PROVIDENCE
Saint Joseph
Medical Center

PROFESSIONAL / AHP STAFF

GENERAL RULES & REGULATIONS

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Professional Staff Administration

818: 847-3939

Incorporates revisions approved through January 22, 2020

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Recognizing that the Professional Staff has a responsibility for the quality of medical care in the Medical Center and accepts and assumes this responsibility subject to the ultimate authority of the Governing Body, and recognizing that the best interests of the patient requires concerted Staff effort, the Professional Staff of Providence Saint Joseph Medical Center organizes these general rules and regulations.

The General Rules and Regulations are reviewed, updated and approved by the Professional Staff and Administrator, are updated on an ongoing basis by actions of the Executive Committee and are submitted to the Board of Directors for approval.

DEPARTMENTAL FUNCTIONS

ORGANIZATION

The Clinical Department shall be supervised by the Clinical Department Committee responsible for supervising all Department activities. The Chairman and Vice Chairman shall be selected as specified in the Bylaws. A representative from the Department of General/Family Practice with privileges in the clinical department will be a liaison committee member. The Clinical Departments may be divided into Sections as appropriate to the function of the Department and as defined in the Department's Rules and Regulations.

DEPARTMENTAL MEMBERSHIP

Each clinical department shall consist of Professional Staff members who's training and/or experience is sufficient to render them Board Eligible or Board Certified in the appropriate specialty or sub-specialty for the department, those who possess other special qualifications, or allied health professionals whose professional activities relate closely to the department and who are assigned to the department by the Credential Committee. All members shall continuously meet the qualifications, standards and requirements for appointment/reappointment to the Professional Staff of Providence Saint Joseph Medical Center as set forth in the Bylaws and these Rules and Regulations.

MEDICAL DIRECTOR AND/OR SUPERVISOR REPORTING REQUIREMENTS

The medical director and administrative supervisor of clinical departments shall, at least once a year, report to their designated professional staff committee or section concerning the past years activity, the budget, staffing, acquisition of equipment, and projected activity. The professional staff committee or section shall have the prerogative of discussing problems that are affecting the physicians functioning and the care of their patients.

The reporting relationships shall include but not be limited to:

1. Heart medical director to cardiology section of the medical committee and to the surgical committee.
2. G.I. laboratory director to the G.I. section of the medical committee.
3. Neurodiagnostics director to the neurology section of the medical committee.
4. Pulmonary laboratory and medical bronchoscopy to the pulmonary section of the medical committee.
5. Vascular lab director to the vascular section of the surgical committee and to the medical committee.
6. Cancer director to the medical, surgical, OB and general/family practice committees.
7. PARC clinic director to the pediatrics committee.
8. Neonatal ICU director to the pediatrics committee.
9. Radiation/Oncology director to the medical and surgical committees.
10. Imaging director to the medical, surgical, OB and general/family practice committees.
11. Laboratory director to the medical, surgical, OB and general/family practice committees.
12. Emergency Medicine director to the medical, surgical, OB and general/family practice committees.
13. Occupational health director to the medical and surgical committees.
14. Rehabilitation medicine director to the medical and surgical committees.
15. TCU director to the medical, surgical and general/family practice committees.
16. Home Health/Hospice director to the medical and surgical committees.
17. O.B. Clinic director to the OB committee.
18. Anesthesia director to the surgical and OB committee.

Contracted technical/professional services will be reviewed for the quality and effectiveness of the service provided at least every two years. Services will be reviewed by the appropriate professional staff committee as agreed by the Chief of Staff.

COMMITTEE MEMBERSHIP & TENURE

Tenure on a Professional Staff committee shall run concurrently with the chairman’s term of office. Any committee and/or sub-committee member shall serve at the behest and concurrence of the chairman. The chairman may remove any committee member, sub-committee chairman or member with the concurrence of the Chief of Staff. Composition of the committees shall be defined as in the Bylaws and only changed by the Medical Executive Committee as provided by the Bylaws.

PRIVILEGES

Within members of a clinical department, privileges shall be granted on the basis of Board Certification, Board Eligibility and individual training, experience, and capability. The Departmental Committee has the responsibility for studying candidate's credentials, qualifications and competence and evaluating them as compared to the privileges requested, and to make recommendations to the Credentials Committee. Within a given Department privileges will be categorized as follows:

I. FULL PRIVILEGES within the members specialized field to include categories, procedures, and operations normally attended to the field. Specific procedures or operations may be accepted by the Departmental and/or Credentials Committee. Individual exceptions will be noted on the privilege sheets.

II. ADDITIONAL PRIVILEGES WITHIN THE SAME SPECIALTY. These privileges as defined by the Department and may require documentation of additional training and experience.

III. LIMITED PRIVILEGES WITHIN THE FIELD. These privileges must be specified and qualifications documented. Members of a Department may apply to other departments for specific privileges. If approved, staff members may exercise these privileges subject to the supervision and evaluation by the Department granting the privileges.

IV. DELINEATION OF PRIVILEGES FORM. A control sheet defining clinical privileges will be kept current for each professional staff member, in the Professional Staff Office. For those with surgical privileges, a copy will be kept by the O.R. Supervisor. The privileges will be on-line and accessible by those hospital departments appropriate to their function and privileges granted.

V. SEDATION/ANALGESIA (CONSCIOUS SEDATION) PRIVILEGES: Members must have approved privileges for the use of parenteral sedation as part of any invasive procedure (when no Anesthesiologist is in attendance). To obtain this privilege you must apply for the privilege, have experience in the use of I.V. sedation/analgesia, demonstrate a knowledge base regarding I.V. sedation/analgesia, and be granted sedation/analgesia privileges by the respective clinical department. A copy of the approved study protocol and application form is available in the Professional Staff Office.

VI. PENDENCY OF APPLICATION - TEMPORARY PRIVILEGES
When an applicant for Professional Staff membership or privileges is waiting for a review and recommendation by the Medical Executive Committee and approval by the Governing Body, temporary privileges may be granted for a limited period of time, not to exceed 120 days, by the CEO, upon recommendation of either the applicable clinical department chairman or the Chief of Staff provided the following requirements are met;

a) Primary source verification of current California licensure
b) Primary source verification of relevant training or experience
c) Verification of current clinical competence
d) Verification of the ability to perform privileges requested
e) Any other criteria as required by the Professional Staff Bylaws
f) Results of National Practitioner Data Bank (NPDB) have been obtained and evaluated
g) Application is "clean" and complete
h) There is no current or previously successful challenge to licensure or registration
i) Practitioner has not been subject to involuntary termination of medical staff membership at another organization
j) Practitioner has not been subject to involuntary limitation, reduction, denial or loss of clinical privileges

VII PROCTORING

Definition:

Focused Professional Practice Evaluation (FPPE)
The Focused Professional Practice Evaluation (FPPE) process evaluates the privilege-specific competence of the practitioner as defined by the organized Professional Staff.

FPPE is utilized to establish current clinical competency for Professional Staff members, those with new privileges or concerns resulting from the OPPE process. FPPE is not considered an investigation as defined in the Professional Staff Bylaws. If FPPE results in an action to perform an investigation, the process defined in the Professional Staff Bylaws shall be followed.

Prospective Proctoring
Prospective proctoring is a review by the proctor of either the patient's chart or the patient personally before treatment. This type of proctoring may be used if the indications for a particular procedure are difficult to determine or if the procedure is particularly risky;

Concurrent Proctoring
Concurrent proctoring is when the proctor actually observes the physician's work. This is usually used for invasive procedures so that the medical staff has first-hand knowledge necessary to satisfy itself that the physician is competent;

Retrospective Proctoring
Retrospective proctoring involves a retrospective review of patient charts by the proctoring physician. Retrospective review is usually adequate for proctoring of non-invasive procedures.

Supervised Privileges:
Provisional Staff members are those new appointees who plan to quality for, and seek category advancement within twelve (12) to twenty-four (24) months of appointment. All privileges for new staff members (Provisional members) or current staff members with new privileges shall be supervised with completion of proctoring within 24 months of initial approval. They shall be subject to peer supervision (direct observation, chart review, retrospective review) by an assigned member of the department granting the privileges. Those privileges in which proctoring has not been completed within 24 months shall be deemed to have been voluntarily withdrawn.

Requests for privileges for which proctoring has not been completed will not be considered if greater than 48 months have passed since those privileges were first granted. Under special circumstances, consideration may be made based on urgent patient care need.

