Medical Staff
General Rules and Regulations
2021

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ARTICLE I: PREAMBLE

In accordance with the Medical Staff ("MS") Bylaws, the MS of West Hills Hospital and Medical Center ("Hospital") has initiated and adopted these General Rules and Regulations. Adherence to these General Rules and Regulations is required of all Practitioners (as the term "Practitioner" is defined in the MS Bylaws) credentialed by the MS including those holding temporary privileges. In these Rules and Regulations and other related MS documents, any Practitioner or staff/administrative person referred to by title or position shall mean the person identified or their designee. The term "days", unless otherwise stated, means calendar days.

ARTICLE II: GENERAL REQUIREMENTS

2.1 Communication from the Medical Staff to Practitioners

A. Routine communication from the MS or Medical Staff Services ("MSS") to Practitioners will occur in electronic format.

B. Each Practitioner is required to have an active personal email account as a condition of initial and continuing Medical or Advanced Practice Professional ("APP") Staff membership.

C. In addition to an email address, each Practitioner must provide MSS with other contact information including an office address and telephone number (if applicable), an exchange telephone number (if applicable), and a home and cellular telephone number. This information will be maintained by MSS as part of the Practitioner's credential file.

D. Practitioners must notify MSS within fourteen (14) days if any of his/her contact information changes.

2.2 Professional Liability Insurance

A. Each Practitioner is required to obtain and maintain professional liability insurance in the minimum amounts of coverage of $1,000,000 per occurrence and $3,000,000 aggregate. Shared allocation of coverage limits is permitted only for an APP and his/her supervising physician.

B. The insurance must be with an insurance carrier authorized by the State of California as a licensed provider of professional malpractice insurance.

C. The insurance must provide full coverage for the types of patients treated and for all treatments/procedures the Practitioner has been privileged to perform in the Hospital.

D. Each Practitioner must immediately report any reduction, restriction, cancellation or termination of required professional liability insurance, or any change in insurance carrier within seven (7) days through a written notice to the Director of MSS. Failure to maintain insurance coverage for any privilege that is held shall result in automatic suspension of such privilege until such time as the Practitioner provides evidence of appropriate professional malpractice insurance coverage.

2.3 Administrative Requirements

A. Any outside contract for inpatient patient care related clinical services must be approved by the MS and must meet appropriate accreditation standards.

B. If the Hospital's Disaster Plan is activated, all credentialed Practitioners are required to perform disaster related duties as they are assigned by the Chief of Staff or the Practitioner's department chairperson.

C. Practitioner participation on and any panel involving payment from the Hospital will occur only pursuant to the relevant Hospital administrative policy. No Practitioner has a right to participation on a Hospital paid panel by virtue of Medical or APP Staff membership.

D. The process for adoption and amendment of the Rules and Regulations and MS policies is described in the MS Bylaws.

ARTICLE III: COVERAGE, AVAILABILITY AND RESPONSE TIME

3.1 Call Coverage and Handoff Communication

A. Each Practitioner shall personally provide or otherwise arrange for continuous care and coverage for each of his/her patients who present to the Hospital for emergency services or are currently Hospital observation patients or inpatients. If a Practitioner is unable to provide care for his/her patients, the Practitioner must provide coverage through another appropriately credentialed Practitioner.

B. At the time of initial appointment and reappointment, each Practitioner will be requested to submit the names of one or more Practitioners who have agreed to provide alternative call coverage. If a Practitioner does not have identified alternative call coverage at the time of initial appointment, the Practitioner must have identified call coverage within four (4) months of initial appointment. The Medical Executive Committee ("MEC") may, for cause, make Practitioner specific exceptions to alternative call coverage requirements.

1. Practitioners providing call coverage must have appropriate privileges necessary to cover the scope of clinical services provided by the Practitioner for whom he/she is providing call coverage.
2. The covering Practitioner must be available to assume responsibility for the patients during the attending Practitioner's absence and must be aware of the status and condition of any Hospital inpatient which he/she is to cover.
3. Failure to have appropriate call coverage, as determined by the MEC, shall result in an automatic suspension of MS Membership and privilege as described in the MS Bylaws. The automatic suspension shall remain in place until appropriate call coverage is obtained and documented by the Chief of Staff.
4. A Practitioner must notify MSS within fourteen (14) days if there is a change in his/her call coverage.

C. Practitioners should provide hand-off communication when assigning call coverage or transferring care to another provider. The information in hand-off communication should include:

1. The patient's pertinent medical history
2. Current treatment plan
3. Pertinent information related to medications
4. Recent or anticipated changes in the patient's condition

3.2 Practitioner Availability and Response Time

A. It is expected that a Practitioner who is on call for his/her own or another Practitioner's patients will respond to calls regarding a Hospital inpatient or Emergency Department ("ED") patient within fifteen (15) minutes by telephone and, whenever reasonably possible, be personally available in the Hospital within thirty (30) minutes of the request if his/her presence at the Hospital is requested. Program or service specific MS policy may define a required response timeframe which is shorter than described above.

B. An attending or ED on-call Practitioner must evaluate a patient in the ED, or immediately (within thirty (30) minutes) after a Hospital admission through the ED, if requested to do so by an ED physician. Any concerns regarding the appropriateness of the ED physician's request should be referred to the Chief of Staff for retrospective review, but the concern review may not result in a delay in care of the patient.

C. An attending or consulting Practitioner is expected to evaluate an inpatient in a timely manner when requested to do so by the patient's direct RN care provider. Any concerns regarding the appropriateness of the RN's request should be referred to the Chief of Staff and Chief Nurse Executive for retrospective review, but the concern review may not result in a delay in care of the patient.

ARTICLE IV: ADMISSION OF PATIENTS

4.1 General Admission Requirements

A. The Hospital shall accept patients for diagnostic and therapeutic care. The Hospital shall not accept patients who primarily need psychiatric or primary substance abuse treatment or who have virulent infectious diseases for which suitable isolation cannot be maintained.

B. The appropriate department chairperson shall contact the attending Practitioner whenever questions arise as to whether a patient should be admitted, retained, discharged or transferred.

C. If a patient requires direct admission to the Hospital, the attending Practitioner shall, whenever reasonably possible, contact the House Supervisor and determine whether there is an available bed.

D. A patient may be admitted to the Hospital only by MS members who have admitting privileges or by Practitioners who have been granted temporary admitting privileges in accordance with the MS Bylaws.

E. No patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In case of a documented emergency, such statement shall be recorded as soon as possible after the emergency has been stabilized, but no later than twenty-four (24) hours after admission.

F. Patients requiring emergency admission through the ED who do not have an attending Practitioner shall be assigned an on-call Practitioner in accordance with the ED Call Panel list described in Article XII.

G. A Practitioner shall not admit, treat, perform surgery or write orders on an immediate family member without prior approval from the Chief of Staff. "Immediate" is defined as parent, sibling, spouse or child. A Practitioner may review the medical record of an immediate family member with the family member's permission.

H. If a Practitioner on suspension due to medical record delinquencies must admit a patient in an emergency situation because no other available Practitioner has the necessary skill set and/or privileges to care for the patient, the Practitioner on suspension must follow the procedures described in the Interdisciplinary Policy – Medical Record Delinquency and Suspension.

