PROVIDENCE
Little Company of Mary
Medical Center
Torrance

PROFESSIONAL STAFF
GENERAL RULES AND REGULATIONS

Approval dates

Medical Executive Committee: 01/10/2023
Board of Directors: 01/24/2023

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ARTICLE I

ADMISSION OF PATIENTS

Section 1.1 General

The Hospital shall accept patients for diagnostic and therapeutic care, except patients who: suffer from serious burns; primarily need psychiatric or substance abuse treatment; have acute psychiatric problems requiring close supervision or restraint which the Hospital cannot provide; or have virulent infectious diseases for which admission is prohibited by State health regulations.

The department chair or designee may contact the attending member when questions arise as to whether a patient should be admitted, retained, or transferred.

Section 1.2 Procedures

Section 1.2.1 General Admissions

A patient may be admitted to the Hospital only by members of the Professional Staff. Members of the medical staff can not provide medical or surgical care for members of their immediate family or domestic partner. This includes treating, observing, writing orders, attending, operating, performing procedures, or consulting. Immediate family members are defined as parents, siblings, spouse, children, grandparents, and grandchildren. Domestic partners are persons not legally married but who have declared relatedness formally through the California Secretary of State.

Special conditions may exist for co-admission, etc. as are outlined in the Bylaws, these Rules and Regulations and/or the department rules and regulations. All members shall be governed by the following:

Patients with identified or suspected communicable diseases will be isolated according to the Centers for Disease Control and Prevention (CDC) Guidelines (see Infection Prevention Manual for details). If any doubt exists as to the admission or the need for isolation, the chair of the clinical department with input from the Chair of the Infection, Blood and Pharmacy Monitoring Committee or Nurse Epidemiologist should be called and a determination shall be made by the department chair concerning the appropriateness of admission to the Hospital.

Section 1.2.2 Surgical Admissions

The following criteria must be met for admissions for elective surgery requiring anesthesia:

A. Appropriate screening tests will be performed for pre-operative patients, based on the needs of the patient as determined by the surgeon and/or anesthesiologist.
   Patients having non-emergent operative or other invasive procedures where there is a determination made of the possibility for administration of blood or blood components will have an assessment regarding the appropriateness of this procedure. Documentation will be made in the patient's medical record that the risks, benefits and alternatives to the operative or other invasive procedure or blood administration have been discussed with the patient.
B. Admission shall generally be at least one (1) hour before surgery.
C. Nothing by mouth for at least 6 hours prior to scheduled surgery except for necessary medications as prescribed by the patient's physician.
D. Pre-anesthesia evaluation must be completed.
E. History and Physical must be in the patient's record before surgery/procedure.

Section 1.2.3 Emergency Admissions

When a patient requires admission to the Hospital for emergency medical treatment, the attending member shall arrange for the admission through the Emergency or Admitting Departments.

Every member must be available or have suitable coverage (see department rules and regulations) for his/her patients who present to the Hospital for emergency or other care. If a member does not respond when on call for his/her practice, does

not respond when on call for other member's practices or if he/she signs out inappropriately (signs out to a non-member or to a member who does not have commensurate privileges), he/she may be levied a fine of $500. The fine if levied would be levied on the patient's regular physician who either did not respond or who signed out inappropriately. The fine shall be levied following approval by the Medical Executive Committee on the recommendation of the department chair. Members shall be considered ineligible for reappointment until all fines are paid in full.
Patients who require emergency admission and do not have an attending member shall be assigned one in accordance with the "E.D. Call Panel" schedule.

Section 1.3 Responsibility

The patient's attending member (physician) shall be responsible for directing and supervising the patient's overall medical management, 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 (except in emergencies), for visiting the patient daily, for the prompt completion and accuracy of the medical record, for necessary special instructions, for medical orders for treatment and medications, and for transmitting information regarding the patient's status to the patient, the referring member, if any, and to the patient's family. In the case of an emergency during hospitalization of any patient, the Hospital "Code Blue Team" policy is initiated.

Whenever these responsibilities are transferred to another member, a note concerning the transfer of responsibility shall be entered in the medical record. It shall state the date responsibility is transferred. In addition, this hand-off between members must include communication of at least the following:

Up-to-date information regarding the patient's care, treatment and services, condition and any recent or anticipated changes provided in an interactive environment that allows the giver and receiver of the information to ask/answer questions.

Any member who cannot or will not assume all of the responsibilities of the attending member shall arrange to have those patients admitted by another member who can and will assume such responsibilities. (See also Professional Staff Bylaws Section 5.1 (e & f) for rule pertaining to podiatric and dental patient admissions.)

When a report is received by the Statement of Concern Committee, stating that a physician has not seen his/her patient, or has failed to perform basic responsibilities regarding documentation and/or patient care.

The report may be submitted by a nurse, physician, ancillary staff, patient, patient's family, or other.

Such a report will warrant investigation, including (but not limited to) a review of the chart, interviewing the patient or patient proxy to better understand and form an opinion on the legitimacy of the claim.

Section 1.4 Psychiatric and Infection Precautions

The attending member, at the time the patient is admitted, shall inform the admitting staff and nursing staff that the patient may be a danger to self or to others or has an infectious or contagious disease or condition. The attending member 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 the suspicions, and the precautions taken to protect the patient and others.

In the event that the patient or others cannot be appropriately protected in the general acute care units of the hospital, arrangements shall be made by the Chief Executive Officer or his/her designee in consultation with the attending member to transfer the patient to a facility where care can be appropriately managed. When indicated, individual nursing care shall be arranged in accordance with Hospital policy.

In accordance with the Hospital policy "Psychologically or Emotionally Disturbed Patients", the attending member shall seek a psychiatric consultation for any patient who has possibly taken an overdose of drugs.

Section 1.5 Priority of Admissions to the Hospital

When the Chief Executive Officer or designee, after consulting with the President of the Professional Staff, determines that bed space is not available, he or she may limit admissions to emergency cases. In such an event, patients will be

admitted using the following order of priority:

First Priority: Emergency Admissions, i.e., patients who have serious medical problems and may suffer death, serious injury, or permanent disability if they are not admitted and provided treatment within four hours.
Second Priority: Urgent Admissions, i.e., patients who have serious medical problems who may suffer substantial injury to their health if they are not admitted and provided treatment within twenty-four hours.
Third Priority: Preoperative Admissions, i.e., patients who are already scheduled for surgery.
Fourth Priority: Routine Admissions, i.e., patients who will be admitted on an elective basis to any service.

Section 1.6 Admission to the Critical Care Unit/s

A designated group of critical care specialists will have oversight for all patients in the intensive care unit, including decisions regarding the admission or discharge to or from the intensive care unit and the management of the patients while in the ICU. A collaborative team approach to management of these patients will be fostered between the intensivist group and the attending/consulting physicians with the intensivist group having final authority over these decisions.

Once the order to admit/transfer a patient to the critical care unit has been issued, the patient must be seen by the admitting physician or intensivist within four (4) hours whether the patient has arrived in the critical care unit or is being held in the Emergency Department or alternative critical care unit location. The only exception to this rule is when the admitting physician has seen the patient immediately (defined as 1 hour) prior to the admission/transfer.

The admitting physician may delegate this requirement to another physician (not the Emergency Department physician), but the admitting physician will still ultimately be held responsible for ensuring that the patient is seen within the mandated four (4) hours.

Patients in the critical care unit/s must be seen daily, by 1:00 pm (1300).

Section 1.7 Priority of Transfers within the Hospital

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

Emergency Department patients awaiting admission
Critical care unit to a telemetry or general care area
Temporary placement in an inappropriate area, for that patient to an appropriate area

The President of the Professional Staff or designee shall be consulted to help prioritize admissions and transfers.

ARTICLE II

ALLIED HEALTH PROFESSIONALS

Section 2.1 Qualifications

Allied Health Professionals (AHPs) are eligible for practice privileges in this Hospital only if they satisfy the minimum qualifications as outlined on the privilege delineation forms and the following:

A. Hold a current California license, certificate or other legal credential in a category of AHPs, which the Board of Directors has identified, as eligible to apply for practice privileges.
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.

Allied health professionals are not members of the Professional Staff.

Section 2.2 Delineation of Categories of AHP Eligible to Apply for Practice Privileges

The Board of Directors shall, periodically review and identify the categories of AHPs, based upon occupation or profession, which shall be eligible to apply for practice privileges in the Hospital. For each eligible AHP category, the Board of Directors shall identify the mode of practice in the Hospital setting (i.e., independent or dependent) and the practice privileges and prerogatives that may be granted to qualified AHPs in that category.