Privileges related to surgery or specific defined procedures will, as possible, be proctored by a staff member in the same specialty with the same privileges.

Operations & Procedures:
When an operation or procedure is being proctored, a staff member who holds unsupervised same or similar privileges shall be obligated, as defined within each Department's Rules & Regulations, to observe the operation/procedure, evaluate performance, and complete a proctoring evaluation for each case. Except in extenuating circumstances approved by Department Chairman the proctor shall not participate in the operation/procedure and shall have no responsibility for care or outcome. After a number of operations or procedures acceptable to the Department Committee, the committee shall evaluate the member's performance and make recommendations regarding change from supervised to unsupervised privileges. The Department Committee may recommend to change some privileges to unsupervised and keep some in the supervised category.

Guidelines for number of operations/procedures by Department for consideration of removal of proctoring requirements and/or category advancement:

Surgery:	Usually 10 (5 major, 5 minor)/at discretion of committee.
OB/GYN:	Adequate number/at discretion of committee.
Medicine:	Number varies by procedure (see delineation sheet)/at discretion of committee.
Pediatrics:	Adequate number/at discretion of committee.
Prof. Service:	Adequate number/at discretion of dept. director/ committee.
Gen/Fam Practice:	Adequate number/at discretion of committee.

All members with unsupervised privileges in their specialty who request privileges for a new procedure within their specialty and who present documentation of having successfully completed training in a recognized program, and documentation of current clinical competency, may be considered for unsupervised privileges for these procedures at the discretion of the Departmental Chairman.

Patient Care:

Physicians subject to supervised privileges shall have all patients proctored concurrently for clinical evaluation of patient, treatment plan, utilization of resources, and ongoing care. The proctor shall review the care usually concurrently, in some cases retrospectively: the proctor shall complete a proctor evaluation on each patient. Physician requesting or providing consultation shall not serve as the proctor. Cases will be proctored for an adequate number of cases as defined within each Department's Rules & Regulations. A member may be granted unsupervised patient care privileges and still be supervised for all or specialty operation/procedure privileges, and vice-versa.

Proctor's Responsibility:
All members of the Professional Staff shall serve as a proctor as defined within each Department's Rules & Regulations Proctoring is a requirement of membership, not an option. Proctoring evaluations shall be completed within three days and returned to the Professional Staff Office. Failure to comply with established proctoring requirements may jeopardize membership status.

Proctoree's Responsibility:
The Professional Staff member being proctored is responsible to obtain a proctor and confirm scheduling with the proctor prior to scheduling an operation or procedure. The Professional Staff Office and clinical areas throughout the hospital maintain a current listing of proctors by department.

If no operation or procedure is scheduled (i.e., medical admissions), the member being proctored must notify the proctor promptly upon scheduling an admission or a request for a consultation. When being evaluated by the Committee, the proctoree will in part be evaluated by comparison of number of admissions, consultations, operations and procedures against the number for which proctors were requested. Failure to comply with established proctoring requirements may result in recommendation for non-advancement from the Provisional Staff category and be considered a voluntary resignation from the Professional Staff or voluntarily relinquishment of those specific privileges held. Hearing and appeal rights shall not be applicable if such recommendation is based on a member's failure to have a sufficient number of cases proctored or because of a failure to maintain a satisfactory level of activity in which to consider such advancement. Hearing and appeal rights shall be applicable if advancement was denied because the member's clinical performance or professional conduct was unsatisfactory

CURRENT CLINICAL COMPETENCY AT TIME OF APPOINTMENT/REAPPOINTMENT

If the activity level is not sufficient to determine current clinical competency, the following documentation must be obtained:

1. CME documentation relevant to the area for which privileges are requested; and
2. Documentation of clinical activity, within the past 2 years, from the physician's primary hospital;
   or
3. Reference verification attesting to the physician's current clinical competency from the appropriate Chief of Service or designee at Providence Saint Joseph Medical Center;
   or
4. Reference verification attesting to current clinical competency from three practitioners who have had direct observation of the physician's clinical practice. At least one of these references should be from a member of the Providence Saint Joseph Medical Center staff.

   A. Leave of Absence or Major Illness - Resumption of Privileges

   When a staff member returns from a leave of absence or extended major illness, he/she shall resume his/her prior staff category and privileges. The chairman of his/her clinical department shall determine if any or all of his/her privileges shall be proctored, based on the circumstances of his/her leave or illness.

TELE-MEDICINE HOSPITAL CREDENTIALING

Telemedicine physicians shall be required to list all past and present hospital and other healthcare entity affiliations as required on the Application for Membership. The credentialing entity (PSJMC) shall require a maximum of 10, randomly selected affiliations, be verified with the primary source in order to demonstrate current clinical competence.

NON-STAFF PHYSICIAN HISTORY & PHYSICAL

The attending physician is responsible for the verification of the history & physical dictated by non-staff physician(s) and for dating, timing and co-signing all non-staff physician history & physicals

NON-MEMBER CONSULTATIONS

1. As stated in the Professional Staff Bylaws any member of the staff may call a consultation by a licensed physician non-staff member who will see the patient and make recommendations but not write orders or care for the patient.
2. A signed authorization by the patient for the consultation must be on the chart at the time the patient is seen.
3. If there is further need for the consultant to see the patient during the continued hospital care of the patient, he/she must obtain temporary privileges as outlined in the bylaws.

ON-CALL PHYSICIAN CATEGORY

On-Call Physician Privileges:

On-Call physicians assigned to this category shall cover the patients of staff members for limited portions of the day, evening or weekends. They shall not cover the staff member's entire fulltime practice except as a locum tenens as set forth in section 7. They shall be trained in the same specialty as the staff member and shall have the same privileges to care for the patients as the staff member.

Malpractice:

The On-Call physician shall have either his own malpractice policy or show proof of coverage on the staff member's policy for the covered time.

Meetings:

On-Call physicians shall not be subject to meeting requirements.

Credentials:

On-Call physicians shall be subject to the same credentials process as staff members. The application fee and annual dues shall be the same as Provisional Staff members.

Monitoring:

The On-Call physician shall be monitored in the department of the staff physician by the standard process.

Duration:

There shall be no limit as to the number of days per year the physician is on call for a staff member as long as he/she does not assume full time coverage of the staff member's practice.

USE OF OUTSIDE PEER REVIEW

A request for outside peer review would come from the Chief of the Department to the Chief of Staff or designee. Use of Outside Peer Review will be considered under the following circumstances:

1. When review by physicians practicing in the same specialty or sub-specialty could be perceived as a potential conflict of interest.
2. If the number of physicians practicing the same specialty or subspecialty on the medical staff is deemed insufficient to perform objective peer review.
3. When a physician who is being reviewed feels that they have a legitimate disagreement with the conclusions of the peer review body. The outside peer review group shall be selected by the department chair. The practitioner, who is being reviewed and requesting outside peer review, is responsible for the cost.

SPECIAL ATTENDANCE

At the discretion of the chairperson or presiding officer, when a member's practice or conduct is scheduled for discussion at a regular or other department, section, or committee meeting, the member may be required to attend. If a suspected deviation from standard clinical practice is involved, the notice shall be given by certified mail at least 7 (seven) days prior to the meeting and shall include the time and place of the meeting, a general indication of the issue involved, and a statement that the practitioner's appearance is mandatory. Failure of a member to appear at any meeting with respect to which he/she was given such notice, unless excused by the Chief of Staff, department chair, or the Executive Committee upon a showing of good cause, shall be a basis for an automatic suspension of all or such portion of the practitioner's clinical privileges as the department or Executive Committee may direct.

Such suspension shall remain in effect until the matter is resolved by subsequent action of the department or Executive Committee. The member shall not be entitled to the procedural rights set forth in Article VI, Section 2 of the Professional Staff Bylaws.

