide the fundamentals of using the electronic medical record or otherwise demonstrate competency in its use during initial credentialing and before commencement of patient care. In addition, providers must attend mandatory education sessions during electronic medical record upgrades or as needed to ensure patient safety.

2.3 Providers are expected to enter orders electronically. Telephone and verbal orders are only permissible in accordance with Valley Presbyterian Hospital policy. Orders submitted on paper must be legible and are allowed only for one of the following conditions:

a. During electronic medical record downtime
b. When not supported by electronic medical record functionality
c. At the discretion of the Medical Executive Committee

2.4 Providers are expected to document patient care electronically. Verbally dictated reports are considered electronic and must be e-signed in the electronic medical record per policy. Handwritten notes must be legible and are allowed only for one of the following conditions:

a. During electronic medical record downtime
b. When required by Valley Presbyterian Hospital for quality or regulatory compliance. Only a structured paper form not available in the electronic medical record will be accepted in this circumstance.
c. At the discretion of the Medical Executive Committee

2.5 All Medical Staff members are required to authenticate documents and orders via electronic signature. Documents are displayed on a computer screen, then after verification of accuracy and completeness, the provider "electronically signs" the documents by pressing a computer key. Each participating provider will be assigned a confidential PIN number, which is not to be given out to other providers or office staff. With signing, Medical Staff members claim responsibility for the accuracy of their documentation in the medical record.

2.6 Medical Staff members that are non-compliant with Valley Presbyterian Hospital Rules and Regulations or policies regarding computerized physician order entry or electronic documentation shall be subject to performance management including monitoring, remedial education, revocation of access rights for certain documentation tools and/or corrective action including suspension pursuant to the Medical Staff Bylaws and Rules and Regulations. Failure to appropriately document in the medical record will also subject the Medical Staff member to the peer review process.

2.7 Regardless of the form in which it is submitted, when the patient chart is complete, the electronic medical record should ultimately contain all orders and documentation of patient care.

2.8 The patient's attending provider and each provider involved in the care of the patient shall be responsible for a complete and legible medical record for each patient. The record shall include identification data, completed medical history and physical examination, including past and current diagnoses, system review, physical examination with impression, special reports such as consultations, autopsies, and operative reports, laboratory and x-ray data,

progress notes, discharge summary, appropriate consents and principal and secondary diagnoses and procedures. The minimum medical record requirements are defined in the *Health Information Management (HIM) Department Policy and Procedure Manual*.

A. History and Physical (H&P) Examination Report - A dictated or computer entered comprehensive and complete general history and physical examination is required on all Hospital patients with the exception of vaginal deliveries. The scope and content of the examination must be relevant to the patient's medical history and the clinical findings.
The office prenatal record with an update of the patient's condition performed at the time of admission is acceptable as the History and Physical for vaginal deliveries.

   In surgical cases, the history and physical must be present in the medical record prior to commencing the procedure. An exception may be made in the case of an extreme emergency where the surgeon will complete a brief H&P.

B. A complete history and physical must be performed within twenty-four (24) hours of admission by a provider, with appropriate privileges. If a surgical H&P is used for an outpatient surgical procedure and the patient is subsequently admitted, a complete H&P must be electronically completed within twenty-four (24) hours addressing the reason for the patient's admission. History and physicals dictated by a nurse practitioner or physician assistant must be countersigned within twenty-four (24) hours by their Supervising Physician. All inpatients and outpatients must have a history and physical completed prior to surgery or major invasive procedure. The history and physical should include all pertinent findings. If the history and physical is performed more than twenty-four (24) hours prior to admission or surgery, any subsequent changes in the patient's status must be reflected in an interval history and physical note recorded in the medical record within twenty-four (24) hours of admission or not more than 24 hours prior to surgery.

C. If a complete history and physical was performed within thirty (30) calendar days prior to the patient's admission to the Hospital for elective surgery, a

reasonably durable, legible copy of the report may be used in the patient's medical record in lieu of the admission history and physical, provided the report was completed by a Medical Staff member or validated and authenticated by a Medical Staff member. There must be an update to the history and physical performed no more than 24 hours prior to admission for surgical patients. The update must be performed no later than 24 hours after admission for medical patients.

D. Histories and physicals for the purpose of medical clearance of surgical patients must be completed within 30 days prior to the surgical procedure. If the History and Physical is completed by a provider who is not a member of the VPH Medical Staff, it must be authenticated by a VPH Medical Staff member. It will be the responsibility of the attending surgeon to identify the VPH Medical Staff member who will countersign the History and Physical performed by a Non Staff Member. An update of the history and physical will count as a countersignature.

E. Nurse Practitioners and Physician Assistants will consistently indicate the name of the responsible physician with each entry in the medical record.

2.9 Timely entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care.

2.10 A medical record lacking any required element or required authentication is considered incomplete. Authentication requires signature, date and time for each entry made into the medical record.

2.11 Medical record entries must be completed promptly and authenticated by the author within fourteen (14) days following the patient's discharge or encounter. Medical records which are incomplete for any reason 14 days after discharge or encounter are considered to be delinquent.

Except for newborns, all inpatient and surgical medical records are audited daily for a timely, complete History and Physical as well as an Operative Report (as appropriate). Providers are notified via telephone if a History and Physical and/or Operative/Procedure Report is not completed. If the report is not completed within 24 hours, the provider is placed on suspension, per the suspension process defined in Rule 2.14.

2.12 Upon the patient's discharge or encounter the Health Information Management Department shall assign deficiencies within the medical record

to the responsible provider(s). If a provider has incomplete records after the patient's discharge or encounter he or she will receive a notice of the incomplete records pursuant to Rule 2.14.

2.13 A discharge summary must be completed by the provider who orders the patient to be discharged, except as provided in this rule. An exception will be made when there exists an order in the medical record indicating that another provider has agreed to perform the discharge summary via direct two-way communication. Such an order to transfer the responsibility of completing and signing a discharge summary should be either included in a comment within the discharge order itself, or as an order to "change attending provider."

2.14 If the provider fails to complete his or her medical records within fourteen (14) days of discharge or encounter or within 24 hours for Histories and Physicals and Operative/Procedure Reports, actions including suspension of admitting, providing care in the Emergency Department or in any hospital based outpatient areas and surgical privileges will be initiated pursuant to the procedure below:

A. A notice of incomplete records with patient information appears on each Medical Staff member's electronic desktop on Monday. If a provider has delinquent records, a follow-up phone call from Health Information Management will occur on Wednesday. If a provider fails to complete his or her delinquent medical records by Thursday, the provider is placed on suspension at 6pm on Thursday. The provider receives a suspension notice on his or her desktop. Admitting and surgical privileges are suspended at that time. When the provider completes his or her delinquent medical records, suspension will be lifted and a notice to that effect will be sent to the physician desktop.

B. If a provider remains on cumulative suspension for 60 days, the provider will be invited to attend the Medical Executive Committee to explain excessive cumulative suspension days. The provider will then be provided 24 hours to complete delinquent medical records. If the provider fails to attend the Medical Executive Committee meeting, then Article 7.7-7 "Failure to Respond or Appear", of the Medical Staff Bylaws will apply.

C. If a provider remains on cumulative suspension for 100 days in a calendar year, the provider's annual dues will be doubled and the provider will be reappointed for one year only at the end of the current appointment period.

If the provider is on suspension for 200 consecutive days at the time of the current suspension, the provider's Medical Staff membership and clinical privileges will be automatically terminated. If the provider opts to reapply within six months of the termination, the application fee is doubled and their appointment will be in effect for one year only.

