MEDICAL STAFF RULES AND REGULATIONS

December 2016

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RULES

These rules and regulations when duly approved by the Medical Staff and adopted by the Board of Directors, shall govern the conduct of Medical Staff members and others providing patient care services at the Hospital in matters addressed by these rules and regulations. A failure to abide by the terms of these rules and regulations on the part of a staff member or any other person providing patient care services at the Hospital shall constitute grounds for corrective or disciplinary action in accordance with the provisions of the Medical Staff Bylaws, including but not limited to, limitation or suspension of privileges, or revocation of membership on the Medical Staff, or other appropriate action.

1. ADMISSION OF PATIENTS

1.1 GENERAL

1.1.1 The Hospital shall accept infants, children, adolescents and young adults for diagnostic and therapeutic care, except patients who suffer from serious burns (unless transfer is contraindicated due to the medical instability of the patient as determined by the Attending Physician); primarily need psychiatric or substance abuse treatment; have acute psychiatric problems requiring close supervision or restraint which the Hospital cannot provide; or have a primary diagnosis of pregnancy. Pregnant patients who are not in active labor may be admitted.

1.1.2 The Department Chair may contact the Attending Practitioner when questions arise as to whether a patient should be admitted, retained, or transferred.

1.1.3 Patients aged 17 or older shall be admitted only with authorization from the Vice-President of Medical Affairs/CMO or designee, or the CEO or designee.

1.2 PROCEDURE

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

1.2.2 All patients who have no private practitioner and who are admitted to CHOC shall be assigned either to the house staff service or to the hospitalists contracted by the Hospital to function full time on the Hospital premises.

1.3 RESPONSIBILITY

1.3.1 The patient's Attending Practitioner shall be responsible for directing and supervising the patient's overall medical care, for completing or arranging for the completion of the medical history and physical examination within twenty-four hours after the patient is admitted or before surgery or any major high risk diagnostic or therapeutic intervention (except in emergencies), for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting information regarding the patient's status to the patient, the referring practitioner, if any, and to the patient's family.

Whenever these responsibilities are transferred to another Staff Member, a note covering the transfer of responsibility shall be entered on the order sheet in the medical record. It shall state the date and time responsibility is transferred.

1.3.2 Any Medical Staff Member who cannot or will not assume all of the responsibilities of the Attending Practitioner shall admit patients only with another Medical Staff Member who can and will assume such responsibilities. (See also the Orthopedic Section and Dental Section Rules pertaining to podiatric and dental patient admissions.)

1.4 PROVISIONAL DIAGNOSIS

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

1.5 ADMISSION PRECAUTIONS

1.5.1 The Attending Practitioner, 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 Practitioner shall recommend appropriate and approved precautionary measures to protect the patient and the staff, and shall note in the patient's record the reason for his/her suspicions, and the precautions taken to protect the patient and others.

1.5.2 In the event the patient or others cannot be appropriately protected in the general acute care service, arrangements shall be made to transfer the patient to a service or facility where his/her care can be appropriately managed.

1.5.3 The Attending Practitioner should also seek assistance from the Psychiatry or Psychology Section for any patient who suffers from an incapacitating emotional illness or substance abuse. CHOC is not a licensed psychiatric facility, and therefore, may refuse to accept a patient or require transfer of a patient to another facility when it appears that the Hospital cannot adequately provide for the safety of the patient.

1.5.4 In all cases in which sexual or physical abuse or neglect is suspected, the attending practitioner shall report such fact by telephone and/or in writing in accordance with the approved Hospital protocol for reporting abuse and neglect. (Refer to the Hospital SCAN Manual found on each patient unit.)

1.6 EMERGENCY ADMISSIONS

1.6.1 When a patient requires admission to the Hospital for emergency medical treatment, the Attending Practitioner shall, whenever possible, contact the Admitting Department and determine whether there is an available bed.

1.6.2 In all cases involving emergency admissions, the Attending Practitioner must be able to demonstrate to the Medical Executive Committee (MEC) and the Chief Executive Officer (CEO) that the admission was due to a bona fide emergency. The history and physical examination report must clearly justify the emergency admission, and the report must be prepared as soon as possible after the patient's admission. For purposes of these Rules, an "emergency" shall be defined as a condition or set of circumstances in which serious or permanent harm to a patient would result if admission was delayed.

1.6.3 Patients who require emergency admission and do not have an Attending Practitioner shall be assigned an Attending Practitioner in accordance with the "Call schedule" Rule.

1.7 ADMISSION TO THE INTENSIVE CARE UNIT

1.7.1 In accordance with California Children's Services (CCS), all patients in the NICU or PICU shall be under the direct supervision of the ICU medical director or appropriate designee and/or the Attending Physician in consultation with the pediatric neonatologist or intensivist.

1.7.2 The Director of the Intensive Care Unit, in consultation with the Vice-President of Medical Affairs/CMO, will resolve any question as to the appropriateness and or priority of admission to or discharge from the Intensive Care Unit.

1.7.3 In the event of a life-threatening circumstance, the Director of the PICU or designee, NICU or designee, OICU or designee may intervene in the clinical management of the immediate problem and will immediately communicate this action to the Attending Physician.

1.7.4 Any pediatric intensivist who admits patients to the PICU must be able to respond to the bedside of the patient within 15 minutes of being called by the PICU nurse.

1.8 PRIORITY OF ADMISSIONS AND TRANSFERS

1.8.1 In a time of acute bed shortage, the established Triage Policy of the Hospital shall go into effect. Children needing admission shall be screened based upon the following:

(a) Patients with a severe illness demanding a level of care provided only at CHOC.
(b) Patients presenting in the CHOC Outpatient Clinic or the Emergency Room.
(c) Emergency admission will supersede elective admissions (medical or surgical).

1.8.2 For patients being admitted as transfers from other facilities, it is required that the necessary practitioners/surgeons be immediately available for the patient's medical care (i.e., pediatric surgeon).

1.8.3 Transfer Priorities

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

(a) Urgent Care to an appropriate bed.
(b) Intensive Care Unit to a General Care area.
(c) Temporary placement in an inappropriate area for that patient to an appropriate area.

1.8.4 Transfer priorities within the Hospital shall be established by the Vice-President of Medical Affairs/CMO in conjunction with the unit Medical Director, when necessary. The attending practitioner will be notified of patient's transfer.

1.8.5 Patients being transferred from physician to physician require timely communication between the practitioners.

1.9 CONSENTS

1.9.1 The Attending Practitioner shall be responsible for securing consent or having consent secured for all procedures that will be performed during the patient's hospitalization. Consent shall be obtained (and documented in writing) for all operations, before surgery, and any other complex medical procedure except when it is an emergency (i.e., the patient may die, suffer significant disability or severe pain unless treatment is immediately provided and no person competent to provide consent is available). The procedure and documentation requirements are set forth in the "Consent for Medical and Surgical Procedures" Rule.

1.9.2 The Attending Practitioner, or his/her designee, shall secure consent prior to admission whenever the procedure will be performed on an elective basis. Hospital personnel shall verify that consent has been obtained by asking the patient (or surrogate decision-maker) to complete the general "Authorization for and Consent to Surgery or Special Therapeutic or Diagnostic Procedures" form.

2. ALLIED HEALTH PROFESSIONALS

2.1 CATEGORIES

2.1.1 The Board of Directors shall secure recommendations from the MEC as to the categories of Allied Health Professionals (AHPs) - dependent, independent or contract provider, based upon occupation or profession, which shall be eligible to apply for professional or technical service or practice privileges in the Hospital. The Board of Directors shall secure recommendations from the Medical Executive Committee as to the job description for each category of dependent AHPs, or practice privileges for each category of independent AHPs. In the event that there is a Hospital employee functioning in the same capacity as the AHP, the AHP must adhere to specific criteria (i.e., orientation, health screening, competencies, TB testing, CME, CPR requirements) to assure one level of care in the facility.

AHP categories eligible to apply for privileges or services as approved by the Medical Executive Committee and the Board of Directors are as follows:

(a) Dependent Allied Health Professional (Provides services under approved job description and under supervision and direction of a Medical Staff Member)

(1) Physician Assistant

(2) Nurse practitioner

(3) Private Scrub Personnel (dental assistant, scrub nurse, scrub technician)

(4) Physical Therapy (infant/child development specialist)

(5) Genetic Counselor

(6) Pathology Assistant

(7) Registered Nurse, First Assistant

(8) Perfusionist

(9) Traditional Chinese Medicine

(b) Independent Allied Health Professional (may practice independently as allowed within the scope of their license, registration or certification and is eligible to apply for practice privileges):

(None at this time)

(c) Dependent and Independent Contract Allied Health Professionals (See 2.4 below)

(1) Speech Pathologist

(2) Audiologist

(3) Perfusionist

2.1.2 An AHP who does not have licensure or certification in an AHP category may not apply for services or practice privileges, but may submit a written request to the Chief Executive Officer, asking that the Medical Staff consider identifying the appropriate category of AHPs as eligible to apply for services or practice privileges. The Medical Staff shall review the request of the AHP to determine if the category is appropriate. If deemed appropriate, the Medical Staff shall identify a job description or privileges for that category. The Medical Staff shall make a recommendation to the Board of Directors regarding the category, and job description or privileges. The Board of Directors shall have final authority on the categories, job description, and privileges of AHPs.

2.2 GENERAL REQUIREMENTS

2.2.1 AHPs holding a license, certificate or such other legal credentials, if any, as required by California law, which authorizes the AHPs to provide certain professional or technical services, are not eligible for Medical Staff membership and may not admit patients. Such AHPs are eligible for practice privileges or for providing services in this Hospital only if they:

(a) Hold a current, unrestricted California license, certificate or other legal credential in a category of AHP which has been approved for practice in the Hospital by the Board of Directors; and

(b) Document their experience, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient treated by them will receive care of the generally recognized professional level of quality and efficiency established by the Hospital, and that they are qualified to exercise practice privileges within the Hospital; and

(c) Are determined, on the basis of documented references, to adhere strictly to the lawful ethics of their respective professions; to work cooperatively with others in the Hospital setting; and to be willing to commit to and regularly assist the Hospital in fulfilling its obligations related to patient care, within the areas of their professional competence and credentials.

(d) If scope of practice is dependent, function under the supervision and direction of a physician on the Medical Staff who has been approved to supervise AHPs; or

(e) If scope of practice allows independent practice, AHP must designate a physician member of the Medical Staff with appropriate privileges, to be responsible, to the extent necessary, for the general medical condition of patients for whom the AHP proposes to render services in the Hospital.

2.3 THE APPLICATION PROCESS

2.3.1 Each dependent and independent AHP shall complete an application for services or practice privileges as prescribed by the Medical Executive Committee and approved by the Board of Directors.

2.3.2 The applicant must list at least two (2) professional references who have personally observed the applicant's practice and are capable of evaluating his/her competency and qualifications. At least one of the two persons listed as references must be a Medical Staff member, including the supervising physician, if any. In addition, if the AHP is a member of a group practice, at least one reference must be provided by a qualified professional who is not a member or affiliated with the group.

2.3.3 The application must include state license, certificate or legal credentials as required by state law; proof of current professional liability coverage in the amount of one million/three million; documentation of experience, background, training and demonstrated ability; documentation of continuing medical education for the past year; information relative to status and services/privileges at other health care facilities/hospitals; evidence of TB testing (within past 6 months) and request for specific privileges as appropriate; and current CPR training for staff categories as follows:

(a) Physician Assistant – PALS
(b) Nurse Practitioner – PALS and/or NRP as appropriate
(c) Private Scrub Personnel – BLS

(d) Physical Therapy – BLS
(e) Genetic Counselor – no requirement
(f) Pathology Assistant – no requirement
(g) Registered Psychologist – no requirement
(h) Registered Nurse First Assistant – no requirement
(i) Perfusionist – no requirement
(j) Traditional Chinese Medicine – BLS
(k) Speech Pathologist – no requirement
(l) Audiologist – no requirement

2.3.4 Verification of references, training, current appointments, license, certification, and criminal background for dependent AHPs will be accomplished similar to the manner in which employee applications are processed by the Human Resources Department. Independent practitioner applications shall be processed in accordance with the procedure set forth in the Medical Staff Bylaws for processing applications for Medical Staff membership and clinical privileges, insofar as the provisions are relevant. Thus, information shall be verified by the Medical Staff Office and the application shall be reviewed by the Interdisciplinary Practice Committee, Credentials Committee, the appropriate Medical Staff department (when department review is warranted), the Medical Executive Committee and Board of Directors.

2.3.5 If it is deemed that an AHP application is not complete, and the AHP is requested to provide such information to the Medical Staff Office by a specific date, failure to provide the information requested by the date shall be deemed a withdrawal of the application.

2.4 EXCEPTIONS TO CREDENTIALING PROCESS - CONTRACT ALLIED HEALTH PROFESSIONALS

2.4.1 On occasion, the Hospital may determine that the interests of patient care are best served by entering into a contract with an entity which provides AHPs to work within the Hospital. These AHPs are neither employees nor independent contractors of the Hospital, nor are they independent professionals working in their own private practice. Rather, they are employees or independent contractors of an entity that has agreed to provide certain health services to the Hospital's patients. For purposes of these rules, these persons shall be referred to as "Contract AHPs" and the entity employed or contracting with them shall be referred to as the "Contracting Entity".

2.4.2 Ordinarily, Contract AHPs must complete the full AHP credentialing process prior to being permitted to render patient care within the Hospital. However, the Contracting Entity may be responsible for credentialing the Contract AHPs pursuant to the terms of the contract with the Hospital. Formal credentialing as described in these rules may be waived for Contract AHPs whom the Contracting Entity warrants to be adequately qualified to perform the patient care activities described in the contract.

2.4.3 Whether the Contracting Entity is responsible for credentialing the Contract AHPs will be determined by the Hospital Administration and shall be made a part of the written contract between the Hospital and the Contracting Entity. If the Contracting Entity will credential the Contract AHPs, the following shall apply:

(a) The Contracting Entity shall provide a written description of the activities to be performed by the Contract AHPs. This description may be contained in the contract itself or in a separate job description.

(b) The Hospital Chief Executive Officer may ask the appropriate Medical Staff department and the Interdisciplinary Practice Committee to review the job descriptions or contract provisions describing the activities of the Contract AHPs for completeness, accuracy and appropriateness.

(c) The Contracting Entity shall review each AHP using standards comparable to those set forth in Section 2.3 at the time the Contract AHP is first associated with the Contracting Entity and then annually thereafter, based on actual performance. The Contracting Entity shall certify, in writing, that this condition is met for all of its Contract AHPs. Upon receipt of this certification, individual Contract AHPs will not be required to submit applications for AHP privileges.

2.5 ORIENTATION

2.5.1 It is the responsibility of the non-surgical Allied Health Professional to attend an orientation class conducted by the Education Department prior to providing services. Orientation classes are held monthly.

2.5.2 For AHPs working in the surgical areas, orientation to the Operating Room (OR) and procedures is to be completed prior to any work in the OR. OR staff will provide basic instructions, testing, and observe demonstration of skills. OR staff will assist with instruction when possible; however, ultimate responsibility for performance and conduct of the surgical AHP rests with the supervising physician.

2.6 DUTIES (UPON APPOINTMENT)

2.6.1 Consistent with his/her approved job description or privileges granted to him or her, exercise independent judgment within his/her areas of competence and, if applicable, within the limits of an approved standardized procedure, provided that a Medical Staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

2.6.2 Participate directly in the management of patients to the extent authorized by his/her license, certificate, other legal credentials, any applicable standardized procedures, job description, and by the privileges granted by the Board of Directors.

2.6.3 Write orders to the extent established by any applicable Medical Staff or Department policies, rules or standardized procedures and consistent with the job description or privileges granted to him or her.

2.6.4 Record reports and progress notes on patients' charts to the extent determined by the appropriate department, and in accordance and consistent with any applicable standardized procedures.

2.6.5 Assure that histories and physicals (when performed by the Allied Health Professional) are countersigned within 24 hours or prior to any high risk diagnostic or therapeutic intervention, whichever comes first.

2.6.6 When rendering service, wear an identification badge on an outer garment and in plain view which shall state the practitioner's name and license category.

2.6.7 Comply with all Medical Staff and Hospital Bylaws, rules and policies.

2.7 PREROGATIVES AND STATUS

AHPs are not members of the Medical Staff, and hence shall not be entitled to vote on Medical Staff or department matters. They are expected to attend and actively participate in the clinical meetings of their respective departments, to the extent consistent with department rules.

2.8 TERMS AND CONDITIONS

An AHP shall be individually assigned to the Department and Section, if applicable, appropriate to his professional training and is subject to biennial reappraisal and disciplinary procedures as are defined by the Interdisciplinary Practice Committee and approved by the Medical Executive Committee and the Board of Directors. AHPs shall be subject to the same terms and conditions of appointment as are Medical Staff members (section 2.5 of the Medical Staff Bylaws). An AHP's exercise of privileges or provision of specified services within any Department, Section or other clinical unit is subject to the Rules and Regulations of that unit and to the authority of the Department Chair and Section Chairman and, as applicable, the unit's medical director. The quality and efficiency of the care provided by AHPs within any clinical unit shall be monitored and reviewed as part of the regular Medical Staff and/or Hospital mechanisms.

2.8.1 An Allied Health Practitioner may request a Leave of Absence (LOA) as outlined in the Medical Staff Bylaws.

2.9 SERVICE DESCRIPTION

Written guidelines for the exercise of clinical privileges or performance of specified services by each category of AHPs shall be developed by the Interdisciplinary Practice Committee, subject to approval by the Credentials Committee, MEC, and BOD, with input, as applicable, from the physician director of the clinical unit involved, from the physician supervisor of the AHP, and, as appropriate, from other representatives of the Medical Staff, and the Hospital's other professional staffs. For each category of AHPs, such guidelines must include at least:

2.9.1 Specifications of classes of patients that may be seen, including any limitations on setting or departments where standardized procedures may be performed.

2.9.2 A description of the services to be provided and procedures to be performed, including any special equipment, procedures or protocols that specific tasks may involve, and responsibility for charting services provided in the patient's medical record.

2.9.3 Definition of the degree of assistance that may be provided to a practitioner in the treating of patients on Hospital premises and any limitations thereon, including the degree of practitioner supervision required.

Notwithstanding the apparent scope of practice permitted to any individual AHP under California law or licensure, the above guidelines may place limitations on the AHPs authorized scope of practice in the Hospital as deemed necessary either for the efficient and effective operation of the Hospital or any of its departments or services, or for management of personnel, services and equipment, or for quality or efficient patient care, or as otherwise deemed by the Board of Directors to be in the best interests of patient care in the Hospital.

2.10 COMPETENCY EVALUATIONS

2.10.1 Each AHP initially appointed to the AHP staff, or granted new practice privileges, shall be subject to competency evaluations which assess their ability to perform within the first three months following appointment. This assessment shall be performed by a Medical Staff member in good standing, an AHP in the same category who has unrestricted privileges to provide the service that will be assessed, or a Hospital Associate in the same category as the AHP being evaluated. Other specific requirements may be noted under each AHP service description. Generally, these evaluations shall consist of demonstrated competence during procedures or a review of medical records. AHPs exercising surgery practice privileges and other invasive procedures shall be observed during surgery or during the procedure. Usually, the observer should not be the supervising physician or otherwise associated in practice with the AHP. Competency evaluations will be required biennially thereafter.

2.10.2 Problems will be brought to the attention of the supervising physician and the appropriate Medical Staff committee in a timely manner.

2.11 EMPLOYER OR CONTRACTOR RESPONSIBILITIES

Any practitioner employing or contracting with an AHP in the care of a specific patient must:

2.11.1 Accept full legal and ethical responsibility for the AHP's performance.

2.11.2 Accept full responsibility for the proper conduct of the AHP within the Hospital, for the AHP's observance of all bylaws, policies and rules of the Hospital and Medical Staff, and for the correction and resolution of any problems that may arise.

2.11.3 Be physically present in the Hospital or immediately available by electronic communication to provide further guidance when the AHP performs any task or function, except in life threatening emergencies.

2.11.4 Maintain ultimate responsibility for directing the course of the patient's medical treatment.

2.11.5 Assure that the AHP provide services in accordance with accepted medical standards.

2.11.6 Provide active and continuous overview of the AHP's activities in the Hospital to ensure that directions and advice are being implemented.

2.11.7 Abide by all bylaws, policies, rules and regulations governing the use of AHPs in this Hospital, including refraining from requesting that the AHP provide services beyond, or that might reasonably be construed as being beyond, the AHP's authorized scope of practice in the Hospital.

2.11.8 Immediately notify the Medical Staff Office in the event any of the following occur:

(a) the scope or nature of his/her professional arrangement with the AHP changes;

(b) his/her approval to supervise the AHP is revoked, limited, or otherwise altered by action of the Medical Board of California;

(c) notification is given of investigation of the AHP or the supervisor of the AHP by the Medical Board of California, or any other applicable board;

(d) his/her professional liability insurance coverage is changed insofar as coverage of the acts of the AHP is concerned.

2.11.9 Comply with all laws and regulations governing his/her supervision of the AHP.

2.11.10 Agree that the AHP shall be his/her employee or agent and not the employee or agent of the Hospital.

2.11.11 Assume full and sole responsibility for making all payments to and establishing all working conditions and terms for the AHP and for complying with all relevant laws with respect thereto, including those pertaining to withholding of federal and state income taxes, payment for overtime, and provision of workers' compensation insurance coverage.

2.11.12 Agree to indemnify the Hospital against any expense, loss, or adverse judgment it may incur as a result of allowing an AHP to practice at the Hospital or as a result of denying or terminating the AHP's privileges.

2.12 DURATION OF APPOINTMENT

2.12.1 The AHP shall be granted AHP Staff Status for no more than 24 (twenty-four) months. Reappointments to the AHP staff shall be processed every other year.

2.13 EFFECTS OF OTHER AFFILIATIONS

No AHP shall be automatically entitled to specific services merely because:

2.13.1 He/she is authorized to practice in this or any other state

2.13.2 He/she is a member of any professional organization

2.13.3 He/she is certified by any board

2.13.4 He/she had, or presently has, services in another health care facility or in another practice setting

2.13.5 He/she had, or presently has, those services or is employed at this Hospital

2.13.6 He/she is or is about to become affiliated with a practitioner or another AHP who is, or with a group of practitioners or AHPs one or more of whose members are, affiliated with this Hospital through employment, contract, Medical Staff appointment or otherwise.

2.14 TERMINATION, SUSPENSION OR RESTRICTION OF SERVICE AUTHORIZATIONS

2.14.1 An independent AHP's privileges or dependent AHP's service authorization shall automatically terminate in the event that the AHP's certification, license, or other legal credential expires or is revoked.

2.14.2 Corrective action with regard to the dependent AHP, including termination or suspension of services authorized, shall be accomplished in accordance with usual Hospital personnel practices or the AHP's employment or other agreement, if any.

2.14.3 Dependent AHPs who terminate employment or contract status with their sponsoring physician/ facility, whether voluntary or involuntary, will automatically lose their privileges.