ADMISSION AND DISCHARGE

1. A patient may be admitted to the Medical Center only by Professional Staff members who have admitting (general) privileges. It is the admitting physician's responsibility to obtain appropriate specialty consultation as may be required by the patient's condition. The requesting physician shall be responsible for obtaining a copy of the wallet license for the Professional Staff Office, obtaining a temporary badge for the consultant at the Nursing Office and for writing an order on the patient chart giving the name of the consultant.
2. Patients of Dental/Podiatric Staff members must be co-admitted by a physician member of the Professional Staff who shall be responsible for the overall medical aspects of the patient's care throughout the hospital stay. The Dental/Podiatric Staff member is responsible for the history and examination relative to their field, and have responsibility for progress notes and discharge summary. Specific to Podiatric History and Physical, Podiatrists may be granted privileges to perform an admission, history and physical examination and assessment of the medical risks of the proposed procedure to the patient within 24 hours of admission. The History and Physical must contain the following key elements:

MEDICAL HISTORY

1. Physician's Name
2. Patient's Name - Spell
3. Medical Record Number
4. Date of Birth
5. Chief Complaint
6. Present Illness
7. Past Medical History
   a. Childhood Illness
   b. Adult Illness
   c. Surgery
   d. Injuries
   e. Allergies
   f. Transfusion Reactions
   g. Drug Sensitivities
8. Social History
9. Family History
10. System Review
    a. H.E.E.N.T.
    b. Cardiovascular
    c. Respiratory
    d. G.I.
    e. G.U.
    f. GYN
    g. Neuromuscular

PHYSICAL EXAM

1. General Appearance
2. Vital Signs
3. Skin
4. H.E.E.N.T.
5. Neck
6. Chest
10. Abdomen
11. Genitalia, Rectum
12. Extremities
13. Back
14. Lymphatics
15. Neurological

7. Breasts
8. Lungs
9. Heart
16. Impression
17. Discussion, Plan
18. Recommendations

The Podiatrist shall identify and shall be responsible for coordinating care with a physician member of the staff who shall be responsible for the care of any medical issue that may be present at the time of admission or that may arise during hospitalization.

3. The admitting (attending) physician is primarily responsible for the care of the patient during their hospitalization. If the primary care is transferred to another physician, it shall be noted in the progress notes and with a specific order in the order sheets.
4. No patient shall be admitted until a provisional diagnosis has been stated.
5. There are three categories of hospital admissions:
   A. Emergency: Immediate threat to the patient's life or well being exists. This situation warrants the highest admitting priority. All reasonable measures are taken to ensure this patient's immediate admission, including the possible displacement or discharge of another less ill patient or temporary admission to the emergency department.

   B. Urgent: Undue or prolonged delay in admission might threaten the patient's life or well being. Normally, such patients should be admitted within 24 to 48 hours. The patient will be called when a bed becomes available.
   C. Elective: The health of the patient will not be endangered by delayed admission. Such patients are usually scheduled several days to several weeks in advance of admission; the majority are for elective surgery. In consideration of the patient, the hospital should make every effort to accommodate the patient's desired date of admission. However, when circumstances dictate, this category of admission can be deferred. When possible these patients should be processed through a pre-admission program including outpatient tests and procedures, and admitted the morning of surgery.
6. If a scheduled admission is to be canceled, the attending physician shall notify the Admitting Office. In the case of canceled surgery, the attending physician or the surgeon shall also notify the Surgery Scheduling Office.
7. In case of an extreme shortage of beds or in case there is doubt about the admitting category, the Supervisor of the Admitting Office, or designee, may call the attending physician, or the appropriate Departmental Chairman, the Chairman of Critical Care (if patient is to be admitted to the unit), the Chief or Vice-Chief of Staff, or a physician designee, to evaluate the necessity and timing of the requested admission.
8. Patients of an Emergency or Urgent nature may be admitted at any time.
9. Future scheduling on elective cases should be done between 9:00 A.M. and 5:30 P.M., Monday through Friday.
10. It is the philosophy of PSJMC to offer comprehensive medical service to the community; however, in certain cases, the patient will be transferred to a facility specializing in the type of care required by the patient.
    A. Patients Not Admitted: Patients diagnosed as, or suspected of having highly communicable diseases as specified by the Department of Health are not permitted to enter, or to remain at Providence Saint Joseph Medical Center. These include:
       1) Cholera
       2) Diphtheria
       3) Plague
       4) Ebola Virus, Lassa Fever and all other viral hemorrhagic illness
       5) Relapsing Fever (louse-borne)
       6) Typhus Fever (louse-borne)
       7) Yellow Fever
    B. The following diagnoses may be admitted to Providence Saint Joseph Medical Center with consultation by the Infection Control Physician or alternate (i.e., Infection Control Practitioner).
       1) Botulism
       2) Chickenpox
       3) Mumps
       4) Pertussis (Whooping Cough)
       5) Rabies
       6) Rubeola (Measles)
       7) Tetanus
       8) Typhoid Fever
       9) Poliomyelitis
    C. Patients who are asymptomatic carriers of the following disease **MAY NOT BE DISCHARGED TO SKILLED NURSING OR INTERMEDIATE CARE FACILITIES** unless prior written approval has been obtained from the Chief of Acute Communicable Disease Control, (213) 974-7941.
       1) Salmonella
       2) Shigella

3) Typhoid

D. Patients with suspected or confirmed tuberculosis may not be discharged or transferred without an individualized, written discharge plan that has been approved by the Los Angeles County Health Department.

E. Patients who will usually be transferred to an institution specializing in the type of care required by the patient:

1) Critical Burns:

a. Critical burn means any one or more of the following:

(1) Second degree burns exceeding 30% of body surface.

(2) Third degree burns of the face, hand, feet and/or genitals.

(3) Third degree burns exceeding 10% of the body surface.

(4) Burns complicated by respiratory tract injury, major soft tissue injury or fractures.

(5) Electrical burns.

(6) Any combination of second and third degree burns which in the aggregate poses a medical problem equivalent in seriousness (1) through(5).

2) Illnesses requiring hyperbaric chamber.

3) Spinal cord injury. (Acute)

4) Psychiatric problems, requiring supervision in a psychiatric facility.

11. Emotionally disturbed patients, suicidal patients, or patients with abnormal behavior associated with substance abuse who are in need of medical or surgical treatment may be admitted, provided they are under strict 24-hour supervision by an attendant. If these patients are a major disturbance on the nursing unit, it may be advised that they be transferred to a closed facility.

12. Patients shall be discharged as early as possible in the day to allow them to leave the hospital before 11:00 A.M. if possible or later if clinical condition allows it.

13. Patients shall be discharged when their condition warrants it and when they no longer need acute hospital level of care. Physicians should work with the patient, the family, Utilization Management staff and discharge planning to effect timely discharge.

UNANSWERED CALL

Failure to respond to nursing calls from the floors, including but not limited to ED and ICU constitutes a danger to patient safety. Accordingly, such failure shall be referred to the Medical Executive Committee for action. Upon receipt of documentation that a physician has failed to timely return a call (timely shall be within thirty (30) minutes of placement of the call) the physician shall be provided with a one-time warning. The warning shall either be through counseling with a Professional Staff officer and/or a written warning.

If the behavior persists and the physician fails to timely return a second call within a twelve (12) month period, the physician shall receive a five (5) day suspension. The suspension shall be instituted pursuant to the Professional Staff Bylaws and Rules and Regulations.

If a third instance occurs in which the physician fails to return calls on a timely basis, the physician may be subject to a suspension for a greater period of time or termination from the Professional Staff. If the total period of suspension exceeds thirty (30) days within a twelve month period, a report shall be made to the Medical Board of California and the National Practitioner Data Bank in that the actions were taken for medical disciplinary cause or reason. Further, failure to timely respond to nursing calls shall be considered by the Medical Executive Committee in determining whether to grant that individual reappointment to the Professional Staff. Nothing in this section precludes the imposition of a summary suspension in the event that it is determined that the physician's conduct constitutes an imminent danger to patient health and safety.

POLICY FOR SURGICAL AND MEDICAL PROCEDURES

An operative, or other high risk procedure report is dictated/documented, signed, dated, and timed upon completion of the operative or other high risk procedure and before the patient is transferred to the next level of care.

Note1: the exception to this requirement occurs when an operative or other high risk procedure **progress note** (as described below) is written immediately after the procedure in which case the full report can be dictated/documented within 24hrs.

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 into the medical record, signed, dated, and timed before the patient is transferred to the next level of care, with inclusion of each and every element 1-7 noted as below.

Note 2: If the practitioner performing the operation or high risk procedure accompanies the patient from the OR to the next level of care, the report can be dictated/documented in the new level of care. (i.e. PACU, ICU)

The elements of the operative or other high risk procedure report shall include the following:

1) Names of the primary and assistant surgeons
2) Name of the procedure(s) performed
3) A description of the procedure
4) Findings of the procedure
5) Any estimated blood loss **if applicable**
6) Any specimens removed **if applicable**
7) The postoperative diagnosis

Co-surgeons shall dictate an operative report if they are of a different specialty. Physicians must sign, date, and time their own operative or procedure reports.