D. Any additional details of the procedure regarding incomplete and delinquent medical records may be obtained from the Director or Operations Manager of the Health Information Management Department.

E. Providers on suspension may not admit other patients to the Hospital, provide care in the Emergency Department , in any hospital based outpatient areas, provide inpatient consultation or perform surgery or deliveries on patients admitted during his/her suspension, by other providers. In unusual circumstances, the Chief of the Medical Staff or his/her designee, or the President/CEO or his/her designee, may waive the suspension temporarily if this appears to be in the best interests of patient care. The Operations Supervisor and/or Pre-Access Case Manager shall be notified by the Chief of the Medical Staff or the President/CEO or their designees**,** of any such waiver granted and its duration.

2.15 A medical record shall not be permanently filed until it is completed by the responsible attending provider or is ordered to be filed by the Medical Records Committee. The Committee Chairperson may authorize the Director of Health Information Management to retire medical records under the following circumstances: when the provider is deceased, has moved from the area, has resigned from the Medical Staff, or is on an extended leave of absence. The Committee Chairperson or Director of Health Information Management must authenticate and date a cover letter for the medical record stating that the record is being filed incomplete and listing what is incomplete on the medical record.

2.16 Hospital policies are to be followed for use of symbols and abbreviations. For corrections in the medical record, appropriate cross-referencing shall be placed in the medical record when necessary to explain the correction. No medical record entry shall be deleted from the medical record. All blanks left in dictated reports must be completed by the dictating provider at the time the report is authenticated.

2.17 Each entry that is made in the medical record shall be signed, dated and, timed by the person making the entry, or their designee involved in the case. The date and time shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time. When a practitioner authenticates an order, that practitioner assumes responsibility for the order as being complete, accurate and final.

RULE 3 SURGERY AND INVASIVE PROCEDURE REQUIREMENTS

3.1 All surgery or invasive procedures performed shall require informed consent of the patient or his legal representative except in emergency, which shall be defined as a condition in which delay may endanger the patient's life and health.

3.2 All material removed from the patient by operative procedure shall become the property of the Hospital and shall remain in the Hospital laboratory for a sufficient time to allow the pathologist to document findings. All objects, including tissue and foreign bodies removed at an operation shall be sent to the Hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. Dentists shall record the tooth number of teeth and/or fragments removed on the operative report. The pathologist's authenticating report shall be made a part of the patient's medical record.

3.3 If a procedure requires a history and physical, then prior to commencing the procedure, the history and physical examination report must be contained in the medical record. If a history and physical examination has been dictated, but not yet present on the medical record, the physician must document a relevant and pertinent history and physical examination in the medical record. In an emergency, the physician shall document a pre-operative note regarding the patient's condition and reason for emergency surgery prior to the surgical procedure commencing.

3.4 When a history and physical examination is not on the medical record prior to surgery or invasive procedure requiring anesthesia, including Level IV Moderate sedation, the procedure will not be started until the history and physical examination has been recorded. The department staff must verify that the history and physical examination is on the medical record before taking the patient to the procedural room.

3.5 Minimum pre-procedure testing shall be determined by the procedural physician and the anesthesiologist based on the procedure to be performed and the clinical status of the patient.

A. Preadmission and preoperative laboratory work from outside laboratories will be accepted from a laboratory run by a licensed technologist and require proficiency testing acceptable to Medicare

and Medi-Cal. Such tests must be made available for review, if required.

B. Outside chest films may be accepted for patients undergoing surgical procedures provided there is a radiologist interpretation. A Hospital radiologist will review outside films if requested and notify the physician of any problems identified. Pertinent outside films accompanied by a radiologist interpretation would be reviewed by the Hospital's radiologist without charge if such a request is made by the attending physician. Such request for film review must be submitted to the Radiology Department twenty-four (24) hours prior to the scheduled surgical procedure.

3.6 Outpatient surgery is designed to accommodate all patients for whom an outpatient procedure is safe and appropriate**.**

3.7 The *Pre-Operative Scheduling* policy is to be followed for all cases scheduled by the surgeon or his/her designee.

3.8 In compliance with the *Universal Protocol within Surgical Services* policy, the surgical site must be marked and involve the patient in the marking process when appropriate. Prior to the start of any surgical or invasive procedure, a final verification process through a formal "time out" is performed to confirm the correct patient, procedure side and site, using active verbal communication must occur and be documented in the medical record.

3.9 All previous orders are canceled during operative procedures.

3.10 An anesthesiologist shall visit every patient after anesthesia and document the presence or absence of any anesthesia-related complications. This note shall be signed, dated and timed by the anesthesiologist within forty-eight (48) hours, post procedure.

3.11 A patient admitted for dental care or podiatric care is a dual responsibility involving the dentist or podiatrist and an M.D. or D.O. member of the Medical Staff.

Dentist's Responsibilities:

A. A detailed dental history justifying Hospital admission.

B. A detailed description of the examination of the oral cavity and a preoperative diagnosis.

C. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments

removed. All tissue including teeth and fragments shall be sent to the Hospital pathologist for examination.

D. Progress notes as are pertinent to the oral condition.

E. Clinical resume (or summary statement).

3.12 Podiatrist's Responsibilities:

A. A detailed podiatric history justifying Hospital admission. A complete medical history and physical may be performed by a podiatrist, if privileges for such have been granted.

B. A detailed description of the examination of the lower extremity(ies) involved and a preoperative diagnosis.

C. A complete operative report describing the findings and techniques. In cases of removal of bones, nails or tissue, the podiatrist shall clearly state the number or amount removed. All tissue including nails and bones shall be sent to the Hospital Pathology Department for examination.

D. Progress notes as are pertinent to the condition of the extremity(ies) involved in the procedure.

E. Clinical resume (or summary statement), and/or discharge summary.

3.13 Primary Care Physician's Responsibilities:

A. Medical history pertinent to the patient's general health.

B. A physical examination to determine the patient's condition prior to anesthesia and surgery.

C. Direct responsibility of the patient's care and treatment during hospitalization.

The discharge of the patient shall be on order of the dentist or podiatrist member of the Medical Staff, concurred with by a discharge order from the primary care physician.

RULE 4 CONSULTATIONS

4.1 Any qualified physician with clinical privileges in this Hospital can be called for consultation within his or her area of expertise and within the limits of clinical privileges that have been granted to him or her.

4.2 Judgment as to the seriousness of the illness and the resolution of any doubt regarding the diagnosis or treatment rests with the physician responsible for the care of the patient. The organized Medical Staff, through its Department Chairpersons and the Medical Staff Executive Committee, has oversight responsibility for assuring that consultants are called as needed.

4.3 An attending physician's responsibility for his or her patient does not end with a request for consultation and the attending physician remains in charge of his or her patients care unless a transfer of patient care to a different attending physician has occurred as described in these Rules and Regulations.

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

4.5 In order to provide optimal communication and coordination among practitioners, requests for consultation must be made by two-way personal communication from the attending physician to the consulting physician. The medical record, Hospital nurses or other Hospital staff are not to be used as intermediaries. The attending physician shall document the consultation request in the patient's medical record by using the "physician consult" order. The order itself does not constitute a completed consultation request unless the necessary personal communication has occurred. If the requested consulting physician does not agree to the consultation, this should be documented in the medical record along with the reason given.

If specialty consultation is needed for a patient in the Emergency Department, the Emergency Department physician shall request the consultation by direct personal communication and document this request in the patient's medical record.

4.6 If there is any reason to doubt or question the care provided to any patient or that a consultation is needed and has not been obtained, a supervisor is notified, who in turn will follow the Chain of Command. The Department Chairperson may then, in appropriate circumstances, confer with the attending physician and request that a consultation be obtained.