2.14.4 An independent AHP is not considered an appointee to the Medical Staff and is not entitled to the procedural due process rights provided in the Fair Hearing Plan for Medical Staff appointees and applicants. However, at any time, the President of the Medical Staff or Department or Section Chair to which the AHP has been assigned may recommend to the Medical Executive Committee (MEC) that the AHP's privileges be terminated, suspended or restricted. After investigation (including, if appropriate, consultation with the Interdisciplinary Practice Committee), if the Medical Executive Committee agrees that corrective action is appropriate, the MEC shall recommend specific corrective action to the Board of Directors. A notification letter regarding the recommendation shall be sent by certified mail to the subject AHP. The notification letter shall inform the AHP of the recommendation and the circumstances giving rise to the recommendation.

2.14.5 An independent AHP with clinical privileges shall have the right to challenge any recommendation which would constitute grounds for a hearing under Article VIII of the Medical Staff Bylaws (to the extent that such grounds are applicable by analogy to the AHP) by filing a written grievance (i.e., a letter objecting to the recommended action and requesting an interview) with the MEC within thirty (30) days of receipt of the notification letter. Upon receipt of a grievance, the MEC or its designee, shall afford the AHP an opportunity for an interview concerning the grievance. Although such interview shall not constitute a "hearing" as established by Article VIII of the Bylaws, and need not be conducted according to the procedural rules applicable to such hearings, the purpose of the interview is to allow both the AHP and the party recommending the action the opportunity to discuss the situation and to produce evidence in support of their respective positions. Minutes of the interview shall be retained.

Within 30 days following the interview, the Medical Executive Committee, based on the interview and all other aspects of the investigation, shall make a final recommendation to the Board of Directors, which shall be communicated in writing, sent by certified mail, to the subject AHP. The final recommendation shall discuss the circumstances giving rise to the recommendation any pertinent information from the interview. Prior to acting on the matter, the Board of Directors may,

in its discretion, offer the affected practitioner the right to appeal to the Board or a subcommittee thereof. The Board of Directors shall adopt the MEC's recommendation, so long as it is reasonable, appropriate under the circumstances and supported by substantial evidence. The final decision by the Board of Directors shall become effective upon the date of its adoption. The AHP shall be provided promptly with notification of the final action, sent by certified mail.

2.14.6 When an AHP is no longer practicing in an approved category, that AHP shall be automatically terminated from the Allied Health Practitioner Staff.

2.15 SUMMARY SUSPENSION

2.15.1 Notwithstanding Section 2.14.4 & 2.14.5, an independent AHPs privileges may be immediately suspended or restricted where the failure to take such action may result in an imminent danger to the health of any individual. Such summary suspension or restriction may be imposed by the President of the Medical Staff, the Medical Executive Committee, or the chair of the department or designee to which the AHP has been assigned. Unless otherwise stated, the summary action shall become effective immediately upon imposition, and the person responsible for taking such action shall promptly give written notice of the action to the AHP, the Board of Directors, the Medical Executive Committee, and the Chief Executive Officer. The notice shall include the reasons for the action and also inform the practitioner of his/her right to file a grievance. The practitioner's right to file a grievance and subsequent interview procedures shall be in accordance with Section 2.14.4 & 2.14.5 except that all reasonable efforts shall be made to ensure that the practitioner is given an interview and that the final action is taken within 45 days or as promptly thereafter as practicable.

2.15.2 Within fifteen (15) working days of the summary action, the Medical Executive Committee shall meet to consider whether the summary suspension should be vacated or continued. The AHP shall be provided promptly with notification of the decision, sent by certified mail.

3. CALL SCHEDULE

3.1 CALL SCHEDULE LIST

3.1.1 A Call schedule has been established for referring emergency room patients who need Hospital care or otherwise require specialty consultation to qualified practitioners.

3.1.2 The Section Chair shall coordinate the assignments to the Call schedule. His/Her decision to deny or terminate a practitioner's participation will be final, subject only to review by the Medical Executive Committee.

3.1.3 Prior to a final adverse decision, a practitioner whose participation on the Call schedule may be denied or terminated will be given a statement of the reasons for the proposed action and an opportunity to appear before the Medical Executive Committee to explain why it should not take the proposed action. The President of the Medical Staff may restrict a practitioner's participation on the Call schedule at any time and until such time as a final decision is reached by the Committee.

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

3.1.5 Service on the Call schedule is not a privilege, but is an obligation of Staff membership. No Medical Staff Member has a right to serve on any Call schedule. A decision to remove a

Member from the Call schedule shall not constitute a denial or restriction of clinical privileges and gives rise to only the limited right of review set forth in this Rule.

3.1.6 Members who have twenty (20) years or more service on the Medical Staff may be excused from mandatory emergency department call panel.

3.2 CONDUCT OF CALL SCHEDULE MEMBERS

3.2.1 Practitioners on call must respond promptly when requested to see a patient. The response time must be reasonable in view of the patient's clinical circumstances. Each member must let the Hospital know how to reach him or her immediately and remain close enough to the Hospital to be able to arrive within a reasonable time.

3.2.2 A member who is unable to provide coverage during his/her scheduled time (including when he or she is detained due to another medical commitment) is responsible for arranging for coverage by a practitioner who meets the criteria for eligibility. The panelist shall inform the Hospital of the name of the practitioner who will provide back-up coverage.

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

3.2.4 If the Hospital lacks the services required to appropriately treat the patient, the patient will be transferred to a more suitable facility, whenever possible, provided the patient is medically fit for transfer. Members will be required to see such patients only if the patient is not medically fit for transfer or cannot be transferred for other reasons.

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

(a) The Emergency Services Physician or an On Call Member must personally examine the patient prior to transfer, and find that the patient is stable. Patients who are not stable may be transferred only if the practitioner finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient, or his/her surrogate decision-maker, requests transfer, after the practitioner has explained the medical risks and benefits of transfer.

(b) In addition: (1) the receiving facility must consent to the transfer, (2) staff and equipment necessary for a safe transfer must be arranged, (3) copies of pertinent medical records must be provided, and (4) the "Transfer Summary Form" must be completed, and a copy sent with the patient.

3.2.6 A patient can be admitted in the name of the On Call practitioner, but if the Emergency Physician so specifies, the panelist must see the patient in the Emergency Department. The On Call practitioner must be notified about each admission prior to the patient leaving Emergency Services.

3.2.7 On Call members shall cooperate with and assist the Emergency Services, Emergency Physicians, and all Departments, Sections and Staff who may call them for assistance. The member shall act in the best interests of patient care and in accordance with the Hospital's philosophy and Rules.

3.2.8 On Call members will see unassigned patients in Emergency Services on a personal physician, private-pay basis. The practitioner retains responsibility for billing and collecting his/her fees. The Hospital has no responsibility for this physician/patient relationship and each member agrees to release the Hospital from any obligation in this regard.

3.2.9 Any treatment refusals by the patient or the patient's family or legal representative shall be referred to the Emergency Physician. No on call member shall presume that his/her services have been refused unless the patient's legal representative has been fully informed of the benefits of the treatment offered and the risks of refusing such treatment and has given an informed refusal of treatment in writing. The Emergency Physician shall be informed of any such refusal of treatment.

4. CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

4.1 POLICY

4.1.1 Patients or their surrogate decision-makers have the right to participate actively in decisions regarding the medical care provided and to decide whether to authorize or refuse procedures recommended by their practitioners (In accordance with the Patient Self Determination Act). Practitioners must give patients/surrogate decision-makers the information they need to make their decisions. Accordingly, diagnostic and therapeutic procedures may be performed only when the patient, or his/her surrogate decision-maker, has been given information about the procedure and has given consent. When the recommended procedure is complex (i.e., involves risks or complications that are not commonly understood), "informed consent" must be secured. (See Section 4.2 below.) Decisions to discontinue life-sustaining treatment raise special concerns, which are discussed in the "Discontinuing Life-Sustaining Treatment" Rule.

4.1.2 Surgical, special diagnostic or therapeutic procedures, anesthesia, and conscious sedation require consent by the patient or his/her surrogate decision-maker. This Rule outlines the basic requirements. Further information and forms are provided in the Consent Manual prepared by the California Association of Hospitals and Health Systems. The Consent Manual is available in Administration, Medical Records, and the Nursing Office. Questions may be directed to the nursing supervisor.

4.2 INFORMED CONSENT DEFINED

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

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

(a) The nature of the recommended treatment.

(b) Its expected benefits, effects, and likelihood of success.

(c) The associated risks, possible complications, and problems related to recovery.

(d) Any alternative procedures and their expected benefits or effects and associated risks and possible complications.

(e) Any independent economic interests a practitioner may have that influence his/her treatment recommendations.

4.3 WHO MAY GIVE CONSENT

If a patient is incompetent by reason of age or condition, consent must be secured from a surrogate decision-maker (i.e., parents or guardians of minors who may not consent, conservators, attorneys-in-fact, the patient's closest available relatives, or the court). (The persons who may give consent are identified in Chapter 2 of the CAHHS Consent Manual.)

4.4 RESPONSIBILITY FOR SECURING INFORMED CONSENT

4.4.1 The patient's Attending Practitioner generally is responsible for giving the patient's surrogate decision-maker the requisite information and securing consent.

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

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

(1) The patient's Attending Practitioner who recommended the procedure shall explain why he or she has advised performance of the special procedure and describe any alternative procedures and their expected benefits and associated risks.

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

(3) After both practitioners have discussed the proposed procedure, the patient's surrogate decision-maker shall be asked for consent.

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

4.5 EMERGENCIES

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

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

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

4.6 PARTICULAR LEGAL REQUIREMENTS

4.6.1 Consent for blood transfusions, HIV blood tests, use of investigational drugs or devices, and participation in human experimentation, must be secured in the manner specified in the laws applicable to these particular procedures. The laws are described in the CAHHS Consent Manual. In the event that blood transfusions are anticipated, it is the responsibility of the practitioner to adhere to the state mandated requirements and to document compliance in the patient's medical record. (Special transfusion order sheets are available on each patient unit.)

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

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

4.7 DOCUMENTATION

4.7.1 The practitioners involved in securing informed consent must document in the patient's medical record prior to the procedure their discussions regarding the proposed procedure and whether they secured consent.

(a) Such documentation should describe any special or unique concerns of or related to the patient.

(b) Such documentation should include reference to discussing the proposed treatment, risks, benefits, indications, alternatives, likelihood of success, problems related to recovery and whether parent/guardian understands and agrees to proceed. This statement is on the general consent form.

4.7.2 The practitioner must document a written order for the procedure as it should be entered on the consent form.

4.7.3 The practitioner's documentation for emergencies (see point 4.5 above), which should be entered in a progress note, must describe:
(a) The nature of the emergency.
(b) The reasons consent could not be secured from the patient's surrogate decision-maker.
(c) The probable result if treatment would have been delayed or not provided.

4.7.4 The Hospital staff is responsible for verifying that consent has been given. This will be done for all operations using general anesthesia and all major invasive procedures, for inpatients and out-patients. This is done one of four ways:

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

(b) Verifying that the special forms required for blood transfusion, HIV blood tests, investigational drugs, investigational devices, or human experimentation have been signed, as required by law.

(c) Verifying that the patient's surrogate decision-maker has signed an informed consent form which contains not only the general provisions set forth in the standard consent form, but also medical information regarding the procedure, and that this form is included in the patient's medical record.

(d) Verifying that the "emergency exception" applies.

4.8 HOSPITAL STAFF ROLE IN PROVIDING INFORMATION

Hospital staff may not provide patients or surrogate decision-makers with medical information regarding any proposed procedure. If a patient or surrogate decision-maker expresses doubt or confusion about a procedure, the patient's Attending Practitioner or the practitioner who is responsible for securing consent shall be contacted and asked to provide the necessary information.

4.8.1 If the practitioner responsible for securing consent is not available, the Hospital staff shall determine whether the patient's doubt or confusion warrants delaying the procedure until the practitioner is available to respond to the questions or concerns.

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

4.8.3 Repeated instances of patient doubt or confusion involving the same practitioner shall be referred to the appropriate Medical Staff Committee for investigation and corrective action.

4.9 CONSENT BY TELEPHONE

4.9.1 Consent by telephone may be acceptable in certain situations. The nursing supervisor should be contacted if there is a question about using the phone to discuss the case and secure consent.

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

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

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

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

4.10 REFUSAL OF TREATMENT

4.10.1 A minor patient's surrogate decision-maker has the right to refuse treatment. If the patient’s parent or guardian refuses consent, it may be desirable and possible to secure court authorization.

4.10.2 If treatment is refused, the Attending Practitioner shall be contacted immediately and shall explain the reason for the treatment and the possible ill effects of refusal. The Attending Practitioner shall enter a brief note in the patient's chart regarding the initial refusal and whether the outcome was consent or continued refusal.

4.10.3 The Refusal to Permit Medical Treatment form should be presented to the patient’s surrogate decision-maker for signature. If the patient’s surrogate decision-maker refuses to sign, the notation “refuses to sign” shall be made at the place for the signature.

4.10.4 If treatment is ultimately refused, an incident report shall be completed and forwarded to the Quality Management Department, along with the appropriate Refusal to Permit Medical Treatment form.

4.10.5 See also the "Discharge of Patients" Rule, the section on leaving against medical advice, and the "Discontinuing Life-Sustaining Treatment" Rule.

5. CONSULTATIONS

5.1 GENERAL

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

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

5.1.3 An Attending Practitioner's responsibility for his/her patient does not end with a request for a consultation.

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

5.2 REQUESTS FOR CONSULTATIONS

5.2.1 The Attending Practitioner ordering a consultation or other service shall indicate on the order which Member he/she designates to perform the service. If the Attending Practitioner does not have a preference, and/or does not indicate what Member the patient is referred to, or if the designated Member is not available to perform the services in a timely manner, then the services shall be performed by the appropriate Member on duty pursuant to the call schedule created by that service/specialty.

5.2.2 Requests for consultation must be made by direct personal communication from the Attending Practitioner to the Consulting Practitioner. Hospital nurses or other employees are not to be used as intermediaries. The Attending Practitioner must document the consultation request.

5.2.3 The Attending Practitioner must tell the patient or the surrogate decision-maker that he or she has requested a consultation and secure the patient's or the surrogate decision-maker's authorization for the consultation. Such authorization can be forgone in emergencies.

5.3 RECOMMENDED CONSULTATIONS

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

5.3.1 When the patient is not a good risk for an operation or treatment.
5.3.2 Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
5.3.3 Where there is doubt as to the choice of therapeutic measures to be used.
5.3.4 In unusually complicated situations where specific skills of other practitioners may be needed.
5.3.5 In instances where the patient exhibits severe psychiatric symptoms.
5.3.6 In the case of drug or chemical overdose or attempted suicide.
5.3.7 Within 24 hours of admission of pregnant patients.
5.3.8 When requested by the patient's surrogate decision-maker.
5.3.9 When Munchausen's Syndrome by Proxy Syndrome is suspected.

5.3.10 When required by Medical Staff, Department, or Hospital Rules.

5.4 REQUESTED OR REQUIRED CONSULTATIONS

5.4.1 A consultation may be requested when the Department Chair or President of the Medical Staff determines that a patient will benefit from such consultation.

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

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

5.5 PERFORMANCE OF AND REPORTING OF CONSULTATIONS

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

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

6. COVERAGE

6.1 GENERAL

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

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

6.1.3 In the event the Attending Practitioner's alternate is not available, the Department Chair or Vice-President of Medical Affairs/CMO must be contacted, and assume responsibility for caring for the patient or appoint an appropriate Medical Staff Member who will assume responsibility until the Attending Practitioner can be reached.

7. DEATHS

7.1 PRONOUNCEMENT OF DEATH

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

7.1.2 If the patient has suffered "brain death" (i.e., the total and irreversible cessation of all functions of the entire brain, including the brain stem), death may be pronounced only in accordance with the Hospital Administrative Policy governing "brain death." (In brief summary, a second, independent physician must confirm the "brain death" and both physicians must document their findings in the patient's record. The patient's family must be informed of the patient's death. If the family objects to terminating treatment or contests the accuracy of the diagnosis, Administration shall be consulted before treatment is discontinued. When a patient meets the criteria for determination of brain death, the option of organ donation shall be proposed to the family.

7.2 AUTOPSIES

7.2.1 It shall be the duty of all Staff Members to attempt to secure consent to meaningful autopsies, whenever possible, in all deaths that meet the criteria listed as follows:

(a) Deaths in which an 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.

(b) Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical decision.

(c) Deaths resulting from high risk infectious and contagious diseases.

(d) 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.

(e) Unexpected or unexplained deaths of patients participating in clinical investigations.

(f) Deaths that are reported to the coroner but not accepted by the coroner, such as deaths of persons on arrival at the Hospital, deaths within twenty-four hours after admission, or deaths of patients who were or might have been injured while hospitalized.

7.2.2 An autopsy may be performed only with a written consent signed in accordance with law. (The persons who may consent to autopsies are identified in the CAHHS Consent Manual, Chapter 10.)

7.2.3 Except in coroner's cases, all autopsies shall be performed by the Hospital pathologist or his designee. Provisional anatomic diagnoses shall be recorded on the medical record by the pathologist within 72 hours after completion of the autopsy and the complete protocol should be made a part of the record within 60 days. Written consent to an autopsy shall not be deemed to include consent to removal of one or more organs for transfer to another person in an organ transplant operation. A specific consent for organ donation shall be obtained.

7.3 CORONER'S CASES

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

(a) Unattended deaths. (No physician in attendance or during the continued absence of the Attending Physician. Also includes all deaths outside hospitals and nursing care facilities).

(b) Wherein the deceased has not been attended by a physician in the 20 days prior to death.

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

(d) Known or suspected homicide, suicide, or accidental poisoning (food, chemical, drug or therapeutic agents).

(e) Following an accident or injury (primary or contributory). Deaths known or suspected as resulting (in whole or in part) from or related to an accident or injury, either old or recent.

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

(g) Where the suspected cause of death is sudden infant death syndrome.

(h) Death associated with a known or alleged rape or crime against nature.

(i) Deaths known or suspected to be due to contagious disease and constituting a public hazard.

(j) Deaths due to occupational diseases or hazards.

(k) Deaths involving any criminal action or suspicion of a criminal act. (Includes child and dependent adult negligence and abuse).

(l) All deaths in the operating rooms and all deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room or elsewhere.

(m) All deaths of unidentified persons.

(n) All deaths where the patient is comatose throughout the period of the physician's attendance. (Includes patients admitted to hospitals unresponsive and expire without regaining consciousness).

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

7.4 NOTIFYING THE NEXT OF KIN

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

7.5 DISPOSITION OF REMAINS AND CONTRIBUTIONS OF ANATOMICAL GIFTS

7.5.1 The patient's remains shall be disposed of in accordance with the instructions of the patient, the patient's legal representative, or his/her next of kin. The order in which the next of kin shall be consulted is set forth in the CAHHS Consent Manual, Chapter 10.

7.5.2 If the patient or his/her family indicates that the patient will contribute anatomical gifts, consent shall be secured in accordance with the relevant law, which is described in the CAHHS Consent Manual Chapter 10. The patient's physician shall comply with the Hospital protocol for identifying potential organ and tissue donors, and, whenever possible, confer with the patient or family about donations.

7.6 DEATH CERTIFICATE

The Attending Physician or other physician last in attendance is responsible for signing the death certificate or ensuring its completion. The certificate must be completed within 15 hours.

8. DISASTER ASSIGNMENTS

8.1 GENERAL

8.1.1 There shall be a plan for the care of mass casualties at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by a disaster planning committee. In addition to the Vice-President of Medical Affairs/CMO, one Medical Staff member shall be included on the disaster planning committee. The plan shall be approved by the Board of Directors.

8.1.2 Practitioners shall be assigned to posts, either in the Hospital, an auxiliary Hospital, or a mobile casualty station in the event of a mass disaster. The practitioner shall be responsible for

reporting to his/her assigned station and performing the assigned duties unless the Vice-President of Medical Affairs/CMO (or designee defined in the plan) changes the assignment.

8.1.3 If patients are evacuated from one section of the Hospital to another, or from the Hospital premises, the Vice-President of Medical Affairs/CMO or designee will arrange for the transfers. All policies concerning direct patient care will be a responsibility of the Vice-President of Medical Affairs/CMO or designee.

8.2 REHEARSALS

The disaster plan shall be rehearsed at least twice each year. The drills should be realistic, and may involve the Medical Staff, as well as Administration, Nursing, and other Hospital personnel. Actual evacuation of patients during the drill is optional.

8.3 EMERGENCY DISASTER CREDENTIALING

8.3.1 In the case of a disaster in which the emergency management plan has been activated and the Hospital is unable to handle the immediate patient needs, the President of the Medical Staff, or in the absence of the President, the Vice-President of the Medical Staff, may grant emergency privileges. In the absence of the President and Vice-President and Department Chair(s), the Chief Executive Officer or the CEO's designee of the Hospital may grant the emergency disaster privileges. If none of the above is available, in the case of a national disaster, the most senior member of the Medical Staff may grant the emergency disaster privileges. The granting of emergency disaster privileges shall be on a case-by-case basis at the sole discretion of the individual authorized to grant such privileges upon presentation of any of the following:

(a) A current picture Hospital ID card.

(b) A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency.

(c) Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).

(d) Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.

(e) Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding practitioner's identity.

8.3.2 An identification badge will be issued to the practitioner.

8.3.3 It is recommended that the practitioner be paired with a currently credentialed Medical Staff Member. Whenever possible, the practitioner granted emergency privileges should act only under the direct supervision of a Medical Staff Member or Hospital employee.

8.3.4 The assignments for practitioners granted emergency disaster privileges should be made in accordance with the Hospital's disaster plan. Generally, the Vice-President of Medical Affairs/CMO or designee will help make assignments.

8.3.5 The verification process of the credentials and privileges of individuals who receive emergency privileges is a high priority and shall begin as soon as the immediate disaster situation is under control, and shall be identical to the process established under the Medical Staff Bylaws for granting temporary privileges to fulfill an important patient care need. A decision (based on information obtained regarding the professional practice of the volunteer) will be made within 72 hours related to the continuation of the disaster privileges initially granted.

8.3.6 A practitioner's emergency disaster privileges will be rescinded as determined by the President of the Medical Staff. A practitioner's emergency disaster privileges will be immediately rescinded by the President of the Medical Staff or his/her designee in the event any information is received that suggests the person is not capable of rendering services in an emergency. There will be no rights to any hearing or review in the event a practitioner's emergency disaster privileges are denied or terminated, regardless of the reason for the action.

9. DISCHARGE OF PATIENTS

9.1 GENERAL

9.1.1 Patients shall be discharged only on the order of the Attending Practitioner or house officer with the approval of the attending practitioner.

9.1.2 Minors shall be discharged only to their parents or legal guardians or a person designated in writing by the parent or legal guardian. The "Health Facility Minor Release Report" in Chapter 9 of the CAHHS Consent Manual must be completed whenever a minor is discharged to anyone except a parent, relative by blood or marriage, or legal guardian.

9.1.3 The Attending Practitioner should inform the Nursing Service of possible discharges as early as possible and enlist the aid of the case manager when appropriate.

9.1.4 At the time of discharge, the practitioner discharging the patient must complete a discharge order sheet, state his/her final diagnosis and complete the discharge instruction sheet. The discharge summary must be completed within 14 days after the patient's discharge.

9.1.5 Overnight leaves of absences are not permitted. If the patient is to be out of the Hospital overnight, a discharge summary must be written by the attending practitioner. The return to the Hospital is treated as a new admission.