MEDICAL RECORDS

1. The attending physician is responsible for the preparation of a complete, current, authenticated and legible medical record for each patient for whom they provide care. This record as appropriate shall include: medical history, physical examination, diagnostic and therapeutic orders, progress notes, results of procedures, operations, consultations and tests, a discharge summary, and an attestation form, where required.
2. On elective admissions, a history and physical examination should be available at the time of admission. If not available or not already dictated, and in the case of emergency or urgent admissions, the history and physical examination should be dictated at the time of admission, if time allows, and must be dictated within 24 hours of admission. When not available on admission, an admitting note should be written indicating the diagnosis, findings and plans for treatment.
3. The history shall include details of the present illness, relevant past social, family history, and system review. The physical examination shall include: general appearance, vital signs, and a description of findings in each system relevant to the diagnosis and/or operation/procedure. A copy of a current (less than 30 days old) dated history and physical examination that meets the requirements for history and physical examination, can as a copy be submitted in lieu of the admission history and report of the physical examination provided these reports are legible, dated, and recorded by a member of the Professional Staff. In such instances, an interval admission note that includes all additions to the history and subsequent changes in physical findings must be recorded, or a statement made that no significant changes have occurred.
4. A consultation that includes all the requirements for a history and physical examination may be used as a history and physical.
5. Informed Consent: The surgeon is responsible for a proper informed consent being received from the patient and/or family, whichever is appropriate and/or in compliance with State laws as applicable. Obtaining an informed consent is the attending surgeon or physician's responsibility. This must be documented in the dictated history and physical, in the progress note, or by completion of the informed consent form in the patient's record prior to surgery or performing a procedure requiring an informed consent. **Exception**: The documentation of the informed consent for blood must be documented within twenty-four (24) hours of the transfusion.
6. All patients, except emergencies, shall have a dictated and transcribed history & physical examination recorded and in the chart prior to being taken to surgery, including patients in Day Surgery, Short Stay Surgery, C-Sections, and GYN Surgery, and those patients having an invasive/non-invasive procedure requiring sedation and/or analgesia. If a patient is declared an emergency (a case where delay may results in injury to a patient) by the surgeon, the surgeon will write a note in the medical record indicating the reason for emergency surgery, factors that may effect the patient as a surgical risk, and will dictate the history & physical immediately after surgery.
   At the time the case is scheduled, the name of the physician responsible for dictating the history and physical will be recorded. The dictated H&P should be available by 2 p.m. the day prior to surgery. If it is not available the physician responsible for dictating the history and physical, and the surgeon (if a different physician), will be so notified. If the H&P is not available the morning of the scheduled surgery, for the first case, the surgeon will be notified and the case canceled or moved to a later time (when possible). For cases scheduled later in the day, the surgeon will be notified re those cases without a history and physical. If they are dictated (STAT) and transcribed and available before the scheduled time, the surgery may proceed; otherwise the case(s) will be canceled or moved to a later time (when possible).
   The same rules applies to patients scheduled for invasive procedures associated with IV Sedation, including those done in the Cardiac Cath Lab, Special Procedures, major procedures in the GI Lab, including Bronchoscopies, Imaging and Radiation Oncology.
   If there is no dictated history and physical, the procedure cannot be done. For minor G.I. Procedures this requirement may be met by completion of the approved form in the Department.
7. Invasive Procedures Without Moderate or Deep Sedation – Outpatient Breast Center:
   Outpatients undergoing invasive procedures without moderate or deep sedation do not require a History & Physical. The physician performing the procedure shall review and document/verifies the patient's past medical history, current medications and known allergies.

8. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. When a patient is to have an operation or invasive procedure, a consultation and/or pre-operative note shall be recorded by the surgeon if the surgeon is not the attending physician.

9. The current obstetrical record shall include a prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the hospital before admission; an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings. These together shall serve as the admitting H&P.

10. Sections: Elective C-Sections with scheduled admissions shall have a transcribed history and physical on the chart prior to surgery.
Non-elective C-Sections may be considered as Emergency surgeries. At a minimum these patients shall have a written pre-op note in the chart declaring the patient to be an emergency, the indications for surgery, and any unusual issues relevant to surgical risk.
In those cases where the history and physical have not been dictated pre-operatively, it must be done (dictate on STAT line) and on the chart within 24 hours.
In all C-Sections, the Obstetrician is responsible to document an informed consent, write a post-operative note immediately after surgery, and dictate an operative report within 24 hours.

11. Progress notes shall be recorded in most cases on a daily basis on all patients, and shall document the need for acute care, plans for diagnosis and treatment, results of tests and response to treatment, and complications.

12. A discharge summary is required on all hospitalized patients, except for normal deliveries, normal newborns and uncomplicated patients hospitalized less than 48 hours. The discharge summary shall include a review of the clinical course, positive findings, description of the patient's condition at the time of discharge, important instructions given to patient and/or family for diet, activity and medications, and follow-up care and plans. In most cases the attending physician shall be responsible for the discharge summary.
If another physician has become the attending physician (by written order), or has on chart review done most of the care, they will be responsible for the discharge summary. Another physician who has been active in the patient's care may do the discharge summary at the discretion of the attending physician.

13. A transfer summary shall accompany all patients transferred to TCU or another skilled nursing facility, an intermediate care service, or another hospital. The transfer summary shall include essential information relative to the patient's diagnosis, hospital course, medications, treatments, dietary requirements, rehabilitation potential, known allergies, and treatment plan and shall be completed, signed, dated and timed by the physician, timely and prior to transfer. Such patient evaluation includes a written report of a physical examination within five (5) days prior to admission or within seventy-two (72) hours following admission.

14. On discharge from the PSJMC TCU, the medical record shall include the patient's diagnosis and condition. If the patient is readmitted to the Acute Unit from the TCU, the previous H&P, may be used if the transfer occurs within 30 days and if there is an update of condition, examination and treatment plan.

15. Pre-op Lab Tests: Minimum pre-operative laboratory test results, as defined by the Surgical Committee, are acceptable if done within seven days prior to surgery for all American Society of Anesthesiology patients, Risk Category I & II (no medical problems, no respiratory or cardiac problems), and for invasive procedures. Results for all other risk groups shall be performed and reported within 72 hours. Lab work must be performed by the PSJMC Lab, a lab previously recognized by PSJMC Lab as meeting required standards, or laboratories at established hospitals.
Other laboratory and diagnostic test results timely and pertinent to patient care should be submitted before or on admission.

16. All medical records shall be authenticated by the responsible physician. Dictated reports shall be signed as they become available during the acute stay, or in the Medical Record Department. Authentication can be by signature or, electronic signature via the information system. All medical record entries shall be dated, timed and signed (authenticated) by the appropriate physician. Signed dated and timed reports sent to the hospital by FAX are acceptable.

17. Professional Staff members are responsible for timely completion of their medical records. Failure to meet this responsibility will result in the SUSPENSION OF PRIVILEGES. Deficiencies initiating suspension are:
    A. Failure to do a history/physical: If the history and physical has not been completed within 24 hours of admission, the responsible physician will be notified and given 24 hours (weekdays) to complete the H&P. If not done, the physician will be suspended until the H&P is dictated.
    B. Failure to do an operative or procedure report: If the operative or procedure report has not been completed within 24 hours of operation/procedure, the responsible physician will be suspended until the operative/procedure report is dictated.
    C. Failure to do a discharge summary on required patients.
    D. Failure to complete TNM Staging form.
    E. Failure to sign, date and time attestations, when required.
    F. Failure to sign, date and time dictated reports.
    G. Failure to sign, date and time entries shall be cause suspension.

- Unsigned orders after 48 hours shall result in a one (1) day suspension
- Accumulation of 05 unsigned orders shall result in a one (1) day suspension.

Such suspension shall not be lifted until completed. Emergent exceptions shall be at the discretion of the Professional Staff Leadership

18. **Failure to complete/answer a physician query**

A. Mandatory completion of the VTE form and that the form be left in the medical record by the physician to ensure compliance. Deficiency shall be considered to be an incomplete medical record.
- That unsigned orders after 48 hours shall result in a one (1) day suspension
- That accumulation of 05 unsigned orders shall result in a one (1) day suspension.