If the attending physician does not agree to request the consultation, the Chief of Staff or the Medical Executive Committee may mandate that a consultation be obtained if deemed necessary.

4.7 Inpatient consultations shall be performed within 24 hours of the documented consultation request, unless a different medically appropriate (later) or medically necessary (sooner) timetable is agreed upon by the attending and consulting physician and this is documented in the medical record.

4.8 A satisfactory consultation includes examination of the patient and the medical record. The attending physician is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation.

A. A consultant report must contain at least the following elements:

- Review of history and medical record;
- Summary of physical findings;
- Diagnostic impression; and
- Recommendations for treatment.

If the consultant's report contains all the required elements of a History and Physical, it may be used as the History and Physical.

B. An authenticated report by the consultant must be included in the patient's medical record after the consultation has been performed within twenty-four (24) hours. When operative procedures are involved, consultations performed before surgery shall be documented before the surgery, except in emergency cases.

RULE 5 CONSENTS

5.1 The Hospital's *General Consent* policy will be followed for all consents, including informed consent, who may give consent, responsibility for securing consent, emergency consent, special consent and consent by telephone, telegraph, facsimile (fax) or email. Patients have the right to participate actively in decisions regarding their medical care and to decide whether to authorize or refuse procedures recommended by their physicians. Physicians must give patients the information they need in order to make their decisions. Accordingly, complex diagnostic and therapeutic procedures may be performed only when the patient, or his or her surrogate decision maker, has been given information about the procedure and has given informed consent.

A. The physicians involved in securing informed consent shall document in the patient's medical record, their discussions

regarding the proposed procedure along with the risks and benefits and whether they have secured the appropriate informed consent.

B. In an emergency situation, the physician's documentation shall be entered in a progress note and must describe:

- The nature of the emergency;
- The reasons consent could not be secured from the patient or a surrogate decision maker;
- The probable result if treatment would have been delayed or not provided.

C. Complex procedures include all operations and invasive procedures, blood transfusions, and other procedures as identified in the California Hospital Association (CHA) manual as being complex. Blood draws and IV punctures for venous access are not considered complex procedures.

D. Informed consent shall be obtained and documented in writing by the attending physician or designee for all operations and other complex medical or surgical procedures.

E. Hospital staff shall verify that informed consent has been obtained from the patient by verifying that the physician has documented in the medical record their discussion with the patient of the proposed treatment or procedure and by asking the patient to complete the "Conditions of Admission" form, including the "Consent to Medical and Surgical Procedures.

RULE 6 PHYSICIAN COVERAGE

6.1 Each physician shall personally provide or otherwise arrange for continuous care and coverage for each of his or her patients who present to the Hospital for clinical care or who are currently Hospital inpatients. If a physician is unable to provide care for his or her patients, then the physician must provide coverage through another appropriately credentialed physician. The covering physician must be a member of the Medical Staff with current privileges and available and qualified to assume responsibility for the patients during the attending physician's absence and must be aware of the status and condition of any Hospital patient which he or she is to cover. Failure to arrange appropriate coverage shall be grounds for corrective action.

A. Each physician shall have on file, in the Medical Staff Services Department, a current contact phone number, as well as an alternate number or form of contact.

B. When not available, each physician shall have on file, in the Medical Staff Services Department, the name and current contact phone number of an alternate covering physician.

C. Each physician shall be responsible for notifying the Medical Staff Services Department, immediately, when any changes are made to contact information. It is each physician's responsibility to maintain current contact information on file in the Medical Staff Services Department, at all times.

6.2 The Emergency Department and/or Patient Care Unit will initiate a call to the attending or on-call physician and will conduct a minimum of two follow-up calls up to the half hour.

The physician on call will respond to all pages or phone calls regarding a patient (inpatient or ED patient) within thirty (30) minutes of being called. The physician will be personally available within a reasonable time (one hour) of any call to provide necessary medical evaluation and stabilizing treatments, if requested by the ED physician or Charge Nurse.

6.3 In the event the attending/admitting physician or the attending/admitting physician's alternate is not available to address an issue regarding a Hospital patient, the Chain of Command shall be initiated to determine the appointment of an appropriate Medical Staff member who will assume responsibility until the attending/admitting physician can be reached.

1. If the Emergency Department or Patient Care Unit is unable to locate the patient's primary care physician or the ED call panel member within thirty (30) minutes, another physician or appropriate specialist may be called by the Emergency Department physician or Charge Nurse.

2. All on-call physicians shall comply with all current federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

RULE 7 EMERGENCY DEPARTMENT (ED) CALL PANEL

7.1 The ED Call Panel has been established for referring unassigned patients who require emergency consultation or hospital admission.

7.2 The Medical Staff Services Director or designee is responsible for working with the Medical Staff call panel members and Hospital Administration to ensure that appropriate ED call coverage is available and posted on the VPH intranet no later than the last day of each month for the following month.

If appropriate coverage is not available in all specialties, the Medical Staff Services Director, or designee, will notify the appropriate Department Chairperson, Hospital Administration and the Chief of Staff.

7.3 At the recommendation of the Department Chairperson and with the approval of the Medical Executive Committee members on the Provisional Staff may be assigned to the ED Call Panel.

7.4 Physicians listed on the ED Call Panel must respond to the Emergency Department or inpatient unit by telephone within thirty (30) minutes and be personally available within one hour to examine the patient, if requested by the Emergency Department physician or Charge Nurse.

Panelists who do not respond within the required timeframe will be referred to their respective Departments for peer review for not following protocol per these Rules and Regulations; and/or may be subject to a mandatory meeting with the Chair of the Department.

A second incident of non-response by a panelist to the Emergency Department or patient care unit will be escalated to the Medical Executive Committee for review and action.

7.5 A panelist who is unable to provide panel coverage during his or her scheduled time is responsible for arranging for coverage by an appropriately credentialed physician who meets the criteria for panel eligibility. The panelist shall inform the Medical Staff Services Department of the name of the physician and the contact information of the covering provider.

7.6 All ED Call Panel members shall comply with all current federal Emergency Medical Treatment and Active Labor Act (EMTALA) requirements.

RULE 8 DRUG/MEDICATION, TREATMENT AND DIAGNOSTIC TESTING ORDERS

8.1 General – The Pharmacy Department policies, will be followed for all drug/medication, treatment and diagnostic testing orders, which include practitioner responsibility, drugs/medications administration, and clinical investigations.

8.2 Review of Drug Orders – Medication orders are reviewed by a pharmacist prior to dispensing and administration except in instances as follows:

A. A Licensed Independent Practitioner is present to administer or monitor administration of a medication;

B. The clinical status of the patient requires immediate treatment;

C. The Pharmacy and or Hospital system is down and downtime procedures are in place.

Refer to *Medication Order Review* policy.

8.3 Procurement of Drugs – Refer to *Pharmacy Supply Chain* policy.

Medications shall not be left at the bedside unless the attending physician so orders in writing, and only when such patient is competent and capable of self-medication.

A. Controlled substances shall not be left at the bedside.

B. Bedside medications may include:

1) Ophthalmic drops and ointments

2) Nitroglycerine tablets

3) Birth control pills

4) Oral hygiene products

5) Antacids

6) Nasal drops

7) Preparations for perianal care

8) Water-based lubricants and moisturizers

8.4 Substitution of Generic Drugs – Generic drugs may serve as a substitute and be dispensed unless ordered by the physician otherwise.