9.1.6 If the patient is going to leave the Hospital on a pass, the attending practitioner shall document his/her written permission on the doctor's order sheet and indicate the approximate number of hours the patient may be gone and the reason. If the pass is for medical treatment at another facility, the nature of the procedure and appropriate aftercare shall be documented in the medical record. The responsible practitioner shall provide post care orders.

9.2 LEAVING AGAINST MEDICAL ADVICE

9.2.1 Should the patient leave or attempt to leave the Hospital without a discharge order from the Attending Practitioner, the nursing staff shall attempt to arrange for the patient (or surrogate decision-maker) to discuss his/her plan with the Attending Practitioner before the patient leaves.

9.2.2 Whenever possible, the Attending Practitioner must explain the reasons he or she recommends continued hospitalization, the risks and consequences of leaving the facility, the benefits of continued hospitalization and any alternatives to continued hospitalization, such as transfer to another facility or outpatient treatment.

9.2.3 The patient who insists on leaving against medical advice shall be asked to sign the form "Leaving Against Medical Advice." A notation of the incident shall be made in the patient's medical record, to include the names of persons who witnessed the incident and the facts leading up to the incident.

9.3 REFUSAL TO LEAVE

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

10. DISCONTINUING LIFE-SUSTAINING TREATMENT, WITHHOLDING AND WITHDRAWING LIFE SUSTAINING SUPPORT, ISSUING DO NOT RESUSCITATE (DNR) ORDERS

10.1 GENERAL

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

10.1.2 In almost all cases, the decisions are to be made by the patient or his/her surrogate decision-maker, after consulting with the patient's physician. The physician is responsible for providing advice about when medical care should be withheld or withdrawn.

10.2 GUIDELINES FOR DECISIONS

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

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

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

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

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

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

10.2.4 All medical treatment may be withheld or withdrawn, except any medical procedure deemed necessary to alleviate pain. Further guidance is provided in the Hospital policy.

10.2.5 Do Not Resuscitate Orders (DNR), or to stop the otherwise automatic initiation of cardiopulmonary resuscitation (CPR), may be proper when:

(a) the patient has a severe congenital malformation incompatible with medical/surgical correction, or conditions or syndromes which have no reasonably conceivable possibility of treatment, recovery or long term survival.

(b) the patient has a progressive acquired disease in which there is no chance of meaningful survival for which the decision has been made for no further aggressive therapy by the Attending Physician and parents or legal guardian.

10.3 PROCEDURE FOR ISSUING ORDERS

10.3.1 Who Must Be Consulted

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

(b) The primary Attending Physician is responsible for providing this information to the patient's surrogate decision-maker, to enable him or her to evaluate a treatment's benefits and burdens. The irreversibility of the child's condition is to be communicated.

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

(d) DNR orders or other forms of life-sustaining treatment when there are no surrogate decision-makers who can act on behalf of the patient may not be issued unless the patient's physician has consulted with the Ethics Committee and confirmed propriety of the proposed order, and notified Administration who will determine whether legal advice should be sought.

10.3.2 Issuing the Order

All orders to withhold or withdraw life-sustaining treatment must be written and signed by a physician on the physician order sheet in the patient's medical record. The physician also must orally inform the nursing staff that such an order has been given to assure that the order is known and understood at the time it is written. no verbal DNR orders will be accepted.

The decision to continue a DNR order upon discharge must be documented in the patient record. A "DNR Discharge" policy exists to identify DNR patients in the Orange County Area. A DNR order must be rewritten by an Attending Physician upon readmission of the patient to the Hospital.

DNR orders in Surgery: If a patient is admitted for surgery with a previous DNR order or orders to be honored in the OR setting, a written DNR order must be entered on the preoperative orders. Whenever the DNR is suspended during the OR period, clear documentation of reinstituting the DNR order is necessary.

10.3.3 Reviewing Other Treatments

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

10.3.4 Documentation

The orders to withhold or withdraw life-sustaining treatment must be supported by complete documentation in the progress notes of all the circumstances surrounding the decision. The notes should summarize the medical situation and the patient's diagnosis and prognosis; the

outcome of any consultations with other physicians; identify who are the decision-makers and describe the information they were given and state their decision.

10.3.5 Maintaining Comfort

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

10.3.6 Dispute Resolution

In the event a dispute arises concerning the issuance of an order to withhold or withdraw treatment, the matter may be referred to Administration and/or the Ethics Committee Chair or Vice-chair. Until the dispute is resolved, life-sustaining treatment should be provided and disputed DNR orders, if any, suspended.

More complete guidance is provided in the Hospital Policies, "Guidelines For Withholding and Withdrawing Life Sustaining Support" and "Guidelines for Do Not Resuscitate Orders".

11. DRUG AND MEDICATION ORDERS

11.1 GENERAL

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

11.1.2 Drugs for bona fide clinical investigations are exceptions. Investigational drugs may be used only if the physician complies with the policy governing use of investigational drugs and secures the Hospital's Institutional Review Board approval. All uses must be in compliance with the federal Protection of Human Subjects regulations, which are described in Chapter 6 of the CAHHS Consent Manual. Investigational drugs must be dispensed by the Hospital pharmacy according to established procedure for handling investigational drugs.

11.2 REVIEW OF DRUG ORDERS

11.2.1 Each physician is expected to review all medications for all patients regularly to ensure discontinuation on all orders that are no longer needed and at least every seven days.

11.2.2 The Hospital has developed policies limiting the duration of drug therapy.

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

11.2.4 A stamp on the order sheet will be used for notifying the physician when the next to last dose of a drug is given.

11.2.5 Orders for drugs must be rewritten when:

(a) Patients return from surgery.
(b) Medication is to be resumed after an automatic stop order has been employed.
(c) Patients are transferred to or from the ICU.

11.3 PROCUREMENT OF DRUGS

11.3.1 All drugs shall be procured from the Hospital pharmacy.

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

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

11.4 ORDERS

11.4.1 Substitution of Generic Drugs

(a) Generic drugs may be dispensed unless ordered otherwise.

(b) The Medication/Nutrition Committee will establish and maintain a list of non-proprietary drugs that may be substituted for a drug which has been ordered by the trade (proprietary) name.

11.4.2 General

(a) Drug orders must be made by a person lawfully authorized to prescribe.

(b) Certain medication orders when written by the house staff must be co-signed by the attending practitioner. The medications are delineated in the Hospital Formulary as approved by the Medical Staff.

11.4.3 Contents of Drug Orders

Each drug order shall include the name of the drug, the dosage and frequency of administration, the route of administration (if other than oral) and the date, time and signature of the prescriber.

11.4.4 Verbal Drug Orders

(a) Drug orders may be given as a verbal order to a registered nurse, licensed pharmacist, or respiratory care practitioner (in the case of drugs used for respiratory therapy).

(b) Verbal orders must be recorded promptly in the patient's medical record, noting the date, name of the person giving the verbal order and the signature of the individual receiving the order. The verbal or telephone order for drugs shall be signed and dated within 48 hours by a duly authorized physician responsible for the patient’s care.

11.4.5 Pre-Printed Drug Orders

Pre-printed orders for drugs may be used for specified patients when authorized by a person licensed to prescribe. A copy of standing orders for a specific patient must be dated, promptly signed by the prescriber, and included in the patient's medical record. These pre-printed orders must:

(a) Specify the circumstances under which the drug is to be administered.
(b) Specify the types of medical conditions to which the pre-printed orders are intended to apply.
(c) Be initially approved by the appropriate Medical Staff committee and be reviewed at least annually by that Committee.
(d) Be specific as to the drug, dosage, route and frequency of administration.

11.5 MEDICATIONS PRESCRIBED FOR RELEASE TO PATIENTS ON DISCHARGE.

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

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

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

12. IMPAIRED MEDICAL STAFF MEMBERS

12.1 PURPOSE

This Rule addresses referral of Medical Staff Members who possibly suffer chemical dependence, or mental or physical impairment, for evaluation and initiation of treatment for the purposes of assisting the Member and protecting patients.

12.2 PHILOSOPHY

Chemical dependence (including dependence on mood-altering drugs, such as alcohol, cocaine, opiates, and depressants) is seen as a medical condition that requires treatment. Untreated or relapsing chemical dependence, mental impairment, or physical impairment is incompatible with safe clinical performance in any medical specialty.

12.3 ASSISTING IMPAIRED MEDICAL STAFF MEMBERS

12.3.1 All Medical Staff Members should share their concerns about chemical dependence, or mental or physical impairment, in themselves or other Members, in confidence, with the Committee on Physician's Health.

12.3.2 The Committee on Physician's Health is dedicated to helping the Members identify chemical abuse, and mental and physical impairments, and helping the Members to obtain treatment to alleviate the problem. Even though the Committee's mission is to assist Medical Staff Members, patient safety must be primary. Thus, if the Committee on Physician's Health finds a risk of harm or danger to patients and the practitioner does not willingly withdraw from clinical practice, the Committee will ask the President of the Medical Staff to initiate corrective action.

12.4 CONFIDENTIALITY

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

12.4.2 The Committee on Physician's Health shall periodically report on its activities to the Medical Executive Committee, without identifying individuals.

12.4.3 The Committee on Physician's Health shall report directly to the Medical Staff Officers or Vice-President of Medical Affairs/CMO on the status of particular cases.

12.5 REPORTING AND INVESTIGATING PROCEDURE

12.5.1 The Committee on Physician's Health will investigate all reports of impairment to determine whether a problem exists. This protocol applies to Members who have, or are reported to have, impairments, as well as applicants who have a history of impairment.

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

(b) If a problem may exist, the practitioner in question will be invited to meet with the Committee or a minimum of two Committee members, to discuss the problem and the findings from the investigation. The interview will be informal.

(c) The Committee may ask the practitioner to be evaluated by a practitioner, including a psychiatrist, other psychotherapist, or substance abuse counselor. The Committee will ask the practitioner to sign a form authorizing disclosure of the results of the evaluation to the Committee. The Committee may pay for the evaluation, although that is discretionary. The practitioner should be given a list of professionals acceptable to the Committee on Physician's Health. The report should address the diagnoses, prognosis, and treatment program recommendation.

(d) Practitioners who have chemical dependency abuse will be referred to the Medical Board of California Diversion Program, or a treatment program of the practitioner's choice approved by the Committee on Physician's Health. Practitioners who have other types of impairment will be referred for treatment approved by the Committee.

(e) The Committee on Physician's Health will draw up a contract between it and the practitioner, delineating the Committee's expectations for treatment and monitoring. The contract, as a minimum, will require the Member to agree to the following conditions, depending upon the nature of the impairment:

(1) To provide documentation from an evaluating or treating professional that initial treatment has been provided and that the Member may safely practice.

(2) To abstain from using any drugs or alcohol, except as approved by the treatment program and the Committee on Physician's Health.

(3) To participate in an ongoing treatment program. Any specific terms, such as continuing psychiatric counseling, securing medical treatment or attending practitioner recovery groups and Alcoholics Anonymous or Narcotics Anonymous should be stated.

(4) To agree to any indicated random testing of bodily fluids, by the treatment program or as directed by the Committee on Physician's Health.

(5) To meet regularly, and at least quarterly, with a monitor appointed by the Committee on Physician's Health.

(6) To allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the re-entry agreement, and the Committee on Physician's Health.

(7) To request a medical leave of absence in the event the Committee on Physician's Health finds that the impairment or failure to comply with the agreement presents a risk to patients.

(8) To sign whatever forms are needed to authorize release of information from the treatment programs to the Committee on Physician's Health, and request that reports shall be made regularly, at defined time intervals, such as quarterly.

(9) To acknowledge that any failure to comply with the conditions will result in immediate referral to the President of the Medical Staff for corrective action.

(10) To provide for post treatment monitoring of a sufficient duration (usually two or three years).

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

(f) When the treating program or the Committee on Physician's Health concludes that the Member cannot practice safely, the Member shall request a leave of absence. Discontinuance of the leave shall be contingent upon the Member satisfying the Committee on Physician's Health that he or she can return safely to practice (if the Member still chooses to comply voluntarily with the established program).

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

12.5.2 The investigation may be closed at any time it appears there is no problem.

12.5.3 If the practitioner refuses to cooperate at any stage, the matter will be referred to the President of the Medical Staff, together with a statement that the practitioner is not participating in a Well-Being Program, and the Committee has reason to suspect that the Member may be impaired as a result of chemical abuse, mental illness or physical injury or condition. The Medical Staff should initiate its own corrective action investigation, and not ask the Committee on Physician's Health to share the confidential information that was gathered during an investigation or while a Member was fulfilling his/her Agreement with the Committee. The Committee on Physician's Health should be asked only to indicate what action may be necessary to protect patients. Other evidence should be developed independently in order to preserve the integrity of the Committee's promises of confidentiality.

12.5.4 After successful completion of the treatment program for a minimum period, such as 2 years, the Committee on Physician's Health shall close the active case. It will open a monitoring case for a defined period of time, such as 3 years, and review the practitioner's status every 6 months.

13. LABORATORY WORK

Laboratory work on all inpatients and pre-surgical patients shall routinely include urinalysis, hemoglobin, hematocrit, white blood count, and when indicated, differential. At the discretion of the physician, the laboratory work may be waived. Tests for PKU, thyroid function and galactosemia are required by law on all newborns unless previously performed.

In appropriate situations at the discretion of the physician, laboratory work performed within 14 days before admission to Children's Hospital at laboratories approved by the Department of Pathology may be incorporated into the chart in place of laboratory work ordinarily done after admission to Children's Hospital

14. MEDICAL EDUCATION

14.1 PATIENT PARTICIPATION

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

14.2 PROFESSIONAL GRADUATE EDUCATION PROGRAM

The Professional Graduate Education Program and Medical Staff regularly communicate about the safety and quality of patient care provided by, and the related educational and supervisory needs of, the participants in professional graduate education programs. The Professional Graduate Education program and the governing body periodically communicate about the educational needs and performance of the participants in the program.

14.3 MEDICAL STUDENTS, RESIDENTS AND FELLOWS SUPERVISION AND PRIVILEGES

Medical students, residents and fellows participating in training programs at the Hospital shall be supervised by Medical Staff Active, Courtesy, Consulting and Provisional Members with appropriate clinical privileges and act in accordance with the agreement governing their training at the Hospital. Specific requirements for volunteer teaching will be defined by the Rules and Regulations. General Attending Physicians in the teaching program will be designated by the Director of Medical Education to provide teaching services and to supervise the medical care of patients involved in the medical education activities. On all teaching patients, the attending of record is ultimately responsible for the care of their patients.

Refer to the attached policy on Supervision of Residents for more detailed requirements.

14.4 RECORD KEEPING

14.4.1 General

(a) Residents, fellows and medical students shall be responsible for completing records pertaining to the clinical services they provide while participating in the residency, fellowship, and medical student training programs at the Hospital.

(b) Residents and fellows should always attempt to contact the attending of record prior to writing any notes or orders.

(c) The need for consultation should be discussed with the attending whenever possible. When writing an order for the consultation, the resident or fellow must discuss the case with the consultant if at all possible.

(d) Normally, orders written by a resident do not require a co-signature by a Medical Staff member, with the exception of the following:

14.4.2 Countersignatures

The attending and supervising practitioner shall review and then countersign the following orders and reports when prepared by a resident:

(a) Admission History and Physical Examination Report

(b) Consultation Reports

(c) Operative Reports (may be dictated by residents who have completed the third year of surgical residency)

(d) Discharge Summaries

(e) Digoxin orders (required co-signature by a senior resident or attending prior to administration)

(f) Prescriptions (if resident is unlicensed)

(g) Insulin orders (must be discussed with the attending prior to administration to patient. Documentation of discussion must be entered in the record).

(h) Chemotherapy (requires co-signature by a hematologist/oncologist or in the case of a rheumatology patient, by a rheumatologist, prior to administration.)

(i) Restraints (in accordance with Hospital policy)

14.4.3 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.

15. MEDICAL RECORDS

15.1 GENERAL

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

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

15.1.3 Use of the CUBS (Computer Users Building Safety) systems is the standard of practice at CHOC. All members of the Medical Staff are required to receive training on the CHOC CUBS electronic medical record system and demonstrate a basic competency in order to receive login information and passwords. This will include mandatory training updates as new functionality is added to the system. Physicians who have not been trained on the system will not be allowed to practice at the institution until such training is complete. A signed agreement to use the CUBS system will be included in the credentialing process for new physicians, as well as those applying for reappointment. These agreements will be renewed biennially. Practitioners who fail to comply with the requirement to utilize CUBS will be subject to disciplinary action which may include suspension of Medical Staff privileges and membership.

15.2 RESPONSIBILITY FOR THE RECORD

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

15.3 COMPLETION OF THE RECORD

15.3.1 Timely Completion

(a) Entries should be made as soon as possible after clinical events occur, to ensure accuracy and to provide information relevant to the patient's continuing care. Verbal orders must be countersigned by the practitioner who issued the order within the time periods established in the Medical Staff Rules. (See the "Orders" and "Drug and Medication Orders" Rules.)

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

(c) Practitioners will receive a weekly notice from the Medical Records Department notifying them of any medical record assigned to them for completion. If a patient's record remains incomplete 13 days after discharge, the Medical Record Department shall make a courtesy telephone call to notify the practitioner as a final reminder before action will be taken to suspend his/her privileges.

(1) Physicians may not admit a suspended partner's patients unless they agree to admit as his/her own patient, thereby assuming responsibility for all chart completion, including dictation of discharge summary.

(2) If the records are still incomplete after 14 days, a limited suspension in the form of withdrawal of admitting and other related privileges shall be imposed until these records are completed. For the purpose of these Rules, "related privileges" mean scheduling surgery, assisting in surgery, consulting on Hospital cases, and providing professional services within the Hospital settings for future patients. This suspension shall not affect the practitioner's call schedule responsibilities or the right to continue to care for a patient the member has already admitted or is treating. The suspension shall continue until the delinquent medical records are completed. When the practitioner completes the records, these privileges will be automatically reinstated.

(3) Physicians who remain on suspension five (5) or more days after suspension was imposed for medical record deficiency will be required to pay a fee of $100.00 in order for privileges to be reinstated. If records are still not completed by the next suspension cycle and the physician remains on suspension, an additional $100.00 will be imposed. If delinquent records have been completed after a fine has been imposed, the fine must still be paid before privileges may be reinstated.

(4) When a practitioner accumulates 30 days of suspension in any consecutive 12 months, a report to the Medical Board of California will be completed as appropriate. Three suspensions for a failure to complete medical records may be considered sufficient cause for termination of the practitioner's Medical Staff membership and privileges.

(5) When all efforts to complete a record have been exhausted, a committee of the Medical Staff may order it filed.

(d) A medical record shall not be permanently filed until it is completed by the responsible Attending Practitioner or is ordered filed by a committee of the Medical Staff which may authorize the Director of Medical Records Department to retire charts under the following circumstances: when the practitioner is deceased and associate is unable to complete the record, the physician of record has moved from the area or is no longer associated with the Hospital, portions of the chart were never received at the time of the patient's discharge and a thorough search has failed to locate them, or the record is 90 days past allocation date, and the physician of record has failed to complete the record even though the record was available for completion.

15.3.2 Use of Symbols and Abbreviations

No symbols or abbreviations may be used on the discharge summary.

15.3.3 Correction of the Medical Record

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

15.3.4 Authentication, Dating and Timing of Entries

The date and time on entries 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.

15.4 CONTENTS

15.4.1 General

Each record shall contain sufficient detail and be organized in a manner which will enable a subsequent treating practitioner or other health care provider to understand the patient's history and to provide effective care. The contents of the record must be legible in order to be useful. Abbreviations and symbols may be used only when they have been approved by the Medical Staff.

15.4.2 Inpatient Records

The inpatient record shall include the following elements:

(a) Identification Sheets

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

(b) Admitting Note

An admitting note must be written in the progress notes within 24 hours of the admission. The Admitting Note shall include an initial diagnostic impression (i.e., a concise statement of the complaints which led the patient to consult with the practitioner, and the date and onset and duration of each), a provisional diagnosis (i.e., the impression (diagnosis) reflecting the examining practitioner's evaluation of the patient's condition based upon the physical findings and history), and a statement of the course of treatment plan must be documented.

(c) History and Physical Examination Report

A history and physical examination ("H&P") shall be written and include all pertinent findings resulting from an inventory of systems. Rectal and pelvic examinations will be done at the discretion of the practitioner. With neonatal admissions, documentation shall include details of the obstetrical and perinatal history including Rh, gravida and parity, serology of mother, estimate of gestational age, place of birth, condition and circumstances of birth, any known complications of pregnancy or labor, and whether eye care and vitamin K were given.

The medical history shall include details of present illness, significant past medical history, and social and family histories.

The H&P shall be written within 24 hours after the patient's admission, unless the patient is to have an invasive procedure or is to be taken to surgery before that time, in which case the H&P report must be placed in the patient's chart before the procedure is performed or patient is taken to surgery. If there are three complaints related to non-legibility of the hand written H&P, the physician will be required to dictate all future H&P reports. In the event it is impossible to have a dictated H&P report prepared and placed in the chart prior to the procedure or surgery (e.g., it is a life-threatening emergency), the physician shall include a handwritten report in the record. (A handwritten H&P may be used for outpatient cases using only local stand-by anesthesia.) Any time a patient has surgery, there must be an interval medical history and physical examination performed and recorded on the chart within the previous 24 hours.

If a complete H&P was performed within 30 calendar days prior to the patient's admission to the Hospital, a reasonably durable, legible copy of the report may be used in the patient's medical record, provided the report was completed by a Medical Staff Member and, there is an interval medical history and physical examination within 24 hours of the admission, and in the case of an invasive procedure, within the previous 24 hours.

The H&P report shall be prepared by the patient's Attending Practitioner, unless he or she delegates this responsibility to another physician or Allied Health Professional. When an Allied Health Professional is allowed to help complete an H&P, the responsible physician must confirm the findings prior to any high risk diagnostic or therapeutic intervention, or within 24 hours, whichever comes first. (See specifically the Medical Staff Bylaws and Orthopedic Section and Dental Section Rules pertaining to the completion of H&P reports when a podiatrist or dentist is the co-admitting doctor.)

An H&P performed by an Advanced Practice Professional (NP or PA) shall be dictated and include all pertinent findings resulting from an inventory of systems.

(d) Consultation Reports

Consultation requests must be documented in the chart. A brief consultation report must be written immediately in the chart after the consultation. This note must include consultant's assessment and recommendation. A complete consultation report must be written or dictated for the chart and signed by the consultant. (See also the "Consultations" Rule.)

(e) Order Sheets

Medication, treatment, and diet orders shall be entered on the order sheet. The order sheet is utilized by physicians, dentists, podiatrists, nurse practitioners, and physician assistants. (See also the "Orders" and "Drug and Medication Orders" Rules.)

(f) Progress Notes

Dated and timed progress notes shall be entered at least daily by the Attending Physician who is familiar with the patient, and more often when warranted by the patient's condition, when there is a significant change in the patient's status or following a procedure performed by the physician. This is in addition to any progress notes written by the resident. The progress notes shall give a chronological picture of the patient's progress, and be sufficient to permit continuity of care and transferability. The progress note shall delineate the course and results of treatment. For patients admitted less than 24 hours, the H&P or short stay discharge note may count as a progress note.