4.2 Responsibilities of the Attending Practitioner

A. If a patient is admitted with ED Bridging Orders, the attending practitioner must enter admitting orders in the medical record within the timeframe described in the MS Policy – Bridge Orders.

B. The patient’s attending Practitioner shall be responsible for directing and supervising the patient’s overall medical care, coordinating all consultations, completing and recording in the medical record a medical history and physical ("H&P") examination, the prompt and accurate completion of the medical record, providing necessary special instructions and transmitting information regarding the patient’s status to the patient, any referring practitioner, a surrogate decision maker and the patient’s family.

C. If a Practitioner’s patient presents to the ED for care, it is expected that the patient's identified Practitioner, or an identified designee, will be available for consultation and to admit the patient to the Hospital if clinically indicated. It is not acceptable to refer patients to the ED backup Practitioner unless the ED backup Practitioner has agreed to assume this responsibility in advance.

D. The name of the attending Practitioner must be identified in the medical record at the time of admission. Whenever the primary responsibility for patient care is transferred to another Practitioner, a note covering the transfer of care shall be entered into the progress note and the new attending Practitioner shall be identified as a "Change Attending Physician" order. Call coverage is not considered a change in attending status.

E. If the admitting Practitioner is not assuming responsibility as the attending Practitioner, this fact must be clearly stated in the admitting orders and initial progress note. The identified attending Practitioner must have knowledge of the patient and have agreed to take responsibility for the care of the patient.

F. Attending Practitioners must abide by all MS policies regarding admission and discharge criteria to various levels of care. This includes admissions to observation status, a medical surgical ("Med/Surg") unit, telemetry and the Intensive Care Unit ("ICU"). There must be appropriate Practitioner communication with Hospital staff regarding the presence of medical conditions requiring admission and continuing stay in various levels of care is required.

G. It is the responsibility of the attending Practitioner to assure laboratory and radiology testing is tailored to the individual needs of the patient. Specific laboratory testing should be determined by such factors as patient age, clinical status and other clinically relevant information.

H. In the event the attending Practitioner is not available to address an issue regarding a Hospital inpatient, the department chairperson or Chief of Staff shall be contacted and he/she shall appoint an appropriate MS member to assume responsibility for the patient until the attending Practitioner can be reached. If this occurs an incident report will be completed and referred to the appropriate MS committee for peer review.

I. Each inpatient must be seen and assessed by their attending Practitioner on a daily basis. Based on the acuity of the patient, more than one daily visit by the attending Practitioner may be clinically indicated. The attending Practitioner must also enter a daily progress note reflecting the results of his/her patient assessment and the status of the patient relative to the treatment plan. Patients may also be seen by APPs and consultants but those visits do not take the place of the required daily assessment by the attending Practitioner.

J. Attending Practitioners are responsible for their observation and admitted patients regardless of the patient's location in the Hospital. This responsibility includes providing continuous care for observation and admitted patients who are temporarily housed in overflow areas of the Hospital including the ED.

4.3 Psychiatric and Infection Admission Precautions

A. The attending Practitioner, at the time the patient is admitted, shall inform the nursing staff if he/she suspects that the patient may be a danger to self or to others or has a significant infectious or contagious disease. The attending Practitioner shall recommend appropriate precautionary measures to protect the patient and the staff and shall note in the patient’s medical record the reason for his/her suspicion and the precautions taken to protect the patient and others.

B. All patients with infectious disease will be admitted and cared for in accordance with the Hospital's infection control policies.

C. In the event a patient or staff members cannot be appropriately protected in the Hospital, arrangements shall be made to transfer the patient to a facility where his/her conditions can be appropriately managed.

D. It is the responsibility of the attending Practitioner to report all cases of reportable diseases in accordance with Title 17 of the California Code of Regulations for the control of communicable diseases and Hospital infection control policies.

4.4 Unit Specific Admission and Observation Status Requirements

A. Admission to a Medical Surgical Unit

1. Any patient admitted directly to the Hospital without being seen by an ED physician must be seen and evaluated by the attending Practitioner or an appropriate physician consultant either immediately prior to or within four (4) hours of a medical/surgical ("Med/Surg") admission.
2. A patient admitted to a Med/Surg bed through the ED without being seen by the attending Practitioner must be seen by the attending Practitioner or an appropriate physician consultant within a timeframe appropriate to the patient's clinical condition and in any case within twenty-four (24) hours of admission. An ED physician may request the attending Practitioner assess the patient sooner than twenty-four (24) hours after admission.
3. The patient's H&P must be completed and available in the medical record within twenty-four (24) hours after admission and prior to any surgery or invasive procedure.

B. Admission or Transfer to an Intensive Care Unit

1. Practitioners must hold appropriate privileges to admit to an Intensive Care Unit ("ICU") bed or level of care.
2. Questions regarding admission or transfer of a patient to a ICU shall be resolved prior to admission or transfer by the attending Practitioner in consultation with the ICU Medical Director.
3. Patients admitted to an ICU level of care must be seen and evaluated by the attending Practitioner or an appropriate physician consultant either immediately prior to or within four (4) hours after the ICU admission.
4. Any patient admitted to an ICU level of care is required to be seen by an appropriate Practitioner consultant who is a specialist in management of the condition requiring ICU care. It is the responsibility of the admitting physician to call an appropriate specialty Practitioner consultant within a reasonable length of time. A reasonable length of time is considered to be within twenty-four (24) hours of admission to the ICU.

C. Observation Status

An ED patient should be placed in observation status when a period of observation and/or further testing is reasonable and clinically necessary to evaluate the patient's condition and determine the need for inpatient admission. Placement in observation status shall be ordered by a Practitioner who has admitting privileges and who will be responsible for the patient's care during the period of observation. Documentation for patients in observation status shall include:

1. An order to "Place in Observation Status"
2. An electronically recorded H&P
3. Orders for diet, activity, medications, diagnostic tests, therapeutic treatments and the frequency of monitoring vital signs.

4.5 Priority of Admissions and Transfers

A. When the Hospital's Chief Executive Officer or the administrator on call determines that bed space is not available, he/she may limit admissions to emergency cases.

B. In such event, patients will be admitted using the following order of priority:
1. Emergency Admissions – 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 (4) hours.
2. Urgent Admissions – 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 (24) hours.
3. Preoperative Admissions – Patients who are already scheduled for surgery.
4. Routine Admissions. Patients who will be admitted on an elective basis to any service.

ARTICLE V: ORDERS FOR MEDICATION, TREATMENT AND DIAGNOSTIC TESTING

5.1 General Requirements Related to Medications, Treatments and Diagnostic Testing

A. It is the Practitioner's responsibility to assure an indication or diagnosis is present in the medical record for every medication, treatment and diagnostic test ordered.

B. All orders for medications, treatments and diagnostic testing shall be entered in the patient's electronic medical record and authenticated by the ordering Practitioner. It is understood there are a limited number of medications that can only be initiated by a paper order set. This list of medications has been approved by the MEC and will be updated as needed. If an electronic format is available for a medication order, it must be utilized by all Practitioners.