Such suspension shall not be lifted until completed. Emergent exceptions shall be at the discretion of the Professional Staff Leadership

19. **SUSPENSION POLICY:**

A. **Alternate Coverage**:
All Professional Staff/AHP with clinical privileges shall designate an alternate practitioner who has agreed to be prepared to respond and provide coverage if the member is unavailable. The designation shall be submitted in writing to the Professional Staff Office.

With the exception of Robotic Surgery privileges, the designated alternate shall possess similar/like clinical privileges and have the appropriate education, training, experience and current clinical competence to serve as an alternate as determined by the Medical Executive Committee or its designee. Should there be any dispute as to the scope of clinical privileges, adequacy of education, training and current clinical competence of the designated alternate, the practitioner may request a hearing pursuant to Section VI for the sole purpose of determining whether that individual meets the requirements to be designated as an alternate.

Failure to designate and continually maintain on file a current qualified alternate shall constitute grounds for automatic suspension of clinical privileges. Said automatic suspension shall not be deemed to have been instituted for medical disciplinary cause or reason and is not reportable to the Medical Board of California under Business and Professions Code Section §805.

The Medical Record Department will analyze charts for deficiencies, including histories and physicals, operative and procedure reports, discharge summaries, and sign, date and time.

B. As soon as they are analyzed, the charts, with deficiencies, will be available for completion by the Professional Staff members in the Medical Records Department.

C. All deficiencies shall be completed within fourteen (14) days of the day of discharge. Professional Staff members unable to complete their charts because of extenuating circumstances (illness, vacation, etc.) are responsible to inform the Medical Records Department.

D. If deficiencies have not been completed by seventh (7^{th}) day after discharge, a notice will be sent to all Professional Staff members who have charts with deficiencies, placing them on notice that unless the deficiencies are corrected within seven (7) days, they will be placed on suspension.

E. On the sixth (6th) day after notification a phone call will be made to all physicians who have not completed their records and are on impending suspension, notifying them that they will be suspended on the following day unless all medical record deficiencies are completed.

F. On the following day the Director of Medical Records (or designee) will develop a list of Professional Staff members who are to be suspended on the basis of delinquent medical records.

G. These names will be added to the names of Professional Staff members already on suspension for Medical Records deficiencies. This updated list will be distributed each working day to the Admissions Department, Surgery, Medical Records Department, Emergency Department, Gastroenterology Laboratory, Cardiac Cath Lab, Special Procedures Lab, Nursing Office, and COO's office. The list will be posted each weekday in the doctor's lounge, surgical lounge, Professional Staff Office, and Medical Records Department.

H. To be removed from the Suspension list the physician must complete ALL DELINQUENT RECORDS. The Suspension list is updated daily by the Director of Medical Records (or designee); only the Chief of Service (or designee) for which the physician is a member, the Chief of Staff (or designee), or under unusual circumstances the Chairman of the Medical Records Committee may remove a Professional Staff member from suspension without the deficient records having been completed. No one in the Medical Records Department may approve removal from the Suspension list or approve admission privileges for any patient until delinquencies are completed.

I. All privileges are suspended for a Professional Staff member on the Suspension list as follows:

1). Admitting Privileges: All admitting privileges are suspended while on the Suspension list. Physicians on suspension for delinquent medical records are not permitted to admit new

patients (exception: emergency admits). When admitting/house supervisor encounters issues associated with a physician on suspension wanting to admit his/her patient, they are to be instructed to personally contact their Department Chairman. Should the Department Chairman decide to temporally lift suspension, the Department Chairman shall contact the house supervisor to personally authorize the admission.

2). Surgery scheduling will not book any future surgery for the physician until he/she is no longer on suspension. In the event a physician on the list already has a surgery scheduled, Future Admissions Office will usually notify the physician of the need to get off suspension, and surgery will place a call to the physician the day prior to the surgery (or the Friday prior to a Monday surgery) to remind them of their delinquent charts.

3). On the day of surgery, OR will not start the case if the physician is still on the suspension list unless otherwise approved by the Chief of Staff or Surgery Department Chair.

4). All privileges to operate or assist in surgery are cancelled when a Professional Staff member is on suspension (unless approved by the Chief of Staff [or designee] or Surgery Department Chair [or designee]).

5). Anesthesia Privileges: Any member of the Department of Anesthesia who is on the Suspension list will not be scheduled for anesthesia.

6). Emergency Department Direct Admits: Patients who are seen in the Emergency Department and require admission will be subject to the same rules regarding admissions, as other patients while the physician is on suspension.

7). Emergency Panel: Members of the Professional Staff who are serving on the Emergency Panel will not be eligible to take call if they are on the Suspension list and will have one day to get off the list before being dropped from the schedule.

8). Diagnostic Laboratories and Panels: Members on suspension will not be able to schedule or perform procedures in the Cardiac Cath Lab, the Special Procedures Lab, or the Gastroenterology Lab. Members on suspension will not be eligible to function on elective panels - to include EKG, Stress Testing, Echocardiogram, EEG, EMG or the Pulmonary Function Laboratory, or the Non-invasive Vascular Laboratory.

J. Members on suspension are not allowed to admit patients or schedule in the name of another member of the staff. If this occurs both the member on suspension and the member allowing their name to be used will be reported to the appropriate departmental Chairman for disciplinary action.

K. Any physician who accumulates forty-five (45) days of suspension in a single calendar year will have an automatic indefinite suspension of privileges for thirty (30) days. After the thirty (30) days, privileges can only be renewed by petition of the Executive Committee. With this automatic suspension, there will be no rights to hearing or review.
There will be written notices issued to the physician on fifteen (15) days, and on thirty (30) days, with a copy to the Chairman of the Service, the Chief of Staff, and the Credentials file. At forty (40) days, there will be a notification letter to the physician of automatic privilege suspension if and when the suspension days reach forty-five (45).

L. Medical Record Compliance
First Occurrence: Shall result in the physician being notified by the Chairman of the Medical Records Committee. Second Occurrence: Shall result in one (1) day accrual towards suspension for each record that is incomplete Practitioner shall receive a list of all incomplete records (as in the past), including a letter with the number of suspension days accrued. Should medical records remain incomplete for more than 14 days after patient discharge, practitioner's professional staff privileges shall be:

- Suspended until records are completed. Accrual of more than 45 days of medical record suspension within a rolling 12 month period of time s hall result in the suspension of the practitioner's professional staff privileges for 30 days.

20. In cases of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or another.

21. Only approved <u>symbols and abbreviations</u> may be used in the medical record. The list of approved abbreviations will be annually evaluated and updated by the Medical Records Committee. An official record of approved abbreviations is attached to the Rules and Regulations in the Professional Staff office and copy is on file in the Medical Records Department.

22. All records are the property of the hospital. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a Court Order, Subpoena or Statute. Unauthorized removal of charts from the hospital is grounds for suspension of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.

23. Professional Staff members shall cooperate with the hospital in complying with technical and substantive requirements of third party systems. This includes completion of attestation forms. Recommendation for appointment to the Professional Staff is contingent upon a signed attestation form and an element of a completed application for membership.

24. The Administrator or the Medical Records Director may sign birth certificates in the event of the

unavailability of the attending physician within the required ten (10) day time frame.

25. Non-staff physicians who are part of a recognized protocol in a program utilized at PSJMC for organ harvest purposes are not required to sign orders utilizing the protocol.

26. POLICY REGARDING HISTORY AND PHYSICAL FOR PATIENTS HAVING SURGERY OR AN INVASIVE PROCEDURE

No patient will be taken to surgery, including C-Sections and GYN Surgery, unless there is a current, dictated, valid history and physical available in the medical record. The exception will be those patients declared an emergency (a case where a delay will result in injury to a patient); in these cases a note will be written in the chart and a history and physical dictated immediately after the surgery. These cases will be reviewed retrospectively.

Documentation of Surgery or Procedure: All patients must have a note, written immediately after surgery or procedure, in the medical record. This can be done by completing the operation/procedure form or written in the progress note.

A completed operative/procedure report must be dictated.