8.5 Verbal and Telephone Orders - Orders dictated to a licensed person by a physician in person are known as verbal orders. Orders dictated to a licensed person by a physician over the telephone are known as telephone orders. Verbal and telephone orders are treated in the same manner. Verbal or telephone orders can be given in emergency situations or situations when the attending physician is physically unable to write the orders. Verbal or telephone orders for medications or IV fluids may be received by a registered nurse only. Verbal and telephone orders for treatments and diagnostic testing may be given to other licensed care professionals (i.e. respiratory therapist, radiology technologist, medical technologist, physical therapist, and dietitian) as related to their scope of practice. Physician assistants and nurse practitioners may also receive and transmit verbal/telephone orders

(including medications and IV fluids) on a patient-specific basis from the supervising physician or pursuant to an approved protocol.

Verbal and telephone orders must be countersigned by the physician within forty-eight (48) hours. Verbal and telephone orders for restraints must be countersigned within twenty-four (24) hours.

All verbal and telephone orders and critical test results, pursuant to Medical Staff policy and procedure, must be require a verification "read-back" of the complete order or test result by the person receiving the order or test result to assure accurate communication.

8.6 Pre-Printed Orders – Pre-printed orders for medications and other forms of treatment may be used for specified patients when authorized by a person licensed to prescribe and/or possessing privileges to issue the orders. Note that physician order sets within the setting of the electronic medical records are not considered to be pre-printed orders, and thus are not specially constrained by this rule. A copy of pre-printed orders for a specific patient must be, dated, timed and signed by the physician, and included in the patient's medical record.

Pre-printed orders must:

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

B. Specify the types of the medical conditions to which the pre-printed orders are intended to apply;

C. Be initially approved and reviewed annually by the relevant Medical Staff Committee;

D. Be specific with respect to all of the relevant information necessary in order to carry out the order, including but not limited to specification of medication, dosage, route and frequency of administration.

RULE 9 INFECTION PREVENTION

9.1 Members of the Medical Staff and those with clinical privileges or practice prerogatives must seek to reduce the risk of health care-acquired infections by following the current Centers for Disease Control and Prevention hand hygiene guidelines per the *Hand Hygiene* policy.

9.2 All members of the Medical Staff that will have direct patient contact are required to submit evidence of Tuberculosis (TB) Test clearance at the time

of Initial Appointment and at the time of Reappointment. If the practitioner has privileges are for telemedicine only, TB clearance is not required.

RULE 10 MEDICAL EDUCATION

10.1 Patient Education – In fulfillment of medical education goals, verbal or written consent must be obtained by any patient who participates in care for teaching purposes; and such consent must be documented by the attending physician.

10.2 Medical Students and Residents participating in training programs at the Hospital shall be supervised by Medical Staff members and act in accordance with the Agreement governing their training at the Hospital; and with the relevant hospital policies. Fellows shall be credentialed and privileged pursuant to the Medical Staff Bylaws.

10.3 Record Keeping –The attending physician is responsible for all entries in the medical record, and shall countersign all reports and/or entries made by the medical/podiatry student or resident.

10.4 Designation in Operative Reports – Residents who act as an assistant surgeon shall be designated in the operative report as “the assisting resident surgeon” and the primary operating surgeon shall be designated as the “primary operating surgeon” in the operative report.

RULE 11 ADVANCED PRACTICE CLINICIAN SUPERVISION

11.1 Each member of the Advanced Practice Clinician (APC) staff will have a designated supervising physician who is a current member of the Medical Staff, and holds privileges in an appropriate clinical department or division.

11.2 The approved APC categories are as follows:

Nurse Practitioner (NP)
Physician Assistant (PA)
Certified Registered Nurse Anesthetist (CRNA)
Registered Nurse First Assist (RNFA)
Orthopedic Surgical Technician
Certified Surgical Scrub Technician
Perfusionist

11.3 The supervising physician shall delegate to an APC only those tasks and procedures consistent with the supervising physician’s specialty or usual and customary practice. Supervising physicians are required to complete and sign a Supervising Letter of Intent for all NP’s, CRNA’s and RNFA’s and a Delegated Services Agreement for all PA’s. An orthopedic surgical technician, certified surgical scrub technician or perfusionist shall perform all

tasks under direct supervision of the surgeon. Refer to Advanced Practice Clinician Rules and Regulations for specific scope of practice guidelines and requirements for each Advanced Practice Clinician category.

11.4 The supervising physician or designee will fulfill all supervision requirements for APC's. For physician assistants, the supervising physician will review and countersign medical record entries as required by California Business and Professions Code section 3502. Supervision, chart review and counter-authentication of orders and other medical record entries for each category of Advanced Practice Clinicians will be performed as described in the Advanced Practice Clinician Rules and Regulations.

RULE 12 DISASTER PLAN

12.1 It shall be the responsibility of the Safety Committee to prepare and keep updated plans for disasters within and outside of the hospital. In the event of such a disaster or preparatory drill, all Medical Staff members shall report to their assigned stations. None shall perform any duties other than those assigned. The Chief of the Medical Staff and the Hospital's President/Chief Executive Officer, or designees, will work as a team to coordinate activities. In cases of evacuation from hospital premises, the Chief of the Medical Staff, or designee, will authorize the movement of patients. All policies concerning patient care will be a joint responsibility of the Chief of Staff and the Hospital's President/Chief Executive Officer. In their absence, the Vice Chief of Staff and the Hospital's President/Chief Executive Officer's designee are next in line of authority, respectively. All Medical Staff members specifically agree to relinquish direction of the professional care of their patients to the Chief of Staff in cases of emergencies.

12.2 Refer to the Medical Staff Bylaws for information on Emergency Privileges and Disaster Privileges that may be granted to non-staff physicians.

RULE 13 MEDICAL STAFF MEETINGS

General Provisions – Medical Staff meetings shall include, but not be limited to, the General Medical Staff meetings, meetings of clinical departments/divisions, meetings of committees established under Rule 14, and meetings of special or ad hoc committees. Standing committees shall be defined in Rule 14.

13.1 Quorum – A quorum of at least two Active Medical Staff members in addition to the Chair of the Committee, Department or Division must be present to vote or for any actions to be approved. The Chair has the right to discuss but shall not vote on matters presented except in circumstances where there is a voting tie. If two Medical Staff members, besides the Chair, are not present,

one non-physician member who has been approved by the Medical Executive Committee may vote or approve actions only as noted under Rule 14 – Medical Staff Committees.

13.2 Manner of Action – The Medical Executive Committee shall determine if any action to be taken at a regular or special General Medical Staff meeting shall be subject to ballot (via US Mail or E-Mail). Ballots will always be permitted relevant to the election of officers and amendment of Bylaws and Rules and Regulations of the Medical Staff. If the Medical Executive Committee determines that ballots are appropriate for other actions to be taken at a Medical Staff meeting, the Medical Executive Committee shall prepare a summary of the issue(s) to be voted upon, and that summary, along with a ballot, will be sent to each member of the Active Medical Staff at least ten calendar (10) days before the date of such meeting.

Except as otherwise specified, the action of a majority of the members voting in person, by US mail-in ballot or e-mail ballot, shall be the action of the Medical Staff.

13.3 Attendance Requirements – Active Staff members of the Medical Staff will be required to attend at least a total of three qualifying Medical Staff meetings in each calendar year. For this purpose, “qualifying Medical Staff meetings” consist of meetings of the General Medical Staff as well as the Medical Staff Member’s own clinical department or division meetings. In lieu of this required attendance, an Active Staff member may provide proctoring of a member of the Provisional Staff. Proctoring of a minimum of three (3) cases will count as attendance at one (1) meeting. Unless exempted as per section 13.4, physicians wishing to be advanced to Active Staff status must have met these attendance requirements prior to advancement, in addition to Membership requirements as set forth in the Medical Staff Bylaws.