(g) Operative Reports and Surgical Notes

A preoperative note, including the preoperative diagnosis, must be charted by the surgeon prior to any major procedure, except in the case of extreme emergency. The surgeon shall also enter a post-operative note in the progress notes immediately following surgery which shall include the name of the primary surgeon and assistants, procedures performed and description of each procedure, findings, estimated blood loss, specimens removed, and post operative diagnosis.

The operative reports shall include pre-operative and post-operative diagnosis, the name of the primary surgeon and any assistants, a description of the techniques used, a description of the indications, findings, and a notation of any tissue removed or altered.

All operative reports must be dictated immediately following surgery. If this report is not dictated within 24 hours, the Medical Records Department will contact the surgeon or the surgeon's office as a courtesy. Failure to dictate within 24 hours will result in the loss of surgery scheduling privileges until this report is dictated. The reports shall be promptly signed, dated, and timed by the surgeon.

(h) Nursing and Ancillary Notes

Notes and reports from the nursing, ancillary and support staff and services involved in the patient's care shall include: (1) Nursing notes, providing a record of the nursing care that is rendered, pertinent observations regarding the patient, including psychosocial and physical manifestations, and of the administration of medications, (2) dietician notes, (3) a vital sign sheet, (4) reports of all X-ray examinations, (5) anesthesia record (see the Anesthesiology Rules) and (6) a pathological report, if tissue or a body fluid was removed.

(i) Discharge Summary

A concise discharge summary shall recapitulate the significant findings and events of the reasons for the patient's hospitalization, significant findings; (procedures performed and treatment rendered); patient condition on discharge, justify the patient's admission and the treatment provided, and identify the recommendations and arrangements for follow-up care, including discharge medications, dietary and activities advice.

After discharge of the patient from the hospital, records shall be promptly completed. No medical record shall be filed until it is complete. Records not completed within 14 days of the patient's discharge shall be considered delinquent. The Practitioner must utilize the "Physician Discharge Summary Form" within CUBS at the time of discharge. This form may be used in lieu of dictation. The Practitioner must complete the "Physician Discharge Summary Form" on all expired patients, inpatients; inter facility transfers and observation patients.

Note: For Outpatient Procedures including OPI, the discharge elements may be incorporated into the procedure note as long as the procedure note title is clearly labeled reflecting both the procedure and discharge sections. Patients discharged form OPI "Outpatient Infusion" can be discharged once they meet the discharge criteria for that service.

(j) Final Diagnosis

The discharge summary shall include a final diagnosis. It shall be recorded in full without the use of symbols or abbreviations. The Attending Practitioner must date and sign the entry of the discharge diagnosis at the time the patient is discharged.

(k) Consent Forms. (See the "Consent for Medical and Surgical Procedures" Rule.)

(l) Restraints

Restraints shall be used only when alternative methods are not sufficient to protect the patient or others from injury. A practitioner's order must be obtained for each use of restraints. The order may be given in writing or orally. It must be time-limited and should include the reason for restraint and the type of restraint to be used. If nursing services staff initiate the restraints, an order for the restraints must be obtained in writing or orally within one hour, as required by the Hospital policy. Any verbal orders given for restraints must be countersigned by the practitioner (or his/her covering practitioner) within 24 hours. The maximum time restraints may be continuously used is established by Hospital policy (#1801.00), as are the requirements for periodic observation of the patient, including a maximum time between observations.

15.4.3 Outpatient Records

With the exception of radiology, pathology and similar diagnostic services, each outpatient record (including outpatient surgery records) shall include the following elements:

(a) Identification sheet (face sheet). (See 15.4.2(a) above.)

(b) A record of the patient's medical history, including screening tests, allergy record, and a neonatal history for pediatric patients as verified by a qualified physician. (Exceptions for history are outlined in the Protocol for Level I Patients)

(c) A physical examination report as performed and verified by a qualified physician. (See 15.4.2c above) (Exceptions for physical examination are outlined in the Protocol for Level 1 Patients).

(d) Consultation reports. (See 15.4.2(d) above.)

(e) Clinical notes, including the dates and time of visits.

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

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

(h) If an operation was performed, a dictated operative report on the outpatient surgery describing the techniques used, the findings, estimated blood loss, and tissue removed or altered, as appropriate; a written record of pre-operative and post-operative instructions; and an anesthesia record (see the Anesthesiology Rules). The Surgeon shall also enter a post-operative note in the progress notes immediately following surgery, which shall include a plan of post-operative care. The operative report must be dictated immediately following surgery. (See 15.4.2(g))

(i) Referral information from other providers.

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

(k) For patients receiving continuous ambulatory care services, there shall be a Problem List of known significant diagnoses, conditions, procedures, drug allergies, and medications.

15.4.4 Emergency Records

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

(a) Adequate patient identification.

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

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

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

(e) Diagnosis.

(f) A description of the treatment provided.

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

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

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

15.5 AVAILABILITY OF RECORDS

15.5.1 Records (both inpatient and outpatient) shall be maintained safely by the Hospital. Each practitioner shall respect the confidentiality of physician-patient communications, information obtained in the course of diagnosing and treating patients, and in medical records.

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

15.5.3 Unauthorized removal of charts from the Hospital is grounds for corrective action against the practitioner.

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

16. ORDERS

16.1 TREATMENT ORDERS

All orders for treatment shall be in writing.

16.2 VERBAL ORDERS

16.2.1 A verbal order shall be considered to be in writing if the practitioner dictates the order to a registered nurse, licensed pharmacist, respiratory care practitioner, or a duly authorized person functioning within his/her sphere of competence and the order is then signed by the responsible practitioner when required by these Rules.

Persons authorized to accept verbal orders for drugs and medications are identified in the "Drug and Medication Orders" Rule. In addition, dieticians can take verbal dietary orders; laboratory personnel can take verbal orders for laboratory examinations; respiratory therapists may take verbal orders for respiratory therapy; physical therapists may take verbal orders for physical therapy, and occupational therapists may take verbal orders for occupational therapy.

16.2.2 All orders dictated over the telephone shall be signed by the person receiving the order, with the name of the practitioner noted. The responsible practitioner shall countersign the order as follows: Restraints = 24 hours; Medicine Orders = 48 hours; All other orders = 14 days.

16.2.3 DNR orders and other orders to withhold or withdraw life-sustaining treatment may not be given as verbal orders, and must be written in the patient's chart by the responsible practitioner.

16.2.4 An order to admit a patient must be included in the initial orders for inpatients.

16.3 LEGIBILITY

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

16.4 CANCELLATION OF ORDERS ON TRANSFER

All previous orders are canceled when a patient goes to surgery or the patient is admitted to the Intensive Care Unit.

16.5 MEDICATION ORDERS

Medication orders shall be given in accordance with the "Drug and Medication Orders" Rule.

16.6 STANDING (PRE-PRINTED) ORDERS

Pre-Printed orders for drugs shall be approved and utilized in the manner described in the "Drug and Medication Orders" Rule. Pre-Printed orders for other forms of treatment may be used for specified patients when authorized by a person licensed and given privileges to issue the orders. A copy of pre-printed orders for a specific patient must be dated, promptly signed by the practitioner, and included in the patient's medical record. These pre-printed orders must:

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

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

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

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

17. OUTPATIENT SERVICES

17.1 SERVICES

17.1.1 Outpatient diagnostic care shall include pathology, clinical laboratory services, radiology, Level one care, pulmonary function, cardiology, and gastroenterology.

17.1.2 Outpatient therapeutic care shall include surgery, rehabilitation, physical therapy, respiratory therapy, and chemotherapy.

17.2 REGISTRATION OF OUTPATIENTS

17.2.1 Patients referred for outpatient services must be registered by the Hospital's outpatient service. A record shall be created in accordance with the "Medical Records" Rules.

17.3 WRITTEN ORDERS

17.3.1 Patients shall receive outpatient therapy only upon the written order of a Medical Staff Member.

17.4 OUTPATIENT SURGERY

17.4.1 Eligible Cases

Guidelines for surgical procedures which may be performed on an outpatient basis are specified and appended to Nursing Policy, Surgical Short Stay Unit.

17.4.2 Pre-Op Evaluation

Each patient shall be evaluated pre-operatively by the surgeon, who shall be responsible for determining what surgical intervention is necessary and for securing the patient's informed consent for the surgery. In addition, if anesthesia other than a local anesthesia will be used and administered by an anesthesiologist, the anesthesiologist shall be responsible for evaluating the patient preoperatively, using the same standards as apply when surgery is performed on an inpatient basis.

17.4.3 Informed Consent

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

17.4.4 Specimens

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

17.4.5 Pre-Op Instructions

Patients registered for outpatient surgery shall be given written pre-operative instructions which address:

(a) Any restrictions on food and drug ingestion prior to surgery;

(b) Any special preparations the patient should make;

(c) Any post-operative instructions; and

(d) The statement that admission to the Hospital may be required in the event of unforeseen circumstances.

17.5 DISCHARGE

Each patient shall be examined by a practitioner prior to discharge from the Hospital

18. PROVISIONAL REVIEW AND PROCTORING POLICY

18.1 GENERAL

All Medical Staff Members initially granted privileges are subject to a minimum provisional period of twelve (12) months from the date of appointment and shall not exceed the maximum provisional period of twenty-four (24) months. During this provisional period, all members shall complete a period of proctoring in accordance with the requirements set forth in the Medical Staff Bylaws.

Proctoring shall include, at a minimum, retrospective chart review. Each department shall establish case review requirements, and describe methods of review for proctoring (i.e., retrospective, concurrent, or direct observation). The member shall be required to be proctored on consecutive cases to begin with the first case seen at CHOC until the requirement for proctoring has been completed. Exceptions to this requirement may only be made by the Department Chair, or in his/her absence, the Department Vice Chair.

If a physician is not able to obtain a proctor from his/her Specialty Section, then the Department Chair is to be contacted and a request made to assist in identifying an appropriate proctor.

18.2 FUNCTION AND RESPONSIBILITY OF THE PROCTOR

The proctor shall be responsible for evaluating the proctored practitioner's performance as follows:

18.2.1 If surgery or an invasive procedure is performed, the proctor shall evaluate the indication for the procedure, the technique for the procedure and how it is performed. He or she shall utilize the patient's chart, discussions with the practitioner and actual observation as the basis for the review. If medical care is provided, the proctor shall review the care of the patient, utilizing the patient's chart, discussions with the practitioner, and actual observation, as necessary, as the basis for the review. Invasive medical procedures will be proctored by observation unless the case is an emergency or as otherwise specified in the Department Rules.

18.2.2 For each case that is proctored, the proctor shall complete the Proctoring Form developed by each department and submit it to the Department Chair through the Medical Staff Office.

18.2.3 Proctoring reports shall be completed fully and in a timely manner after the patient's discharge.

18.2.4 The proctor's primary responsibility is to evaluate the proctored practitioner's performance. However, if the proctor believes that intervention is warranted in order to avert harm to a patient, he or she may take any action he or she finds reasonably necessary to protect the patient.

18.2.5 If the proctor and the proctored practitioner disagree on the appropriate treatment of a patient, the dispute shall be referred to the Department Chair or President of the Medical Staff for resolution.

18.2.6 A proctor may or may not act as the assistant in a surgical procedure.

18.3 RESPONSIBILITY OF THE PROCTORED PRACTITIONER

18.3.1 The proctored practitioner shall be responsible for notifying a proctor for each patient whose care is to be evaluated. A list of proctors eligible to proctor the practitioner will be provided to the proctor at the time privileges are granted. For surgical or invasive medical procedures that will be observed, the proctored practitioner shall be responsible for arranging the time of the procedure with the proctor.

18.3.2 The proctored practitioner shall provide the information that is requested by the proctor regarding the patient and the planned course of treatment.

18.4 RECIPROCAL PROCTORING

Proctoring requirements may be satisfied by a review of cases performed at other hospitals only if the following conditions are met:

18.4.1 The proctoring is concurrent with the practitioner's staff appointment to CHOC and performed by a member who has unrestricted privileges at CHOC to perform the same procedure or the proctor is a practitioner who has an extraordinary reputation for doing particular procedures.

18.4.2 The case is done at a Hospital accredited by the Joint Commission.

18.4.3 The Medical Staff is given access to portions of the patient's medical record, if requested.

18.4.4 The proctor must submit a written report to CHOC.

18.4.5 No more than fifty percent (50%) of the required cases to be proctored may be submitted from other Joint Commission facilities.

18.4.6 Adult cases proctored must be approved by the Department Chair.

18.5 DURATION OF PROCTORING

18.5.1 All practitioners are expected to complete proctoring in six months. They must complete their proctoring within twenty-four (24) months and will be notified of their incomplete status every six months. The Medical Staff Office personnel will keep track of the number of proctor forms completed and forwarded to them.

18.5.2 When the number of cases for that practitioner has been met, the Medical Staff Office will notify the Department Chair/department committee for recommendations to lift the proctoring requirement; i.e., advancement to Class I privileges. This recommendation is forwarded to the Department, the Medical Executive Committee and the Board of Directors..

18.5.3 The practitioner will be promptly notified of this recommendation.

18.5.4 Practitioners who have completed their proctoring requirements may not transfer out of their Provisional Category until twelve months have elapsed.

18.6 EXTENSION OF PROCTORING

Every six months, all members who have not completed their proctoring will be sent a notice advising them of their remaining proctoring requirement. A staff member may request an extension of proctoring if he or she has not had a sufficient number of cases to satisfy the proctoring requirements in whole or in part. This request must describe the practitioner's case load and the circumstances which will enable him or her to meet the requirements if an extension is granted. Any extension granted must be for a defined period of time not to exceed six months. A maximum of twenty-four (24) months of proctoring will be permitted.

18.7 EXTENSION OF PROCTORING DUE TO UNSATISFACTORY REPORTS

If a practitioner completes the necessary volume of proctored cases but fails to perform satisfactorily during proctoring as concluded by the Department, he or she shall be proctored on 3 additional cases at a time, for a maximum number of 24 cases. Failure to satisfactorily complete proctoring shall have the consequences set forth in the Medical Staff Bylaws. This provision does not, however, preclude the initiation of corrective action at an earlier time.

18.8 FAILURE TO COMPLETE PROCTORING WITHIN 24 MONTHS

If a practitioner fails to satisfy the proctoring requirements within 24 months, the file will be referred to the Department Chair for a recommendation for an automatic termination of the practitioner's staff membership and/or particular clinical privileges. The member shall not be entitled to any hearing and appeal if advancement was denied because of a failure to have a sufficient number of cases proctored or because of a failure to maintain a satisfactory level of activity.

18.9 PROCESS FOR COMPLETION OF PROVISIONAL PERIOD

18.9.1 Each Provisional member who has completed his/her proctoring will be evaluated after at least twelve months from his/her initial appointment to determine satisfactory completion of his/her provisional period. The appropriate Department Chair shall prepare a recommendation for advancement to Active, Courtesy or Consulting Status based upon his/her evaluation of the proctored individual's performance to include the following:

(a) The individual's current clinical competence, judgment, management of complicated cases, and operating skills and techniques as determined by review of the member's proctor reports.

(b) Volume of patient activity.

(c) Participation in Medical Staff activities.

18.9.2 The Department Chair's recommendation will then be forwarded to the Credentials Committee, the Medical Executive Committee and the Board of Directors.

18.9.3 The member will be promptly notified of this recommendation.

19. REAPPOINTMENT POINT SYSTEM

Mandatory Requirements:

There must be a record of CHOC patient activity for all individuals requesting renewal of clinical privileges with the exception of the full time Pathologists*. This activity could be in the form of patient contacts, i.e., inpatients, clinic, ER, outpatient surgery or consultations, H&P for pre-admission patients; or any procedure. (Exceptions for rare situations will be made by the MEC). Patient referrals will count as activity for the Community Active category. Members with no clinical or referral activity may be placed in the Affiliate Staff Category.

A. Requirements for Staff Category:

Staff Category	Number of patients per two-year reappointment period	Number of points required
Active	Minimum of two	4 or more
Courtesy	Minimum of two	Up to 4
Consulting	Minimum of two	n/a
Community Active (General Pediatricians and Family Practitioners only)	At least two referrals per year. If privileged, no more than two admits per year	n/a
Affiliate	n/a	n/a

B. Point System

Type	Number of points
1. Patients	One point per 10 patients
2. Teaching CHOC Residents – including teaching in clinics, wards, lectures	Two points per year
3. Committee/Department Meeting Attendance - 50% attendance/year	One point per meeting per year, maximum two points per year
4. CHOC-based educational conferences	One point per six meetings/CME credits per year, maximum two points per year
5. ER Call – at least 2 times per year	Two points per year
6. Past completed service of 20 years with 10 years as Active status	Two points per year

* All Full Time Pathologists will be eligible for Active Status.

20. REAPPOINTMENT POLICY FOR INACTIVE COURTESY/CONSULTING MEMBERS

All reappointment applicants for clinical privileges at Children's Hospital of Orange County (CHOC) who are inactive at CHOC are required to submit at least 5 recent pediatric case summaries (within past two years) with their reappointment application for privileges. These case summaries must include a variety of cases and must be applicable to the privileges requested at CHOC. The cases must have been performed at another Joint Commission accredited Hospital.

Additional summaries may be required if those submitted are inadequate or not representative of the privileges requested. The summaries will remain as a permanent part of each applicant's credentials file at CHOC. This documentation will be reviewed by the Department Chair as part of the quality improvement assessment for reappointment.

PROCEDURE:

1. Physicians and podiatrists are required to submit summaries of recent cases as outlined below:

   Family Practice - History and Physical and Discharge Summary

   General Surgery & Surgery Subspecialists - History and Physical, Operative Report and Discharge Summary

Gynecology - History and Physical, Operative Report and Discharge Summary

Internal Medicine Subspecialists - History and Physical and Discharge Summary or Consultation Report

Pediatrics - History and Physical and Discharge Summary

Psychiatry - Discharge Summary or Extensive Consultative Report

2. Dentists are required to submit summaries of recent Hospital cases, or office cases using the form approved by the Dental Section.

3. Psychologists are required to submit at least five pediatric case summaries representative of the privileges requested.

This process will be allowed for one reappointment period only. If there is no CHOC activity at the following reappointment time, the member will be dropped or may become an Affiliate Staff member.

21. RELEASE OF INFORMATION

To insure confidentiality for the patient, copies of the Hospital record, or information therein, should only be released to outside agencies, physicians and patient/legal guardians in accordance with Federal and State laws and Hospital policies.

In police investigative cases, the conditions specified in the "Press Code of the California Hospital Association" shall control the provision of the information.

Information may be released to social and welfare agencies only when (1) a specific request is made; and (2) when the request is specifically authorized as being within the powers of the agency, as documented at the time of request; and (3) when the use of the information is in the beneficial interest of the patient.

Information may be provided to the news media and to the public for publicity purposes, only (1) with the approval of the Public Relations Department of the Hospital; and (2) with the approval of the Hospital Chief Executive Officer; and (3) with the approval of the Attending Physician; and, (4) with the written consent of the patient/legal guardian.

When the media requests photographing or filming a patient in the Hospital, such permission will be given only:

(a) If, in the opinion of the Attending Physician, the patient's condition will not be jeopardized, and

(b) If the patient (or in the case of a minor, or incompetent, the parents, legal guardian or other person empowered to provide such consent) consents in writing, and, in addition,

(c) If circumstances exist where it would be necessary to install or use equipment which could interfere with the operation of the Hospital or the service to patients, consent must be obtained from the Chief Executive Officer of the Hospital before using such equipment.

(d) Release of information involving medical techniques or practices should be approved by the physician who performs the service, and also by the Hospital CEO. Information shall not be patient-specific without the written consent of the patient.

22. RESEARCH

Practitioners who desire to conduct research should be encouraged to conduct reasonable research projects utilizing patient records and other data sources. The practitioners should be given, whenever possible, access to all appropriate equipment and resources necessary for the research project.

All research undertaken by Medical Staff Members or others involving Hospital patients must be approved by the Institutional Review Board (CHOC IRB). All research must be conducted in accordance with the Rules and policies governing research, approved by the Institutional Review Board and Medical Executive Committee.

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

Review of medical charts for research purposes will be approved by the Vice-President of Medical Affairs/CMO. No charts used in this review will be taken from the Medical Records Department. No staff members shall allow any other person access to these records unless specifically approved by the Vice-President of Medical Affairs/CMO or the Medical Executive Committee.

23. SPECIALTY AND SUBSPECIALTY REFERRALS

Patients whose Attending Physician has not designated a specific member of the Medical Staff or group to provide a service shall be seen by an on-call physician listed on a schedule maintained by the Medical Staff. This shall pertain to both inpatient and outpatient services, including those involving residents, and emergency room visits.

Each section, whose members have agreed to provide on-call service, will have an on-call list containing those members. This list shall provide each participating physician with an equal opportunity to furnish services.

Attending physicians have the right to request a specific physician or physician group to perform services. If a specific physician or group is specified, that physician or group will be contacted to provide the service.

24. UTILIZATION REVIEW

24.1 GENERAL

24.1.1 Each Attending Practitioner must document the need for his/her patient's admission and for the continued hospitalization.

24.1.2 The documentation shall include:

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

(b) Plans for Post-Hospital care.

24.1.3 Justification for Continued Hospitalization

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

25. COMMITTEES

25.1 ADMINISTRATIVE AFFAIRS COMMITTEE (AAC)

25.1.1 Composition

The AAC shall consist of the following:

(a) Chairman, appointed by the President of the Medical Staff

(b) Four to six additional members of the active Medical Staff

(c) Vice President of Medical Affairs/CMO

(d) Chief Executive Officer or designee (ex officio) (nonvoting)

(e) President of the Medical Staff (ex officio) (nonvoting)

25.1.2 Responsibilities and Functions

The responsibilities and functions of the AAC shall be to:

(a) Conduct review and, as necessary, revision of the Medical Staff Bylaws, Rules and Regulations, and the accompanying policy manuals;

(b) Serve as an advisory task force to the Administration and MEC for matters pertaining to administrative affairs of the Medical Staff.

25.1.3 Reporting

The AAC shall report on its activities to the MEC, keep records and minutes of committee meetings, and observe all confidentiality policies.

25.1.4 Meetings

The AAC shall meet as needed.

25.2 AMBULATORY SERVICES COMMITTEE

25.2.1 Composition

The Ambulatory Services Committee shall consist of the following representatives from:

(a) Medical Staff

1. Rheumatology
2. Endocrinology
3. Hematology
4. Urology
5. Clinical 7 Biochemical Genetics
6. Pulmonology
7. Orthopedic Surgery
8. Pediatrician, Clinic Pediatricians
9. Others as may be identified

(b) Executive Director, CS Administration

(c) VP Ancillary & Support Services

(d) Quality Management

This Committee is co-chaired by a member of the Medical Staff and the Executive Director of Ambulatory Services.

25.2.2 Functions

It is the responsibility of the Ambulatory Services Committee to ensure safe, high quality, value-driven patient care is delivered in the Ambulatory Care setting with a focus on clinical quality, patient safety, performance improvement, patient satisfaction, physician satisfaction, compliance with regulatory requirements and accreditation standards, and assurance of a delivery model that is aligned with the Ambulatory and CHOC strategic plan.