27. PATIENTS UTILIZING OTHER OUTPATIENT AREAS: (05/2011)

A. Non-invasive outpatient therapy, such as Occupational Therapy, Physical Therapy, Speech Therapy, etc., and Home Therapy. These patients must have recorded in their medical record;
   1. The referring/responsible provider
   2. A working diagnosis
   3. An initial assessment by the therapist
   4. A plan and goal of therapy, and
   5. Regular progress notes by the therapist
   6. There shall be a yearly update to the assessment by the therapist with confirmation of continued need by the referring provider

B. Therapies including low-risk invasive procedures (i.e., Blood Transfusion) or procedures with light to moderate sedation. These patients must have in their medical record;
   1. The referring/responsible physician/provider
   2. An abbreviated History and Physical
   3. Documentation of allergies or other unusual risks
   4. Informed consent, and
   5. Appropriate progress notes by the therapist
   6. If the diagnosis involves long-term therapy, there shall be yearly updates to the History and Physical including significant changes to the patient's condition

C. Therapies including high-risk activities such as chemotherapies and procedures utilizing deep sedation and general anesthesia. These patients must have recorded in their medical record;
   1. A copy of a complete History and Physical which may be from a hospital admission, physician's office, or one created for the therapy program
   2. Informed consent
   3. Progress Notes must be written or dictated after each session
   4. Updated to the History and Physical must be updated with any significant change in the patient's condition, at least yearly

RESOURCE UTILIZATION/CASE MANAGEMENT

1. Patients admitted to the Medical Center are reviewed as to the need for acute hospitalization regardless of source of payment for health care. Evaluation for utilization purposes is based on information contained in the medical record. The provision of this information is the responsibility of the attending physician.
2. Patients may be screened before, or at the time of, admission and will be reviewed within 24 hours of admission and again at various intervals thereafter. If a history and physical is not available at admission, there shall be an admitting note describing the condition requiring hospitalization. Orders, tests and results should be supportive to the admitting diagnosis and acuity level. On-going progress notes should describe the patient's condition and diagnostic and/or therapeutic modalities which necessitate continued hospitalization.
3. Should there be insufficient documentation or other questions regarding the patient's status at any time during the review process, the attending physician will be contacted by a Physician Advisor for clarification.

ORDERS

1. Orders shall be provided by a person who is lawfully authorized to prescribe and who has been assigned clinical privileges as a member of the Professional Staff. Orders shall normally be written.
2. Verbal/Telephone orders may be accepted and recorded by a licensed nurse; nurses may accept medication orders only from a person lawfully authorized to prescribe. To ensure appropriate recognition of ordering physicians, disclosure of physician dictation number by the ordering physician is mandatory. (11/16/11)

Limited verbal/telephone orders may be accepted by other specific professional personnel.

A. Pharmacists may accept orders related to drug therapy.
B. Dietitians may accept orders related to diet. Dietitians may initiate nutrition education of patients whose physicians have ordered current and/or discharge therapeutic diets.
C. Physical therapists may accept orders related to physical therapy evaluation and modalities.
D. Respiratory care technicians may accept orders regarding treatment programs in respiratory care.
E. Laboratory technologists may accept orders regarding blood and blood components.

3. Orders shall include the date, and time the order was written, and the prescriber's signature.
4. The Infection Control designated physician (or designee), or the hospital epidemiologist, may institute or modify isolation on any patient.
5. Only the PSJMC "order sheet" shall be used for writing orders.
6. Patients to be admitted from the ED shall have orders written by the admitting physician prior to admission.
7. Standardized order sets shall be initiated only upon the written or verbal order of authorized prescribing professionals. The prescriber shall complete and sign, date and time the orders (or give a verbal/telephone order regarding their use) before they are initiated. Per approved unit policies, critical care orders may be initiated on admission to the unit.
8. Before a patient is transferred to a different level of care, all orders shall be reviewed by the physician and, if necessary, rewritten as appropriate for the new level of care. Prior to transfer from ICU, patients there 48 hours or more, must have their orders rewritten.
9. Respiratory orders must be renewed when a patient is transferred from a monitored floor to a non-monitored floor.
10. Use of Stroke Order Sets for stroke patients is mandatory (08/2011)
11. Orders are discontinued at the time of surgery. The surgeon is responsible to rewrite the orders post-op or to define who should be called to rewrite the medical orders. If this is not done the attending physician will be called.
12. All diagnostic and treatment services to be performed or conducted at PSJMC may be ordered only by licensed physicians and surgeons, dentists, podiatrists, and allied health professionals in categories which have been approved by the Board of Directors to exercise practice privileges including the interpretation of diagnostic radiology studies or the performance of ordered treatment services.
13. Stop Orders: Regarding routine lab tests, ECG's, chest x-rays, and blood gases, the physician must specify the test and the number of days for the daily test which may not exceed five days.
14. No radiographic imaging study will be performed in this institution without a stated clinical indication for the procedure from the ordering physician.
15. Written orders for diagnostic studies from Chiropractors will be honored according to Title 16 of the Board of Chiropractic Examiners.
16. Verbal/Telephone Orders:

A. All physician initiated entries are to be authenticated.
B. Verbal/Telephone Orders for restraints and/or D.N.R. must be authenticated < 24 hrs.
C. Verbal/Telephone Orders for Medication must be authenticated < 48 hrs.

D. All other orders must be authenticated within 14 days after discharge of the patient. The "Physician Signature Discharge Report" will list all of the physician's unsigned orders, all of which may be authenticated by a single signature, date and time, affirming that the physician has reviewed and approved of all the entries. The physician may alternatively choose to authenticate each entry listed in the report if he/she so desires.

PHARMACY/MEDICATIONS

1. The availability and use of all medications within Providence Saint Joseph Medical Center shall be in accordance with the operating principles of the Drug Formulary System, as determined by the Professional Staff. The system incorporates generic substitution and approved therapeutic substitution within specific therapeutic categories. When a non-formulary drug is ordered, the pharmacist will inform the prescriber of those formulary drugs which are pharmacologically similar. If the prescriber wants a non-formulary drug for a specific patient, a Non-Formulary Request Form is filled out by the requesting prescriber and returned to the Pharmacy. The Pharmacy will obtain it within forty-eight (48) hours.
2. All medications must be processed through the hospital Pharmacy. A prescriber desiring a patient to use his own medication must write an order for the specific medication. The medication will be supplied to the patient only if the pharmacist can positively identify the drug, and it is properly labeled.
3. A medication order must include: the date (the time); name of medication; dosage (not a range); frequency; route of administration, if other than oral; and physician dictation number or printed name and signature of the prescriber.

   For PRN orders with variable doses and frequencies, nursing administers medications according to Medication Management policy. All PRN orders must have an indication for use. If more than one medication is ordered for the same indication it must be indicated which one is to be used first, which one is to be used next, etc. Any unclear orders must be clarified before administration.
4. Medication orders in the standardized order sets must be initially approved and reviewed as necessary by the Pharmacy and Therapeutics Committee of the Professional Staff.
5. No medications may be left at the bedside.
6. Orders for Schedule II controlled substances (narcotics, hypnotics, and stimulants), all hypnotics, oral antibiotics and oral

antifungals have a ten (10) day renewal requirement; all other medications have a thirty day renewal requirement unless:
   A. The order specifies an exact number of doses to be administered;
   B. An exact period of time for administration is specified;
7. Physicians prescribing Schedule II drugs must have a current DEA license on file in the Professional Staff Office.
8. The use of an investigational drug must be previously approved by the Research/IRB Committee of the Professional Staff. Approved investigational drugs must be dispensed from the Pharmacy.
9. Medication Reconciliation: The primary physician is responsible for their patient's medication reconciliation on admission and discharge. At the completion of patient procedures, the consulting physician will authorize or acknowledge the medication reconciliation by their e-signature. This authorization or acknowledgement is not a medication order, assessment, or evaluation prescribed by the primary or other consulting physician, but a release of the patient to return to their prior level of care, treatment and release of the current active medication orders as set forth by the prescribing practitioner.

DRUG OVERDOSE/ATTEMPTED SUICIDE PATIENTS

No patient with a known or suspected suicidal potential, drug dependency, emotional illness and/or psychiatric disorder, shall be admitted to the hospital unless there is also a medical/surgical/obstetrical problem. Special observation, per hospital patient care procedure S-8, shall be required in the care of these patients. The patient's primary physician shall be responsible for obtaining consultation by a member of the psychiatric/psychological staff or mental health referral service.

Patients who develop suicidal potential, emotional illness, drug or alcohol withdrawal or psychiatric disorders while hospitalized shall have a consultation by a member of the psychiatric/psychological staff or referral service. Appropriate services, whether available in the Hospital or requiring outside referral, shall be offered to such patients. Special observation, per hospital patient care procedure S-8, shall be required in the care of these patients.

Emergency Room patients presenting themselves in the same condition shall be referred for psychiatric evaluation.