The Board of Directors shall secure recommendations from the Medical Executive Committee as to the categories of AHPs which should be eligible to apply for practice privileges and as to the practice privileges, prerogatives, terms and conditions which may be granted and apply to AHPs in each category. The delineation of categories of AHPs eligible to apply for practice privileges and the corresponding practice privileges, prerogatives, terms, and conditions for each such AHP category, when approved by the Medical Executive Committee and the Board of Directors, shall be set forth in the Initial Application for Allied Health Professionals.

Section 2.3 Procedure for Granting Practice Privileges

An AHP must apply and qualify for practice privileges; and practitioners who desire to supervise or direct AHPs who provide dependent services must also apply and qualify for membership/privileges on the Professional Staff. Applications for initial granting of practice privileges shall be submitted and processed in the following manner once the application is completely verified:

A. review by the department chair and department for recommendation regarding selection followed by;
B. review by the Credentials Committee for recommendation regarding selection followed by;
C. review by the Medical Executive Committee for recommendation for selection followed by;
D. approval of the Medical Executive Committee's recommendation by the Board of Directors.

Bi-annual reappointment applications for continuation of practice privileges shall be submitted and processed in the following manner once the reappointment application is complete and necessary information verified:

A. Review by the department or sub-section chair for recommendation regarding reappointment followed by;
B. review by the Credentials Committee for recommendation regarding reappointment followed by;
C. review by the Medical Executive Committee for recommendation for reappointment followed by;
D. approval of the Medical Executive Committee's recommendation by the Board of Directors.

Requests for additional categories of AHP shall be made by Professional Staff members. Requests shall be in writing stating the specific category to be added and shall be considered by the Board of Directors based on recommendation of the clinical department and the Medical Executive Committee.

Each AHP shall be assigned to the clinical department appropriate to his/her occupational or professional training and, unless otherwise specified in the Rules and Regulations, shall be subject to terms and conditions paralleling those specified in Article II of the Professional Staff Bylaws, as they may logically be applied to AHPs and appropriately tailored to the particular AHP's profession.

Section 2.4 Prerogatives

The prerogatives, which may be extended to an AHP, shall be defined in the Professional Staff Rules and Regulations or Hospital policies. Such prerogatives may include:

A. Provision of specified patient care services under the supervision or direction of a physician member of the Professional Staff and consistent with the practice privileges granted to the AHP and within the scope of the AHP's licensure or certification.

1) AHPs may perform Medical Screening Examinations of patients, in various departments, under specific instances outlined in the PLCMMCT Standardized Procedure/s addressing Medical Screening Examination/s.

B. AHPs shall not be members of any division, department or committee, but will be assigned to the appropriate division, department or committee for evaluation of credentials, determination of privileges, supervision, proctoring, peer review and performance improvement.

C. Attendance at the meetings of assigned division, department or committee and attendance at Hospital education programs in the field of practice.

Section 2.5 Responsibilities

Each AHP shall:

A. Meet those responsibilities required by the Professional Staff Rules and Regulations, and if not so specified, meet those responsibilities specified in Section 2.2 of the Professional Staff Bylaws as are generally applicable to the more limited practice of the AHP.

B. Retain appropriate responsibility within his/her area of professional competence for the care and supervision of each patient in the Hospital for whom he/she is providing services.

C. Participate, as appropriate, in patient care audit and other performance improvement activities, evaluation, and monitoring activities required of AHPs in supervising initial appointees of his/her same occupation or profession, or of a lessor included occupation or profession, and in discharging such other functions as may be required from time to time.

Section 2.6 Corrective Action

A. An officer of the Professional Staff, the chair of any clinical department, the chair of any standing committee of the Professional Staff or the Chief Executive Officer may make a request to the Medical Executive Committee for an investigation or corrective action whenever an Allied Health Professional engages in conduct that is perceived to be harmful to patient safety, detrimental to the delivery of quality patient care, or disruptive of Hospital operations. The investigation and review of any corrective action taken shall be carried out as specified in this section.

B. The Medical Executive Committee may appoint a standing or ad hoc committee or other designee to carry out an investigation, which shall proceed in a prompt manner and may include an informal meeting with the Allied Health Professional. At the conclusion of its investigation, the committee or designee shall forward a report, together with any recommendation for corrective action, to the Medical Executive Committee.

C. The Medical Executive Committee shall consider the report and recommendation of the committee or designee and shall make its own recommendation concerning any corrective action.

D. In the event that the Medical Executive Committee recommends suspension or termination of AHP status or reduction in clinical privileges, the Allied Health Professional shall be entitled to a review hereunder. If the Allied Health Professional waives his/her right to review, the matter shall be forwarded, together with the supporting materials, to the Board of Directors for a final decision.

E. Where immediate action is necessary to prevent imminent danger to the health of any individual (including an imminent threat to the operations of the Hospital), the President of the Professional staff, the chair of a clinical department or the Medical Executive Committee may restrict an Allied Health Professional's status or privileges immediately. The Allied Health Professional then shall have the right to meet informally with the Medical Executive Committee, which shall have the authority to continue, modify, or terminate the restriction. In the event the restriction continues in any significant form, the Allied Health Professional shall have the right to obtain review hereunder. The restriction shall remain in effect pending any such review.

F. In the event of a final decision to impose corrective action on an Allied Health Professional, the Hospital may make a report to the National Practitioner Data Bank and appropriate licensing board under standards and procedures to be determined by it.

G. An Allied health Professional shall be given the opportunity to have any of the following recommended actions reviewed, according to the procedures described below, before it becomes final and effective (except for a summary restriction, which shall be effective immediately):

1. Denial of an application for appointment or reappointment to AHP status;
2. Denial of a request for initial or additional privileges (except temporary privileges);
3. Reduction or suspension in existing privileges (except temporary privileges); or,
4. Suspension or expulsion from AHP status.

H. Notwithstanding the above, an Allied Health Professional shall have no right to obtain review in any of the following instances:
   1. When an application is denied because it is incomplete; or
   2. When an application is denied because the Allied Health Professional is not from a category that the Hospital has accepted for practice on its premises; or
   3. When an application is denied or AHP status or practice privileges are revoked because of the existence of an employment, contractual, panel, or other relationship between the Hospital and any other AHP in the affected category which limits the number of AHPs in that category who may practice at the Hospital; or
   4. When an application is denied or AHP status or practice privileges are revoked because the physician who is required by law or Professional Staff policy to act as the Allied Health Professional's supervising physician: (a) has given up or been deprived of that right; (b) no longer agrees to act as the supervising physician; or, (c) has resigned or otherwise been separated from the Professional Staff; or
   5. When the AHP's certificate or license expires, is revoked, or is suspended; or
   6. Conviction of a crime in this state or elsewhere or has pleaded guilty or nolo contendere with respect to any felony or who has been convicted or pleaded guilty or nolo contendere with respect to any misdemeanor related to (i) controlled substances; (ii) illegal drugs; (iii) Medicare, MediCaid, or insurance fraud or abuse; (iv) violence against another, including sexual assault or abuse, or (v) any other illegal activity involving patients or otherwise substantially and adversely related to the qualifications, functions and duties of the AHP applicant or member.

I. The procedures set forth below shall apply to AHPs from all categories that the Hospital has accepted for practice on its premises.

J. The Allied Health Professional shall be notified of his/her right to obtain review as soon as practicable after the Medical Executive Committee has decided to make an adverse recommendation or has taken summary action. To obtain review, the Allied Health Professional shall submit a written request to the Medical Executive Committee within fifteen (15) days of the notice to the Allied Health Professional. In the event that the Allied Health Professional does not request review in this manner, he/she shall be deemed to have waived any review rights.

K. Review shall be in the form of a meeting with a panel or committee appointed by the Medical Executive Committee. Within a reasonable time in advance of the meeting, the Chief Executive Officer shall give the Allied Health Professional written notice of the time and date of the meeting and a written summary of the reasons for the recommendation or action. If appropriate, this summary shall include references to representative patient care situations or to relevant events. The panel or committee may include an AHP from the appropriate category as a member.

L. The panel or committee shall set guidelines to assure that the meeting is held in an orderly manner and that the Allied Health Professional has a reasonable opportunity to challenge the recommendation or action and to respond to the reasons given for it. A practitioner holding Professional Staff or AHP status at the Hospital may accompany and represent the Allied Health Professional at the meeting. In its sole discretion, the panel or committee may permit the Allied Health Professional and the Medical Executive Committee to be accompanied or represented by legal counsel or other representative at the meeting, and it may choose to be advised by legal counsel without regard to whether the parties are represented by counsel.