C. A Practitioner's orders must be clear, legible and complete. Orders that are unclear, illegible or incomplete will not be carried out until rewritten or clarified.

D. Inpatient medications, treatment and diagnostic testing orders may only be accepted from an appropriately credentialed Practitioner and the order must be within the credentialed Practitioner's scope of practice as defined by state law and within the scope of the Practitioner's privileges.

E. Outpatient diagnostic testing orders may only be accepted from an appropriately licensed Practitioner and the order the Practitioner gives must be within the licensed Practitioner's scope of practice as defined by state law. Outpatient diagnostic testing orders may be accepted from licensed practitioners who are not members of the MS.

F. No medications shall be administered except by licensed personnel authorized to administer medications and upon the order of a person lawfully authorized to prescribe.

G. Medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia National Formulary, the American Hospital Formulary Service, the FDA Orange Book Class A or a newly released medication approved by the Pharmacy and Therapeutics Committee for use in the Hospital. Whenever possible, medications that are ordered for patients should be those listed in the Hospital formulary.

H. Except in an emergency situation, the use of non-formulary medications will be reviewed and approved by the Pharmacy and Therapeutics Committee prior to use. The emergency use of non-formulary medications is described in the Interdisciplinary Policy – Drug Formulary.

I. Generic medications may be dispensed unless specified "Do Not Substitute" or "DNS" by the prescribing Practitioner.

J. The use of investigational medications or treatments must be in compliance with the federal Protection of Human Subjects regulations and must be dispensed by the Hospital pharmacy according to established procedure for handling investigational medications and investigational protocols.

K. Orders for medications must include the name of the drug, dosage, frequency of administration, route of administration (if other than oral) and the date, time and signature of the prescriber.

1. If medications are to be given on an as-needed or "prn" basis, the order must be specific as to why and when the medication is to be administered based on the clinical findings and condition of the patient.
2. If the order is for a dosage range, more than one (1) drug for the same indication, and/or for more than one (1) route of administration, there must be additional information provided by the ordering Practitioner to

allow staff to determine the specific dosage, drug and/or route of administration to use based on the patient's clinical findings and condition.

L. Orders will automatically stop and any new or continuing orders, including drug orders, must be re-entered when a patient:

1. Has a surgical procedure in the Operating Room ("OR")
2. Has a level of care change from an outpatient setting to an inpatient setting, from an ICU to a lower level of care or from a lower level of care to an ICU

M. When an automatic stop order has been implemented, a Practitioner must either re-enter the patient's orders or review and authenticate the patient's electronic order summary with any additions or deletions appropriately noted. The use of an order such as "resume all previous orders" is not acceptable and will not be followed by staff.

5.2 Review of Drug Orders

A. Each Practitioner is expected to review all medications on a daily basis to ensure discontinuation of drugs that are no longer needed.

B. Unless ordered for a specific time period, automatic drug stop orders shall be carried out as follows:

1. Antibiotics – Seven (7) days
2. Narcotics, hypnotics, and tranquilizers – Seven (7) days
3. Ketorolac – Five (5) days
4. All Other non-scheduled drug classes – Thirty (30) days

C. Practitioners will be notified by pharmacy through the electronic medical record when an automatic drug stop order has occurred.

5.3 Procurement of Medications

A. All medications shall be procured from the Hospital pharmacy except as specified in this Section.

B. All medications brought to the Hospital by patients will be turned over for safekeeping to the pharmacy and may be administered to the patient only if the medication is clearly identified by the Hospital's pharmacist and specifically ordered as a "Patient's Own Medication" by the patient's attending Practitioner.

5.4 Verbal and Telephone Orders

A. Orders dictated to a licensed person by a Practitioner are known as verbal orders if dictated in person or telephone orders if dictated telephonically. Verbal orders may be given only in an emergency situation when the Practitioner is physically unable to electronically enter the orders. Telephone orders may be given only when the Practitioner is physically unable to electronically enter the orders.

B. It is not acceptable for a Practitioner to utilize a verbal or telephone order for personal convenience.

C. All verbal or telephone orders must be authenticated or countersigned by the ordering Practitioner or designee within forty-eight (48) hours pursuant to the Interdisciplinary Policy – Telephone, Verbal and Written Orders.

D. Practitioners caring for a particular patient may authenticate verbal or telephone orders given by another Practitioner on the patient's care team if the authenticating Practitioner is sufficiently familiar with the clinical circumstances surrounding the order and holds appropriate privileges to authenticate the order.

E. Verbal or telephone orders for restraint must be signed by the Practitioner as described in the Interdisciplinary Policy – Restraint.

F. Verbal or telephone orders for medications or IV fluids may be received by a pharmacist or a registered nurse.

G. Verbal or telephone orders for treatments and diagnostic testing may be given to other licensed care professionals (i.e. respiratory therapist, radiology technologist, medical technologist, physical therapist, and dietitian) as related to the licensed care professional's scope of practice.

H. Read-back of verbal and telephone orders shall occur pursuant to the Interdisciplinary Policy – Telephone, Verbal and Written Orders.

5.5 Electronic and Pre-printed Order Sets

A. Electronic or pre-printed order sets for any treatment may be used for a specific patient when authorized by a Practitioner who is licensed and appropriately credentialed to issue the specific orders. All electronic and pre-printed order sets must reflect current best medical practice and be approved and reviewed pursuant to the Interdisciplinary Policy – Physician Order Set Development and Review. Electronic and pre-printed order sets must:

1. Be initiated only by the order of an appropriately credentialed Practitioner
2. Be age and patient population specific
3. Be appropriately timed, dated and authenticated in compliance with Hospital policy

B. Electronic order sets must be utilized by Practitioners when available. Paper pre-printed order sets may only be used when an electronic version is not available.

C. An electronic or pre-printed order set may be initiated by a nurse or other clinical staff if all of the following specific circumstances are met:

1. Initiation of a specific electronic or pre-printed order set by a nurse or other clinical staff has been approved by the MEC
2. Situations when the order set should be initiated are clearly defined and initiation of the order set does not require clinical decisions that are outside of the scope of practice for the nurse or other clinical staff
3. The order set is clearly specified for a defined population of patients (such as ICU or newborns) or a specific patient condition (such as a Code or AMI)
4. The nurse or other clinician implementing the order set has verified competencies related to the specific order set he/she will be implementing
5. The order set is initiated only when time-sensitive orders are necessary
6. The responsible Practitioner is notified as soon as feasible after the order set is initiated
7. The initiation of the order set is documented and the order later authenticated by the responsible Practitioner

ARTICLE VI: CARDIOPULMONARY RESUSCITATION AND LIFE-SUSTAINING TREATMENTS

6.1 Decisions to Withhold or Withdraw Medical Care

A. Decisions to withhold or withdraw medical treatment are to be made by the patient or his/her surrogate decision-maker after discussions with the patient's attending Practitioner.

B. The attending Practitioner, or designee, is responsible for providing information and advice regarding when medical treatment should be withheld or withdrawn.

C. The attending Practitioner, or designee, should always review any information available regarding a patient's advance directives when discussing issues related to withholding or withdrawal of medical treatment.