25.2.3 Reporting

The findings and recommendations relating to the Ambulatory Services Committee's activities are presented to the Board of Directors through the Joint Leadership Committee.

25.2.4 Meetings

The Ambulatory Services Committee shall meet at least quarterly.

25.3 ANCILLARY AND DIAGNOSTICS COMMITTEE

25.3.1 Composition

This Committee is co-chaired by a member of the Medical Staff and the Vice President of Ancillary & Support Services

The Ancillary and Diagnostics Committee shall consist of the following representatives from:

(a) Medical Staff

1. Medical Director Metabolic Disorders,
2. Neurology
3. Hospitalist(s)
4. Radiology
5. Cardiology
6. Others as may be identified

(b) Quality Representative

(c) Orthopedic Institute Representative or designee

(d) Respiratory Therapy Director or designee

(e) Laboratory Services Director

(f) Clinical Services Director

(g) Cath Lab Director

(h) Senior Regulatory Specialist

(i) Diagnostic Services Director

(j) Imaging Services Director

25.3.2 Functions

It is the responsibility of the Ancillary and Diagnostics Services Committee to ensure safe, high quality patient care in areas of Cardiac non-invasive diagnostics, Neurodiagnostics and Sleep Lab, Laboratory, Radiology, Rehabilitation, Respiratory Therapy, and Specialty Laboratories.

The Ancillary and Diagnostics Services Committee will be responsible for the following:

1. The promotion of best practices, standards, and recommendations established by nationally recognized professional organizations;
2. Monitor key performance metrics, set goals for improvements,
3. Charter and oversee Performance Improvement (PI) Teams as needed,
4. Develop/approve policies and procedures that relate to Ancillary and Diagnostic Services

Specific Goals and Objectives: Design and implement balanced scorecard of Key Performance Indicators including goals and best practice external comparative data as available.

25.3.3 Reporting

The findings and recommendations relating to the Ancillary and Diagnostic Services Committee's activities are presented to the Board of Directors through the Joint Leadership Committee.

25.3.4 Meetings

The Ancillary and Diagnostic Services Committee shall meet at least quarterly.

25.4 EMERGENCY DEPARTMENT IMPROVING ORGANIZATIONAL PERFORMANCE (IOP) COMMITTEE

25.4.1 Composition

This Committee is co-chaired by a member of the Medical Staff and the Hospital Associate Director of the Emergency Department.

The Emergency Department (IOP) Committee shall consist of the following representatives from:

(a) Medical Staff

1. Emergency Department physicians
2. ICU – Intensivist(s)
3. Hospitalist(s)
4. Others as may be identified

(b) Quality Department Representative

(c) Medical Director Laboratory

(d) Director Laboratory Services

(e) Medical Director Imaging

(f) Director Imaging Services

(g) Medical Director Surgery

(h) Administrative Director Perioperative Services

(i) Case Workers - Clinic

(j) Executive Director Ambulatory Services

(k) CHOC Medical Foundation Director

(l) VP Patient Care Services & CNO

(m) VP Ancillary & Support Services

(n) Other Department representatives as may be required

25.4.2 Functions

It is the responsibility of the Emergency Department (IOP) Committee to provide a safe, clinically excellent experience for patients and families, accomplished by efficient resource utilization that minimizes ED length of stay and patients who leave without being seen. To engage in continuous development of, and approve policies and procedures that relate to the Emergency Department. To monitor department statistics and performance metrics and set goals for improvement in the areas of emergency department access, throughput, lab and imaging turnaround times, disposition, ED returns, arrival to evaluation and initiation of treatment, procedural sedation, pain management, patient satisfaction, and other priorities that may be identified.

25.4.3 Reporting

The findings and recommendations relating to the Emergency Department (IOP) Committee's activities are presented to the Board of Directors through the Joint Leadership Committee.

25.4.4 Meetings

The Emergency Department (IOP) Committee shall meet at least quarterly.

25.5 EVIDENCE-BASED MEDICINE COMMITTEE

25.5.1 Composition

The Evidence-Based Medicine Committee shall consist of the following representatives from:

(a) Medical Staff
Hospitalist Medicine
Critical Care Medicine
Neonatology
Specialty Care
Primary Care
Emergency Medicine
(b) Nursing
(c) Quality Management
(d) Pharmacy
(e) Respiratory Therapy
(f) Residency Leadership
(g) Clinical Information Systems
(h) Selected Ancillary Representatives

This Committee is co-chaired by a member of the Medical Staff and the Manager of Clinical Quality.

25.5.2 Functions

It is the responsibility of the Evidence-Based Medicine Committee to provide oversight for the coordination and improvement of highest quality, evidence-based care delivery at CHOC and surrounding community, and to monitor process and outcome data for targeted populations and disease conditions. This includes Critical Care Guidelines as well as other evidence-based guidelines. This responsibility spans the CHOC Children's continuum of care; Emergency Department, Inpatient, and Ambulatory Care.

25.5.3 Reporting

The findings and recommendations relating to the Evidence-Based Medicine Committee's activities are presented to the Board of Directors through the Medical Executive Committee and the Joint Leadership Committee.

25.5.4 Meetings

The Evidence-Based Medicine Committee shall meet at least quarterly.

25.6 CANCER COMMITTEE

25.6.1 Composition

The Cancer Committee includes the following:

(a) Cancer Liaison physician appointed by the committee chairperson

(b) At least one physician member from the following departments/sections: Pediatric Oncology, Radiation Oncology, Pediatric Surgery, Pediatric Neurosurgery, Pediatric Orthopedic Surgery, Pediatric Radiology, Pathology, and any other department involved in the treatment of cancer patients.

Representatives from:
(c) CHOC Administration
(d) CHOC Institutes
(e) Quality Department
(f) Rehabilitation Department
(g) Child Life
(h) Tumor Registry
(i) Pharmacy
(j) Nursing

(k) Palliative Care
(l) Pastoral Care
(m) Outpatient Services
(n) Social Services Department
(o) Psychology
(p) Blood and Marrow Transplant (BMT)
(q) Home Health
(r) Clinical Research (COG Office)
(s) Blood and Donor Services
(t) Case Management
(u) Dietary
(v) Community Member
(w) Any other department/section involved in the treatment of cancer patients.

The Cancer Committee is chaired by an appointed member of the Medical Staff and co-chaired by the Clinical Director, OICU/ONC/BMT

25.6.2 Responsibilities:

(a) Responsible and accountable for all cancer program activities at CHOC;

(b) Designates one coordinator for each of the four areas of Cancer Committee activity: cancer conference, quality control of cancer registry data, quality improvement, and community outreach. The Cancer Liaison Physician must fulfill the role of the community outreach coordinator;

(c) Develops annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care;

(d) Evaluates annual goals and objectives for clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care;

(e) Establishes the cancer conference frequency, format, and multidisciplinary attendance requirements for cancer conferences on an annual basis;

(f) Ensures that the required number of cases is discussed at cancer conference and that at least seventy-five (75) percent of the cases discussed at cancer conferences are presented prospectively;

(g) Monitors and evaluates the cancer conference frequency, multidisciplinary attendance, total case presentation, and prospective case presentation on an annual basis;

(h) Establishes and implements a plan to evaluate the quality of cancer registry data and activity on an annual basis;

(i) Completes site specific analysis that includes comparison and outcome data and disseminates the results of the analysis to the medical staff;

(j) Reviews ten (10) percent of the analytic caseload to ensure that AJCC staging is assigned by the managing physician and recorded on a staging form in the medical record on at least ninety (90) percent of eligible analytic cases;

(k) Reviews ten (10) percent of the analytic caseload to ensure that ninety (90) percent of cancer pathology reports include the scientifically validated data elements outlined in the CAP protocols.

(l) Provides a formal mechanism to educate patients about cancer-related clinical trials;

(m) Reviews the percentage of cases accrued to COG clinical trials each year;

(n) Monitors community outreach activities on an annual basis;

(o) Offers one cancer-related educational activity each year;

(p) Completes and documents the required studies that measure quality and outcomes;

(q) Implements two improvements that directly affect patient care;

(r) Establishes subcommittees or work groups as needed to fulfill cancer program goals.

25.6.3 Reporting

The Cancer Committee shall report on all of its activities to the Joint Leadership Committee.

25.6.4 Meetings

The Cancer Committee shall meet at least quarterly.

25.7 CREDENTIALS COMMITTEE

25.7.1 Composition

The Credentials Committee members shall be:

(a) Chairman (secretary-treasurer of the Medical Staff)

(b) Medical Staff Coordinator (staff)

(c) Three active Medical Staff representatives from the Department of Medicine and three active members of the Department of Surgery

(d) Other department and section representatives as invited by the chairman

(e) Vice President of Medical Affairs

(f) Representative from Risk Management

25.7.2 Responsibilities and Functions:

The responsibilities and functions of the Credentials Committee shall be to:

(a) Coordinate Medical Staff responsibilities related to the granting or modification of staff membership status and clinical privileges with the Medical Staff;

(b) Develop or coordinate, and recommend to the Executive Committee policies, procedures, protocols and forms for application, reapplication or modification of membership status for the Medical Staff;

(c) Review the recommendations of the clinical departments regarding reappointment applications for membership, department and section affiliation, clinical privileges or modifications thereof;

(d) Recommend standards for the content, organization and maintenance of individual credentials files, including arrangements for reporting and integrating quality review and other practitioner-related data;

(e) Work with the appropriate administrative component to promote the efficiency and integrity of the credentials process;

(f) Evaluate the credentials, delineation of privileges and reappraisal systems and report annually on the status thereof to the MEC and the Board of Directors;

(g) When necessary, investigate, review and report on matters including the clinical or ethical conduct of any practitioner, assigned or referred by: the President of Medical Staff, the Vice-President of Medical Affairs/CMO, or the Medical Executive Committee.

25.7.3 Reporting

The Credentials Committee shall report all of its activities to the MEC. New applications shall be referred to appropriate department for respective delineation of privileges. All confidentiality policies shall be observed.

25.7.4 Meetings

The Credentials Committee shall meet at least quarterly.

25.8 CRITICAL CARE COMMITTEE ("CCC")

25.8.1 Composition

The CCC shall consist of representatives from the following:

(a) Hospital administration

(b) Director/Coordinator of Bone Marrow Transplant Program

(c) Nursing

(d) Ambulatory Care

(e) Critical Care Unit

(f) Emergency Department

(g) Anesthesia

(h) Department of Medicine

(i) Department of Surgery

(j) Cardiology Section

(k) Pharmacy

(l) Psychology

(m) Respiratory Services

(n) Quality/Risk Management

(o) Transport Physician and Coordinators

(p) ECMO Director and Coordinator

The CCC shall be co-chaired by an appointed member of the Medical Staff and a Hospital Associate Critical Care Leader.

25.8.2 Responsibilities and Functions

It is the responsibility of the Critical Care Committee to oversee and manage the provision of patient care and services in the PICU, NICU, and the OICU. The committee develops, reviews, and implements patient care policies and procedures, reviews the systems, and processes for the oversight and review of aggregate data of critical care programs, including ECMO, Neonatal, Pediatric Transport and Blood and Bone Marrow Transplant. The committee also reviews and evaluates criteria based monitors and screens at least annually.

Additional responsibilities and functions shall be to:

(a) Formulate and periodically review operational policies and procedures required in the critical care areas, including admission appropriateness and discharge policies;

(b) Assure appropriate implementation of established operational policies and procedures;

(c) Periodically evaluate protocols for treatment modalities in each clinical area and recommend revisions as necessary;

(d) Review the results of all cardiopulmonary resuscitation results;

(e) Evaluate and recommend continuing education programs for the medical and nursing staffs;

(f) Periodically evaluate adequacy of equipment and supplies in the critical care areas and recommend alterations as necessary; and

(g) Oversight and review of all Morbidity and Mortality Conferences.

25.8.3 Reporting

The CCC shall report its findings and recommendation to the Joint Leadership Council.

25.8.4 Meetings

The CCC shall meet at least quarterly.

25.9 EDUCATION COMMITTEE

25.9.1 Composition

The Education Committee shall be comprised of:

(a) Director of Medical Education (Chairperson)

Representatives from:

(b) Library

(c) Medical Staff

(d) Nursing

(e) Quality Management

(f) Allied Health Professionals, as appropriate

(g) Vice-President of Medical Affairs/CMO

(h) Chief Executive Officer

25.9.2 Duties

The Education Committee shall organize continuing education programs and coordinate them with the Hospital-wide quality improvement program, and supervise the Hospital's professional library services. In particular, the Committee shall:

(a) Develop and plan, or participate in, programs of continuing education that are designed to keep the Medical Staff informed of significant new developments and new skills in medicine and that are responsive to quality review findings.

(b) Evaluate the effectiveness of the educational programs so developed and implemented, and annually report its effectiveness.

(c) Analyze, on a continuing basis, the Hospital's and Staff's needs for professional library services.

(d) Act upon continuing education recommendations from the Medical Executive Committee, the departments, or other committees responsible for patient care quality improvement, evaluation, and monitoring functions.

25.9.3 Meetings

The Committee shall meet at least quarterly.

25.10 ETHICS COMMITTEE

25.10.1 Composition

The Ethics Committee shall consist of the following:

(a) Co-Chairs - a Medical Staff member appointed by the President of the Medical Staff and a Hospital Associate.

(b) Members of the committee to be appointed by the chairman in concert with the President of the Medical Staff.

Medical Staff representatives from:

(c) Oncology / Hematology

(d) Neurology

(e) Surgery

(f) Medicine

(g) Emergency Medicine

(h) Psychology

Nursing representatives from the following:

(i) Pediatric Intensive Care Unit

(j) Neonatal Intensive Care Unit

(k) Medical / Surgical / Neuroscience Unit

(l) Oncology/ Hematology

Other representatives from:

(m) Administrative representatives

(n) Vice President of Medical Affairs/CMO

(o) Other members may include: attorney, ethicist, lay person, Patient and Family Centered Care representative

25.10.2 Responsibilities and Functions

The responsibilities and functions of the Ethics Committee include education, cultural diversity, policy development and case consultation:

(a) Education

(1) Provide a forum for the discussion of ethical issues relevant to the CHOC community.

(2) Provide education to members as well as associates, administration, Medical Staff and the community and to assist in the development of educational programs, consisting of conferences and medical library resources in biomedical ethics.

(3) Monitor relevant legislation, court decisions, regulations with respect to ethical implications upon medical practice here at CHOC.

(b) Policy and Guideline Development

Assist in drafting and reviewing Hospital policies and guidelines with respect to ethical issues, for further discussion and consideration by the Governing Body.

(c) Case Review/Consultation

Recommendations resulting from a committee consultation are advisory only; the consultation is intended to enhance, and in no way replace the patient-family-physician relationship. Final treatment decisions are to be made by patient/family and the responsible physician. Case reviews may be concurrent or retrospective.

(1) Review the care of a patient concurrently upon the request of the patient, family or any member of the Hospital staff associated with that patient's care when ethical issues are raised.

(2) Review cases concurrently in which there is serious and irresolvable disagreement among staff responsible for the care of a patient or conflict between patient, family and staff.

(3) Review selected cases in which the Attending Physician, patient and or parent have elected to forego treatment.

(4) Other patients' rights issues.

25.10.3 Reporting

The Ethics Committee shall report all activities and recommendations to the Joint Leadership Committee, keep records and minutes of all committee meetings and activities, and observe all confidentiality policies.

25.10.4 Meetings

The Ethics Committee will meet at least quarterly.

25.11 HEALTH INFORMATION MANAGEMENT COMMITTEE ("HIMC")

25.11.1 Composition

The Health Information Management Committee shall consist of the following:

Qquality Mmanagement, Hhealth Iinformation Mmanagement, IInformaticists and Medical Staff personnel. The committee is co-chaired by a Medical Staff member and the director of ~~Medical Records Department~~Health Information Management. The committee is co-chaired by a Medical Staff member and the director of Medical Records Department.

25.11.2 Duties

(a) Review, trend and report data concerning completeness and accuracy of the medical record. Reviews, trends, and reports data including measures addressing the presence, timeliness, readability, quality, consistency, clarity, accuracy, completeness, and authentication of data and information contained within the medical record. Inpatient and ambulatory records are reviewed and reported from multiple disciplines. (Disciplines reporting to the Health Information Management Committee include ambulatory physicians, anesthesiologists, emergency room physicians, pathologists, dentists, inpatient Medical Staff including other departments of medicine and surgery, radiologists, psychologists, nursing and other multi-disciplinary personnel as deemed necessary.)

(b) Approves policies and procedures related to medical records, including security and confidentiality

(c) Ensures effectiveness of processes to manage clinical data and information.

(d) Report medical records statistics:

(1) Medical records delinquency rate

(2) H&P delinquency rate

(3) Operative report delinquency rate

(4) Transcription turnaround time

(e) Reviews and reports from the Pediatric Health Information System (PHIS) as applicable

(f) Ensures that information in patient records supports clinical decision making

(g) Reviews and reports from the Pediatric Health Information System (PHIS) as applicable.

(h) Oversees the Information Privacy and Security Committee and Forms Committee

(i) Systematically analyses and addresses adverse trends in medical records statistics

(j) Ensures that information in patient records supports clinical decision making.

(k) Report on bedside computerized multi-disciplinary approach to medical records

(l) Report on patients with restraints as related to compliance with CHOC policies

(m) Charters and oversees performance improvement teams as needed

(n) Report on Health Information Management Department IOP projects

25.11.3 Reporting

This committee reports to the Joint Leadership Committee on a quarterly basis

25.11.4 Meetings

This committee shall meet at least quarterly.

25.12 INTERDISCIPLINARY PRACTICE COMMITTEE ("IDPC")

25.12.1 Purpose

The purpose of the IDPC shall be to review and evaluate all standardized procedures performed by Registered Nurses and other Allied Health Professional (AHP) personnel throughout the Hospital as well as to determine those individuals qualified to perform said procedures. It is also this committee's duty to re-evaluate on an ongoing basis all the above procedures and to decide if additional privileges may be granted to new members of the Nursing Staff and AHP Personnel.

25.12.2 Background

AHPs, particularly those in Nursing, are assuming more responsibilities in the areas of patient care in hospitals. Part of this trend is expressed in the State of California Business and Professional Code, Section 2725. In response to the law and these trends, the IDPC was formed to develop collaborative efforts between Medicine and Nursing to develop standardized procedures and qualifications of AHP.

25.12.3 Composition

The IDPC shall consist of the following:

(a) Chairman

(b) Vice-President of Patient Care Services or designee

(c) Chief Executive Officer or designee

(d) Three members of the active Medical Staff as appointed by the Medical Executive Committee of the Medical Staff

(e) Three registered nurses as appointed by the Vice President of Patient Care Services

(f) Two licensed or certified health professionals other than registered nurses who perform clinical functions requiring standardized procedures by invitation according to specialty.

25.12.4 Responsibilities and Functions

The IDPC shall be responsible for:

(a) Developing recommended policies and protocols pursuant to the appropriate scope of practice including the granting of expanded privileges to registered nurses to provide for the assessment, planning and direction of the diagnostic and therapeutic care of patients.

(b) Reviewing and recommending for approval by the Medical Executive Committee any policies and protocols that are proposed to be implemented in this Hospital by responsible professional organizations in the field.

(c) Approving the credentials and making recommendations for granting and/or rescinding of such privileges.

(d) Periodically reviewing approved interdisciplinary practice programs, protocols and policies.

(e) Identifying functions and/or procedures which require the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses, and initiating the preparation of such standardized procedures.

Prior to approval of standardized procedures, consultation shall be obtained from appropriate staff in the medical and nursing specialties under review.

Standardized procedures shall:

(1) be in writing and show date(s) of approval including approval by the IDPC;

(2) specify the standardized procedure functions which registered nurses are authorized to perform and under what circumstances;

(3) state any specific requirements which are to be followed by registered nurses in performing all or part of the functions covered by the particular standardized procedure;

(4) specify any experience, training, or special education requirements for performance of the functions;

(5) establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform the function;

(6) provide for a method of maintaining a written record of those persons authorized to perform the functions;

(7) specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions, for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, the fact should be clearly stated;

(8) set forth any specialized circumstances under which the registered nurse is to communicate immediately with a patient's physician concerning the patient's condition;

(9) state any limitations on settings or departments within the facility where the standard procedure for functions may be performed;

(10) specify any special requirements for procedures relating to patient record keeping;

(11) provide for periodic review of the standardized procedure (at least every three years).

(f) the review and approval of all such standardized procedures covering practice by registered nurses and other AHPs.

(g) recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee on Interdisciplinary Practice or by delegation to the Assistant Administrator/Nursing and Pharmacy.

25.12.5 Reporting Mechanism

The IDPC shall report on all recommended Standardized Procedures to the Medical Executive Committee which shall recommend final approval to the Board of Directors. The IDPC shall report on all recommended granting of privileges for AHPs and employees performing standardized procedures to the Medical Executive Committee, which recommends final approval to the Board of Directors.

25.12.6 Meetings

The committee shall meet at least annually or on-call as required by the chairman.

25.13 JOINT LEADERSHIP COMMITTEE ("JLC")

25.13.1 Composition

Multidisciplinary membership includes:

(a) Co-chair, President-Elect of the Medical Staff
(b) Co-Chair, Chief Operating Officer
(c) President of the Medical Staff
(d) Vice President of Medical Affairs and Chief Medical Officer
(e) Physician Co-chairs of each Performance Improvement (IOP) Committees
(f) Vice President, Patient Care Services
(g) Chief Financial Officer, or VP Finance Hospital Operations, as alternate
(h) Chairperson of the Department of Surgery
(i) Chairperson of the Department of Medicine
(j) Emergency Department Medical Director
(k) Chief Strategy Officer
(l) Secretary / Treasurer of the Medical Staff
(m) Chief Quality and Patient Safety Officer
(n) Pediatrician-in-chief (ex-officio)
(o) Surgeon-in-chief (ex-officio)
(p) Vice President of Ancillary

Ad hoc / non-voting members:

(q) CHOC Institutes Directors
(r) Hospital President and Chief Executive Officer

25.13.2 Functions

(a) Prioritizes performance improvement activities based on mission, vision, and strategies of the organization.

(b) Receives results of performance improvement from IOP coordinating committees and Institutes. Reports key elements, findings and analysis to the Medical Executive Committee. Uses this information to direct activities.

(c) Review significant findings in aggregate data from IOP Coordinating Committees

(d) Prevents duplication and recommends resources and technology to accomplish the performance improvement function.

(e) Selects at least one high-risk/error-prone process annually for performance improvement using Failure Mode and Criticality Analysis and FOCUS-PDCA methodology..

(f) Identifies cross-functional patterns or trends.

(g) Reviews Performance Improvement plan on at least an annual basis..

(h) CHOC Institutes report once a year, or on an as needed basis.

25.13.3 Reporting

The Joint Leadership Committee reports to the Medical Executive Committee. Identified peer review issues are reported directly to Medical Staff Department Chairs or administrative department managers/directors as appropriate.

25.13.4 Meetings

The committee meets at least quarterly.