M. A record shall be made of the meeting, to be maintained by the panel in the form of minutes, a tape recording, or a Certified Shorthand Reporter. If a record is maintained by means of a tape recording or a Certified Shorthand Reporter, any party requesting the original of the transcript will bear the cost of the preparation of the transcript.

N. The recommendation or action of the Medical Executive Committee shall be affirmed unless the Allied Health professional proves, by a preponderance of the information presented that the recommendation or action was arbitrary and capricious.

O. Following the meeting, the panel or committee shall issue a written decision and report, a copy of which shall be provided to the Allied Health Professional and to the Board of Directors.

P. The Board of Directors shall consider the decision and report. At its discretion, the Board of Directors may allow the Allied Health Professional to submit a written statement to it commenting on the decision and report. The Board of Directors then shall make the final decision on the matter, in accordance with its own procedures.

ARTICLE III
CHAIN OF COMMAND

See Service Area Policy: Chain of Command: Patient Care Conflict Resolution.

ARTICLE IV

EMERGENCY DEPARTMENT CALL PANEL

Section 4.1 Emergency Department (E.D.) Call Panel List

An E.D. Call Panel has been established for referring patients who need hospital care to qualified members. All emergency patients who do not have a practitioner practicing on the Staff will be assigned to a member according to the rotational E.D. call panel. Members sharing the responsibility for on-call backup coverage to the Emergency Department will be assigned definite call days. The call day is 24 hours from 7:00 A.M. to 7:00 A.M. A roster of members by specialty will be available in the Emergency Department.

Prior to a final adverse decision, a member whose participation on the E.D. Call Panel 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 Professional Staff may restrict a member's participation on the E.D. Call Panel at any time and until such time as a final decision is reached by the Medical Executive Committee. Any adverse decision as to a member's participation on the E.D. Call Panel shall entitle the member to a hearing under Article VII of the Professional Staff Bylaws.

Section 4.2 Conduct of E.D. Call Members

Members of the Medical Staff on ED call must respond when requested, by the ED physician or his/her representative, to see a patient. The need for physical presence shall be at the sole discretion of the ED physician. Members on call must communicate (by phone) with the Emergency Department physician when called within 30 minutes. Response timed for physical presence shall be within 60 minutes from the time the ED physician requests physical presence. Response time for physical presence may be extended past 60 minutes if the ED physician agrees.

Any disagreements about ED call, be it response time by phone, request for physical presence or response time for physical presence, shall be addressed after the event by the Chairs of the Departments of Emergency Medicine and the member’s department. Members shall never dispute a request by the ED MD for physical presence during the event.
Each panelist 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 the specified 60 minute period for physical presence.

A panelist member who is unable to provide panel coverage during the scheduled time is responsible for arranging for coverage by a member who meets the criteria for panel eligibility. The panelist member shall inform the Hospital’s Medical Staff Services Department of the name of the replacement member who will provide back-up coverage.

When scheduled on call, each member 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.

The Emergency Department will document the names of all members who do not respond to a call from the Emergency Department when they are on the call list and forward them to the Medical Staff for follow-up.

Indigent or non-insured patients will be transferred to a more suitable facility whenever possible, provided the patient is medically fit for transfer. Panelist 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.

If there is no practitioner of choice, nor company practitioner, the Emergency Department member will do follow-up care for industrial cases.

All transfers shall be carried out in accordance with the Hospital policy on transfers. In summary, it requires:
The Emergency Department member or E.D. Call Panelist 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 member finds, within reasonable medical probability, that the expected medical benefits of the transfer outweigh the risks posed by the transfer, or the patient, or the surrogate decision-maker, requests transfer, after the member has explained the medical risks and benefits of transfer.

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 necessary transfer forms must be completed, and copies sent with the patient.

A patient can be admitted in the name of the panelist member if both the panelist member and E.D. member concur, but if the Emergency Department member so specifies, the panelist member must see the patient at that time. The panelist member must be notified about each admission prior to the patient leaving the Emergency Department.

A panelist member shall cooperate with and assist the Emergency Department, Emergency Department members, and all Departments, Divisions and Staff who may call a panelist member for assistance. The panelist member shall act in the best interests of patient care and in accordance with the Hospital's philosophy and rules.

Panelist members will see unassigned patients in the Emergency Department on a personal, private-pay basis. The panelist member retains responsibility for billing and collecting of fees. The Hospital has no responsibility for this relationship and each panelist member releases the Hospital from any obligation in this regard.

ARTICLE V

CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

Section 5.1 Policy

Patients have the right to participate actively in decisions regarding their medical care and to decide whether to authorize or refuse treatment recommended by members. Members must give patients the medical information they need to make their decisions. Accordingly, treatment may be performed or given only when the patient, or the surrogate decision-maker, has been given information about the treatment and has given consent except in emergencies. Treatments which require consent (informed and written) are outlined in the policy: Consents. Decisions to discontinue life-sustaining treatment raise special concerns, which are discussed in the Hospital Policy: Foregoing Life Sustaining Treatment for Adult Patients.

If a patient has not received the necessary medical information regarding the treatment to give consent and signed a consent prior to receiving pre-operative medication with side effects causing sedation, the procedure must be delayed until the patient is competent to sign as determined by the member. If the member wants to proceed without signed consent, he or she must document the intention to proceed and must document that the medical information regarding the treatment necessary to give consent was given by the member to the patient prior, either in the office or in the hospital prior to pre-

operative sedation/medication administration. Further information and forms are provided in the Consent Manual prepared by the California Association of Hospitals and Health Systems (CAHHS). The Consent Manual is available in the Risk Management Department, Health Information Services Department and the Nursing Office.

Section 5.2 Informed Consent Defined

Informed consent is a process whereby the patient, or the surrogate decision-maker, is given medical information about the treatment by the member, prior to the treatment, which will enable him or her to reach a meaningful, informed decision regarding whether to give consent.

Information for consideration must include the risks, benefits and alternatives of the treatment, sedation or anesthesia and blood. Additionally, discussion with the patient should be conducted in a language and at a comprehension level comfortable for the patient. See Hospital Policy: Interpreter Service.

Section 5.3 Who May Give Consent

Informed consent must be secured from competent patients. 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 unemancipated minors, conservators, attorneys-in-fact, the patient's closest available relatives, or the court).

Section 5.4 Responsibility for Securing Informed Consent

The patient's attending member is responsible for giving the patient, or the surrogate decision-maker, the requisite medical information about the treatment and securing consent.

Members other than the patient's attending member also have a duty to provide medical information about the treatment and secure consent, when they will provide specialized services at the request of or together with the patient's attending member.

Section 5.5 Emergencies

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, or the surrogate decision-maker. The emergency exception applies only to the treatment which is immediately necessary and for which consent cannot be secured. Consent should be secured for all further, non-emergency treatment that may be necessary.

Section 5.6 Particular Legal Requirements

Consent for blood transfusions, HIV blood tests, hysterectomies, use of investigational drugs or devices, participation in reuse of hemodialysis filters, treatment for breast cancer, and use of psychotropic medications must be secured in the manner specified in the laws applicable to these particular procedures. The laws are described in the CAHHS Consent Manual.

Special requirements for consent also apply to discontinuing life sustaining treatment (See Article XII Discontinuing Life Sustaining Treatment).

The attending member shall be responsible that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

Section 5.7 Documentation

The members involved in securing informed consent shall document, in the patient's medical record, that prior to the treatment, the risks, benefits and alternatives of the treatment, sedation or anesthesia and blood were discussed with the patient or surrogate decision maker and that the patient or surrogate decision maker consented to the treatment.

In addition to documenting consent, the member shall indicate in the patient's record the procedure to be performed and how it should appear on the Hospital consent form.

The member's documentation for emergencies (see Section 5.5 above), which should be entered in a progress note, and describe: the nature of the emergency; the reasons consent could not be secured from the patient or a surrogate decision-maker; and the probable result if treatment would have been delayed or not provided.

The Hospital staff are legally 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 outpatients.

Section 5.8 Consent by Telephone

Consent for medical or surgical treatment should be obtained by telephone only if the person having legal capacity to consent for the patient is not otherwise available. If a telephone is used, the responsible member must, to the extent possible, provide the patient's legal representative with the information the member would disclose if the person were present.

When consent is obtained by telephone, two (2) authorized individuals should witness the conversation. Authorized individuals are registered nurses and members. The patient or surrogate decision-maker should be informed of all individuals listening to the conversation.