13.4 The Medical Executive Committee may approve Active Medical Staff membership to any Medical Staff member for whom the above requirements are not met if that member demonstrates an active interest in the operation and improvement of the Hospital and agrees to serve on Medical Staff committees where requested or assigned. Likewise, the Medical Executive Committee is authorized to place any Medical Staff member in the most appropriate Medical Staff category based on their current level of participation, interest, experience, and competency.

13.5 Designation and Terms of Chairs - Unless otherwise specified, the chairperson and members of all standing committees shall be appointed by the Chief of Staff of the Medical Staff, subject to approval by the Medical Executive Committee. Ad Hoc Medical Staff Committee members may be appointed to any Medical Staff committee by the committee chairperson or by the Chief of Staff of the Medical Staff. The Hospital President/Chief Executive Officer and/or Sr. Vice President of Quality shall be members of all Medical Staff committees, without vote unless otherwise specified. A Medical

Staff Committee Chair may serve for an indefinite period of time, with the term renewed every two years corresponding with the terms of the Medical Staff Officers, unless a new Chair is appointed by the Chief of Staff; with the exception of the Quality Committee Chair, as this position is held by the current Medical Staff Secretary/Treasurer. Should a Chair not be able to attend a meeting, another physician member of the committee will be requested to Chair the meeting. The Chief of Staff shall be an ex-officio member on all committees of which they are not otherwise assigned.

13.6 Except as otherwise provided in these Rules and Regulations or the Medical Staff Bylaws, committees established to perform required Medical Staff functions may include any category of Medical Staff members; allied health professionals; representatives from Hospital departments such as administration, nursing services, or health information services; representatives of the community; and persons with special expertise, depending upon the topic to be discussed. The President/Chief Executive Officer, or his or her designee, in consultation with the Chief of Staff, shall appoint any non-Medical Staff members who serve in non-ex officio capacities. The committee chair, after consulting with the Chief of Staff and President/Chief Executive Officer, may call on outside consultants or special advisors.

13.7 General Medical Staff Meetings – Regular meetings of the members shall be held as needed but at least two times per year. The Medical Staff leadership shall determine the date, place and time of the regular meetings, and notice shall be given to the members at least ten (10) days prior to the meeting.

13.8 Other Medical Staff Meetings - Special or Ad-Hoc meetings may be called by the Medical Executive Committee, departments or divisions to perform specified tasks. Unless otherwise specified the Chairperson and members of all committees shall be appointed by and removed by the Chief of Staff subject to consultation with and approval of the Medical Executive Committee. Medical Staff committees shall be responsible to the Medical Executive Committee and/or Quality Committee. These meetings are categorized below:

A. Ad Hoc Meetings – Ad Hoc meetings may be called by members of a Department or Division, and chaired by the Department/Division Chairperson or designee to address specific issues. No business other than the issue being addressed may be brought forth at the ad hoc meeting. Notice for ad hoc meetings shall be emailed, mailed or delivered to the members of the department/division no later than ten (10) days prior to the meeting. The notice of the meeting shall include the date, time and location, and the stated purpose of the meeting. The Department/Division shall schedule the meeting within fifteen (15) days after receipt of request.

B. Special Meetings - Special meetings of the Medical Staff may be called at any time by the Chief of Staff or the Medical Executive Committee, or shall be called by the Medical Executive Committee upon the submission of a petition requesting such a special meeting signed by twenty (20) percent of the Active Staff Medical Staff membership.

C. The person(s) calling or requesting the special meeting shall state the purpose of such meeting in writing to the Chief of Staff. If the special meeting is called based on a petition, the petition shall clearly state the purpose of the meeting at the top of each signature page. If the purpose is not written at the top of each signature page, the pages missing the purpose will be considered null and void.

The Medical Executive Committee shall schedule the meeting within fifteen (15) days after receipt of such request.

No later than ten (10) days prior to the meeting, notice shall be mailed via email or US mail or delivered to the members of the Medical Staff. The notice of the meeting shall include date, time and place, and the stated purpose of the meeting. No business shall be transacted at any special meeting except that stated in the notice calling the meeting. If mailed, the notice of the meeting shall be deemed delivered when deposited, postage prepaid, in the United States mail addressed to each staff member at his address as it appears on the records of the Hospital.

13.9 Vacancies and/or Removals of Chairs or Members – If the Chair or any member of a committee ceases to be a member in good standing of the Medical Staff, suffers a loss or significant limitation of practice privileges or if any other good cause exists, that member may be removed by a majority vote of the Medical Executive Committee. Vacancies on any committee shall be filled in the same manner in which an original appointment to such committee is made.

RULE 14 MEDICAL STAFF COMMITTEES

The Medical Staff Committees noted below are standing committees of the Medical Staff and shall meet all provisions as noted under Rule 13. The

following non-physician members have been granted voting rights by the Medical Executive Committee for the committees noted, shall a quorum not be present:

Sr. Vice President, Quality or Sr. Vice President/Chief Nursing Officer
Infection Control Committee
Utilization Management Committee
Patient Safety Committee
Interdisciplinary Practice Committee
Bioethics Committee

Sr. Vice President, Quality
Medical Record Committee

Sr. Vice President, Quality or Director of Pharmacy
Pharmacy and Therapeutics Committee

Sr. Vice President, Quality
Quality Committee

14.1 Standing Committees of the Medical Staff are:

14.1.1 Bioethics Committee
14.1.1a Palliative Care Subcommittee
14.1.2 Bylaws Committee
14.1.3 Credentials Committee
14.1.4 Infection Prevention Committee
14.1.5 Intensive Care Unit (ICU) Committee
14.1.6 Interdisciplinary Practice (IDP) Committee
14.1.7 Medical Education Committee
14.1.8 Medical Informatics Committee
14.1.9 Medical Record Committee
14.1.10 Multidisciplinary Peer Review Committee
14.1.11 Patient Safety Committee
14.1.12 Pharmacy and Therapeutics Committee
14.1.12a Medication Safety Subcommittee
14.1.13 Physician Well-Being Committee
14.1.14 Quality Committee
14.1.15 Utilization Management Committee

14.1.1 Bioethics Committee

Composition – The Bioethics Committee shall consist of a culturally diverse multidisciplinary team, including representation by physicians, nurses, social

workers, administration, community, legal and clergy. The members of the committee shall be sufficiently qualified through experience, expertise and diversity of its members, to address ethical and proposed research activities. In addition to possessing the professional competence necessary to review specific ethical issues and research activities, the Bioethics Committee shall be able to ascertain the acceptability of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The Bioethics Committee shall therefore include persons knowledgeable in these areas. If the Bioethics Committee regularly reviews research that involves a vulnerable category of subjects, such as children, prisoners, pregnant women, or handicapped or mentally disabled persons, consideration shall be given to the inclusion of one or more individuals who are knowledgeable about and experienced in working with these subjects.

Duties – The Bioethics Committee serves as an advisory committee on issues pertaining to bioethics, including making recommendations to practitioners, patients and families, in the best interest of the patient. The Bioethics Committee acts as mediator in consultations with concerned parties to facilitate communication and aid in conflict resolution, as well as to provide education of Hospital staff on bioethical issues.

Frequency of Meetings – The Bioethics Committee shall meet as often as necessary and/or when Bioethics Consultations are requested, but at least annually. It shall maintain a record of all activities and report to the Medical Executive Committee.