D. A No-Cardiopulmonary Resuscitation order ("No-CPR") means to stop the otherwise automatic initiation of cardiopulmonary resuscitation ("CPR"). A No-CPR order is appropriate when requested by the patient or his/her surrogate decision-maker and the patient has an underlying incurable medical condition, does not have any reasonably conceivable possibility of recovering or long-term survival and there is no medical justification or purpose which would be achieved by applying CPR should the natural course of a patient's medical condition cause vital functions to fail.

E. CPR will be initiated when cardiac or respiratory arrest is recognized unless a No-CPR Order is given. No resuscitative measures will be taken if the Practitioner writes "No-CPR", "No Code" or "Do Not Resuscitate".

F. An order to limit the scope of CPR may be warranted in limited situations. If a partial resuscitation order is issued, the physician must specify precisely which modalities shall be used and which shall not during CPR. Partial resuscitation orders must be clear and unambiguous.

G. No-CPR orders and orders to limit the scope of CPR must be entered in the patient's medical record and authenticated by a physician prior to initiation.

H. Orders to hold or limit resuscitation should be reviewed whenever there is a significant change in the patient's clinical condition or level of care to assure the orders remain constant with the patient's condition and desire.

I. Procedures related to the withholding or withdrawal of life support should follow the Interdisciplinary Policies – Withholding Resuscitative Services (DNR) and Withdrawal of Life Sustaining Treatment.

J. It is the responsibility of the attending physician to clearly record the patient's code status as an order in the medical record at the time of an ICU admission and whenever there is a change in the ICU patient's code status.

ARTICLE VII: CONSENTS AND REFUSAL OF TREATMENT

7.1 General Requirements for Consents and Refusal of Treatment

A. It is the responsibility of the Practitioner performing a complex treatment or procedure to assure that informed consent has been obtained and is documented in the medical record prior to performing a complex treatment or procedure.

B. Another Practitioner credentialed to perform the same complex treatment or procedure may act as the performing Practitioner's designee in obtaining and documenting informed consent. When the Practitioner obtaining the informed consent will not be performing the treatment or procedure he/she must make the patient aware of the name of the Practitioner who will perform the complex treatment or procedure.

C. Policies and procedures related to obtaining and documenting informed consent are described in the Interdisciplinary Policy – Consent.

7.2 Refusal of Treatment and Leaving Against Medical Advice

A. Policies and procedures related to refusal of treatment are described in the Interdisciplinary Policy – Refusal Medical of Treatment.

B. Policies and procedures related to leaving against medical advice ("AMA") are described in the Interdisciplinary Policy – AMA Against Medical Advice.

C. A patient or the patient's surrogate decision-maker has the right to refuse treatment.

D. If a patient or the patient's surrogate decision-maker refuses treatment, the attending Practitioner shall be contacted immediately and discuss the treatment refusal issue with the patient. The attending Practitioner shall enter a brief note in the patient's medical record regarding the initial refusal and whether the patient did consent to treatment at a later time.

E. If a proposed treatment is refused, the Hospital Form – Partial Refusal of Care should be presented to the patient or the surrogate decision-maker for signature. If the patient or the surrogate decision-maker refuses to sign, the notation "refuses to sign" shall be made at the place for the signature and the Practitioner should enter a summary of the consent related discussion in the medical record.

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

G. Whenever possible, the attending Practitioner shall discuss with the patient the implications and possible adverse clinical outcomes associated with leaving the Hospital AMA.

H. If the patient cannot be located or refuses to sign the form, the nursing staff shall notify the attending Practitioner and document facts surrounding the departure in the patient's medical record.

I. When a recommended treatment is refused or a patient leaves AMA, an Incident Report shall be completed and forwarded to the Hospital Risk Manager. If staff or a Practitioner has serious patient safety concerns related to a refusal of treatment or leaving AMA, the administrator on call should be contacted immediately.

ARTICLE VIII: CONSULTATIONS

8.1 General Requirements for Consultation

A. Good medical practice includes the appropriate and timely use of consultation.

B. Any qualified Practitioner can be called for consultation within his/her area of expertise and within the limits of privileges that have been granted.

C. Requests for consultation must be made by direct personal communication from the requesting Practitioner to the consulting Practitioner. Hospital nurses or other Hospital staff may only be used to contact a consulting Practitioner for the purpose of relaying the requesting Practitioner's pager or phone number. The requesting Practitioner should document the consultation request in the medical record.

D. Once requested by direct Practitioner to Practitioner communication, the consultation must be performed in a timely manner as determined by the condition of the patient and the wishes of the Practitioner requesting the consultation.

E. Consultations may only be requested by the attending Practitioner or another Practitioner who is actively involved in care of the patient during the current episode of care. An episode of care is defined by a unique account number. Practitioners may not "self-assign" themselves to case without a valid consultation request even if the Practitioner has provided clinical services to the patient during a previous inpatient or outpatient episode of care.

F. The consultation and specific diagnostic and therapeutic procedures related to a consultation will be done at the Hospital unless specific diagnostic or therapeutic capabilities are not available at the Hospital.

G. A consultant must enter a brief note in the medical record when a patient is seen in consultation. If there are any emergent conditions identified, the consultant must immediately contact the attending Practitioner.

H. The consultant's full report shall be entered electronically or dictated and placed in the medical record within twenty-four (24) hours after the consultation is performed. The full consultation report shall include a review of the patient's record by the consultant, a pertinent H&P examination, the consultant's opinion, the reasons thereof and clearly state the consultant's recommendations.

I. An attending Practitioner's responsibility for a patient does not end with a request for consultation. The attending Practitioner remains in charge of his/her patient's care unless a transfer of patient care to a different attending Practitioner has occurred and the change in attending status has be entered as an order and recorded in a progress note.

8.2 Recommended and Required Consultations

A. Consultation is recommended in the following instances:

1. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
2. Where there is doubt as to the choice of therapeutic measures to be used.
3. In unusually complicated situations where specific skills of other Practitioners may be needed.
4. In instances where the patient exhibits severe psychiatric symptoms.
5. When requested by the patient or a surrogate decision-maker.

B. Consultation is required in the following instances:

1. When the department chairperson or Chief of Staff determines a patient will benefit from a consultation. A consultation will be required only after the department chairperson or Chief of Staff has discussed the situation with the patient's attending Practitioner.
2. When required as part of the MS's peer review process.
3. When otherwise required by Hospital or MS Policy.

ARTICLE IX: DISCHARGE OF PATIENTS

9.1 General Requirements for Discharge

A. Patients shall be discharged only on the order of the attending Practitioner or designee.

B. The attending Practitioner shall assure that the record is complete, state the final diagnosis and authenticate all entries in the medical record.

C. Appropriate discharge instructions for care will be given to the patient and/or family using the current Hospital format and forms. A copy of all discharge instructions is to be retained in the medical record.

D. Minors shall be discharged only to their parents, a legal guardian or a person designated in writing by the parent or legal guardian. This shall not preclude minors legally capable of contracting for medical care from assuming responsibility for himself/herself upon discharge.

E. The attending Practitioner should inform the Nursing Service of possible discharges as early as possible and enlist the aid of the Discharge Planning Coordinator when appropriate.