The member shall note the exact time, nature and any limitation of the consent in the patient's record. The witness shall countersign and date this note.

The member 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 or her relationship to the patient and confirm that consent was given for treatment. The facsimile, telegram or letter should be placed in the patient's record.

Section 5.9 Refusal of Treatment

If a patient or the patient's surrogate decision-maker refuses treatment, the attending member shall be contacted immediately. It shall be the member's responsibility to explain and document the reason for the treatment and the possible ill effects of refusal. The attending member shall enter a brief note in the patient's chart regarding the initial refusal and whether the outcome was consent or continued refusal.

If treatment is ultimately refused, a signed copy of the Refusal of Treatment form will be forwarded to the Risk Manager.

ARTICLE VI

CONSULTATIONS

Section 6.1 General

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

Any qualified member can be called for consultation within his or her area of expertise and within the limits of clinical privileges which have been granted to him or her.

An attending member's responsibility for his or her patient does not end with a request for a consultation.

The consultation and specific diagnostic and therapeutic procedures will be done at the Hospital unless suitable diagnostic or therapeutic facilities are not provided within the confines of the Hospital.

Section 6.2 Requests for Consultations

Requests for consultation should be made by direct personal communication from the attending member to the consulting member. The attending member should discuss the need for the consultation and the time frame in which the consultation should be done. The time frame in which consultations need to be done should be based, at least, on the acuity of the patient.

Hospital nurses or other employees are not to be used as intermediaries. The attending member must document the consultation request in the patient's record (Progress Notes or Doctor's Order Sheet).

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

Section 6.3 Required Consultations

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

In unusually complicated situations where specific skills of other members may be needed;

In instances where the patient exhibits severe psychiatric symptoms or if there is a possible or suspected drug or chemical overdose or attempted suicide;

In all pediatric surgery inpatients under 12 years of age (consult must be done by a pediatrician or family practitioner with pediatric privileges). This consult is not mandatory prior to surgery if the situation is an emergency.

In all cardiac/thoracic surgery patients with a diagnosis of Methacillin Resistant Staph Aureus (MRSA) of the surgical wound. This consult shall be by an infectious disease specialist.

In instances when a member may be required to have consultations on all, or some, of his or her cases, as determined by the Medical Executive Committee. In such situations, the member shall be responsible for informing the assigned consultants of each admission and for arranging for timely consultations;

When otherwise required by Hospital, Department or elsewhere in these Professional Staff Rules.

Section 6.4 Requested Consultations

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, he or she may call this to the attention of his or 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 attending member.

Section 6.5 Performance of and Reporting of Consultations

A consultation shall include an examination of the patient and the medical record. The attending member is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for the consultation.

A legibly written or typed opinion signed by the consultant must be included in the patient's record. When operative procedures are involved, consultations performed before surgery shall be reported on the chart before the operation, except in emergency cases.

ARTICLE VII

COVERAGE

Section 7.1 General

Each member shall arrange coverage for their patients. The attending member is responsible for informing the covering member about the beginning and ending dates of coverage and for assuring that the covering member will be available and qualified to assume responsibility for patients during the attending member's absence. The attending member shall also make the covering member aware of the status and condition of each hospitalized patient involved.

A failure to arrange appropriate coverage shall be grounds for corrective action. In the event the attending member's alternate is not available, the department chair or President of the Professional Staff must be contacted. He/she will assume responsibility for caring for the patient or appoint an appropriate member who will assume responsibility until the attending member can be reached.

ARTICLE VIII

CREDENTIALS FILES

Section 8.1 General

The credentials files of applicants and members shall contain all relevant information that is needed to evaluate the professional competence and performance of applicants and members.

The credentials files shall be retained in strict confidence in the Medical Staff Services Department.

It is expressly understood that the contents of the credentials file constitute records and proceedings of a Professional Staff committee that is responsible for evaluating and improving the quality of care provided in the Hospital.

Section 8.2 Contents

Each credentials file shall include the application and re-application forms, and all correspondence, and other documents pertaining to the professional qualifications, performance, and Professional Staff activities and responsibilities of the applicant or member.

Section 8.3 Complaints and Statements of Concern

Purpose: To provide a mechanism for patients, patients' family members, hospital personnel and Medical Staff members to communicate patient care issues or concerns which relate to a Professional Medical Staff member. These will then be dealt with via the peer review process which is protected by Evidence Code 1157.

Process: Issues or concerns must be communicated in writing using the Unusual Occurrence Report program. All reports will be reviewed by the Performance Improvement (PI) and Risk Management (RM) Departments. UNUSUAL OCCURRENCE REPORTS ARE NOT TO BE PRINTED AND MAINTAINED BY OTHER HOSPITAL PERSONNEL.

Unusual Occurrence Reports are referred to the Statement of Concerns (SOC) Council of Officers which is comprised of the Professional Staff President, President-Elect, Secretary/Treasurer, Department Chairmen and the Physician Well Being Chair. These individuals determine follow-up action as follows:

Speak with member; or
Letter to member with no response required; or
Letter to member with response required; or
Refer to the Department for peer review; or
Refer to Department or Committee for general discussion; or
Refer to Department Chair for action and follow-up; or
Refer to Physician Well Being Committee; or
Attend SOC meeting; or
Initiation of investigation/disciplinary review under the Medical Staff Bylaws; or
Behavior Agreement/Contract; or
Monitor for trends/patterns; or
Operational issue, no medical staff action required

A semi-annual and annual summary of the SOCs received will be prepared and presented to the Medical Executive Committee for review, and follow-up action as necessary.

Additionally, a detailed peer review summary, by member, to include SOCs will be prepared and attached to the reappointment packet which will be reviewed by the department, or sub-section chair, and action taken as necessary.

The original document, along with any follow-up, shall be stored in the member's Statement of Concern file.

Section 8.4 Confidentiality

The following applies to records of the Professional Staff and its departments/committees responsible for the evaluation and improvement of patient care:

The records of the Professional Staff and its departments/committees responsible for the evaluation and improvement of the quality of patient care rendered in the hospital shall be maintained as confidential.

Access to such records shall be limited to duly appointed officers and departments/committees of the Professional Staff for the sole purpose of discharging Professional Staff responsibilities and subject to the requirement that confidentiality be maintained.

Information which is disclosed to the Board of Directors of the Hospital or its appointed representatives, in order that the Board of Directors may discharge its lawful obligations and responsibilities, shall be maintained by that body as confidential.

Information contained in the credentials files of any member may be disclosed with the member's consent, or to any professional staff or professional licensing board, or as required by law. However, any disclosure outside of the Professional Staff shall require the authorization of the President of the Professional Staff and the concerned department chair and notice to the member.

A member shall be granted access to his/her own credentials file, subject to the following provisions:

Timely notice of such shall be made by the member to the President of the Professional Staff or his/her designee.

The member may review, and receive a copy of, only those documents provided by or addressed personally to the member. A summary of all other information, including peer review committee findings, letters of reference, proctoring reports, etc., shall be provided to the member, in writing, by the designated officer of the Professional Staff. Such summary shall disclose the substance, but not the source of the information summarized.

The review by the member shall take place in the Medical Staff Services Department, during normal work hours, with an officer or designee of the Professional Staff present.

In the event a Notice of Charges is filed against a member, access to his/her own credential file shall be governed by Article VII of the Professional Staff Bylaws.

Section 8.5 Member's Opportunity to Request Correction/Deletion of, or to Make Addition to Information in the Credential File

When a member has reviewed his/her file as provided under Section 8.4, he/she may address to the President of the Professional Staff a written request for correction or deletion of information in his/her credential file. Such request shall include a statement of the basis for the action requested.

The President of the Professional Staff shall review such a request within a reasonable time and shall recommend to the Medical Executive Committee, after such review, whether or not to make the correction or deletion as requested. The Medical Executive Committee, when so informed, shall either ratify or initiate action contrary to this recommendation, by a majority vote.

The member shall be notified promptly, in writing, of the decision of the Medical Executive Committee.

In any case, a member shall have the right to add to his/her own credential file, upon written request to the Medical Executive Committee, a statement responding to any information contained in the file.

Section 8.6 Disclosure to Hospital Board of Directors

The contents of the credential files may be disclosed to the Board of Directors insofar as is necessary to enable the Board of Directors to properly fulfill their legal responsibilities. Disclosure should be limited to the member(s) or subcommittee(s) that are responsible for evaluating and analyzing such information. Generally, any portion of a credentials file that is reviewed by the Board of Directors should not be included in or maintained as a part of Board of Directors records or minutes. Board of Directors actions shall refer, as appropriate, in summary fashion and by identification number to any credentials file material. All portions of credentials files reviewed by the Board of Directors shall be returned to and maintained by the Medical Staff Services Department.