14.1.1a Palliative Care Subcommittee

Composition – The Palliative Care Subcommittee shall consist of at least three (3) physician members of the medical staff including at least one physician with extensive experience in palliative care, as well as a representative from Social Services, a representative from Nursing, and the Vice President of Quality.

Duties – The Palliative Care Subcommittee shall be a subcommittee of the Bioethics Committee and will work collaboratively with physicians, nurses and patient's family members to address the physical, emotional, social and spiritual needs of patients; and seek to improve the quality of life for persons with a life-threatening/terminal illness. The subcommittee shall provide the best possible options for continuum of care for patients including hospice and/or sub-acute facilities. It will participate in Bioethics consultations to assist in determining the best care possible for patients who have no decision making capabilities and/or there is family conflict with decision making.

Frequency of meetings – The Palliative Care Subcommittee shall meet as often as necessary, but not less than quarterly. It shall maintain a record of all activities and report to the Bioethics Committee.

14.1.2 Bylaws Committee

Composition – The Bylaws Committee shall consist of at least four (4) members of the Medical Staff, including the Chief of Staff, the Secretary/Treasurer of the Medical Staff. The Senior Vice President for Quality and the Medical Staff Director shall be ex-officio members without vote. The Chairperson shall be appointed by the Chief of Staff.

Duties - The duties and responsibilities of the Bylaws Committee shall be to:

A. Conduct a biennial review of the Medical Staff Bylaws, Rules and Regulations.

B. Submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices.

Frequency of Meetings - The Bylaws Committee shall meet as often as necessary but at least annually; and, shall maintain a permanent written record of its proceedings and actions. The Bylaws Committee shall report its activities and recommendations to the Medical Executive Committee.

14.1.3 Credentials Committee

Composition – The Credentials Committee shall consist of Active Staff members of the Medical Staff selected in such a manner so as to ensure, insofar as feasible, representation from each of the major clinical specialties; each of the Clinical Department chairs or their designee, the Chief of Staff or designee, and the Hospital President/Chief Executive Officer or Sr. Vice President of Quality, as ex-officio member.

The Credentials Committee Chairperson may enlist ad-hoc participation by the appropriate Clinical Department or Clinical Division Chairperson as appropriate.

Duties - The duties of the Credentials Committee shall be to:

A. Review and evaluate the qualifications of each practitioner applying for initial appointment, reappointment or modification of clinical privileges;

B. Submit required reports and information to the Medical Executive Committee regarding the qualifications of each practitioner applying for membership or particular clinical privileges including recommendations with respect to appointment, membership category, department affiliation, clinical privileges, proctoring and any imposed special conditions;

C. Investigate, review and report on matters referred by the Chief of Staff, Medical Executive Committee or Department Chairpersons regarding the qualifications, conduct, professional character or competence of any applicant or Medical Staff Members;

D. Assist the Medical Staff departments and Medical Executive Committee in the evaluation of new technologies and the development credentialing criteria for the granting of new clinical privileges when applicable;

E. Assist the Medical Staff departments and Medical Executive Committee in the development of credentialing criteria for procedures which are performed by more than one clinical discipline,

F. Develop and implement, with Medical Executive Committee approval, credentialing policy and procedure and,

G. Submit periodic reports to the Medical Executive Committee on its activities and the status of pending applications.

Frequency of Meetings - The Credentials Committee shall meet as often as necessary but at least every two (2) months, and maintain a permanent written record of its proceedings and actions. The Credentials Committee shall report to the Medical Executive Committee.

14.1.4 Infection Prevention Committee

Composition - The Infection Prevention Committee shall consist of at least five (5) members, including Medical Staff representatives from the clinical departments of Medicine, Surgery, Obstetrics and Gynecology, Pediatrics and Pathology. Non-voting members shall include a representative from each of the following areas: Nursing Services, Administration, and an individual employed in a surveillance or epidemiological capacity. The Committee may include non-voting consultants in microbiology and non-voting representatives from other relevant Hospital services.

Duties The duties of the Infection Prevention Committee shall include:

A. Developing of a Hospital-wide infection control program and maintaining surveillance over the program;

B. Developing a system for reporting, identifying and analyzing the incidence and cause of nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

C. Developing and implementing a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, isolation and sanitation techniques;

D. Developing written policies defining special indications for isolation requirements;

E. Coordinating action on findings from the Medical Staff's review of the clinical use of antibiotics;

F. Acting upon recommendations related to infection prevention and control received from the chief of staff, the Medical Executive Committee, departments and other committees;

G. Reviewing sensitivities of organisms specific to the facility, and

H. Reporting to relevant Hospital staff, Medical Staff administration and required external agencies any nosocomial and community acquired infections of epidemiological significance.

Frequency of Meetings - The Infection Prevention Committee shall meet as often as necessary, but not less than quarterly. It shall maintain a record of its proceedings and shall submit reports of its activities and recommendations to the Medical Executive Committee.

14.1.5 Intensive Care Unit (ICU) Committee

Composition - The ICU Committee Chair shall be appointed by the Chief of Staff. This committee shall include chairs of the major clinical departments or their designees plus the nursing supervisor of the intensive and coronary care units, and the Senior Vice President for Quality, as ex-officio member.

Duties shall include but may not be limited to:

A. Evaluate the quality of patient care within the unit(s);

B. Assess unit operations; clinical and support services

C. Assess equipment needs.

Frequency of Meetings The ICU/CCU Committee shall meet as often as necessary, but at least twice per year and report to the Medical Executive Committee.

14.1.6 Interdisciplinary Practice (IDP) Committee

Composition - The Interdisciplinary Practice (IDP) Committee shall consist of at least two members of the Medical Staff, an equal number of nursing staff,

the Sr. VP, Quality, the Sr. VP and Chief Nursing Officer, as well as ad hoc members, as needed.

Duties – The IDP Committee duties are to evaluate and make recommendations regarding the need for, and appropriateness of, Hospital services performed by members of the Allied Health Professional Staff and/or to review and evaluate any standardized procedures for the nursing or other ancillary staff, such as respiratory therapists who request to perform duties outside of their scope of practice.

Frequency of Meetings - The Interdisciplinary Practice Committee shall meet as often as necessary, but at least two times per year.

14.1.7 Medical Education Committee

Composition – The Medical Education Committee shall consist of physician members and other healthcare professionals whose number shall be appropriate to the size of the Hospital and the amount of program activities produced annually. The composition shall include Committee members who shall serve staggered two year terms in order to assure continuity. The physician chair of the Continuing Medical Education Committee shall be appointed by the Chief of Staff.

Duties The Continuing Medical Education Committee shall plan, implement, coordinate and promote ongoing special clinical and scientific programs for the Medical Staff and perform the following duties:

A. Identify the educational needs of the Medical Staff;

B. Formulate clear statements of objectives for each program;

C. Assess the effectiveness of each program;

D. Choose appropriate teaching methods and knowledgeable faculty for each program; and

E. Documenting staff attendance at each program.

F. Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner;

G. Establish liaison with the quality improvement program of each department in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity;

H. Maintain close liaison with other Hospital Medical Staff and committees concerned with patient care;

I. Advise the Medical Executive Committee and administration of the financial needs of the medical education program by the submission of a annual proposed educational budget;

J. Address cultural and linguistic competence issues as required by California Assembly Bill (AB) 1195 (Cultural & Linguistic Competency);

K. Implement procedures to monitor physicians' increased competence, improved performance and to measure for optimum patient care outcomes; and,

L. Ensure that the contents of presentations will be based on scientific methods generally accepted by the medical community. Data will be objectively selected from peer-reviewed literature and will be presented in an unbiased manner. Internal outcomes data can be utilized to substantiate a need for education on a particular subject or process.