25.14 MEDICAL STAFF PERFORMANCE COMMITTEE (MSPC)

25.14.1 Goals

To establish a centralized committee for improving physician performance on an individual and aggregate level to accomplish the following:

1. Improve patient outcomes by pursing and maintaining excellence in practitioner performance.
2. Create a culture with a positive approach to practitioner peer review
3. Promote efficient use of practitioner and quality resources.
4. Provide accurately and timely performance data for practitioner feedback and reappointment (ongoing professional practice evaluation (OPPE)).
5. Support medical staff educational goals to improve patient care.
6. Provide a link with the hospital performance improvement structure to assure responsiveness to system improvement opportunities identified by the Medical Staff.

25.14.2 Scope

The Medical Staff Performance Committee (MSPC) will be responsible for evaluating and improving physician performance in the following areas:

- Technical Quality: Skill and judgment related to effectiveness and appropriateness in performing the clinical privileges granted
- Service Quality: Ability to meet the customer service needs of patients and other caregivers
- Patient Safety/Patient Rights: Cooperation with patient safety and rights, rules and procedures
- Resource Use: Effective and efficient use of hospital clinical resources
- Relations: Interpersonal interactions with colleagues, hospital staff and patients.
- Citizenship: Participation and cooperation with medical staff responsibilities.

Responsibilities

Evaluation of Individual Cases

- Review of cases referred by the Trauma Committee
- Initial review of all cases of sufficient complexity of management or seriousness of outcome requiring physician peer review based on cases identified by Review indicators, ongoing departmental audits or through referrals to the Quality Management staff.
- Obtain reviews and recommendations from specialists on the medical staff or from external specialists when required.
- Communicate with the physician involved with the case to obtain input prior to making determinations when opportunities for improvement may exist.
- Make determinations regarding individual or Hospital PI opportunities for improvement based on individual case review.
- Circumstances that may require external peer review include, but are not limited to:
    - Need for specialty review when there are no medical staff members of the institution with the identified specialty within the organization.
    - The peer review committee cannot make a determination and requests external review.
    - The individual whose case is under review requests external peer review. The individual will be responsible for costs incurred for the external peer review. The reviewer will be selected

by, and report to, the Medical Staff Performance Committee, with a copy provided to the individual whose case is under review.

- The Medical Staff Performance Committee and/or the Medical Executive Committee request an external review.
- When dealing with the potential for litigation.
- When dealing with ambiguous or conflicting recommendations from internal reviewers or medical staff committees or when there does not appear to be a strong consensus for a particular recommendation.
- When a medical staff member requests permission to utilize new technology or perform a procedure new to this organization and the medical staff does not have the necessary subject matter expertise to adequately evaluate the quality of care involved.
- When the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file or for assistance in developing a benchmark for quality monitoring.

Peer Review activity time frames (external review):

- Cases undergoing external peer review are to be reviewed within one month of referral.
- The Medical Staff Performance Committee will develop a roster of individuals / company(ies) that may be utilized in external peer review.
- The Chief Quality and Patient Safety Officer will be responsible for contacting the external peer reviewer. A report will be made at the next meeting of the Medical Staff.
- In those instances where peer review falls out of the required time frames, the reasons for the delay will be documented in the committee minutes of the Medical Staff Performance Committee. All efforts will be made to complete the peer review process as soon as practicable within the confines of the delay.

Peer Review activity time frames (internal review):

- Cases undergoing internal peer review are to be reviewed within one month of referral.
- Communication with the practitioner(s) involved with the case will be conducted by formal letter sent via US mail to the involved practitioner(s) and by an email notifying the practitioner(s) that a letter is being sent. The language in the email will be as follows:

  Dear Dr. xx: This email is being sent to alert you that a case in which you were involved was reviewed by the CHOC Medical Staff Performance Committee. The letter cannot be attached to this email in order to maintain confidentiality and 1157 protection. In addition, the Medical Staff Performance Committee is requesting a response by (month/day/year). If you do not receive your letter by (month/day/year), please email me.

  Thank you for your attention to this matter.

  Signed: XXXX, CPMSM, Director of Medical Staff Services

- In those instances where peer review falls out of the required time frames, the reasons for the delay will be documented in the committee minutes of the Medical Staff Performance Committee. All efforts will be made to complete the peer review process as soon as practicable within the confines of the delay.

Evaluation of Rate and Rule Indicators

- Perform regular review of adverse outliers from aggregated results of Rule indicators and of adverse patterns, trends and outlier status for Rate indicators relevant to all dimensions of physician performance within the scope of the committee. The purpose of this review is to determine if additional analysis or focus studies are needed. This function may be delegated to an individual member of the committee or to a subcommittee.
- Identify individual or Hospital PI opportunities for improvement and determine if additional analysis or focus studies are needed.

Oversight of Other Medical Staff Physician Performance Evaluation Committees

Although the vast majority of initial review of individual cases, along with rule and rate indicator results, will be performed by the MSPC, some medical staff departments or committees will continue to perform some of these functions either as a quality control mechanism or as a multi-disciplinary educational process. The department or the group will refer to the quality office any case meeting medical staff review indicator criteria for initiation of the case review process by the MSPC. The following areas will perform this function as described below:

- Image Based Specialties (Pathology, Radiology, Cardiac Images): Image Based Specialties will perform routine quality review of diagnostic image interpretation by physicians (e.g. surgical pathology or cytology slides, radiologic images). Cases with misinterpretations or missed findings resulting in significant change in treatment, or significant adverse outcomes potentially related to physician care, as defined by Review indicators, will be referred to the quality office to initiate the MSPC peer review process.
- Emergency Department: The Emergency Department may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education. For those indicators determined by the MEC as reportable to the medical staff, the department will report the results to the MSPC. Cases resulting in significant adverse outcomes potentially related to physician care, as defined by Review indicators, will be referred to the quality office to initiate the MSPC peer review process.
- Anesthesia Department: The Anesthesia Department may perform review of specific processes and outcomes as appropriate for departmental performance improvement and education. For those indicators determined by the MEC as reportable to the medical staff, the department will report the results to the MSPC. Cases resulting in significant adverse outcomes potentially related to physician care, as defined by Review indicators, will be referred to the quality office to initiate the MSPC peer review process.

Improvement Opportunities

The role of the MSPC is to assure when opportunities for improvement are identified, the appropriate individuals are notified of the issues and a reasonable improvement plan is developed. This will be accomplished through the following:

- Communicate individual improvement opportunities to the appropriate department / section chair, whom, with the assistance of the MSPC Chair or designee, develops and improvement plan if necessary.
- Communicate system improvement opportunities to the appropriate hospital committee.
- Track responses with improvement plans
- Review the improvement plan on a scheduled basis
- Report to the MEC regularly regarding actions taken to improve care and any cases where action was not taken when requested or actions are perceived to be inadequate.

Measurement System Management

- Approve requests to the quality management department for additions or deletions to indicators, criteria or focused studies for evaluating physician performance.
- At least annually review the indicators, screening tools and referral systems for effectiveness in collaboration with the medical staff department chairs and recommend changes to the MEC.
- In coordination with Medical Staff Departments, define the appropriate content and format for physician performance feedback reports.
- No changes can be made to the charter and policies without approval of the MEC.

Membership

The MSPC will be comprised of eleven (11) members with a balanced representation of the main specialties areas of the hospital. The representation shall be comprised of three (3) members from the three hospital based departments, Radiology, Emergency Medicine and Anesthesia, four (4) members from the Medicine Department

including one each from ambulatory, Hospitalist, intensive care and sub-specialty, and four (4) members from surgery including one (1 general surgery and three (3) from the surgical specialties. The President of the Medical Staff, the President Elect and the Secretary/Treasurer, the Chief Medical Officer, the Medical Director of Quality and Patient Safety, the Surgeon-in-Chief and the Pediatrician-in-Chief, and representatives from the Quality Department, are ex-officio members without vote. Physicians and Residents may be invited to the meeting as needed.

The Committee members will be appointed by the Chief of Staff based on the recommendations from the Committee Chair and approved by the MEC. Representative members will serve for a three year term except for initial committee members. The initial committee will have staggered terms with a third of the members assigned initial terms of one year, a third assigned initial term of two years and a third assigned initial term of three years. Members may serve up to two consecutive terms and are eligible for reappointment to the committee after one year.

The Chair of the MSPC will be the Past President of the Medical Staff. In case the Past President cannot serve, the Chair of the MSPC will be appointed by the President of the Medical Staff, and approved by the MEC for a term of one year. To be eligible for appointment as Chair, the members must have served on the committee at some point in time for at least one year, except for the first Chair of the Committee. The Chair, if not serving in the position of past President of the Medical Staff, will be a non-voting member of the MEC.

The Vice Chair of the MSPC will be appointed by the President of the Medical Staff, and approved by the MEC for a term of two years. To be eligible for appointment as Vice Chair, the member must have served on the committee for at least one year, and have a strong understanding of the peer review process as conducted at this hospital.

Committee members will be expected to attend at least two thirds of the committee meetings over a twelve month period to maintain membership. Committee members will be expected to participate in appropriate education programs provided by the Hospital or Medical Staff to increase their knowledge and skills in performing the Committee's responsibilities.

Case Review Assignments: cases will be assigned to an individual physician member who will be expected to review the case prior to the next scheduled meeting and to present the case at the next scheduled meeting. In those instances where peer review falls out of the required time frames (medical record incomplete, practitioner under review is not available, reviewing committee rescheduled, etc.) the reasons for the delay will be documented in the minutes of the reviewing medical staff committee. All efforts will be made to complete the peer review process as soon as practical within the confines of the delay.

Each member, in turn and at least annually, will be responsible for review of the Ongoing Professional Practice Evaluation Report (OPPE) prior to the scheduled meeting. An assignment schedule will be developed by the Medial Staff Services Department or Quality Department.

Meetings

The MSPC shall meet at least quarterly per year and, as needed on an ad hoc basis. A quorum for purposes of making case determinations will be based on the presence of 50% of the voting members at a regularly scheduled meeting. A majority will consist of a majority of voting members present.

Reporting

The MSPC reports to the Medical Executive Committee. Identified peer review issues are reported directly to Medical Staff Department Chairs or administrative department managers/directors as appropriate.

25.15 MEDICAL STAFF PHYSICIAN WELL BEING COMMITTEE

The Medical Staff of CHOC Children's is committed to supporting the well-being and health of the members of the Medical Staff. In doing so, it seeks to also protect patient welfare, improve patient care and improve the effective functioning of the Medical Staff. The Health and Well-Being program provides education about practitioner health, addressing prevention of physical, psychiatric, or emotional illness, and facilitates confidential diagnosis, treatment, and rehabilitation of practitioners who suffer from a potentially impairing condition.

The Medical Staff Physician Well-Being Committee is a standing peer review committee of the Medical Staff, in accordance with the Business and Professions Code, Section 805, and as such, is afforded the same protections of confidentiality for its records in accordance with Evidence Code Section 1157. The Committee is advisory to the Medical Executive Committee (MEC) and other such appropriate departments or committees as the MEC shall designate. The Medical Staff Physician Well-Being Committee is not a substitute for a personal physician or a disciplinary body.

25.15.1 Composition; Term

The Well Being Committee shall be composed of five to nine (5-9) individuals who are members in good standing of the CHOC Medical Staff and have indicated an interest and willingness to serve in this capacity. Individuals will be appointed by the President of the Medical Staff and approved by the Medical Executive Committee. The individual should not be a member in any peer review committee, including but not limited to the Medical Staff Performance Committee, Credentials Committee, Medical Executive Committee or CHOC Board of Directors. The term of appointment shall be three years in staggered terms. There are no limitations as to how many terms any individual member may be appointed.

The Chairman of the Well Being Committee shall be appointed by the President of the Medical Staff and approved by the Medical Executive Committee. Except for the first Chair, the Chairman shall have served at least one year on the Well Being Committee prior to appointment. The term of the Chairmanship shall be three years. There are no limits to the number of successive terms that a particular Chair may serve.

25.15.2 Duties

The duties of the Medical Staff Physician Well Being Committee shall include, but not be limited to the following:

(a) Development of measures, such as educational programs, to assist the Medical Staff and other hospital staff to recognize the signs and symptoms of potential or actual impairment ;
(b) Identify those individuals who are, or may be impaired, together with a recommendation or requirement for diagnosis, treatment, and/or rehabilitation;
(c) Mechanism for self-referral by a practitioner or referral by other staff;
(d) Referral of the affected practitioner to the appropriate professional internal or external resource(s) for diagnosis and treatment of the condition;
(e) Maintain confidentiality of the provider seeking referral or referred for assistance, except as limited by law, ethical obligation, or when patient safety is threatened;
(f) Monitoring of the affected practitioner and the safety of patients until the rehabilitation or, if applicable, any disciplinary process is completed;
(g) Reports to the Medical Executive Committee (MEC) instances in which a practitioner is providing unsafe treatment.

The committee is an advisory body, and its activities are confidential, concerned primarily with the needs of the physician in question. The committee shall not actively seek out instances of impairment, nor shall it provide treatment or supervision of clinical practice. Members of the

committee shall not participate in any corrective action against any physician being assisted by the committee.

In the event that information received by the committee demonstrates a reasonable likelihood that the health or known impairment of the physician poses an unreasonable risk of harm to patients, that information shall be referred to the President of the Medical Staff for corrective action.

When a monitoring plan has been developed and a monitor assigned to a practitioner, the monitor shall report to the committee periodically on the physician's compliance with the plan.

25.15.3 Meetings

The Medical Staff Physician Well Being Committee will be at least quarterly and as often as is necessary to conduct committee business (DHS Title 22, Section 70703(d). The members are expected to attend at least two-thirds of all meetings. The members will also be expected to participate in ongoing educational activities relative to the committee scope of responsibility.

25.15.4 Reporting; Evaluation

The Medical Staff Physician Well Being Committee shall report to the MEC no less than quarterly on activities that may involve issues regarding CHOC Medical Staff members.

25.15.5 Records and Confidentiality

All records of the Medical Staff Physician Well Being Committee shall be maintained confidentially. Any records regarding any specific physician shall be maintained separately from the general records of the committee.

25.16 MEDICATION AND NUTRITION COMMITTEE

25.16.1 Composition

The Medication and Nutrition Committee shall consist of the following:

(a) Four to five members of the active Medical Staff representing major clinical areas to include a representative from the Department of Medicine, the Department of Surgery, the Sections of Cardiology, Critical Care, Infectious Disease and Hematology/Oncology.

Representatives from:
(b) Nursing Department
(c) Pharmacy Department
(d) Vice-President of Medical Affairs/CMO
(e) Medical Staff
(f) Nutrition Department
(g) Quality Management Department
(h) Administration

The Committee shall be co-chaired by an appointed member of the Medical Staff and the Executive Director of Pharmacy Services.

25.16.2 Responsibilities and Functions

The responsibilities and functions of the Medication/Nutrition Committee shall be to:
(a) Oversee the continuous monitoring of the drug and nutrition ordering practices of the Medical Staff.
(b) The development of systems and criteria to be used in the ongoing assessment and improvement of Medical Staff activities in the following areas:
(c) Drug usage evaluation
(d) Establish and maintain standards of drug use practice

(e) Use educational measures and activities to secure a higher level of understanding and to improve drug usage practices by physicians and non-physician practitioners who are directly involved in the preparation and administration of medication.
(f) Recommend and advise Hospital employees and Medical Staff about drug use and cost containment when possible and without compromise to the patient.
(g) Review issues and monitoring results forwarded from the Nutrition Department.
(h) Approve policies and procedures related to nutrition and medication safety throughout the organization
(i) Oversee Medication Safety Subcommittee
(j) Coordinates screening of high risk nutritional interventions

25.16.3 Reporting

The Medication/Nutrition Committee shall report on its activities to the Joint Leadership Committee. It shall keep records and minutes of all committee meetings and activities and observe all confidentiality policies.

25.16.4 Meetings

The Medication/Nutrition Committee shall meet at least quarterly.

25.17 MEDICAL /SURGICAL COMMITTEE

25.17.1 Composition

The Medical / Surgical Committee shall consist of the following:

(a) Co-Chairs – A Medical Staff member and a Hospital Associate who is the Director of Clinical Services, Medical/Surgical/Neuroscience Unit

(b) Physician Representatives:
- Pediatric Surgery
- Gastroenterology
- Community Pediatrician
- Infectious Disease
- Neurology
- Pulmonary
- Hospitalist(s)
- Hospitalist
- Assistant Medical Director, SCAN Team

(c) Chief Resident(s)
(d) Administrative Director, Perioperative Services
(e) Executive Director, Acute Care
(f) Pain Management Nurse Practitioner
(g) Family Advisor Council (FAC) member
(h) Clinical Manager, Infection Prevention
(i) Diagnostic Services Manager
(j) Director, Respiratory Services
(k) Director, Laboratory Services
(l) Director, Emergency Department
(m) Director, Pharmacy
(n) Clinical Nurse Specialist, Med/Surg/Neuroscience
(o) Executive Director, Patient Access and Throughput
(p) Quality Representative

25.17.2 Responsibilities and Functions:

The responsibilities and functions of the Medical / Surgical Committee shall be to:

(a) Ensure safe, high quality patient care in the inpatient Medical/Surgical Units.

(b) Develop/approve policies and procedures that relate to the Medical/Surgical.
(c) Promotes best practices, standards, and recommendations established by nationally recognized professional organizations
(d) Oversees and receives reports from the Suspected Child Abuse and Neglect Committee (SCAN)
(e) Monitors performance metrics and set goals for improvement in the areas of quality, patient safety, patient flow, infection prevention, rapid response team outcomes, patient satisfaction, and other priorities as identified by the committee
(f) Charters and oversees PI teams as needed
(g) Specific Goals and Objectives: To implement and maintain evidence-based best practices, safety initiatives, and quality care in the Medical/Surgical Department.

25.17.3 Reporting

The Medical / Surgical Committee shall report on its activities to the Joint Leadership Committee. It shall keep records and minutes of all committee meetings and activities and observe all confidentiality policies.

25.17.4 Meetings

The Medical / Surgical Committee shall meet at least quarterly.

25.18 NOMINATING COMMITTEE

25.18.1 Composition

The Nominating Committee shall consist of the following:

(a) Past President of Staff, Chairman
(b) Two active staff members elected by the Medical Executive Committee
(c) Two active staff members appointed by the President of Staff

There will be no substitutions in membership.

25.18.2 Responsibilities and Functions

The responsibilities and functions of the Nominating Committee shall be to:

(a) Choose candidates for President-Elect
(b) Choose candidates for Secretary/Treasurer
(c) Choose candidates for three members at large of the Medical Executive Committee
(d) Chose candidates for one Community Active member at large of the Medical Executive Committee.

The Nominating Committee shall nominate one or more nominees for each office.

The nominations of the committee shall be reported to the Medical Executive Committee at least ninety (90) days prior to the end of the year.

The Nominating Committee shall ensure the candidates meet the qualifications described in these bylaws.

The chairman shall receive any nominations from the membership at large.

25.18.3 Candidate Criteria:

The Nominating Committee will ensure that the membership of the MEC is both exemplary and diverse. As the elected leadership of the Medical Staff, the members of the MEC should exemplify the values of leadership, collegiality, commitment to excellent patient care, and respectful treatment of all members of the hospital community.

The Nominating Committee shall have access to the credentials file of all nominees for any position and shall give great weight to all findings related to ethics and citizenship.

The Nominating Committee shall consider the views of other members of the Medical Staff in selecting and recommending potential nominees.

The Nominating Committee shall review records of prior involvement in Medical Staff activities, including but not limited to, Medical Staff committee meeting attendance. This shall serve as one measure of commitment to responsibility. Other measures to be considered include but are not limited to the following:

- Active Staff membership for at least three (3) years;
- Leadership experience and activities;
- Collegiality;
- Commitment to excellent patient care;
- Integrity; and
- Ethics

Given the diversity of practice on the Medical Staff, the Nominating Committee shall strive to ensure diversity of specialty and practice model among the nominees for Medical Staff Officers and Members at Large. To the fullest extent possible, the Nominating Committee shall strive to present qualified nominees to ensure that the composition of the officers and members of the MEC should inspire confidence in the voting membership that all members of the Medical Staff will be adequately represented.

25.18.4 Reporting

The Nominating Committee shall report to the Medical Executive Committee.

25.18.5 Meetings

The Nominating Committee shall meet every other year for elections in accordance with Section 8.2-3 or as called by the Medical Executive Committee.

25.18.6 Quorum

The quorum requirement for the Nominating Committee is five (5) members of the Committee who are entitled to vote on committee matters.

25.19 OR COMMITTEE

25.19.1 Composition:

The committee shall be co-chaired by an appointed member of the Medical Staff who shall be from either the Department of Surgery or the Department of Anesthesia and the Administrative Director of Perioperative Services. Membership of the committee shall include representatives from the following:

(a) Department of Surgery Chair

(b) Department of Anesthesia Chair

(c) Department of Surgery Section Chairs (or designee(s)

(d) Department of Medicine Gastroenterology Section Chair (or designee)

(e) Department of Medicine Pulmonary Section Chair (or designee)

(f) Surgeon-in-Chief

(g) Medical Director of Perioperative Services

(h) Medical Director of Anesthesia Services

(i) VP Patient Care Services/Chief Nursing Officer

(j) Surgical Services Management Team representatives

(k) Director of Cardiac Catheterization Lab

(l) Quality Department Representative

(m) Risk Management Representative

Ex-officio members without vote include:

(n) President of the Medical Staff

(o) Vice President of Medical Affairs / Chief Medical Officer

25.19.2 Responsibilities and Functions

The OR Committee is responsible and accountable for the following:

(a) Development of policies, procedures, rules and regulations

(b) Block time assignments

(c) Resolution of physician issues in the use of surgical and procedural areas

(d) Recommendations for Surgical Services and Anesthesia capital budget

(e) Sets the standard of practice in hospital sterilized goods and instrumentation, post-anesthesia recovery of patients, surgical standards of practice, anesthesia standards of practice and aseptic technique for the organization

(f) Facilitate value analysis and product standardization with cost savings targets

(g) Works with the Infection Prevention Committee to ensure that the perioperative services' policies are in accordance with acceptable standards of medical practice and surgical patient care and that the Surgical Services/Anesthesia services are integrated into the hospital-wide Quality Assessment Performance Improvement Program.

25.19.3 Reporting

OR Committee reports to the Joint Leadership Committee

25.19.4 Meetings

The committee meets at least quarterly.

25.20 PATIENT SAFETY COMMITTEE ("PSC")

25.20.1 Composition

The PSC shall consist of the following:

(a) Medical Director of Quality and Patient Safety, Co-Chair
(b) Risk Manager, Co-Chair
(c) Vice President Medical Affairs and Chief Medical Officer
(d) Vice President of Patient Care Services and Chief Nursing Officer
(e) Executive Director of Quality
(f) Director of Regulatory Affairs & Clinical Quality
(g) Executive Director of Pharmacy, or designee
(h) Administrative Director for Respiratory Therapy & Pulmonary Function Lab, or designee
(i) Hospital representatives

(j) Community physicians
(k) Resident Program representative
(l) Inpatient Nursing representative(s)
(m) Outpatient Nursing representative(s)
(n) Parent/Community member

25.20.2 Functions

(a) Provides oversight for National Patient Safety Goal Compliance
(b) Commissions annual FMEA selection and ensures appropriate follow up.
(c) Provides oversight, reviews, evaluates, and acts upon opportunities identified through external patient safety drivers.
(d) Provides oversight for Safety, Emergency Management and Infection Control Committees.
(e) Prioritizes and provides oversight for patient safety policies and procedures.
(f) Reviews and makes recommendations for patient safety policies and procedures.
(g) Reviews legal claim activity to support process improvement and organization-wide learning.
(h) Provides oversight for patient safety / related Performance improvement teams.