F. It is the responsibility of the attending Practitioner to coordinate discharge planning and to discharge a patient from the Hospital in a timely manner.

ARTICLE X: DEATHS

10.1 General Requirements Regarding a Patient Death

A. If a patient arrives at the Hospital dead or dies in the Hospital, a qualified Practitioner shall pronounce the patient dead within a reasonable time.

B. Registered nurses may pronounce death pursuant to standardized procedures. The patient's remains, however, may not be released until a physician has made an authenticated entry of the pronouncement of death in the patient's medical record.

C. A diagnosis of neurological death shall be made pursuant to the Interdisciplinary Policy – Withholding and Withdrawing Life Support.

D. The Attending Practitioner is responsible for notifying the next of kin in all cases of death.

E. The attending Practitioner is responsible for signing the death certificate or ensuring its completion within fifteen (15) hours after the death of a patient unless the case has been identified, reported and accepted as a Coroner's Case.

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

G. The patient's Practitioner and Hospital staff shall comply with the Interdisciplinary Policy – Organ and Tissue Donation, for identifying potential organ and tissue donors, and, whenever possible, confer with the patient or family about donations.

H. If the patient or his/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.

10.2 Autopsies

A. MS members shall attempt to secure an autopsy in deaths that meet the following criteria:

1. Deaths in which an autopsy would explain unknown or unanticipated medical or surgical complications
2. Deaths in which the cause is not known with certainty or clinical grounds
3. Deaths in which an autopsy would allay concern of or reassure the public or family regarding the death
4. Cases of unusual academic interest

B. An autopsy may be performed only if authorized in accordance with law. The persons who may consent to autopsies are identified in the Interdisciplinary Policy – Autopsy.

C. Except in coroner's cases, all autopsies shall be performed by the Hospital pathologist or his/her designee. Communication between the attending Practitioner and the pathologist prior to performance of an autopsy is essential. Autopsies of suspected infectious etiology will be performed at the discretion of the pathologist in consultation with the attending Practitioner. Provisional anatomic diagnoses shall be medically recorded on the medical record by the pathologist within seventy-two (72) hours after completion of the autopsy and the complete protocol should be made a part of the medical record within sixty (60) days.

D. California Coroner's Statutes, as described in the Health and Safety Code 10250, and Government Code 27491, decrees that all certain deaths require the notification of the Medical Examiner Coroner. The attending

Practitioner, or designee, shall notify the Coroner when he/she has knowledge of his/her patient's death if any of the below circumstances pertain. Coroner notification shall occur pursuant to the Interdisciplinary Policy – Post-Mortem Care.

1. Known or suspected homicide
2. Known or suspected suicide
3. Death related to an accident whether the accident occurred immediately or at some remote time
4. Death related to an injury whether the injury occurred immediately or at some remote time
5. Grounds to suspect that the death occurred in any degree from a criminal act of another, including known or alleged rape
6. No history of Practitioner in attendance
7. Wherein the deceased has not been attended by a Practitioner in the 20 days prior to death
8. Wherein the Practitioner cannot reasonably state the cause of death.
9. Death due to poisoning (food, chemical, drug, therapeutic agents
10. All deaths due to occupational disease, injury, or hazard.
11. All deaths during or within 24 hours after a surgical procedure
12. All deaths where a patient has not fully recovered from an anesthetic, whether in surgery, recovery room, or elsewhere
13. All solitary deaths, that is, unattended by Practitioner, family member, or any other responsible person in the period preceding death
14. All deaths in which the patient is comatose throughout the period of Practitioner's attendance, whether in home or Hospital
15. All deaths of unidentified persons
16. All deaths where the suspected cause of death is sudden infant death syndrome (SIDS).
17. All deaths in prisons, jails, or of persons under the control of a law enforcement agent
18. All deaths of patients in state mental Hospitals
19. All deaths where there is no known next of kin
20. All deaths caused by a known or suspected contagious disease constituting a public health hazard
21. All deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, starvation, exposure, strangulation, aspiration, acute alcoholism or drug addiction
22. All deaths associated with known or suspected self-induced or criminal abortion
23. Fetal deaths of older than 20 weeks' gestational age

ARTICLE XI: MEDICAL RECORDS

11.1 General Medical Record Requirements

A. A medical record must be maintained for each patient encounter.

B. The medical record must be accurate, legible when written, promptly completed, properly filed, appropriately retained and accessible.

C. The attending Practitioner is responsible for the preparation of a complete, current, accurate and pertinent medical record.

D. For inpatient admissions the medical record shall include a complete H&P examination, progress notes, operative reports and a discharge summary.

E. Each Practitioner shall be responsible for timely completion and accuracy of the medical record during the course of the patient treatment. This includes documentation of information necessary to justify the admission, substantiate the diagnosis, document a treatment plan, reflect changes in the patient's condition relative to the treatment and document the need for continuing Hospitalization. It also includes documentation of orders,

evaluations, treatments, test results, care plans, care provided, treatment, interventions and the patient's progress and the patient's response to those treatments, interventions and care.

F. When clinically indicated or when requested by the department chair or Chief of Staff, primary source documentation of diagnostic tests performed outside of the Hospital must be included in the patient's Hospital record to support admission and/or proposed treatments or procedures.

G. Failure to complete medical records in a timely manner will result in an automatic suspension of the Practitioner's privileges as described in the MS Policy – Medical Record Delinquency and Suspension.

H. Failure to complete a required electronic or dictated H&P and/or operative report within the timeframes described in these R&Rs will result in responsive action by the MS pursuant to the MS Policy – Medical Record Delinquency and Suspension.

I. Entries in patient medical records are to be made only by persons given this right by nature of their scope of practice and involvement in care of the patient. Those individuals authorized to make entries in the medical record include, but are not limited to, credentialed Practitioners, LVNs, RNs, dieticians, pharmacists, rehabilitation therapists, social workers, respiratory care therapists, radiology technicians and chaplains.

J. All entries made in the medical record must be either entered electronically, dictated or written in a manner that is clear, legible, and complete.

K. If two licensed Hospital staff members are unable to read a written medical record entry, it is considered illegible.

L. Any Practitioner orders that are unclear, illegible, or incomplete will not be carried out until they have been rewritten or otherwise clarified.

I. All entries in the patient's medical record shall be timed, dated and authenticated when the entry is made. Exceptions to this requirement, related to the authentication of verbal or telephone orders, are described in the Interdisciplinary Policy – Telephone, Verbal and Written Orders.

M. In the event it is necessary to correct a written entry in a medical record, the person who made the entry shall line out the incorrect data with a single line in ink leaving the original writing legible. The person shall note the reason for the change and date, time, and authenticate the strikeout. Appropriate explanation for the strikeout shall be entered in the progress note section of the medical record if the reason for the strikeout is not self-evident. A strikeout or any other correction to the medical record shall never involve erasure or obliteration of the material that is corrected.

N. Corrections to final electronic entries must be made by adding an addendum or edit to the electronic entry.

O. No medical record entries shall be removed from the medical record.

P. All blanks left in dictated reports must be filled in by the dictating Practitioner at the time the report is authenticated.