ARTICLE IX

DEATHS

Section 9.1 Pronouncement of Death

If a patient arrives at the Hospital dead or dies in the Hospital, a physician shall pronounce the patient dead within a reasonable time. Exceptions: specified job classifications of registered nurses may pronounce "no-code patients" as outlined in Hospital Policy: Pronouncement of Death of Adult Patients. 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 record.

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 policy. In brief summary, a second, independent member must confirm that "brain death" had occurred and both members 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.

Section 9.2 Autopsies

It shall be the duty of all members to attempt to secure consent to meaningful autopsies. Autopsies should be requested in a subset of deaths in which one of the following criteria is met:

A. The death is completely unanticipated and unexplained.
B. Death of a patient participating in a clinical investigation in which more detailed cause of death information is required to complete the study.
C. Death is 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.

An autopsy may be performed only if authorized in accordance with law. (The persons who may consent to autopsies are identified in the CAHHS Consent Manual).

Except in coroner cases, all autopsies shall be performed by Hospital pathologists. Provisional anatomic diagnoses shall be recorded on the patient's record by the pathologist within seventy-two (72) hours after completion of the autopsy and the complete report should be made a part of the record within two (2) months.

Section 9.3 Coroner's Cases

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

Violent, sudden, or unusual deaths; or
Unattended deaths; or
Deaths related to or following known or suspected self-induced or criminal abortions; or
Known or suspected homicide, suicide, or accidental poisoning; or
Deaths known or suspected as resulting in part from or related to an accident or injury, either old or recent; or
Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration; or
Where the suspected cause of death is sudden infant death syndrome; or
Death in whole or in part occasioned by criminal means or associated with a known or alleged sexual crime; or
Deaths suspected to be due to contagious disease that has not been reported to the Department of Health Services; or
Deaths due to occupational diseases or hazards

The coroner also asks for reports of deaths due to pneumoconiosis and therapeutic misadventures as well as deaths during or within twenty-four hours after operations.

Section 9.4 Notifying the Next of Kin

The attending member or designee is responsible for notifying the next of kin in all cases of death.

Section 9.5 Disposition of Remains and Contributions of Anatomical Gifts

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

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

Section 9.6 Death Certificate

The attending member or other member last in attendance is responsible for signing the death certificate or ensuring its completion.

ARTICLE X

DISASTER ASSIGNMENTS

Section 10.1 General

There shall be a plan (Disaster 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 the Emergency Disaster Committee and Hospital Administration.

All voluntary members shall be assigned to posts, either in the Hospital, another community hospital, or a mobile casualty station in the event of a mass disaster. The member shall be responsible for reporting to his or her assigned station and performing the assigned duties unless the Disaster Assignment Chair changes the assignment.

If patients are evacuated from the Hospital premises, the attending member or department chair and President of the Professional Staff shall be consulted. All policies concerning direct patient care will be a joint responsibility of the department chairs and the Chief Operating Officer. In their absence, the vice chairs and alternate in administration are next in line of authority.

See Bylaws, Article V, for details regarding emergency Disaster Privileges.

Section 10.2 Rehearsals

The disaster plan shall be rehearsed at least twice each year. The drills should be realistic, and may involve members, as well as Administration, Nursing, and other Hospital personnel.

ARTICLE XI

DISCHARGE OF PATIENTS

Section 11.1 General

Patients shall be discharged only on the order of the attending member or designee. Minors shall be discharged only to their parents or legal guardians or a person designated in writing by the parent or legal guardian.

The attending member should inform the nursing unit of possible discharges as early as possible and enlist the aid of discharge planners when appropriate.

At the time of discharge, the member discharging the patient shall complete his/her portion of the necessary documentation in the EMR. This should include medication reconciliation and discharge instructions. It is expected that the member will evaluate the patient on the day of discharge.

A patient may be discharged without an evaluation on the day of discharge if:

1. The patient has been evaluated the day prior.

2. The patient is stable for discharge, confirmed by communication between the patient's nurse and physician prior to discharge on the day of discharge.

3. The patient, nurse, patient's family and physician are all in agreement with patient discharge.

4. Discharge order, all discharge documentation and medication reconciliation will be placed in EMR by the physician.

The discharge summary must be completed within fourteen (14) days after the patient's discharge (See also Article XVII Medical Records).

Section 11.2 Leaving Against Medical Advice

If a patient indicates that he or she will leave the Hospital without a discharge order from the attending member, the nursing staff shall attempt to arrange for the patient to discuss his or her plan with the attending member before the patient leaves.

Whenever possible, the attending member shall discuss with the patient the implications of leaving the Hospital against medical advice.

The patient who insists on leaving against medical advice shall be asked to sign the form "Leaving Hospital Against Medical Advice". If the patient refuses to sign the form, or cannot be located, the nursing staff shall document in the patient's record the facts surrounding the patient's departure.

Section 11.3 Refusal to Leave

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

ARTICLE XII

DISCONTINUING LIFE SUSTAINING TREATMENT

See organization-wide policies and procedures.

ARTICLE XIII

MEDICATION ORDERS

Section 13.1 General

All 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 Pharmacy and Therapeutics Committee.

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

Section 13.2 Review of Medication Orders and Automatic Stop Orders

Each member is expected to review all medications for all patients regularly to ensure discontinuation of orders that are no longer needed.

Medication orders must be reviewed and either re-ordered, revised or cancelled by the responsible physician/member and when the patient changes levels of care.

Section 13.3 Procurement of Medications

All medications shall be procured from the Hospital pharmacy.

All 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 by the nurse only if the medication is clearly identified and visually evaluated for integrity by the Hospital's pharmacist and specifically ordered by the attending member.

Under no circumstances may narcotics, barbiturates, or hypnotics be brought into the Hospital by a member or a patient for administration to the patient at any time.

Section 13.4 Orders for Medications

13.4.1 Substitution of Generic Medications

Equivalent generic medications may be substituted unless ordered otherwise by the prescriber.

The Pharmacy and Therapeutics Committee will establish and maintain a list of therapeutic equivalent medications. The list shall be reviewed annually by this Committee and members informed by publication in the Staff newsletter.

13.4.2 General

Medication orders must be made by a person lawfully authorized to prescribe them. No medications shall be administered except by licensed personnel authorized to administer medications. This shall not preclude administration of aerosol medications by respiratory therapists. Any history of medication or serum sensitivity should be recorded prominently. Only medical oncologists may prescribe chemotherapeutic agents for cancer treatment.

13.4.3 Contents of Medication Orders

Each medication order shall be legible, include two patient identifiers (name, medical record number, date of birth), the name of the medication, the dosage (see below for pediatric population), frequency of administration, the route of administration, indication (see circumstances when required below), and the date, time and signature of the prescriber. Dose ranges are unacceptable.

Dosages for medications (oral and injectable) ordered for patients less than or equal to 12 years of age must be weight based.

The indication for a medication must be included in the order whenever that is prescribed on an as needed basis (PRN).

Orders that are illegible, unclear or incomplete (using the required elements as noted above) or contain abbreviations from the Do Not Use Abbreviation list shall not be carried out until the prescribing physician or his/her designee clarifies and/or completes the order.

13.4.4 Verbal Medication Orders

Medication orders may be given as a verbal order to a registered nurse, licensed vocational nurse, licensed pharmacist, or respiratory therapist (in the case of medications used for respiratory therapy), registered dietician (in the case of non-drug dietary, vitamin, mineral and trace elements orders only) and physical therapist (in case of medications used for physical therapy) only in cases of emergency when the prescribing member is unable to write the order due to performance of other immediately emergent tasks. Verbal or telephone orders may not be accepted for chemotherapy medication.

All verbal medication orders must be dated, timed, and signed by the prescriber within 48 hours. The prescriber shall be the member who issued the order or the member to whom he or she transferred responsibility for the patient. The member accepting responsibility for the patient may countersign the verbal order issued by the other member if it appears proper. If there is any question about the order (e.g., why it was given or whether it was accurately noted), the member accepting responsibility should refer the matter back to the member who issued the order, who shall clarify the order and countersign it within the required time.

13.4.5 Medications Prescribed for Release to Patients Upon Discharge

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

All patients must receive information regarding discharge medications. This information must include use and storage of each medication, the precautions and relevant warnings, and the importance of compliance with directions. The information must be provided by a pharmacist or registered nurse, unless it was already provided by a member. See Hospital Policy: Counseling to Patients with New Prescriptions.