Frequency of Meetings - The Medical Education Committee shall meet every other month, but not less than quarterly and maintain a permanent record of its proceedings and actions. The Committee shall report substantive issues to the Medical Executive Committee.

14.1.8 Medical Informatics Committee

Composition - The Medical Informatics Committee shall be composed of a core team of practitioners including, but not limited to the Medical Informatics physician lead and physician representation from the Departments of Internal Medicine, Surgery, Obstetrics and Gynecology, and Emergency Department, a physician representative from the Clinical Documentation Improvement (CDI) Project, as an adjunct member, and members of the Hospital Administration team, such as the Chief Information Officer and any other administrative members, as deemed necessary. The composition of this committee may include the Medical Staff Chief of Staff and the Chief Executive Officer or his/her designee, as ex-officio members.

Duties – The role of the Medical Informatics Committee is to represent all physicians and clinicians in improving patient are by:

A. Enhancing patient safety (i.e., reduction of Adverse Drug Events (ADE's)

B. Enhancing physician satisfaction (i.e., through automating clinical decision support, streamlining the care process, improving physician communication effectiveness

C. Improving physician time and efficiencies supported by technology (i.e., eliminate time looking for paper chart)

D. Increasing the impact of patient care quality and efficiency (i.e., outcomes, treatment regimens)

E. Increasing physician adoption of technology (i.e., use of computerized physician order entry (CPOE))

F. Representing physician viewpoint and perspective in information technology decisions to be made by the Hospital.

Frequency of Meetings - The Medical Informatics Committee shall meet at least quarterly. The committee shall maintain a permanent record of its proceedings and activities and report to the Medical Executive Committee.

14.1.9 Medical Record Committee

Composition - The Medical Records Committee shall consist of the physician Chair, physician representation from the Emergency, Medicine, Surgery, Obstetrics/Gynecology and Pediatrics Departments, the Health Information Management Director, the Senior Vice President for Quality, and the Chief Nursing Officer.

Duties - The duties of the Medical Records Committee shall include:

A. Review and make recommendations for Medical Staff and Hospital policies, rules and regulations relating to medical records, including completion, forms and formats, filing, storage, destruction, availability and methods of enforcement;

B. Maintain a record of all actions taken and submit periodic reports to the Quality Committee concerning medical records practices in the Hospital.

Frequency of Meetings – The Medical Records Committee shall meet as often as necessary, but at least quarterly. It shall maintain a permanent record of its proceedings and activities, and shall report to the Medical Executive Committee.

14.1.10 Multidisciplinary Peer Review Committee (MDPR)

Composition – The Multidisciplinary Peer Review Committee shall consist of the Chair or Vice Chair of each major clinical department/division, the Sr. Vice President for Quality, the Director of Quality, and the Chief Nursing Officer. The Chair of the committee shall be appointed by the Chief of Staff.

Duties – The MDPR Committee will review all cases that have been scored by the respective Department/Division. The committee shall have available, the actions of all cases that have been reviewed by the Department/Division. The duties of the MDPR Committee include but are not limited to the following:

A. Review all peer review cases after cases have been reviewed by individual departments/divisions.

B. Determine if conflict of interest exists when a member of the Medical Staff requested to perform peer review cannot render an unbiased opinion.

C. Validate that the score determined for each case is appropriate.

Frequency of Meetings – The MDPR Committee shall meet as often as necessary, but not less than quarterly, and maintain a permanent written record of its proceedings and actions. The MDPR Committee shall report to the Medical Executive Committee.

14.1.11 Patient Safety Committee

Composition – The Patient Safety Committee shall be composed of a multidisciplinary team representing the patient safety teams that are responsible for key priorities that VPH has identified as high risk, high volume and/or problem prone. The committee members include the physician Chair, the Senior Vice President for Quality, the Quality Director, the Chief Nursing Officer, the Nursing Directors from the Medical, Surgical, Intensive Care and Telemetry units, and the Team Leaders for the Code Blue/Rapid Response Team, Falls Team, Medication Reconciliation Team, Restraints Team, Sepsis Team and Skin Integrity Team.

Duties – The committee oversees the organization-wide patient safety activities and patient safety teams by fostering a culture that promotes a commitment to continually improve patient safety and the quality of patient care and services, providing guidance and support for the patient safety efforts and reports to the Quality Committee. Manages the flow of information from the patient safety teams to ensure appropriate and timely follow-up of quality improvement projects, assesses and prioritizes patient safety projects, monitors and evaluates the progress of patient safety teams and assigns patient safety activities to the appropriate cross-functional team.

Frequency of Meetings – The Patient Safety Committee shall meet as often as necessary, but at least quarterly, and maintain a permanent written record of its proceedings and actions. The Patient Safety Committee shall report to the Quality Committee.

14.1.12 Pharmacy and Therapeutics Committee

Composition - The Pharmacy and Therapeutics Committee shall be an interdisciplinary committee of the Medical Staff and shall consist of at least five (5) members of the Medical Staff representing the range of Medical Staff clinical departments. Hospital representatives include a voting representative from the pharmaceutical service and a non-voting representative from the nursing service and a non-voting representative from Administration. The Committee shall be chaired by a member of the Medical Staff appointed by the Chief of Staff.

Duties - The duties of the Pharmacy and Therapeutics Committee are to:

A. Evaluate and improve the quality and safety of patient care provided to patients related to medication usage and nutritional care;

B. Develop, implement, assess, and improve appropriate quality control and performance improvement measures for medication usage and nutrition care;

C. Review and recommend to the Medical Executive Committee, relevant policy, procedures, and protocols that may be necessary for the operation of medication usage and nutritional care programs;

D. Establish a process for the annual review and revision of the drug formulary to include:

- development and implementation of an assessment process for the introduction of new medications; and
- implementation of a therapeutic interchange program;

E. Review significant adverse drug reactions;

F. Review aggregate data relevant to medication errors;

G. Oversee clinical care related to the nutritional needs of patients; and

H. Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

Frequency of Meetings – The Pharmacy and Therapeutics Committee shall meet as often as necessary, but at least quarterly, and maintain a permanent written record of its proceedings and actions. The Pharmacy and Therapeutics Committee shall report to the Medical Executive Committee at least quarterly.

14.1.12a Medication Safety Subcommittee

Composition – The Medication Safety Committee is composed of a multidisciplinary team that includes the pharmacy Chair, the physician Chair of the Pharmacy and Therapeutics Committee, the Senior Vice President for Quality, the Pharmacy Director, the Quality Director, the Sr. VP and Chief Nursing Officer, and representation from Nursing Directors. The committee is chaired by a Pharmacist with direct reporting to the Chair of the Pharmacy and Therapeutics Committee.

Duties – The committee is responsible for data aggregation, review, analysis, and development of action plans related to medication errors, in a proactive and retrospective approach. The committee functions to evaluate, assess, identify deficiencies, and develop methods to address the 11 procedures and systems associated with medication errors, which include: Prescribing, Prescription Order Communication, Product Labeling, Product Packaging and Nomenclature, Compounding, Dispensing, Distribution, Administration, Education, Monitoring, and Use.

Frequency of Meetings - The Medication Safety Committee shall meet as often as necessary, but at least quarterly, and maintain a permanent written record of its proceedings and actions. The Medication Safety Committee shall report to the Pharmacy and Therapeutics Committee.

14.1.13 Physician Well-Being Committee

Composition – The Physician Well-Being Committee shall consist of a physician chairperson appointed by the Chief of Staff. Two (2) additional members shall be selected by the Chair with the approval of the Chief of Staff. The majority of the members shall be physicians. Committee members shall serve two (2) year terms and may be reappointed.