Q. Practitioners may not use any unapproved abbreviations which are identified in the MEC approved "Do Not Use" abbreviation list.

R. The attending Practitioner is responsible to assure all coding/abstraction questions are answered and the discharge summary completed in a timely manner.

S. In an emergency situation there may not be time to electronically enter, dictate or write an H&P prior to providing care and/or performing a procedure. In such case the Practitioner should document the nature of the emergency situation in the medical record, enter a brief note if possible and complete required medical record documentation as soon as reasonably possible.

T. A medical record shall not be permanently filed until it is completed by the responsible attending Practitioner or is ordered to be filed as incomplete by the Director of Health Information Management. The Director of Health Information Management must clearly document in a permanent record the date the medical record has been filed as incomplete and the exact reason the medical record could not be completed. Any questions regarding the filing of an incomplete record will be referred to the Hospital administration.

11.2 Content of History and Physical Examinations

A. A Complete H&P includes:

1. Chief Complaint
2. History of present illness
3. Medications and medication allergies
4. Review of systems
5. Physical examination
6. Assessment and provisional diagnosis
7. Treatment plan
8. A detailed podiatric exam when the patient is undergoing treatment by a podiatrist
9. A detailed dental exam when the patient is undergoing treatment by a dentist

A Complete H&P must be dictated/transcribed, electronic or typewritten. Except in emergency situations, a Complete H&P cannot be handwritten.

B. An Interval H&P Update Note reflects a current assessment and evaluation of a patient's medical status relative to a recent prior Complete H&P. The assessment and evaluation are required regardless of whether or not there were any changes in the patient's condition. This means the Interval H&P Update Note must contain either documentation of the changes in the patient's condition or a clear statement indicating that no changes have occurred. When used as part of an inpatient admissions H&P, an Interval H&P Update Note must be entered in the progress notes within twenty-four (24) hours after admission and prior to surgery or an invasive procedure.

C. A Focused H&P examination, when required for outpatient procedures, may be entered electronically, dictated or hand written. A Focused H&P examination may be utilized for those outpatient procedures identified by the MEC as requiring an examination but not requiring a Complete H&P examination. A Focused H&P examination shall include:

1. Pre-procedural or pre-treatment diagnosis
2. Description of an indication(s) for the procedure(s) to be performed
3. Lists of current medications
4. Drug allergies
5. Summary of relevant past medical/surgical history
6. Summary of relevant laboratory testing
7. Focused physical assessment as clinically indicated

11.3 Required Medical Record Patient Assessment Content

A. All inpatient admissions require a Complete H&P in the medical record within twenty-four (24) hours after admission and prior to surgery or an invasive procedure. Because of this time sensitive CMS requirement, almost all patients admitted for elective surgery will require an Interval H&P Update Note in addition a Complete H&P which is usually performed prior to admission.

B. If a Complete H&P was performed within thirty (30) calendar days prior to the patient's admission to the Hospital, a typewritten or electronic copy of the Complete H&P report may be used in the patient's medical record in lieu of dictating a new admission Complete H&P after admission provided:

1. The H&P report was completed by a privileged Practitioner, or;
2. The H&P report was completed by a California licensed physician who has been reviewed by MSS and classified as a "non-privileged provider", and;
3. The medical record contains an Interval H&P Update Note.

C. The MSS process for classification as a non-privileged provider involves verification of current California licensure, NPI verification and verification of a clear sanction check. A request for verification of non-privileged provider status must be made to MSS at least four (4) business days prior to the admission or procedure by a privileged Provider. It is the privileged Providers responsibility to request and verify completion of the non-privileged provider status classification. An H&P performed by a practitioner who has not been classified by MSS as a "non-privileged provider" may not be used at the Hospital.

D. Outpatient procedures requiring a Complete H&P include the following:

1. Any procedure performed in the Operating Room
2. Any procedure performed that requires general, spinal, or major regional anesthesia
3. Any procedure performed in the Cardiac Cath Lab
4. Vertebroplasty or Kyphoplasty
5. Any interventional endovascular procedure other than those listed below

E. Outpatient procedures requiring a Focused H&P include the following:

1. Procedure involving the use of Moderate or Deep Sedation, unless a Complete H&P is required
2. Chemo-embolism
3. Therapheres
4. Declots
5. Permacath Insertion
6. Interventional Radiology drains and biopsies, except thyroid
7. Liver biopsy
8. Myelogram
9. Diagnostic angiograms
10. Circumcision

Other outpatient procedures should have an assessment documented as determined to be appropriate by the performing Practitioner.

F. Emergency Department records require the following electronic documentation:

1. Chief Complaint or reason for visit
2. History of present illness
3. Review of relevant family, social and past medical history
4. Drug allergies and review of relevant medication history
5. Physical examination
6. Assessment and care plan

G. Outpatient clinic records require the following documentation:

1. Chief complaint or reason for visit
2. History of present illness
3. Review of relevant family, social and past medical history
4. Drug allergies and review of relevant medication history
5. Physical examination
6. Assessment and care plan

H. Obstetrical and normal newborn medical records require the following documentation:

1. For all scheduled obstetrical patients, a copy of the office prenatal record must be sent to the Hospital before admission.
2. An interval obstetrical admission H&P note must also be entered into the medical record within twenty-four (24) hours after admission and, whenever possible, prior to delivery.
3. If a prenatal obstetrical record is not available at the Hospital, the attending Practitioner must electronically enter, dictate or write a Complete H&P at the time of admission. A written Complete H&P can only be utilized for normal vaginal deliveries. C-Sections require an electronic or dictated Complete H&P.
4. Normal newborns must have an electronic admission note and a Complete H&P recorded in the medical record.
5. The electronic discharge note may take the place of a complete discharge summary for normal vaginal deliveries and normal newborns.

11.4 Progress Notes

A. Each Practitioner who renders professional services to a patient shall enter a progress note on the day he/she renders professional services. Every acute care inpatient shall have at least one progress note per day entered in the medical record by the attending Practitioner. If medically indicated, assessments shall be made and progress notes entered more often than once daily.

B. Progress notes shall give a chronological picture of the patient's clinical condition and hospital course and describe the course and results of treatment in sufficient detail to facilitate communication and continuity of care.

C. Progress notes shall include both subjective complaints and objective findings and shall refer to the results of clinically relevant laboratory, radiology, pathology, or other diagnostic tests or procedures that have been performed.

D. Progress notes shall include a description of complications, Hospital-acquired conditions, Hospital-acquired infections, and unfavorable reactions to medications and/or anesthetic agents.

E. A concise clinical treatment plan shall be updated as appropriate as changes occur in the patient's condition. When diagnoses are modified, deleted or added, the reasons for doing so shall be documented in the progress notes.

F. The progress note or other relevant medical record document shall reflect interdisciplinary care planning including collaboration of care planning with the patient and/or the patient's family.

G. A discharge progress note must be entered on the day of discharge that addresses the patient's condition at discharge, discharge diagnosis, discharge medications, discharge instructions and plan for follow-up care.