No medications shall be taken from the Hospital unless a prescription has been written for the medication and the medication has been properly labeled by the pharmacist in accordance with state and federal laws for use outside the Hospital.

ARTICLE XIV

DUES

The Medical Executive Committee shall determine the dues payment each year. Members shall be sent one (1) request to pay dues by regular mail delivery. The second and final request shall be sent by Certified Mail, Return Receipt Requested. Following this, if the dues payment is not received, a member shall be considered as deemed to have resigned his/her membership/privileges and this matter shall be referred to the Medical Executive Committee for appropriate action.

ARTICLE XV

CONTINUING EDUCATION

Section 15.1 General Policy

A. Continuing medical education is an educational activity directly related to patient care, community and public health, or preventative medicine. The content of continuing medical education includes the basic medical sciences, the discipline of clinical medicine, and the provision of health care to the public. Continuing medical education is designed to enable physicians to maintain the highest quality of appropriate medical care in a complex and rapidly changing health care system. Its goal is to continually improve the quality of health care.

B. The following criteria must apply to activities designated as Category I:
   1. The content of the activity must be directly related to patient care, community and public health, or preventative medicine.
   2. The need for the activity must be documented, including how the need was determined and by whom.
   3. Each activity should clearly indicate the educational objectives that can be realistically accomplished within the framework of the offering.
   4. Each activity must be evaluated in terms of fulfilling the needs and meeting the objectives.
   5. Category I credit is awarded on the basis of the actual time spent in the designated educational activity.
   6. See Accreditation and Certification Guide published by the CMA for additional details.

C. Patients shall not be allowed to attend any continuing education programs.

Section 15.2 Director of Medical Education

A. Appointment

The Director of Medical Education, shall be an Active Staff member not under corrective or disciplinary action for the duration of the term, will be appointed by the President of the Professional Staff~~,~~ subject to approval by the Medical Executive Committee at its next scheduled meeting. The Director shall have a two year term.

B. Functions of Director of Medical Education

The Director shall arrange and correlate all Professional Staff Continuing Educational activities, serve on the Physician Excellence Council and as Vice-Chair of the Health Education Committee, assure that the Continuing Medical Education Program remains accredited by the CMA Accreditation Committee, cooperate with the Health Education Committee and arrange medical education programs needed as a result of performance improvement activities performed by the clinical departments and Professional Staff committees, be aware of the educational needs of the Professional Staff, respond and arrange programs accordingly, and submit an annual report to the Medical Executive Committee.

C. Limitations

A member shall not hold the position of Director of Medical Education at the same time as the position of President of the Professional Staff.

ARTICLE XVI

IMPAIRED PROFESSIONAL STAFF MEMBERS

Section 16.1 Purpose

This rule addresses referral of 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.

Section 16.2 Assisting Impaired Members

All members should share their concerns about chemical dependence, or mental or physical impairment, in themselves or other members, in confidence, with the Professional Staff Physicians' Well-Being Committee.

The Professional Staff Physicians' Well-Being Committee 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 members, patient safety must be primary. Thus, if the Professional Staff Physicians' Well-Being Committee finds a risk of harm or danger to patients and the member does not willingly withdraw from clinical practice, the Committee will ask the President of the Professional Staff to initiate corrective action.

Section 16.3 Confidentiality

The Professional Staff Physicians' Well-Being Committee shall maintain strict confidentiality. It will release information only with the express agreement of the member, as needed to carry out Professional Staff duties, or as required by law. Releases to carry out Professional Staff duties shall be limited, insofar as possible, to protecting patients and carrying out Professional Staff Physicians' Well-Being Committee activities.
The Professional Staff Physicians' Well-Being Committee shall periodically report on its activities to the Medical Executive Committee, without identifying individuals.

The Professional Staff Physicians' Well-Being Committee shall report directly to the President of the Professional Staff on the status of particular cases.

Section 16.4 Reporting and Investigating Procedure

The Professional Staff Physicians' Well-Being Committee will investigate all reports of impairment to determine whether a problem exists regardless of the source (Nursing, patient, other Hospital employee or member). This protocol applies to members who have impairments, as well as applicants who have a history of impairment.

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

If a problem exists, the member 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.

The Committee may ask the member to be evaluated by a practitioner, including a psychiatrist, a psychotherapist, or a substance abuse counselor. The Committee will ask the member 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 member should be given a list of professionals acceptable to the Professional Staff Physicians' Well-Being Committee. The report should address the diagnoses, prognosis, and treatment program recommendation.

If appropriate, the Professional Staff Physicians' Well-Being Committee will draw up a contract between it and the member, 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:

Provide documentation from an evaluating or treating professional that initial treatment has been provided and that the member may safely diagnose and treat patients.

Abstain from using any drugs or alcohol, except as approved by the treatment program and the Professional Staff Physicians' Well-Being Committee.

Participate in an ongoing treatment program. Any specific terms shall be stated.

Agree to any indicated random testing of bodily fluids, by the treatment program or as directed by the Professional Staff Physicians' Well-Being Committee.

Meet regularly, and at least quarterly, with a monitor appointed by the Professional Staff Physicians' Well-Being Committee.

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 Professional Staff Physicians' Well-Being Committee.

Request a medical leave of absence in the event the Professional Staff Physicians' Well-Being Committee finds that the impairment or failure to comply with the re-entry agreement presents a risk to patients.

Sign whatever forms are needed to authorize release of information from the treatment programs to the Professional Staff Physicians' Well-Being Committee, and request that reports shall be made regularly, at defined time intervals.

Acknowledge that any failure to comply with the conditions will result in immediate referral to the President of the Professional Staff, for corrective action.

Provide for an adequate period of monitoring following treatment (period to be determined by the Committee).
Participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.

When the treating program or the Professional Staff Physicians' Well-Being Committee concludes that the member cannot practice safely, the member will request a leave of absence. Discontinuance of the leave shall be contingent upon the member satisfying the Professional Staff Physicians' Well-Being Committee recommendations that he or she can return safely to practice.

When indicated based upon the severity and duration of the chemical dependence, or mental or physical impairment, the member may be examined by an appointed panel of Department members and/or to be proctored and have reports of satisfactory performance on the cases.

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

If the member refuses to cooperate at any stage, the matter will be referred to the President of the Professional Staff, together with a statement that the member is not participating in a Professional Staff Physicians' 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 Executive Committee shall initiate its own corrective action investigation. The Professional Staff Physicians' Well-Being Committee 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 Professional Staff Physicians' Well-Being Committee's promises of confidentiality.

After successful completion of the treatment program (period to be determined by the Committee), the Professional Staff Physicians' Well-Being Committee shall close the active case. It will open a monitoring case for a defined number of years, and review the member's status at defined intervals.

ARTICLE XVII

MEDICAL RECORDS

Section 17.1 General

Records must be maintained for all patients who receive treatment at the Hospital, including inpatients, outpatients, and emergency patients. Records may be retained in electronic or physical format.

Section 17.2 Responsibility for the Record

The attending member and each member involved in the care of the patient shall be responsible for preparing a complete and legible medical record for each patient.

Section 17.3 Completion of the Record

17.3.1 Timely Completion

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.

Patient records shall be completed and authenticated by an attending member within fourteen (14) days following the patient's discharge. See the Delinquent Chart Policy for action to be taken if charts are not completed within fourteen (14) days following discharge.

If the member is deceased, has moved from the area, is on leave of absence, or has resigned, and all efforts to complete the record have been exhausted, the President of Staff, or his designee, will make the final determination whether to permanently file the record.

17.3.2 Use of Electronic Signature / Authentication

The use of electronic signatures is acceptable throughout the patients' medical records.
Patient records may be authenticated under the guidelines of Hospital policy/procedure: "Authentication".

17.3.3 Correction of the Patient Record

In the event it is necessary to correct an entry in a patient's record, the member shall line out the incorrect data with a single line in ink, leaving the original writing legible. 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. Any cross-outs with or without reentry's in the report should be noted as "error," dated, and initialed.

17.3.4 Authentication, Dating and Timing of Entries

Each entry that is made in the patient's record shall be authenticated, dated, and timed by the person making the entry. The date and time shall be the date and time that the entry is made, regardless of whether the contents of the note relate to a previous date or time.

Indications of authentication shall include written (original or facsimile copy) signatures or initials, or computer entry.

Section 17.4 Contents

Each record shall contain sufficient detail and be organized in a manner which will enable a subsequent treating member 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. The patient's record must be accurate; consequently, only those who are involved in the care of the patient will be allowed to make entries in the record.