SPECIAL CARE UNITS

1. Special care units include the Critical Care Unit, the Telemetry Unit, and the Neonatal Intensive Care Unit (Rules and Regulations for the NICU are in the Pediatric Department Rules and Regulations. Patients admitted to the special care units shall meet the guidelines for admissions of that unit.
2. Patients will be admitted to the Critical Care Unit based on the patient's serious or critical condition requiring specialized nursing care on a concentrated and continuing basis and meeting the approved admitting criteria. Admission to the Critical Care Unit shall be based on the order of the attending physician or consultant, who will be expected to maintain close supervision of the patient at all times.
3. The attending or consulting physician is responsible to inform and advise the patient and relatives of the need for intensive care.
4. Mandatory Intensivist Consultation on Neuro Patients in the ICU: Any Neuro patient is required to have an Intensivist Consultation (IR Team can facilitate)
5. Patients will be seen within four (4) hours of transfer/admission to the Critical Care Unit by the attending or consulting physician or sooner as dictated by the nature of the patient's condition.
6. Upon transfer or prior to admission of a patient to a special care unit, the orders must be reviewed and new orders must be given by the responsible physician.
7. When the Critical Care Unit is filled to operational capacity, requests for admission will be handled on the basis of the patient's diagnosis, nature of the problem, and the need for and availability of qualified nursing staff. The ICU Committee Chairman or member of the Committee shall be consulted if requests for beds cannot be effectively handled by the nursing staff. The ICU Chairman/or designees have the authority and responsibility to triage and transfer patients out of the ICU/CCU/& the Telemetry Unit in the case of a disaster, an emergency, or when patient volume exceeds optimal operational capacity.

   If an individual patient is determined to no longer require ICU/CCU/or Telemetry Unit Care, the admission and discharge criteria will be one mechanism utilized by the Medical Director in determining triage eligibility. Triage and transfer will be done in consultation with the patient's attending physician. If the attending physician refuses to transfer the patient, the Chair of the Department may be called in consultation.

   When the telemetry is filled to capacity, requests for admission will be handled on the basis of need. The ICU Committee Chairman or a member of the Committee, or the Cardiology Committee Chairman or a member of the Committee, shall be consulted if requests for beds cannot be handled effectively by the staff.
8. The Chairman of the Intensive Care Unit (ICU) Committee shall be a member of the Active Category of Professional Staff and act as Director of the unit. If unavailable, and there is no defined acting director, other members of the ICU Committee can be called upon as Acting Director.
9. The Chairman of the ICU Committee or designee or the Chairman of Clinical Cardiology or designee shall have the authority to recommend or require consultation by a qualified specialist where it appears advisable in the interest of patient care.
10. Any physician who is a member of the Professional Staff and has general privileges shall have admitting privileges to the

Critical Care Unit with the understanding that he/she will obtain appropriate specialty consultation as may be required by the patient's condition.

11. Admissions to the Telemetry Unit will be based on the order of the attending or consulting physician. The principal criteria for admission shall be the patient's need for more nursing care than can be provided on the general medical surgical units, but less than provided by the Intensive Care Unit and/or a need for cardiac monitoring. On the Telemetry Unit, a physician must see the patient within twelve (12) hours of admission or sooner, dictated by the nature of the patient's condition.
12. Patients admitted to the ICU, CCU and Telemetry units will have the protocol for Emergency Orders for Monitored Patients enforced unless otherwise ordered by the attending physician, or the patient is a DNAR status. These orders may be modified at the discretion of the attending physician.
13. In general, patients shall not be admitted to the Critical Care Unit on whom resuscitation procedures would not be indicated. It will be the responsibility of the attending or consulting physician to make the determination as to the appropriateness of future resuscitation measures. This will not be a criterion for discharge or transfer from the unit.
14. Patients are to be admitted to the Telemetry Unit only on the order of the attending or consulting physician. Patients may be transferred to the Telemetry Unit on telemetry after being observed and treated in the Critical Care Unit.
15. Patients with suspect or definite acute myocardial infarction may be admitted to the Telemetry Unit at the discretion of the attending physician. Non-myocardial infarction patients requiring ECG monitoring may be admitted to the Telemetry Unit on a bed-available basis. Preference will normally be given to the patient who has suffered a myocardial infarction.
16. A physician, or his alternate, assuming care for critically ill patients should examine the patient, record observations and plans, at least on a daily basis or more often as indicated by the patient's condition.
17. Obtaining 12-Lead Electrocardiograms (EKG's) in the Critical Care Nursing Division: Critical Care nurses may obtain 12-lead EKG's per pre-printed emergency orders as deemed necessary by changes in their patient's physiological status. As the nurse cannot make the assessment by herself whether or not the findings are significant, the EKG must be entered in the chart. The responsible physician then decides whether to discard the EKG or to have the EKG formally interpreted.
18. Either daily rounds will be made by the Director or designee with nursing, or the Director or designee will be available for consultation or evaluations. The Chairman or designee of Clinical Cardiology will be available to nursing staff for rounds or patient care review as necessary.
19. Patients admitted to the CCU with an acute or suspected MI are seen by a physician or consulting cardiologist within two (2) hours of the time of admission. Patients with a complicated MI admitted by a non-cardiologist receive cardiology consult within one (1) hour of the complication."
20. When a cardiologist or internist is managing the care of a cardiac patient in the Critical Care Unit, he/she will act as the coordinator of Cardiac Care.

EMERGENCY DEPARTMENT

1. The care of patients in the Emergency Department is under the supervision of the Emergency Room physicians.
2. All patients coming to the Emergency Department will be interviewed to identify those who have a private physician on staff. If requested by the patient or family, a reasonable attempt will be made to reach the patient's private physician by telephone before the patient is examined. Otherwise, the Emergency Department physician on duty will initially evaluate and care for the patient before calling the private physician to report findings.
3. Members of the Professional Staff may direct their own patients to the Emergency Department for evaluation and/or treatment. When appropriate to the patient's problem they should call and notify the Emergency Room staff of the patient's problem and give any special requests or instructions.
4. Members of the Professional Staff may see their own out-patients in the Emergency Department for Examination and treatment. When this is done the physician should be readily available to the department and is responsible for appropriate documentation and disposition of the patient.
5. Inpatients are not brought to the Emergency Department for examinations or treatment, except that a staff doctor may transfer an inpatient to the Emergency Cast Room for application or removal of a simple cast. Also, a staff physician may request the Emergency Department physician to suture a laceration of an inpatient following an incident if acceptable to the Emergency Department Physician.
6. In no event shall the provision of emergency services and care be based upon, or affected by, the person's race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services, except to the extent that a circumstance such as age, sex, pre-existing medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.
7. All patients sent to the Emergency Department with telephone orders from a private physician will be seen by the Emergency Department physician on duty. An appropriate charge will be made, based on the level of services received.

Emergency Department On-Call Panels

Service on the Emergency Department (ED) call panel shall be open to all members of the Professional Staff who have completed proctoring as Provisional staff member.

The scheduling of participants on the call panel shall be done on an equitable basis and shall initially be the responsibility of the Section.

In the event that a determination is made by the Medical Executive Committee that the Section is not scheduling call on an equitable basis, the Medical Executive Committee reserves the right to assume the responsibility of scheduling the call panel. Further, The Medical Executive Committee delegates the responsibility for creating an equitable schedule to the Chief of Staff.

There will be an Emergency Department Primary Care Panel. When supported and recommended by the appropriate Section and Department, additional specialty panels may be approved by the Executive Committee.

1. The Emergency Department Primary Care On-Call Panel

   A. The On-Call Emergency Department Primary Care Panel is composed of Active, Associate or Provisional Category staff members primarily active at PSJMC in good standing who are members of the Department of Medicine or the Department of General and Family Practice. All new members are eligible for the panel after attaining unsupervised admitting privileges.

   B. The number of physicians on the panel will be determined by the Patient Care Committee. Eligible Professional Staff members wanting to participate must forward their request in writing via the Professional Staff Office to the Patient Care Committee.

      The number of call slots assigned per month shall be initially distributed evenly among panel members participating in any given month. Trading call shifts with another panel member is allowed. However, any changes made to the schedule shall be communicated to the Emergency Department by the panel member making the change. As required by the Department of Health Services, the name of the actual on-call individual shall be communicated to the Emergency Department for posting on the Daily On-Call Schedule. It is the responsibility of the Emergency Department panel member to communicate the correct name of the on-call physician.