11.5 Operative Reports

A. At the conclusion of surgery or an invasive procedure, an immediate electronic post-procedural report shall be entered into the medical record. The term "immediately" means before the patient is moved to the next level of care. If the Practitioner performing the procedure accompanies the patient from the operating or procedure room to the next area of care, the immediate post-procedural note may be entered at the next level of care location. The immediate electronic post-procedural report must contain at least the following elements:

1. Primary surgeon and assistant(s)
2. Pre- and postoperative diagnosis(es)
3. Name and description of the specific procedure(s) performed
4. Description of the findings
5. Tissue removed or altered

6. Estimated blood loss
7. Complications

B. In addition to the immediate electronic post-procedure report, an electronic or dictated complete operative report must be completed as soon as reasonably possible, but in any case within twenty-four (24) hours, after completing a surgical or invasive procedure. Complete operative reports shall include at least the following elements:

1. Patient identification
2. Date and time of surgery
3. Name(s) of the surgeon(s) and assistants or other Practitioners who performed surgical tasks
4. Pre and post-operative diagnosis
5. Name of specific procedure(s) performed
6. Type of anesthesia administered
7. A detailed account of the findings, tissue removed or altered, as well as the details of the technique
8. Identification of the use of prosthetic devices, grafts, tissues, transplants
9. If significant surgical tasks are conducted by Practitioners other than the primary Practitioner (i.e. opening and closing, harvesting grafts, dissecting tissue, removing tissue, altering tissue, implanting devices), the report must contain the Practitioner's name and a description of the specific significant surgical tasks performed
10. Complications, if any
11. Estimated blood loss

C. Completion of both the immediate electronic post-procedural report and the electronic or dictated complete operative report is the responsibility of the operating Practitioner.

11.6 Anesthesia Medical Record Documentation

A. The required content of medical record documentation for moderate and deep sedation is described in the Interdisciplinary Policy – Procedural Sedation. The required content of medical record documentation for general, spinal and major regional anesthesia is described in the current Form – Anesthesia Record Form.

B. Depending on the procedure to be performed, prior to moderate/deep sedation or anesthesia, all patients require either a Complete or Focused H&P

C. Records of each procedure involving the use of moderate/deep sedation or anesthesia shall include:

1. pre-anesthetic assessment
2. re-evaluation immediately prior to induction
3. intra-anesthetic record
4. post-anesthetic examination

D. An immediate pre-inducation assessment must be performed by an appropriately credentialed Practitioner immediately prior to moderate/deep sedation or anesthesia to determine if the patient remains a candidate for the sedation/anesthesia planned. This re-evaluation shall be recorded in the medical record and include a review of vital signs, oxygen saturation, the patient's physical status, and the safety and readiness of equipment and rescue supplies.

E. Post-anesthesia evaluation

1. Following inpatient general, spinal and major regional anesthesia, a post-anesthesia follow-up note shall be written by a qualified Practitioner within forty-eight (48) hours. The post-anesthesia note shall include an assessment of:
   • vital signs and cardiopulmonary status

- level of consciousness, mental status, pain status, hydration status, and nausea/vomiting.
- any follow-up care and/or observations
- any complications occurring during post-anesthesia recovery.

2. Following outpatient anesthesia, after the patient has recovered from anesthesia and prior to discharge, a post-anesthesia follow-up note, including the elements described above shall be written by an appropriately credentialed Practitioner.

11.7 Discharge Documentation

A. Final discharge diagnosis shall be recorded in full, without the use of symbols or abbreviations, by the attending Practitioner at the time of discharge of each patient.

B. Every patient requires an electronic discharge note entered in the medical record at the time of discharge.

C. A medical record is considered incomplete if it does not have an authenticated discharge summary recorded within forty-eight hours (48) of discharge.

D. All Hospital inpatients require a complete discharge summary entered or dictated at the time of discharge or as soon thereafter as is feasible, but no later than fourteen (14) days following discharge. A complete discharge summary shall include:

1. A recapitulation of the reasons for Hospitalization and significant findings
2. Principal and all secondary diagnoses
3. All operative procedures performed and treatment rendered, using accepted disease and operative terminology
4. The outcome of the treatments, procedures, or surgery
5. Disposition and the condition of the patient on discharge
6. Documentation of follow-up care including post-discharge diet, activity, medications, and plans for follow-up

E. For patient stays less than 48 hours and normal newborns and normal vaginal deliveries, an electronic discharge note can be used in place of a discharge summary and must contain the following elements:

1. Discharge diagnosis
2. Condition on discharge
3. Disposition
4. Documentation of follow-up care including post-discharge diet, activity, and medications.

11.8 Medical Record Delinquency and Suspension

A. All medical record entries must be completed within the timeframes required by the Bylaws, these Rules and Regulations, licensure and accreditation standards and Hospital Policy. A medical record is incomplete if it lacks a required element within a specific timeframe such as an admission H&P, operative report or discharge summary. The MEC may by policy place Practitioners on suspension for incomplete medical records in addition to suspensions for delinquent medical records. All records become delinquent fourteen (14) days after discharge.

B. A patient's medical record is complete when it contains authenticated entries regarding the patient's condition on arrival, diagnosis, test results, therapy, condition and in-Hospital progress, final diagnosis, condition at discharge and all other elements required in these Rules and Regulations and Hospital medical record policies. Whenever reasonably possible, all medical record entries must be concurrently entered electronically and authenticated.

C. Medical records must be completed promptly and authenticated by responsible Practitioners within fourteen (14) days following the patient's discharge or outpatient visit. Medical records that remain incomplete for any reason fourteen (14) days after the patient's discharge are considered to be delinquent.

D. Failure to complete all required medical records elements including authentications within fourteen (14) days after the patient's discharge, or failure to complete specific elements with shorter required completion timeframes, will be grounds for suspension as described in the MS Policy – Medical Record Delinquency and Suspension.

11.9 Confidentiality, Safeguarding of Medical Records and Access to Information

A. The content of a Hospital medical record may be in any form or medium including electronic, written, photographic or other film or videotape format.

B. All records are the property of the Hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, a subpoena, statute, or other legal authority, and shall not otherwise be taken away without permission of the Chief Executive Officer or when required by law.

C. Written consent of the patient or legal representative is required for release of medical information consistent with Hospital policy and applicable law.

D. All members of the medical and APP staff, and their respective employees and agents, must maintain the confidentiality, privacy and security of all Protected Health Information in records maintained by the Hospital or by business associates of the Hospital, in accordance with any and all privacy and security policies and procedures adopted by the Hospital to comply with current federal, state and local laws and regulations, including, but not limited to, the HIPAA Privacy Regulations. Protected Health Information may not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with the Hospital 's health information privacy policies and applicable law. Medical record information about a patient whom a Practitioner is treating can be furnished by the Practitioner to any health care provider within the facility who has responsibility for that patient's care. This applies to all patients as defined by the California Confidentiality of Medical Information Act and the Health Insurance Portability and Accountability Act of 1996.

E. All Practitioners have the obligation to protect the rights of patients to privacy and confidentiality of any protected health information that may be acquired from the patient or other sources. Care and judgment must be used in order to avoid improper disclosure.

F. Access to the medical records of patients may be afforded to Practitioners for bona fide research subject to prior approval by the Chief Executive Officer. Confidentiality of personal information concerning the individual patient must be maintained at all times.