17.4.1 History and Physical Examination Report

A history and physical examination ("H&P") shall include: chief complaint, details of present illness, relevant past, social and family histories (appropriate to the patient's age), a summary of the patient's relevant psychosocial needs (as appropriate to the patient's age), a review of body systems and a report of relevant physical examinations, conclusions drawn from the admission H&P, a statement on the course of action planned for the patient for this episode of care, diagnosis or diagnostic impression and reason for admit.

Only members of the Professional Staff may complete admitting histories and physicals for admitted patients. However, if a patient is referred to the hospital by a non-member, that non-member's history and physical may be included in the record and may be used by the treating member. The admitting or treating member still bears the burden for completing a history and physical (dictated or short form as required by the Professional Staff).

The H&P report shall be completed by the attending member, unless he/she delegates this responsibility to another member or he/she is required by the Professional Staff Bylaws or Rules and Regulations to delegate or share this responsibility with another member (See the Professional Staff Bylaws Article V pertaining to the completion of H&P reports when a podiatrist or dentist is the co-admitting member).

H&Ps performed prior to registration or inpatient admission may be used if the following conditions are met:
1. The H&P was completed less than 30 days prior to the registration or inpatient admission; and
2. An update/interval note is completed and a physical examination is performed and documented in the patients' medical record within 24 hours after registration or inpatient admission.

H&P for Operative and Other Invasive Procedures: The medical H&P must be completed and in the patient record prior to the operation/procedure being performed.
H&Ps performed prior to registration or inpatient admission may be used if the following conditions are met:
1. The H&P was completed less than 30 days prior to the registration or inpatient admission; and
2. An update/interval note is completed and a physical examination is performed and documented in the patients' medical record prior to an operative or other invasive procedure.
3. Short form H&Ps may be handwritten in lieu of dictated and transcribed H&Ps.

H&P for Deliveries: The prenatal record may be utilized as the H&P as long as the following conditions are met:
1. The prenatal record contains the required elements; and entries have been made less than 30 days prior to delivery, and
2. The patient is examined and the prenatal record is updated to reflect the patient's condition upon admission.

An H&P may be utilized rather than the prenatal record.

An H&P performed prior to registration or inpatient admission may be used if the following conditions are met:
1. The H&P was completed less than 30 days prior to the registration or inpatient admission; and
2. An update/interval note is completed and a physical examination is performed and documented in the patients' medical record prior to an operative or other invasive procedure.

The prenatal record is to include all required elements with interval/update note or the H&P must be on the record prior to delivery.

H&P for Outpatient Surgery: An H&P is required for outpatient surgery. If the medical history and physical was done within 30 days prior to registration or admission, an update/interval note must be done and on the record prior to surgery. Interval/update notes must state that the physician has examined the patient, reviewed the H&P and there have or have not been changes; any changes must be documented.

H&P for Outpatient Admissions for Diagnostic Studies (Series Injections, Physical Therapy, Laboratory Testing, Radiological Testing, etc): An H&P is not required.

Image Guided Biopsies: The physician will perform a focused assessment which includes a review of the patient's past medical history related to the procedure, current medications and known allergies.

H&P Update/Interval Notes: Interval/update notes must state that the physician has examined the patient, reviewed the H&P and there have or have not been changes; any changes must be documented.

If a Consultation Report or an Emergency Department (ED) Dictated Note contains those required elements for an H&P Report, the Consultation Report or ED Dictated Note may be used as the H&P.

17.4.2 Consultation Reports

Consultation requests must be documented in the chart. Consultation reports must provide a written opinion, signed by the consultant, including findings on physical examination or of other data and information. See also Article VI of these Rules and Regulations for details regarding specific requirements for consultations.

If a Consultation Report contains those items necessary for an H&P Report (See H&P Section above), the Consultation Report may be used as the H&P.

17.4.3 Progress Notes

Progress notes shall be entered at least daily, and more often when warranted by the patient's condition. 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. Members who are not able to visit their patients daily shall arrange to have the patients visited by his/her associate or alternate. Associates or alternates must be members. Progress notes can also be use to document any referrals/communications to other providers.

17.4.4 Operative/Procedure Reports

An operative or other high-risk procedure report is documented upon completion of the operative or other high-risk procedure and before the patient is transferred to the next level of care.

The operative or other high-risk procedure report includes the following information:

1) Preoperative and postoperative diagnoses
2) The name(s) of the licensed independent practitioner (s) who performed the procedure and their assistant(s)
3) The name of the procedure performed
4) A description of the procedure and techniques used
5) Findings of the procedure
6) Any estimated blood loss
7) Any specimen(s) removed

Note 1: The exception to this requirement occurs when an operative or other high-risk procedure progress note (as described below) is documented immediately (or as soon as reasonable possible) after the procedure, in which case the full report can be documented within a time frame defined by the hospital. Our practice is to monitor and suspend if operative reports are not documented within 48 hours Mon-Fri. (See below for exceptions.)

Note 2: If the practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be documented at that time in the new unit or area of care.

When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. The progress note shall include:

1) Name(s) of the primary surgeon(s) and assistant surgeon(s)
2) Procedure(s) performed
3) Description of each procedure finding
4) Estimated blood loss (if applicable)
5) Specimens removed (if applicable)
6) Postoperative diagnosis

Exceptions include heart cath procedures where there has been no significant incident that impacts patient care, i.e., code or surgical referral. In these cases, the computer-generated report will suffice in lieu of a formal operative report.
The transcribed operative/procedure report shall be made available in the medical records as soon as possible after the surgery/procedure and shall be authenticated by the surgeon.

The following procedures which are usually done at the bedside do not require a dictated operative report; a note or completion of the Immediate Post-Procedure Note shall suffice:

1. Lumbar puncture
2. Thoracentesis
3. Central lines
4. Incision and drainage
5. Paracentesis
6. Arthrocentesis
7. Chest tube placement
8. Circumcision
9. Wound debridement
10. Bone marrow aspiration/biopsies
11. Fine needle aspirations
12. Suturing
13. Endotracheal intubations

17.4.5 Anesthesia Records

The pre-anesthesia evaluation shall document the surgical procedure anticipated, choice of anesthesia, previous drug history, other anesthesia experience, potential anesthesia problems and American Society of Anesthesiology (ASA) score. Post-anesthesia notes shall include the presence or absence of complications related to anesthesia.

17.4.6 Diagnostic Studies

The record shall include pertinent and timely completed laboratory, radiology, pathology and other diagnostic studies performed during the hospitalization. If diagnostic studies are performed outside of the hospital, copies of these reports must be in the patient's record as soon as possible after admission.

17.4.7 Discharge Summary/Final Diagnosis/Final Progress Note

A discharge summary is required on all inpatients (see below for exceptions) and must include the date of admission, date of discharge, reason for hospitalization, the significant findings, the procedures performed and treatment rendered, final diagnoses, the condition of the patient on discharge, and plans for follow-up care, including discharge instructions to the patient and/or family and discharge medications, dietary and activities advice. A dictated discharge summary including the above is required for all non-surgical pediatric patients regardless of length of stay or patient condition.

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require less than a 48 hour period of hospitalization, normal newborn infants and uncomplicated obstetric deliveries. The progress note must include the date of admission, date of discharge, final diagnoses, patient's condition at discharge, discharge instructions and follow-up care required.

The Discharge Summary/Final Diagnosis/Final Progress Note must be completed within fourteen (14) days following patient discharge.

17.4.8 Emergency Records

The emergency record must include the time and means of arrival, final diagnosis, conclusions at termination of treatment, including final disposition, condition at discharge and instructions for follow-up care. The record also documents when a patient receiving emergency care leaves against medical advice.

17.4.9 Autopsy Report
An autopsy report must be included in the complete record, if performed.

Section 17.5 Availability of Records

Records shall be maintained safely by the Hospital. Each member shall respect the confidentiality of member-patient communications, information obtained in the course of diagnosing and treating patients, and patient's records.

Records are the property of the hospital and may be removed from the Hospital only in accordance with a court order, subpoena or statute. Unauthorized removal of charts from the Hospital is grounds for corrective action against the member.

Patient records will be retained in accordance with the Hospital Policy: Medical Records Retention.

Free access to all medical records of all patients shall be afforded to members for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients (See Hospital Policy: Release of Patient Identifiable Information. All such projects shall be approved by the Institutional Review Board of Providence Little Company of Mary Medical Center Torrance (PLCMMCT) before records can be studied. Subject to receipt of a written request, present or former members shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

ARTICLE XVIII

ORDERS

Section 18.1 Treatment Orders

All orders for treatment shall be in writing and must be dated, timed and authenticated by the ordering practitioner.