25.20.3 Reporting

The Patient Safety Committee will report to the Joint Leadership Committee

25.20.4 Meetings

The Patient Safety Committee shall meet at least quarterly and, as needed on an ad hoc basis.

25.21 SENTINEL EVENT COMMITTEE

25.21.1 Composition

The Sentinel Event Committee shall consist of the following:
(a) President of the Medical Staff, Chair
(b) President Elect of the Medical Staff
(c) Secretary-Treasurer of the Medical Staff
(d) Past President of the Medical Staff
(e) Vice President of Medical Affairs/Chief Medical Officer
(f) Executive Vice President/Chief Operating Officer
(g) Vice President Patient Care Services/Chief Nursing Officer
(h) Executive Director, Quality/Risk
(i) Risk Manager

25.21.2 Responsibilities and Functions

The responsibilities and functions of the Sentinel Event Committee shall be to:

(a) Review and approve sentinel event and near miss root cause analysis findings and action plans,

(b) Monitor implementation of action plans, fostering process improvements,

(c) Analyses adverse event aggregated, segmented data to identify trends and opportunities for process improvements,

(d) Ensures appropriate dissemination of information regarding lessons learned to support organizational learning, while maintaining patient confidentiality,

(e) Analyses CHCA CHAPS data related to adverse events that occur at other children's hospitals, and incorporated pertinent findings into proactive process improvements to reduce the risk of such events at CHOC,

(f) Approves policies and procedures related to sentinel events, near misses, and root cause analyses.

25.21.3 Reporting

The Sentinel Event Committee reports to the Medical Executive Committee.

25.21.4 Meetings

The Sentinel Event Committee shall meet at least quarterly and, as needed on an ad hoc basis.

25.22 TRAUMA COMMITTEE

25.22.1 Composition

The Trauma Committee shall consist of the following"

a) Trauma Medical Director
b) Trauma Nurse Coordinator
c) Surgical Services Director
d) Critical Care Physician(s)
e) Pediatric Surgery Physician(s)
f) Radiologist(s)
g) Anesthesiologist(s)
h) Neurosurgeon(s)
i) Orthopaedic Surgeon(s)
j) Emergency & Trauma Services Director
k) Vice President of Medical Affairs / Chief Medical Officer
l) Vice President of Patient Care Services / Chief Nursing Officer
m) Medical Director Lab / Blood Bank
n) Blood Bank Supervisor
o) Radiology Department Director
p) Trauma Registrar

25.22.2 Responsibilities and Functions

The responsibilities and functions of the Trauma Committee shall be to:

a) Evaluate care of a trauma patient from a clinical and systems perspective and perform interdisciplinary implementation of improvement strategies.
b) Key performance indicators (KPIs) will be monitored.
c) Establish objective criteria for identifying issues for review.
d) Develop a culture that promotes and fosters both system and patient care improvements that aligns with national standards of care.
e) Review performance and safety of the Trauma Program.
f) Improve patient outcomes.

25.22.3 Reporting:

The Trauma Committee reports to the Joint Leadership Committee.

25.22.4 Meetings

The Trauma Committee shall meet at least quarterly, and as needed on an ad hoc basis.

25.23 UTILIZATION MANAGEMENT COMMITTEE ("UMC")

25.23.1 Composition

The UMC shall consist of the following representatives from:

(a) Medical Staff
(b) Nursing

(c) Quality Management
(d) Case Management
(e) Selected Ancillary Representatives

This Committee is co-chaired by a member of the Medical Staff and the director of case management.

25.23.2 Functions

It is the responsibility of the Utilization Management Committee (UMC) to oversee and conduct ongoing case review, track and trend data, evaluation and improvement of the clinical necessity, appropriateness and efficiency of care and services provided at Children's Hospital of Orange County. The utilization management program and the managed care entities work closely together to identify opportunities for improvement in the appropriateness, efficiency, clinical and cost effectiveness of the care and services provided and ultimate improvement in patient outcomes.

The utilization management plan outlines the objectives, criteria and systems used in the utilization management process. The plan incorporates provisions for the integration of the committee with other committees within the IOP plan structure.

25.23.3 Reporting

The findings and recommendations relating to utilization management activities are presented to the Board of Directors through the Joint Leadership Committee. Noted patient care trends and other non-peer review related opportunities for improvement in patient outcomes and organizational performance are integrated into the Hospital's IOP plan through the Joint Leadership Committee.

25.23.4 Meetings

The UMC shall meet at least quarterly.

CHILDREN'S HOSPITAL OF ORANGE COUNTY
POLICY ON CONFIDENTIALITY OF HOSPITAL CREDENTIALS FILES, MEDICAL STAFF PERFORMANCE IMPROVEMENT PROFILES, AND RECORDS OF MEDICAL STAFF COMMITTEES AND DEPARTMENTS

I. POLICY STATEMENT:

It shall be the policy of Children's Hospital of Orange County to maintain, to the fullest extent possible permitted by law, the confidentiality of all credentials files, profiles, and all discussions and/or deliberations relating to credentialing, quality assessment, and peer review activities. Disclosure of any such records, information, and/or communications shall be permitted as described in this policy.

II. PURPOSE OF POLICY:

It is the express purpose of this policy to enhance quality patient care within the hospital by encouraging good faith credentialing, quality assessment, and peer review activities among the members of the Medical Staff and appropriate personnel of the Medical Staff Office and Quality Management Department.

III. APPLICATION

This policy shall apply to all credentialing files and records maintained by the Hospital on behalf of its Medical Staff, including, but not limited to, the credentials and peer review files of individual practitioners, the records and minutes of all Medical Staff Committees and Departments, and the records of all Medical Staff credentialing, quality assessment, and peer reviewing activities conducted under the authority of the hospital.

The policy shall also apply to any and all discussions and/or deliberations regarding credentialing, quality assessment, and peer review matters that take place in the course of Medical Staff Committee and Department meetings.

IV. MAINTAINING CREDENTIALS FILES AND MEDICAL STAFF PERFORMANCE IMPROVEMENT PROFILE:

It is the policy of the Medical Staff Organization at CHOC to maintain two files on each practitioner of the Medical Staff. The Medical Staff Office compiles practitioner specific information as a result of the initial credentialing process and the reappointment process.

The Quality Management Department maintains the Medical Staff Performance Improvement Profiles that consist of accumulated information resulting from the Medical Staff's Improvement of Organizational Performance program. This information will be utilized by the peer review process and will be considered at the time of reappointment and renewal of clinical privileges.

This accumulated information will be utilized to provide objective data with which to assist the Medical Staff leaders and the governing body in assessing and confirming the current, consistent and acceptable performance of all members of the Medical Staff.

All information contained in the practitioner's peer review files is privileged, confidential, and protected from disclosure to the fullest extent permitted by California state and federal law.

V. PROCEDURE

1. LOCATION OF CREDENTIALS FILES AND PROFILES

   Each member of the Medical Staff has a designated credentials file and profile. Each is a separate, practitioner specific file. The Credentials File is maintained in the Medical Staff Office. The Medical Staff Performance Improvement Profile is located in the Quality Management Department.

2. CONTENTS OF THE CREDENTIALS FILES

   a. The completed and verified application for medical staff membership, including information on training, experience, references, reports from the National Practitioner Data Bank, liability information, current licensure and Drug Enforcement Administration (DEA) registration and requests for clinical privileges.

   b. Documented evidence that the Medical Staff evaluated and acted upon the above provided information.

   c. Specific and current clinical privileges recommended by the Medical Staff and approved by the Board of Directors.

   d. Data pertinent to reappraisal and reappointment, including current licensure, DEA registration, continuing medical education, attendance at required meetings, staff category, proctoring information, malpractice activities, board certification and health status.

   e. Evidence that the Medical Staff critically evaluated the above information and assessed the current clinical competence for privileges requested, as well as evidence that appropriate action was taken on reappointment and renewal of privileges.

3. CONTENTS OF MEDICAL STAFF PERFORMANCE IMPROVEMENT PROFILE

   a. Patterns of care as demonstrated in findings of performance improvement activities, such as surgical case review, blood usage evaluation, utilization management, quality and behavioral assessment.

      Some specific medical staff departments such as Pathology, Radiology and Emergency Medicine will identify appropriate quality performance indicators to be utilized in their reappointment process.

   b. Aggregated data and physician specific peer review cases addressing medical outcome and standard of care.

   c. Memorandums summarizing physician specific counseling sessions and update reports as outlined in the medical staff Bylaws, Article VII, Section 7.1-1 and the medical staff policy on Reporting Mechanism for Clinical/Behavioral Performance of Medical Staff Members.

   d. This documentation could relate to practitioners-related patient care concerns or alleged improper behavior or conduct . This documentation summary shall be placed in the profile as outlined in the Medical Staff Bylaws, Article XIV, Section 14.8-1, Insertion of Adverse Information.

4. RECORDS OF MEDICAL STAFF COMMITTEES AND DEPARTMENTS

a. Minutes and related documents and reports of Medical Staff Committees and Departments shall be maintained in an orderly and accessible fashion in the Medical Staff Office, under the custody of the personnel in the Medical Staff Office.

b. Minutes and reports of committees or departments shall be maintained in an especially confidential manner when they pertain to credentialing, quality assessment, or peer review matters. Such minutes shall be protected under State Evidence Code 1157.

c. Minutes and related documentation shall not be routinely distributed to committee or department members, but shall be made available at the meetings of these committees or departments or for their review in the Medical Staff Office in accordance with the section of this policy entitled "Access". Copies of minutes distributed at meetings are not to be removed from the meetings. Items attached to the agenda packets are equally confidential and are not to be removed unless authorized by the department or committee chairperson.

VI. GENERAL ACCESS

Unless otherwise stated, an individual permitted access as defined below shall be afforded a reasonable opportunity to inspect the records requested and to make notes regarding the contents, in the presence of her/her Section or Department Chairperson, or the Medical Director (or an authorized medical staff services or quality management department designee). In no case shall an individual remove the records (or portions thereof) from the Medical Staff Office or Quality Management Department, or make copies of them, without the express written permission of the Medical Staff President and Chief Executive Officer.

1. ACCESS BY INDIVIDUALS PERFORMING OFFICIAL HOSPITAL OR MEDICAL STAFF FUNCTIONS

a. The following individuals shall be permitted access to credentials files and Medical Staff Performance Improvement Profiles to the extent described:

1. Personnel in the Medical Staff Office shall have access to all credentials files as needed to fulfill their respective responsibilities.

2. Personnel in the Quality Management Department and Medical Staff Office shall have access to all Medical Staff Performance Improvement Profiles as needed to fulfill their respective responsibilities.

3. Medical Staff Officers and the Medical Director shall have access to all credentials files and Medical Staff Performance Improvement Profiles only as needed to fulfill their respective responsibilities.

4. Members of the Medical Staff Committees shall have access to the minutes and reports of the committees on which they serve and, when necessary to fulfill their responsibilities under the Medical Staff Bylaws, to the credentials, quality assessment, and peer review files of individual practitioners.

5. Department Chairpersons shall have access to all Medical Staff records relating to the activities of their respective departments. Department Chairpersons shall also have access to the credentials, quality assessment, and peer review files of individual practitioners whose qualifications or performance they are reviewing in an official manner for credentialing or counseling.

6. Section Chairpersons may have access to the credentials file of a respective individual practitioner within the section whose qualifications or performance they are reviewing for appointment or reappointment or upon the consent of the Department Chairperson.
7. Department members shall have access to the minutes (and related documents or reports) of meetings of the department to which they are assigned.

8. Attorneys and consultants engaged by the hospital to assist a Medical Staff Committee or Department shall have access to the credentials, quality assessment, and peer review files of the practitioner being reviewed, and to any other relevant Medical Staff records which are necessary to enable such consultants to perform their duty.

9. The Director of Quality Management, Risk Manager, and Quality Management Advisor shall have access to the minutes of all regular or ad hoc Medical Staff Committee or Department meetings, and to any quality assessment or risk management information contained in credentials files.

10. The Hospital's President and Chief Executive Officer (or authorized designee) shall have access to credentials files, Medical Staff Performance Improvement profiles and such other medical staff records as are necessary for the performance of official functions.

11. Each of the above individuals shall be permitted access to the described documents/records provided that he or she has signed and dated the appropriate "Confidentiality Agreement" (attached to this Policy as Appendix A) at the time of assignment to the department or committee on which he or she serves.

2. ACCESS TO CREDENTIALS FILE BY MEMBERS OF THE MEDICAL STAFF

a. A practitioner may have copies of any documents within their own credentials file which the practitioner submitted (i.e., the initial appointment application, application for reappointment, request for privileges, or correspondence from the practitioner) or which were addressed to him/her.

b. A practitioner shall also have the right to inspect documents regarding:

1. Questions presented to the practitioner concerning quality of care matters.
2. National Practitioner Data Bank response.
3. Meeting attendance
4. Number of admissions/consultations/procedures
5. Suspensions for failure to complete medical records

c. Additional summarized information from the files may be requested as follows:

1. The practitioner provides a written request to the Credentials Committee to inspect specific items in their files providing reasons for the request.
2. A summary of the file will be prepared by the Credentials Committee and will be available for review at the assigned committee meeting.

d. The individual has the right to request correction of information contained in their credentials file and may respond to possible discrepancies according to the Bylaws Article 14, Section 14.8-4.

3. ACCESS TO MEDICAL STAFF PERFORMANCE IMPROVEMENT PROFILE BY MEMBERS OF THE MEDICAL STAFF

   a. All practitioners may have access to their Medical Staff Performance Improvement Profile prior to reappointment and during regular business hours through an appointment with the Director of Quality Management.
   b. The individual has the right to request correction of information contained in their Medical Staff Performance Improvement Profile and may respond to possible discrepancies according to the Bylaws Article 14, Section 14.8-4.

4. ACCESS BY ORGANIZATIONS OR INDIVIDUALS OUTSIDE OF THE HOSPITAL

   a. Requests from Other Hospitals:

      1. If a physician has not been the subject of any recommendation or corrective action set forth in Article 7.1-5 (d) - (g) of the Medical Staff Bylaws, then the Hospital's President and Chief Executive Officer (or designee), President of the Medical Staff, or Chairperson of the Credentials Committee/Department may release information contained in that physician's credentials file in response to a request from another health care organization or medical staff.

         Such request must be in writing and shall indicate whether the physician is a member of the requesting hospital's medical staff, exercises privileges at that hospital, or is applying for medical staff membership and privileges there, and shall further include the physician's authorization for the release of the requested information. Disclosure shall be limited to the information requested and shall be accompanied by a statement that the information is being provided with the expectation that the requesting hospital will continue to maintain appropriate confidentiality.

      2. If a physician has been the subject of any recommendation or action set forth in Article 7.1-5 (d) - (g) of the Medical Staff Bylaws, then no information shall be released upon request of another institution until the physician has provided the Hospital with a specific, signed release deemed satisfactory by Hospital legal counsel.

         All responses to such requests shall be reviewed and approved by the Hospital's President and Chief Executive Officer (or designee), after consultation with the President of the Medical Staff.

   b. Requests from Hospital Surveyors

      1. Requests for records covered by this Policy from hospital surveyors from the Joint Commission or the Department of Health Services (DHS), shall be immediately referred to the Chief Executive Officer for further disposition in accordance with applicable laws, regulations, and/or accreditation standards.
      2. Under no circumstances shall original or photocopied records be removed from Hospital premises, unless there is shown to be explicit statutory or regulatory authority to the contrary, which authority has first been reviewed by Hospital legal counsel.

   c. Requests from State Professional Boards

      Certain State laws permit the State Medical Board to request Medical Staff records concerning individual practitioners on the Medical Staff of the Hospital. Legal counsel will be solicited before the request is granted.

d. All subpoenas pertaining to Medical Staff records shall be referred to the Hospital's President and Chief Executive Officer (or designee) who may first consult with the President of the Medical Staff and legal counsel regarding the appropriate response.

e. Other Requests:
All other requests for Medical Staff records (or portions thereof) by persons or organizations outside the Hospital shall be reviewed by the Medical Director, the Chairperson of the Credentials Committee or the Hospital's President and Chief Executive Officer (or his authorized designee). The release of any information may be conditioned upon approval by the Medical Executive Committee and/or the Hospital Board of Directors.

VII. SANCTIONS

All suspected violations of this Policy shall be reported to the Medical Executive Committee. The Medical Executive Committee, or an ad hoc committee appointed by the Medical Executive Committee, shall conduct a prompt investigation and determine if there has in fact been a violation of any of the provisions of this Policy.

If it is determined that a violation has occurred, the committee shall, depending on the nature and severity of the violation (1) issue a written warning, (2) issue a written reprimand, or (3) recommend more severe disciplinary action in accordance with the Medical Staff Bylaws, which may include a recommendation to revoke the medical staff appointment and clinical privileges of the individual found to have violated the policy.

CHOC MEDICAL STAFF
PEER REVIEW POLICY

Purpose:
To ensure that the hospital, through the activities of its medical staff, assesses the performance of individual granted clinical privileges and uses the results of such assessments to improve care.

Goals:
1. Improve the quality of care provided by individual physicians;
2. Monitor the performance of practitioners who have privileges;
3. Identify opportunities for performance improvement and for patient safety; and
4. Monitor significant trends by analyzing aggregate data; and
5. Assure that the process for peer review is clearly defined, fair defensible, timely and useful.

Definitions:
Peer Review
"Peer review" is the evaluation of an individual practitioner's professional performance and includes the identification of opportunities to improve care. Peer review differs from other quality improvement processes in that it evaluates the strengths and weaknesses of an individual practitioner's performance, rather than appraising the quality of care rendered by a group of professionals or a system.

Peer review is conducted using multiple sources of information including: 1) the review of individual cases, 2) the review of aggregate data for compliance with general rules of the medical staff, and 3) clinical standards and use of rates in comparison with established benchmarks or norms.

The individual's evaluation is based on generally recognized standards of care. Through this process, practitioners receive feedback for personal improvement or confirmation of personal achievement related to the effectiveness of their professional, technical, and interpersonal skills in providing patient care.

Peer
A "peer" is an individual practicing in the same profession and who has expertise in the appropriate subject matter. The level of subject matter expertise required to provide meaningful evaluation of a practitioner's performance will determine what "practicing in the same profession" means on a case-by-case basis. For example, for quality issues related to general medical care, a physician (MD or DO) may review the care of another physician. For specialty-specific clinical issues, such as evaluating the technique of a specialized surgical procedure, a peer is an individual who is well-trained and competent I that specialty.

Peer Review Body
The peer review body designated to perform the initial review by the Medical Executive Committee or its designee will determine the degree of subject matter expertise required for a provider to be considered a peer for all peer reviews performed by or on behalf of the hospital. The initial peer review body will be the Medical Staff Performance Committee (MSPC) unless otherwise designated for specific circumstances by the MEC.

Conflict of Interest
A member of the medical staff requested to perform peer review may have a conflict of interest if they may not be able to render an unbiased opinion. An automatic conflict of interest would result if the physician is the provider under review. Relative conflicts of interest are either due to a provider's involvement in the patient's care not related to the issues under review or because of a relationship with the physician involved as a direct competitor, partner or key referral source. It is the obligation of the individual reviewer to disclose to the peer review committee the potential conflict. It is the responsibility of the peer review body is to determine on a case by case basis if a relative conflict is substantial enough to prevent the individual from participating. When either an automatic or substantial relative conflict is determined to exist, the individual may not participate or be present during peer review body discussions or decisions other than to provide specific information requested as described in the Peer Review

Process in Attachment A.

Policy:

1. All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.
2. The involved practitioner will receive provider-specific feedback on a routine basis.
3. The medical staff will use the provider-specific peer review results in making its recommendations to the hospital regarding the credentialing and privileging process and, as appropriate, in its performance improvement activities.
4. The hospital will keep provider-specific peer review and other quality information concerning a practitioner in a secure, locked file. Provider-specific peer review information consists of information related to:
   - performance data for all dimensions of performance measured for that individual physician,
   - the individual physician's role in sentinel events, significant incidents or near misses,
   - correspondence to the physician regarding commendations, comments regarding practice performance, or corrective action.

5. Only the final determinations of the MSPC and any subsequent actions are considered part of an individual provider's quality profile. Any written or electronic documents related to the review process other than the final committee decisions shall be considered working notes of the committee and shall be destroyed by policy after the committee decision has been made. Working notes include potential issues identified by hospital staff, preliminary case rating, questions and notes and the physician reviewers and requests for information from the involved physicians and any written responses to the committee.

6. Peer review information in the individual provider quality profile is available only to authorized individuals who have a legitimate need to know this information based upon their responsibilities as a medical staff leader or hospital employee. However, they shall have access to the information only to the extent necessary to carry out their assigned responsibilities. The CMO will assure that only authorized individuals have access to individual provider quality profiles and that the files are reviewed under the supervision of the Director of Medical Staff Services or designee. Only the following individuals shall have access to provider-specific peer review information and only for purposes of quality improvement:

   - The specific provider;
   - Medical staff officers;
   - Medical staff department chairs (for members of their departments only);
   - Members of the Medical Executive Committee, Credentials Committee, and Medical Staff Performance Committee;
   - Hospital Risk Manager or designee;
   - Chief Quality and Patient Safety Officer
   - Medical Staff/Quality Department professionals to the extent that access to this information is necessary for the re-credentialing process or formal corrective action;
   - Individuals surveying for accrediting bodies with appropriate jurisdiction, e.g. JCAHO or state/federal regulatory bodies; and
   - Individuals with a legitimate purpose for access as determined by the hospital board of directors.
   - The hospital CEO when information is needed to take immediate formal corrective action for purposes of summary suspension by the CEO.

7. No copies of peer review documents will be created and distributed unless authorized by medical staff policy or bylaws, the MEC, the Board or by mutual agreement between the President of the Medical Staff and the CMO for purposes of deliberations regarding corrective action on specific cases.

Circumstances requiring peer review:
Peer review is conducted on an ongoing basis and reported to the appropriate committee for review and action. The procedure for conducting peer review is described in the Process and Timelines Procedure document. Additional evaluation will be conducted when there is a sentinel event, near miss or an unusual individual case.

Circumstances requiring external peer review:
The MSPC will make recommendations on the need for external peer review to the President of the Medical Staff and the CMO. External peer review will take place under the following circumstances if deemed appropriate by the Medical Executive Committee or by the Board of Directors. No practitioner can require the hospital to obtain external peer review if it is not deemed appropriate by the MEC or Board of Directors. Circumstances requiring external peer review may include but not necessarily limited to:

- Litigation - when dealing with the potential for a lawsuit.
- Ambiguity - when dealing with vague or conflicting recommendations from internal reviewers or medical staff committees and conclusions from this review will directly impact a practitioner's membership or privileges.
- Lack of internal expertise – When no one on the medical staff has adequate expertise in the specialty under review; or when the only practitioners on the medical staff with that expertise are determined to have a conflict of interest regarding the practitioner under review as describe above. External peer review will take place if this potential for conflict of interest cannot be appropriately resolved by the medical executive committee or governing board.
- Miscellaneous issues - when the medical staff needs an expert witness for a fair hearing, for evaluation of a credential file, or for assistance in developing a benchmark for quality monitoring. In addition, the medical executive committee or governing board may require external peer review in any circumstances deemed appropriate by either of these bodies.