Members shall be selected from the Active Staff category who express a special interest in the Committee's function and are not otherwise engaged in the peer review or corrective action processes of the Medical Staff. The President/Chief Executive Officer is not a member of this Committee but will be advised of Committee activities on a regular basis by the Chief of Staff.

Duties - The Physician Well-Being Committee shall not have any disciplinary function with respect to a practitioner's staff membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges. The Committee, however, shall have the ability to make recommendations to the Medical Executive Committee for actions and/or investigations whose appropriateness the Committee believes the Executive Committee should be advised.

The Physician Well-Being Committee shall perform the following duties:

A. Provide education about practitioner health, addressing prevention of physical, psychiatric, or emotional illness;

B. Facilitate confidential diagnosis, treatment, and rehabilitation of Medical Staff members who suffer from potentially impairing conditions;

C. Aid the staff member in regaining or retaining optimal professional function consistent with the protection of patients;

D. Educate the Medical Staff and other organizational staff about illness and impairment recognition issues specific to health care practitioners;

E. Allow for self-referral by Medical Staff members and referral by other organizational staff;

F. Referral of affected members to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;

G. Maintain the confidentiality of the member seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;

H. Receive referrals for consideration from members of the Medical Staff, Board of Directors, Administration, other Hospital personnel and other community and regulatory sources and evaluate the credibility of any referral, complaint, allegation, or concern received while maintaining the confidentiality of the referring party.

I. Evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a member of the Medical Staff;

J. Monitor impaired members during programs of treatment and rehabilitation. Failure to meet terms and conditions of treatment and rehabilitation in its entirety or any portion thereof, will result in the Physician Well-Being Committee reporting to the Medical Executive Committee the practitioner's failure to cooperate and recommend for the Medical Executive Committee to enact suspension and initiate termination if appropriate.

K. Monitor compliance with any mandatory drug treatment programs.

L. Report to the appropriate internal or external authorities when required by law, or the safety of a patient or staff is threatened.

Frequency of Meetings - The Physician Well-Being Committee shall meet as often as necessary and maintain a permanent written record of its proceedings and actions. The Physician Well-Being Committee shall report to the Medical Executive Committee.

14.1.14 Quality Committee

Composition - The Quality Committee shall be composed of the following voting members: the Medical Staff Secretary/Treasurer, who shall serve as the Committee's chairperson; the Director of the Pharmacy; the Director of Quality and Risk Management; the Infection Prevention Manager, the Chair of the Emergency Department; the Director of Case Management; the Director of Health Information Management; the Chair of the Patient Safety Committee; the Chief Nursing Officer; the Director of Infection Prevention; the Senior Vice-President for Quality; the Chair of Radiology; the Chief of Staff; the Chair of the Medical Records Committee; the President/Chief Executive Officer or his/her designee; the Hospital Compliance Officer; the Chief Information Officer or designee, representation from the Board of Directors; representation from the Environment of Care Committee and a representative from the community.

Duties – The Quality Committee has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The fundamental responsibilities and duties of the Quality Committee shall be to set priorities for the organization's performance improvement activities
that are designed to improve patient care processes and outcomes including but not limited to:

-Annually assess organizational performance and report on the Patient Safety and Error Reduction Program;

-Identify opportunities for improvement;

-Prioritize continuous quality improvement team projects;

-Review the financial impact and budget of Continuous Quality Improvement team projects.

-Assure adequate allocation of resources for performance improvement;

-Develop performance improvement training programs for the committee and staff;

-Foster communication between the Medical Staff, departments, and Hospital services;

-Coordinate all performance improvement activities;

-Assist the Board of Directors and Medical Staff in maintaining and implementing the Organization's mission, vision and guiding principles;

-Oversee the integration and appropriate reporting of all organizational performance improvement activities;

-Oversee the development of a plan, review aggregate data, and assess performance related to the NIAHO Accreditation Standards and ISO 9001 criteria for leadership and performance improvement;

-Oversee the quality control and performance improvement activities of the nursing and Hospital support services;

-Oversee the development and implementation of clinical practice guidelines;

-Develop programs to assess the satisfaction of staff, patients and other important customers;

-Serve as a forum for discussion of administrative and financial issues that have impact on patient care services;

-Plan and facilitate design of patient care services that are appropriate to the scope and level of care required by the community and patient population served; and

-Oversee programs to assure compliance with NIAHO Standards and Federal or State regulations.

Frequency of Meetings – The Quality Committee shall meet as often as necessary, but not less than ten (10) times per year. The Quality Committee shall submit regular written reports to the Medical Executive Committee and to the Board of Directors.

14.1.15 Utilization Management Committee

Composition - The Utilization Management Committee shall consist of the utilization review physician advisors, the Senior Vice President for Quality, the Director of Case Management, the Chief Nursing Officer, nursing representation from the Medical/Surgical, Acute Care, Telemetry, and Acute Rehabilitation patient care units. The Chair of the committee shall be appointed by the Chief of Staff.

Duties – The duties of the Utilization Management Committee shall include:

A. Conducting concurrent and retrospective utilization management review designed to evaluate the appropriateness of admissions to the Hospital, length of stay, discharge process, use of medical and Hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its monitoring and other pertinent data to the Quality Committee and shall make recommendations for the utilization of resources and appropriate level of care commensurate with patient care and safety;

B. Establishing a utilization management plan which shall be approved by the Quality Committee, Medical Executive Committee and Board of Directors; and

C. Obtaining, reviewing, and evaluating information and statistical data obtained or generated by the Hospital's Case Management Department.

Frequency of Meetings - The Utilization Management Committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a monthly report of its activities and recommendations to the Quality Committee.

RULE 15 MEDICAL STAFF CLINICAL DEPARTMENT MEETINGS

15.1 There are six (6) Medical Staff Departments and three (3) Divisions, as follows:

Emergency Medicine Department
Medicine Department
    Cardiology Division
    Radiology Division
Obstetrics and Gynecology Department
Pathology Department
Pediatrics Department
Surgery Department
    Anesthesiology Division

15.2 All Medical Staff Departments/Divisions shall meet as often as necessary, but not less than quarterly. Attendance requirements are noted under Rule 13.

Department and Division meetings shall consist of a General Session and an Executive Session. The General Session meetings will have standing agenda reports from select departments that provide statistics, updates and/or policies and procedures that relate to the respective department/division.

Any new business agenda items must be approved by the Chair of the Department or Division prior to being added to the agenda.

The Executive Session meetings will consist only of the Department/Division Medical Staff members, the Hospital Director of the respective Department/Division, the Sr. VP of Quality, the Director of Quality, a Quality Coordinator, and the Sr. VP and Chief Nursing Officer. The Chief of Staff and/or President/Chief Executive Officer are ex-officio members. The Executive Session agenda will have standing agenda items such as the Credentials Report and Peer Review Report. Any new business agenda items must be approved by the Chair of the Department/Division prior to being added to the agenda.

RULE 16 ADOPTION AND AMENDMENT TO RULES AND REGULATIONS

16.1 The Medical Executive Committee shall adopt such General Rules and Regulations as may be necessary for the proper conduct of its work as outlined in the Medical Staff Bylaws. Amendments to the Medical Staff General Rules and Regulations shall be made by the Medical Staff Executive Committee and shall become effective after approval by the Board of Directors.

16.2 The General Rules and Regulations shall be reviewed and revised, if necessary, once every two years**,** and more often as required, to reflect the actual practices of the Medical Staff.

APPROVALS

Signed:

Chief of the Medical Staff Date

Chairman, Board of Directors Date