G. Only staff and Practitioners will have access to the patient's medical record. Protected health information may be accessed and/or disclosed during communications between qualified professional persons having responsibility for the patient's care.

H. Each Practitioner agrees to comply with the information security policies of the Hospital set forth in the information Security Agreement, System Access Authorization and Connectivity Agreement. Inappropriate access to and/or disclosure of protected health information shall be subject to MS Corrective Action.

I. Each Practitioner understands that patient medical records are confidential and access to medical records is limited to those who have a need to know the information contained in the medical record in order to provide care for the patient or to participate in a Medical Staff sanctioned peer review process. Failure to comply with the information security policies of the MS or Hospital may result in termination of access to Hospital computer systems the initiation of MS Corrective Action.

J. Loss of Medical Staff membership or limitation, reduction, or loss of privileges for any reason may be grounds to terminate access to the medical record system immediately and without notice to the Practitioner.

K. Each member of the MS shall have access to previous Hospital records of patients he/she is attending on an outpatient or inpatient basis, when affiliation with the patient is evidenced by documentation of previous Hospital care. Patient consent must be obtained by a requesting physician when affiliation is not evidenced in previous healthcare records.

L. At the time of admission, all appropriate previous records will be made available for the use of the attending and consulting staff responsible for care of the patient.

M. Subject to prior approval by the Director of Health Information Management, former members of the MS may be permitted access to information from the medical records of their patients covering periods during which they provided care for the patient in the Hospital.

ARTICLE XII: EMERGENCY DEPARTMENT CALL PANEL

12.1 Emergency Department Call Panel List

A. The ED Call Panel has been established to assure appropriate ED care of unassigned patients who require specialty consultation and/or Hospital admission by a credentialed Practitioner. The ED Call Panel has been designed to comply with all Emergency Medical Treatment and Active Labor Act ("EMTALA") requirements.

B. The department chairpersons and the Medical Director of the ED are responsible for working with the MEC and Hospital Administration to ensure appropriate ED call coverage is available and a written ED Call Panel list is developed and clearly posted. If appropriate ED call coverage is not available in all specialties, then the Medical Director of the ED shall immediately notify the Hospital administrator on call.

C. Call on the ED Call Panel begins at 7am on the day of call and ends at 7am on the next day.

D. Practitioners may participate on an ED Call Panel regardless of their MS Category. Unless an exception is made by the MEC, a Practitioner must complete core proctoring requirements prior to ED call. Completion of advanced proctoring requirements prior to taking ED call may also be required by the MEC including the following:
    a. General cardiologist must complete coronary angiography proctoring requirements if this privilege has been granted.
    b. Interventional cardiologist must complete PCI proctoring requirements prior to taking STEMI call.

E. Practitioners are required to serve on the ED Call Panel when requested by the MEC. Service on the ED Call Panel is not a privilege but is an obligation of MS membership when required by the MEC. No MS Member has a right to serve on any ED Call Panel. Existing MEC requirements for Practitioner ED Call Panel service may be eliminated by the MEC in the event alternative ED Call Panel coverage becomes available. Removal of any Practitioner from an ED Call Panel does not constitute a denial or restriction of privileges and does not give rise to hearing rights.

F. Mandatory ED Call Panel participation for any group of Practitioners may be recommended by the MEC and becomes effective when approved by the Board.

G. The unassigned medicine panel shall be only for those patients who do not meet any of the following criteria:
    a. the patient requests a provider on staff at the hospital
    b. the patient's primary care provider is on staff at the hospital
    c. the patient's PCP has designated a physician on staff to care for their patients at the hospital
    d. the patient belongs to an IPA which has contracted providers on staff at the hospital
    e. the patient has been admitted under a provider still on staff at West Hills Hospital within the last six months who agrees to admit the patient again
    f. the patient was referred to the emergency department by a physician with staff privileges.

In every case (except those mandated by contract with IPAs or insurance companies) the patient's preferences shall supersede the above designation.

If a patient is mistakenly misclassified, every attempt shall be made to rectify the situation in a collegial manner. Dispute resolution shall occur between the lead hospitalist and the chief of medicine or chief of staff.

12.2 Emergency Department Call Panel Member Requirements

A. Practitioners on the ED Call Panel must respond to the ED by telephone within fifteen (15) minutes and, whenever reasonably possible, be personally available in the ED within thirty (30) minutes of being called. The ED

on-call Practitioner must come in to the ED to examine a patient if requested to do so by the ED Practitioner. Program or specialty specific MS or Hospital policies may require a shorter response time.

B. A Practitioner may only be on the ED Call Panel at only one hospital at a time. An ED Call panelist who is, for whatever reason, unable to provide coverage during his/her scheduled ED Call Panel time is responsible for arranging alternate coverage by an appropriately credentialed Practitioner who meets the eligibility criteria for the ED Call Panel. Eligibility criteria for ED Call Panel participation may include the Practitioner having a personal services agreement ("PSA") with the Hospital. The on-call panelist shall inform the Medical Director of the ED of the name of any substitute Practitioner who will provide coverage and the specific time period which will be covered by the substitute Practitioner. The Hospital will update the ED Call Panel list to reflect any schedule changes and assure an accurate and up to date ED Call Panel list is maintained.

C. Each ED Call Panel Practitioner shall accept the care of all patients who are referred to them without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion, physical or mental handicap, insurance status or ability to pay.

D. If a Practitioner fails to respond to an ED Call Panel obligation, the ED physician shall initiate the Interdisciplinary Policy – Chain of Command and immediately notify the administrator on call. The occurrence shall also be reported on an incident report and sent for review to the appropriate MS committee.

E. All ED Call Panel Practitioners and other MS members shall comply with the Interdisciplinary Policy –Screening & Stabilization ("EMTALA") and any other EMTALA related Hospital policies.

ARTICLE XIII: SURGERY AND INVASIVE PROCEDURE REQUIREMENTS

13.1 General Surgery and Invasive Procedure Requirements

A. All material removed from the patient by operative procedure shall become the property of the Hospital. All specimens shall be identified and sent to the Hospital laboratory for examination except as described in the MS Policy – Surgical Pathology Exemption.

B. Required preoperative testing shall be determined by the operating Practitioner and the anesthesiologist based on the procedure to be performed and the clinical status of the patient.

C. Procedures requiring an assistant to the surgeon are identified in the MS Policy – Major Procedures Requiring an Assistant to the Surgeon. Additionally, all Practitioners performing cardiac surgery on bypass must comply with the provisions of Title 22 Section 70435(b)(2).

D. Any member of the Department of Surgery holding surgical privileges shall be deemed to have "surgical assist" privileges. Members of other departments requesting surgical assisting privileges must provide evidence of current competence and appropriate professional liability coverage for surgical assisting.

13.2 Anesthesiologist Post-Op Requirements

A. An anesthesiologist will be available until the patient is stable in the PACU. An anesthesiolosist will be in the hospital until the patient has demonstrated respiratory and cardiovascular stability or has been transferred to the ICU. It is the responsibility of the anesthesiologist to verify the patient's status prior to leaving the hospital.