Participants in the review process:
Participants in the review process will be selected according to the medical staff policies and procedures. The work of all practitioners granted privileges will be reviewed through the peer review process. Clinical support staff will participate in the review process if deemed appropriate. Additional support staff will participate if such participation is included in their job responsibilities. The peer review body will consider and record the views of the person whose care is under review prior to making a final determination regarding the care provided by that individual providing that individual responds in the required timeframe.

In the event of a conflict of interest or circumstances that would suggest a biased review beyond that described above, the MSPC or the MEC will replace, appoint or determine who will participate in the process so that bias does not interfere in the decision-making process.

Thresholds for intensive review:
If the results of individual case reviews for a physician exceed thresholds established by the Medical Staff described below, the MSPC will review the findings to determine if further intensive review is needed to identify a potential pattern of care.

Thresholds:
- Any single egregious case
- Within any 12 month period of time, any one of the following criteria:
    - 2 cases rated care physician inappropriate
    - 4 cases rated either physician care controversial or inappropriate
    - 6 cases rated as having documentation issues regardless of care rating

Peer review for specific circumstances:
In the event a decision is made by the Board of Directors to investigate a practitioner's performance or circumstances warrant the evaluation of one or more providers with privileges, the medical executive committee or

its designee shall appoint a panel of appropriate medical professionals to perform the necessary peer review activities as described in the Medical Staff Bylaws

Peer Review Time Frames
Peer review will be conducted by the medical staff in a timely manner. The goal is for routine cases to be completed within 90 days from the date the chart is reviewed by the Quality Advisor and complex cases to be completed within 120 days. Exceptions may occur based on case complexity or reviewer availability.

Oversight and Reporting
Direct oversight of the peer review process is delegated by the MEC to the MSPC. The responsibilities of the MSPC related to peer review are described in the MSPC charter. The MSPC will report to the Board of Directors through the MEC at least quarterly.

Statutory Authority
This policy is based on the statutory authority of the Health Care Quality Improvement Act of 1986 42 U.S.C. 11101, et seq. and California State Law. All minutes, reports, recommendations, communications and actions made or taken pursuant to this policy are deemed to be covered by such provisions of federal and state law providing protection to peer review related activities. Documents, including minutes and case review materials, prepared in connection with this policy should be labeled with language consistent with the following:

"Statement of confidentiality"
Data, records, documents, and knowledge, including but not limited to minutes and case review materials, collected for or by individuals or committees assigned peer review functions are confidential, not public records, shall be used by the committee and committee members only in the exercise of proper functions of the committee, and are not available for court subpoena in accordance with California Business & Professions Code 1157 and California State law."

Informal Review Process

1. If the outcome of this case review results in any informal actions, monitoring, or counseling, the Bylaws state that this shall be documented in the member's profile (Article VII, Section7.1-1). The individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's profile along with the original documentation.

2. A Medical Staff leader may address these matters using other applicable policies. (Also see policy on Reporting Mechanism for Clinical/Behavioral Performance of Medical Staff Members).

Informal Investigations - Initial Review

1. Whenever a serious concern has been raised, or where the collegial efforts have not resolved an issue, regarding:

   (a) the clinical competence or clinical practice of any Medical Staff member, including the care, treatment or management of a patient or patients which may be detrimental to patient safety or to the delivery of quality patient care within the Hospital
   (b) Known or suspected violations which are contrary to the Medical Staff Bylaws or Rules and Regulations;
   (c) Behavior/conduct which is disruptive to Hospital operations, unethical; or below applicable professional standards

   the matter may be referred to the President of the Medical Staff, any other Medical Staff officer, any department chair, any Medical Staff committee, the chair, the Board of Directors, the Vice-President of Medical Affairs, or the Chief Executive Officer.

2. The person to whom the matter is referred shall make sufficient inquiry to satisfy himself or herself that the question raised is credible and/if so, shall forward it in writing to the Medical Executive Committee.

3. No action taken pursuant to this Section, shall constitute an investigation.

Investigating Committee

If the Medical Executive concludes that a formal investigation is indicated, the corrective action process defined in Article VII of the Medical Staff Bylaws is to be implemented.

Outside Review

An outside review consultant or agency may be used whenever a determination is made by the Investigating Committee and Medical Staff officers that

1. The clinical expertise needed to conduct the review is not available on the Medical Staff; or
2. The individual under review is likely to raise, or has raised, questions about the objectivity of other practitioners on the Medical Staff; or
3. The individuals with the necessary clinical expertise would not be able to conduct a review without risk of allegations of bias, even if such allegations are unfounded.

EXPECTATIONS OF PHYSICIANS GRANTED PRIVILEGES AT CHILDREN'S HOSPITAL OF ORANGE COUNTY

This document describes the expectations that physicians have of each other as members of our medical staff. The expectations described below reflect current medical staff bylaws, policies and procedures and organizational policies. This document is designed to bring together the most important issues found in those documents and key concepts reflecting our medical staff's culture and vision.

Medical staff leaders will work to improve individual and aggregate medical staff performance through non-punitive approaches and providing appropriate positive and constructive feedback that allows each physician the opportunity to grow and develop in his or her capabilities to provide outstanding patient care and valuable contributions to our hospital.

Technical Quality of Care:

1. Achieve patient outcomes that consistently meet or exceed generally accepted medical staff standards as defined by comparative data, medical literature and results of peer review activities.
2. Provide appropriate patient care by selecting the most effective and appropriate approaches to diagnosis and treatment including the use of evidence-based guidelines when available as recommended by the appropriate specialty.
3. Provide for patient comfort, including prompt and effective management of acute and chronic pain according to accepted standards in the medical literature.

Quality of Service:

1. Ensure timely and continuous care of patients, 24 hour per day, seven days per week, by clear identification of covering physicians and by appropriate and timely answering service and electronic communications availability.
2. Evaluate each patient as often as necessary but at least every twenty-four hours and document findings in the medical record at that time.
3. Participate in emergency room call coverage as determined by the departments.
4. Request consultations by providing adequate communication with the consultant including a clear reason for consultation and make direct physician-to-physician contact.
5. Respond to requests for inpatient consultations in a timely manner by performing the consult or otherwise notifying the referring physician.
6. Respond promptly to nursing requests for patient care needs.
7. Support the medical staff's efforts to enhance patient satisfaction rates for physicians.
8. Communicate effectively with other physicians and caregivers, patients and their families.
9. Provide appropriate supervision and timely communication to Residents, Fellows and Allied Health Personnel when they are involved in your clinical cases.

Patient Safety/Patient Rights

1. Participate in the hospital's efforts and policies to maintain a patient safety culture, reduce medical errors.
2. Follow nationally recognized recommendations (CDC) regarding infection control procedures and precautions when participating in patient care.
3. Maintain medical records consistent with the medical staff bylaws and rules and regulations including but not limited to chart entry legibility and timely completion of History and Physical examination reports, Operative Reports, procedure notes, appropriate abbreviations and discharge summaries.
4. Respect patient rights including discussion of unanticipated adverse outcomes with patients and/or appropriate family members and respect for patient privacy by not discussing patient care information and issues in public settings.
5. Wear appropriate and accessible (i.e. above waist) identification at all times.

6. Discuss end-of-life issues when appropriate to a patient's condition, including advance directives and patient and family support, and honor patient/family desires.

7. Effectively utilize the advanced technologies including computerized order entry and electronic medical records.

Resource Utilization:

1. Provide quality patient care that is cost effective by cooperating with efforts to appropriately manage the use of valuable patient care resources.

2. Cooperate with guidelines for appropriate hospital admission, level of care transfer, and timely discharge to outpatient management when medically appropriate.

3. Provide accurate and timely discharge orders and instructions in collaboration with other caregivers.

Peer and Co-Worker Relationships:

1. Act in a professional, respectful manner at all times to enhance a spirit of cooperation and mutual respect and trust among members of the patient care team.

2. Refrain from inappropriate behavior including but not limited to impulsive, disruptive, sexually harassing or disrespectful behavior. Refrain from documentation in the medical record that does not directly relate to the patient clinical status or plan of care and is derogatory or inflammatory.

3. Privately address disagreements in a constructive, respectful manner.

(a) Citizenship

1. Review your individual and specialty data for all dimensions of performance and utilize this data to continuously improve patient care.

2. Respond in the spirit of continuous improvement when contacted regarding concerns about patient care.

3. Respond in a timely manner when provided information on medical staff matters requesting medical staff member input. If input is not given, accept decisions made by medical staff leadership.

4. Make positive contributions to the medical staff by participating actively in medical staff functions and serving when requested.

5. Help to identify issues affecting the physical and mental health of fellow medical staff members and cooperate with programs designed to provide assistance.

CHILDREN'S HOSPITAL OF ORANGE COUNTY
REPORTING MECHANISM FOR CLINICAL/BEHAVIORAL PERFORMANCE OF MEDICAL STAFF MEMBERS

Through CHOC's Quality Improvement program, each member's activities and clinical competencies are monitored for quality of care and professional performance and tracked through an occurrence screening process (Safety Reporting System – SRS). Occurrences which pose a potential risk are reviewed by the Chair of the Medical Staff Performance Committee (MSPC) and a Senior Quality Department Designee as follows:

1. Occurrences involving rule violations, questions of medical care, patient complaints, and validated behavioral occurrences contrary to the code of conduct shall be referred by the Quality Department to the MSPC.
2. Occurrences deemed unfounded by the Chair of MSPC and Senior Quality Department Designee shall be deemed closed, and no record made in the medical staff member's profile.
3. Occurrences involving minor behavior issues (not referred to MSPC) will be placed in the member's profile. The member shall be notified that the occurrence has been placed in the file, and he or she will be given the opportunity to respond. These minor occurrences will be marked not validated or minor.
4. Repeated minor occurrences shall be grounds for counseling at the discretion of the Chief Medical Officer, Medical Staff Officer, and Department Chair.
5. Occurrences indicating a potential threat to patient safety or medical staff well-being shall be immediately acted upon as specified below.

Remedial action in addressing these concerns, for repeated minor occurrences, or for patterns identified through ongoing professional practice evaluation (OPPE) involve the following:

1. INITIAL COUNSELING: A counseling session is held with the member and the department chair, and the Chief Medical Officer. This approach is viewed as educational and remedial rather than punitive. These sessions most often achieve an indicated change in the pattern of care and instills an obligation to continuously improve the quality of care provided. Documentation of this session is then placed in the member's profile and is reflected in the Quality Improvement reports provided to the MEC and the BOD.

2. FURTHER EDUCATION: As part of this improvement process, education through formal programs, seminars, monitors, or reading material may be offered to assist the member..

3. MONITORING/EVALUATION: Ongoing monitoring of the member's progress is evidenced in the continuous occurrence screening process and OPPE.

4. OUTCOME EVALUATION: The outcome of this monitoring is assessed through the OPPE process.

5. FURTHER ACTION: If subsequent to the counseling process, it is determined that the member's activities and/or clinical competencies continue to be of concern as reported through occurrence screening, a more intense process may be initiated. This would include the establishment of an informal ad hoc committee established by the President of the Medical Staff in consultation with the Medical Executive Committee to further determine the extent and validity of the alleged problems. Limited interviews may be conducted with the department chair, and the Chief Medical Officer to facilitate this process. If it is determined that the information obtained through this inquiry process is reasonably believed to be reliable and substantiates the concerns, formal action will be initiated as per the Medical Staff Bylaws.

6. FORMAL DISCIPLINARY ACTION: As a last resort, formal action must be taken in the event the member does not show improvement in his/her clinical competence or behavior patterns. In the event that formal corrective action is recommended, this process is initiated by the Medical Executive Committee and forwarded to the BOD. Guidelines are established in the Medical Staff Bylaws which address the process for formal corrective action.

Revised 10/2010

CHOC MEDICAL STAFF
POLICY ON SUPERVISION OF RESIDENTS

PURPOSE

To define the levels of supervision required for residents in inpatient and outpatient settings. CHOC follows the institutional requirements of the Accreditation Council for Graduate Medical Education (ACGME). ACGME states that "[medical] residents must be supervised by teaching staff in such a way that the residents assume progressively increasing responsibility according to their level of education, ability and experience." This process is the underlying educational principle for all graduate medical education, regardless of specialty or discipline.

SCOPE

1. Attending physicians are responsible for the care provided to each patient, and they must be familiar with each patient for whom they are responsible. Fulfillment of that responsibility requires personal involvement with each patient and each resident who is participating in the care of the patient. Each patient must have an attending physician whose name is recorded in the patient record. It is recognized that other staff physicians may at times be delegated responsibility for the care of the patient and provision of supervision to the residents involved. It is the responsibility of the attending physician to be sure that the residents involved in the care of the patient are informed of such delegation and can readily access a staff practitioner at all times.

2. Within the scope of the training program, all residents must function under the supervision of attending physicians with appropriate clinical privileges. A responsible attending physician must be immediately available to the resident in person or by telephone or other telecommunication device as appropriate and be able to be present within a reasonable period of time.

3. Each training program is constructed to encourage and permit residents to assume increasing levels of responsibility, commensurate with their individual progress in experience, skill, knowledge, and judgment.

4. The provisions of this policy are applicable to all patient care services, including but not limited to, inpatient, outpatient, and the performance and interpretation of all diagnostic and therapeutic procedures.

5. In order to ensure the quality of patient care and to provide opportunity for maximizing the educational experience of the resident in the ambulatory setting, it is expected that an appropriately privileged physician will be available for supervision during clinic hours.

DEFINITIONS

1. **Resident**: The term ‘resident’ refers to an individual who is engaged in a graduate training program in medicine (which includes all specialties; i.e., pediatrics and surgical) and participates in patient care under the direction of medical staff physicians. The term resident includes "fellows" and “medical students” as well.

2. **Graduate Medical Education**: Graduate medical education is the process by which clinical and didactic experiences are provided to residents to enable them to acquire those skills, knowledge, and attitudes which are important in the care of patients.

3. **Attending Physician**: Attending physician refers to licensed, independent physicians and surgeons, regardless of the type of appointment, who have been credentialed and privileged at CHOC in accordance with applicable requirements. Attending physicians may provide care and supervision only for those clinical activities for which they are privileged.

4. **Supervision**: Supervision refers to the dual responsibility that an attending physician has to enhance the knowledge of the resident and to ensure the quality of care delivered to each patient by any resident. Such control is exercised by observation, consultation and direction, and includes the imparting of knowledge, skills, and attitudes by the practitioner to the resident and the assurance that the care is delivered in an appropriate, timely, and effective

manner. Supervision may be provided in a variety of ways including person-to-person contact with the resident in the presence of the patient, person-to-person contact in the absence of the patient, and through consultation via the telephone or such telecommunication devices as appropriate. If on-site supervision is not available, the staff physician must be able to be present, if needed, within a reasonable period of time.

ROLES, RESPONSIBILITIES, AND DOCUMENTATION:

Each resident is responsible for communicating to the attending physician significant issues as they relate to patient care. Such communication must be documented in the record.

The attending physician is responsible for, and must be personally involved in, the care provided to individual patients in inpatient and outpatient settings. When a resident is involved in the care of the patient, the responsible attending physician must continue to maintain a personal involvement in the care of the patient and must see the patient daily. The attending physician is expected to fulfill this responsibility, at a minimum, in the following manner:

1. The attending physician will direct the care of the patient and provide the appropriate level of supervision based on the nature of the patient's condition, the likelihood of major changes in the management plan, the complexity of care, and the experience and judgment of the resident being supervised. Medical or surgical services must be either rendered under the supervision of the attending physician or be personally furnished by the attending physician. Documentation of this supervision will be by progress notes entered into the record by the attending physician or reflected within the resident's progress note at a frequency appropriate to the patient's condition. In all cases, there shall be, at the minimum, a daily note. Where the provision of supervision is reflected within the resident's progress note, the note shall include the name of the attending physician with whom the case was discussed as well as summarize the nature of that discussion.

2. For patients admitted to an inpatient service, the attending physician must meet the patient early in the course of care (within 24 hours of admission) and personally document, in a progress note, the attending physician's findings and concurrence with the resident's initial diagnosis and treatment plan as well as any modifications or additions. The progress note must be properly signed and dated. Attending physicians are expected to be personally involved in the care of the patients assigned to them in a manner consistent with the clinical needs of the patient and the graduated level of responsibility of the resident. This must be documented by a personal note by the attending physician or be reflected in the resident's note. Attending practitioner or covering partner must respond to a hospital call from the resident within 30 minutes.

3. All outpatients in the emergency room and clinics for which the attending physician is responsible should be seen by, or discussed with, the attending physician at that initial visit. This must be documented in the chart via a progress note by the attending physician or reflected in the resident's note to include the name of the attending physician and the nature of the discussion. All notes must be signed and dated.

4. The attending physician, in consultation with the resident, will ensure that discharge or transfer of the patient from an inpatient or outpatient service is based on the specific circumstances of the patient's diagnoses and therapeutic regimen. This may include specifics on physical activity, medications, diet, functional status, and follow-up plans. Evidence of this assurance will be documented by countersignature of the discharge summary or outpatient discharge note.

5. In addition to the above, the appropriate attending physician or consultant shall review and then countersign and date the following orders and reports:

    a. Admission History and Physical Examination
    b. Consultation Reports
    c. Operative Reports (may be dictated by residents who are PGY2 or above)
    d. Discharge Summaries (as in 4 above).
    e. Digoxin orders (requires co-signature or verbal order by cardiologist prior to administration)
    f. Insulin orders (must be discussed with the attending prior to administration and this discussion is to be

documented in the medical record).

g. Chemotherapy (requires co-signature by a hematologist/oncologist or in the case of a rheumatology patient, by a rheumatologist, prior to administration.)

h. Prescriptions (if written by an unlicensed resident)

i. Restraints (in accordance with hospital policy)

6. The residents, as individuals, must be aware of their limitations and not attempt to provide clinical services or do procedures for which they are not trained. They must know the supervision requirements in this document as well as additional guidelines for supervision in the residency manual.

7. Diagnostic or therapeutic procedures require a high-level of expertise in their performance and interpretation. Although gaining experience in performing such procedures is an integral part of the education of the resident, such procedures may be performed only by residents who possess the required knowledge, skill, and judgment, and under an appropriate level of supervision by attending physicians. Examples include procedures not performed in the operating room, such as aspirations, biopsies, bronchoscopies, etc. Attending physicians will be responsible for authorizing the performance of such procedures, and such procedures should only be performed with the explicit approval of the attending physician.

   Excluded from these requirements are procedures that, although invasive by nature, are considered elements of routine and standard patient care. Examples are peripheral intravenous lines, lumbar punctures, and blood draws. Residents may perform these low risk procedures independently once they have successfully been proctored as outlined in the Resident Procedure Policy.

8. For procedures performed by surgical residents outside of the operating room, such as in the emergency department or patient care unit, either the surgeon, the emergency medicine physician, or the appropriate attending physician could supervise the procedure provided that physician has the appropriate privileges in the procedure being performed.

9. All procedures in the operating room shall be performed with an attending physician (surgeon) in the OR suite. As above, such procedures may be performed only by residents who possess the required knowledge, skill, and judgment. For these procedures, the attending physician will evaluate the patient and write a pre-procedural note describing the findings, diagnosis, plan for treatment, and/or choice of specific procedure to be performed.

   a. For those instances where the surgeon wishes to use two operating rooms, surgery cannot be started in the next room until the surgery in the previous room has been completed. The attending must be present and actively participate in the surgical pause when it is performed prior to starting the actual procedure.

GRADUATED LEVELS OF RESPONSIBILITY

As part of their training program, residents should be given progressive responsibility for the care of the patient. The determination of a resident's ability to provide care to patients without a supervisor present or act in a teaching capacity will be based on documented evaluation of the resident's clinical experience, judgment, knowledge, and technical skill. Ultimately, it is the decision of the attending physician as to which activities the resident will be allowed to perform within the context of the assigned levels of responsibility. The overriding consideration must be the safe and effective care of the patient that is the personal responsibility of the attending physician.

- Medical students may be present in the OR and may perform procedures at the discretion of the attending physician/surgeon.
- Residents may supervise medical students in the OR
- Medical students may not perform any “hands-on” while the attending physician/surgeon is out of the room.

EMERGENCY SITUATIONS

1. An "emergency" is defined as a situation where immediate care is necessary to preserve the life of, or to prevent serious impairment of the health of a patient. In such situations, any resident, assisted by other healthcare associates,

shall be permitted to do everything possible to save the life of a patient or to save a patient from serious harm. The appropriate attending physician will be contacted and apprised of the situation as soon as possible. The resident will document the nature of that discussion in the patient's record.

2. In emergency situations involving diagnostic or therapeutic procedures with significant risk to the patient, the resident must consult with, and obtain approval from, the attending physician who will be available to assist or to advise as appropriate. In such cases, the attending physician will determine, based on the circumstances of the case and the resident's level of experience, whether to be physically present, or to be available by telephone or other telecommunications device. If circumstances do not permit the attending physician to write a pre-procedural note, the resident's note will include the name of the responsible attending physician. The note will indicate that the details of the case, including the proposed procedure, were discussed with, and approved by, the attending physician. In such cases, an attending physician must see the patient and countersign the resident's pre-procedural note within 24 hours.

PRIVILEGING RESIDENTS AS INDEPENDENT PRACTITIONERS

Residents who provide independent medical care outside of their training program must be licensed, credentialed and privileged for the duties they are expected to perform. In this capacity, they are not working under the auspices of a training program and must meet the requirements for medical staff appointment, and are subject to the provisions contained in the Medical Staff Bylaws, and rules and regulations.

EVALUATION OF RESIDENTS AND SUPERVISORS

1. Each resident will be evaluated according to accrediting and certifying body requirements on the basis of clinical judgment, knowledge, technical skills, humanistic qualities, professional attitudes, behavior, and overall ability to manage the care of a patient. Evaluations will occur on every rotation. Written evaluations will be discussed with the resident by the residency director at least bi-annually.

2. If at any time a resident's performance or conduct is judged to be detrimental to the care of a patient(s), action will be taken immediately to ensure the safety of the patient(s).

3. Each resident rotating through the various services in the hospital will be given the opportunity to complete a confidential written evaluation of attending physicians and of the quality of the resident's training at the hospital. Such evaluations will include the adequacy of clinical supervision by the attending physician. The evaluations will be reviewed by the program director, division chiefs, and the hospital's leadership to identify areas where improvements can be made and they will strive to create an atmosphere that assists residents in being comfortable completing evaluations.

MONITORING PROCEDURES

At a minimum, the monitoring process will include the following:

1. Review for compliance with inpatient and outpatient documentation requirements as part of the medical record completeness and accuracy assessment.
2. Monitoring the supervision of diagnostic and therapeutic procedures involving residents to ensure consistency with the graduated levels of supervision.
3. Monitoring all incidents, such as medication errors, and risk events with complications to ensure that the appropriate level of supervision occurred.
4. A review of resident comments related to their CHOC experience.
5. Analysis of events where violations of graduated levels of responsibility may have occurred.
6. In addition to the above monitoring, all adverse occurrences affecting patient care are reviewed by the medical staff as defined in the Medical Staff Bylaws and Rules and Regulations.