Section 18.2 Verbal Orders

A verbal order shall be considered to be in writing if the member dictates the order to a registered nurse, license vocational nurse, licensed pharmacist, respiratory care practitioner, or a duly authorized person functioning within his or her sphere of competence and the order is then dated, timed, and authenticated by the ordering practitioner or another practitioner who is responsible for the care of the patient. All medication verbal orders must be authenticated within 48 hours. Verbal orders may only be issued for: telephone orders, emergency situations, cardiopulmonary resuscitation activities or rapid transfers.

Persons authorized to accept verbal orders for drugs and medications are identified in the Article XIII regarding Drug and Medication Orders. 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; and physical therapists may take verbal orders for physical therapy.

The responsible member shall be the member who issued the order or the member to whom he or she transferred responsibility for the patient. The member accepting responsibility for the patient may countersign the verbal orders issued by the other member if they appear proper. If there is any question about the order (e.g., why it was given or whether it was accurately noted), the responsible member should refer the matter back to the member who issued the order, who shall clarify the order and countersign it within the required time.

Do not resuscitate (DNR) orders and other orders to withhold or withdraw life-sustaining treatment may not be given as verbal orders, except as noted in the policy "Discontinuing Life-Sustaining Treatment," and must be written in the patient's chart by the responsible member.

Section 18.3 Cancellation of Orders on Transfer

All orders must be reviewed and either re-ordered, revised or cancelled by the responsible physician/member when the patient moves to a different level of care and this includes do not attempt cardiopulmonary resuscitation (DNA-CPR) orders. This shall be appropriately documented in the patient’s record.

Section 18.4 Medication Orders

Medication orders shall be given in accordance with Article XIII Medication Orders.

Section 18.5 Respiratory Therapy

Respiratory therapy orders must be reviewed and reordered at least every five (5) days. Respiratory treatment orders must be re-written when the patient is transferred into and out of a unit.

Section 18.6 Physical Therapy

Members must either specify the physical or occupational therapy treatment modality or sign the Physical Therapy Treatment Plan.

18. 7 Clinical Order Set

The Medical Executive Committee delegates clinical order set development, review, revision and approval to Providence Health & Services System and affiliate clinical expert collaboration groups, such as Clinical Program Services institute focus groups and Clinical Decision Teams. Clinical Practice guidelines and standardized order sets are considered approved by Providence Little Company of Mary Medical Center medical staff upon approval by designated review expert groups. When a new/revised order sets have been approved, PH&S is responsible to communicate these updates to Clinical caregivers. If the MEC has concerns or feedback regarding order sets, the MEC or designee can communicate with clinical expert collaboration leaders for consideration."

ARTICLE XIX
OUTPATIENT SERVICES

Section 19.1 Services

Outpatient diagnostic care shall include pathology, clinical laboratory services, radiology, cardiology, pulmonary function, Medication Therapy Management (MTM) clinic and gastroenterology.

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

As needed, the medical staff may be involved in establishing policy, procedure, protocol and oversight of outpatient services.

Section 19.2 Admission of Outpatients

Patients referred for outpatient services must be admitted to the Hospital's outpatient service. A record shall be created in accordance with the Rule governing medical records.

Section 19.3 Written Orders -

Patients shall receive outpatient therapy only upon the written order of a licensed physician**.** All outpatient orders shall include patient name, date of birth, test/treatment ordered, diagnosis for each test ordered, a legible signature of the ordering physician that is dated and timed.

Section 19.4 Outpatient Surgery

19.4.1 Eligible Cases

Any surgical procedure may be performed on an outpatient basis, provided the patient may be safely cared for on an outpatient basis.

19.4.2 Anesthesia

All types of anesthesia may be used for patients undergoing outpatient surgery.

19.4.3 Pre-Op Evaluation

Each patient shall be evaluated pre-operatively by the surgeon (see Section 17.4 for requirements for History and Physical), who shall be responsible for determining what surgical intervention is necessary and for securing the patient's informed consent for the surgery. In addition, when an anesthesiologist administers anesthesia, other than a local anesthesia, the anesthesiologist shall be responsible for evaluating the patient preoperatively, using the same standards that apply when surgery is performed on an inpatient basis.

19.4.4 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 Article V Consent for Medical and Surgical Procedures)

19.4.5 Specimens

All anatomical parts, tissues and foreign objects that are removed during surgery except those exempted from review in the departmental rules and regulations will be submitted to the 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 record.

19.4.6 Pre-Op Instructions

Patients admitted for outpatient surgery shall be given pre-operative instructions which address:
A. Any restrictions on food, liquid 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.

19.4.7 Discharge

Each patient shall be discharged from the Hospital in accordance with Hospital Policy: Discharge of Patients from Ambulatory Services.

ARTICLE XX

PERFORMANCE IMPROVEMENT/PEER REVIEW

The Professional Staff is accountable to the Board of Directors and has a leadership role in organizational performance improvement activities. The Professional Staff shall provide leadership through the departments, Physician Excellence Council and Medical Executive Committee for the process of measurement, assessment and improvement of processes as defined in the "Organizational Plan for Performance Improvement and Patient Safety".

ARTICLE XXI

RESEARCH

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

All research undertaken by members, or others, involving Hospital patients must be approved by the Providence Saint Joseph Health Centralized Institutional Review Board. Decisions to approve research are based on evaluation of the risks, benefits and resources required of the Hospital. All research must be conducted in accordance with the rules and policies governing research, approved by the Providence Saint Joseph Health Centralized Institutional Review Board.

A member may use or allow the use of the Hospital's name in published works only with the permission of the Administration. However, members may identify themselves as members of the Hospital's Professional Staff within the limits of accepted professional ethics and practices.

ARTICLE XXII

RESTRAINTS

The Hospital-wide policy on the "Use of Restraints" shall provide a patient-focused framework to guide any actual restraint or seclusion use through individual orders given by members. The Professional Staff's responsibility shall include assessment and reassessment of the patient and the provision of orders thereafter. See also Hospital Policy: Use of Restraints.

ARTICLE XXIII

UTILIZATION MANAGEMENT

Section 23.1 General

Each attending member must document in the record the need for the patient's admission and for continued hospitalization. The current Utilization Management Plan will be maintained in the Case Management Department and made available for study by any member.

The documentation shall include:

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

Plans for post-hospital care.

Section 23.2 Justification for Continued Hospitalization

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

ARTICLE XXIV

ORGANIZED HEALTH CARE ARRANGEMENT

Providence Little Company of Mary Medical Center Torrance, as part of the Little Company of Mary Service Area, and the medical staff members have established a Little Company of Mary Service Area Organized Health Care Arrangement under 45 CFR 164.501, as a clinically integrated health care setting, including all Little Company of Mary System facilities, services and programs, the employees, and practitioners and other clinicians who are members of the medical staff and/or who otherwise have medical staff privileges at Providence Little Company of Mary Medical Center Torrance in the Little Company of Mary Service Area ("LCMSA OHCA"). Under the LCMSA OHCA, all of the members, including members of the medical staff, may rely on a Joint Notice of Privacy Practice and Acknowledgment. Further, members of the LCMSA OHCA may use and disclose protected health information in the conduct of their joint operations and joint activities, all in a manner consistent with the requirements of HIPAA.

Notice of Privacy Practices. Each member of the medical staff shall be required to use and conform to the terms of the Joint Notice of Privacy Practice developed and used by the Little Company of Mary Service Area with respect to protected health information created or received as part of each medical staff member's participation in the LCMSA OHCA and to comply with all applicable Providence Little Company of Mary Medical Center Torrance, medical staff and HIPAA requirements, policies and procedures relating to the confidentiality of protected health information.

Each medical staff member is responsible for their own compliance with applicable state and federal laws relating to protected health information. The establishment of the LCMSA OHCA shall not in any way create additional liabilities by or among the members of the LCMSA OHCA or cause one or more LCMSA OHCA members to assume responsibilities for the acts or omissions of any other member of the LCMSA OHCA, and each member of the LCMSA OHCA shall be individually responsible for their own acts or omissions with respect to compliance with HIPAA requirements.

The Medical Executive Committee may establish from time to time such additional rules and requirements to assure conformity with the above requirements, including requiring each medical staff member at the time of their initial appointment and any subsequent reappointment, to sign and acknowledge their individual responsibilities with respect to the above requirements.