   C. The Patient Care Committee may deny requests to participate on the panel or terminate a physician's participation on the panel. Such decisions shall not be considered a denial, termination, or limitation of clinical privileges, and shall not be reportable to regulatory agencies. The physician who is denied an emergency department panel slot or is terminated from the panel shall be given a statement of the reason(s) for the proposed action and afforded an opportunity to appear before the Patient Care Committee to appeal. The physician's participation on the Panel may be restricted at any time until a final decision is reached. Reasons for suspension or termination from the panel include but are not limited to the following:
      - Failure to designate another panel physician to provide coverage if not available
      - Suspension of privileges for delinquent medical records (see "J" below) or any other reason detailed in the Professional Staff Bylaws and Rules & Regulations.
      - Failure to see assigned patients within 12 hours of admission to the floor or within 4 hours of admission to the ICU depending on patient needs. If specialist is managing patient upon admission the primary panel physician will not be required to see the patient until the morning of the following day.
      - Failure to call appropriate consults
      - Failure to see assigned patients on a daily basis to manage care and communicate with consultants, nursing staff, family members etc.
      - Failure to respond to calls from the ED or floor staff within 30 minutes.
      - Failure to meet documentation requirements
      - Failure to provide patient care within expected standard for the Professional Staff as determined by the Patient Care Committee.

   D The initial appointment to the ER panel shall be for one year with automatic reappointments if the panel member remains in good standing as a member of the medical staff and as a panel member. The latter is defined as a record of routinely following the rules of participation, including but not limited to prompt evaluation of patients, following all the rules and regulation of the PSJMC medical staff and the respective Department, compliance with all applicable core measures and patient treatment guidelines. The ER committee, with oversight and approval by the Credentials Committee, will carry out the reappointment process.

   E. Patients seen in the Emergency Department who are to be admitted and who do not have a staff physician will be assigned the on-call physician from the Primary Care Panel. The Emergency Department physician may call a panel member out of turn when the best interest of the patient dictates and where clinically indicated. Patients seen in the Emergency Department who are not admitted will be referred to their family physician. If they do not have a family physician, they will be referred to a Primary Care Panel physician when follow-up care is indicated. Panel members shall not deny these patients at least one follow-up visit; the physician is not necessarily responsible for future care. If the physician elects not to provide follow-up care after the one follow-up visit, he/she will refer the patient to another care setting where the patient can obtain appropriate care. It is advised that this referral process be documented to include the reason for referral, type of referral, referral instructions and the information provided to the patient (facility/name, address, phone number, etc). Patients returning to the ED within 72 hours of discharge for the same condition will be readmitted to the same panel physician who discharged them, just as any of their other patients, to insure continuity of care.

   F. The member of the Primary Care Panel who is on call is responsible for the evaluation and/or admission and disposition of all patients for whom they are called by the Emergency Department. Panel physicians shall, when on

call, notify the Emergency Department about how to reach them, and must respond to Emergency Department call in a timely manner, not to exceed thirty minutes.

G. Each physician on the Panel shall have appropriate experience and judgment consistent with the standards of membership of the PSJMC staff, and shall exercise that judgment in requesting specialty consultation on Panel admissions in the same manner as they would with other patients they admit to the Medical Center.

H. The Patient Care Committee will assess the performance of new members of the Primary Care Panel. They shall be initially approved for a three-month probationary period and evaluated at the end of that period for consideration of extended appointment on the Panel.

I. A panel member who is unable to provide coverage during his/her scheduled time is responsible for arranging for coverage by another Panel member unless exceptions may be made by the Patient Care Committee Chairman or his designee, as determined by need. The Panel member shall inform the E.D. of the name of the practitioner who will provide coverage.
A failure to arrange in advance for appropriate coverage may be grounds for suspension from the Panel and may subject the Panel member to disciplinary action.

J. Panel members on suspension for delinquent medical records will not be allowed to take call. An immediate suspension from the panel for three months will occur if a panel member is on suspension for medical records while on call. If the above infraction takes place a second time, the panel member will be removed from the panel. The panel member may re-apply for panel membership after 6 months have elapsed. These actions are not subject to appeal. The Chair of the Patient Care Committee or the MEC may undertake disciplinary actions.

K. Each physician shall accept the care of all patients who are referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, religion, ethnicity, citizenship, pre-existing medical condition, physical or mental handicap, insurance status, economic status, or ability to pay for medical services. When requested~~,~~ by the emergency department staff, ~~P~~panel members also shall provide consultation on the same non-discriminatory basis.

L. Indigent or uninsured patients, or patients whose insurance requires that they be treated at specific facilities, will be transferred to a more suitable facility whenever appropriate, according to the Hospital's transfer policy, provided the patient's condition has been stabilized and the patient is otherwise medically fit for transfer, or the patient demands transfer notwithstanding the medical risks. Panel members will be required to see such patients only if the patient is not transferred or the E.D. requests specialty consultation for the adequate care of the patient.

M. Panel members will see unassigned patients in the E.D. on a private-pay basis. The Panel member will be responsible for billing and collecting his/her fees. The Hospital has no responsibility for this physician/patient relationship and each Panel member agrees to release the Hospital from any obligation in this regard.

N. A Panel member shall cooperate with and assist the E.D. and E.D. physician. The actions of the Panel member shall be in the best interests of patient care and shall be consistent with the Hospital's and Community standards.

O. It is the expectation of the MEC that ED panel members, as well as all physicians on staff at PSJMC will fully cooperate with the documentation requirements and standards of care as mandated by regulatory agencies and consistent with our professional organizations ` treatment guidelines and standards of care. This includes but is not limited to case managers and social services workers and Allied Health Professionals.

CARDIOPULMONARY RESUSCITATION (CPR)

Code Blue Response Team

1. The responsibility for management of a patient sustaining an in-house cardiopulmonary arrest resides with the Providence Saint Joseph Medical Center Rescue Team.
2. The Providence Saint Joseph Medical Center Rescue Team consists of Emergency Department physicians, other qualified physicians of the Professional Staff responding to a Code Blue, and defined members of the Medical Center.
3. Cardiopulmonary resuscitation is initiated without a physician order when cardiac or pulmonary arrest occurs, unless the attending or responsible physician has written (or given an appropriate telephone order), a Do Not Attempt Resuscitation ("DNAR") order in the chart.
4. The attending or consulting physician, if immediately available, may assume responsibility for the resuscitation. If not immediately available, the attending physician will be notified and communicate with the Emergency Department or responding physician as possible.
5. The Emergency Department physician may cede the responsibility for continued management of the arrest to another physician when mutually agreeable.

POLICIES RELATING TO BIOETHICAL ISSUES

I. DEFINITIONS

Advance Healthcare Directives: Any written or documented oral statement by the patient that specifies what treatment the patient would want in the future or that names someone to be the recognized decision-maker should the patient loose decisional capacity. Oral directives to the physician and charge nurse by a patient with decisional-capacity are recorded in the medical record and are valid for the duration of the hospitalization or 60 days, whichever is shorter.

Benefit (to patient): Outcomes that can be experienced by the patient in a positive way; e.g., conscious life extended more than minutes/hours may be considered to be a benefit of CPR. However, only the patient/surrogate can decide whether the benefit is sufficient to offset the risks and burdens of resuscitation and continued life.

Best Interests: A standard of judgment made by someone other than the patient in which the risks, burdens, and benefits of a proposed course of treatment are weighed. "Best interests" is sometimes described as the choice that a reasonable person in the patient's circumstances would choose. The President's Commission suggests that when judging a "patient's best interests, such factors as the relief of suffering, the preservation or restoration of functioning, and the quality as well as the extent of life sustained" be considered.

Cardiopulmonary Resuscitation ("CPR"): In the acute-care setting, CPR includes all elements of basic and advanced cardiopulmonary resuscitation that are available and potentially effective in restoring cardiac or pulmonary function after cardiac or respiratory arrest has occurred.

Decision-Making Capacity: A patient's ability to understand the nature and consequences of recommended treatments and options, the risks and benefit of consenting to or refusing treatment and to make and communicate a considered decision based on full information and on personal values.

Do Not Attempt Resuscitation Order ("DNAR") Order: A Member's written order or witnessed telephone verbal order not to initiate CPR in the event of a patient's cardiac or pulmonary arrest.

Futile: An intervention is futile if it is intended to achieve a result which is impossible or not realistically foreseeable for the intervention to achieve or will not prevent the patient's imminent demise or result in an acceptable ongoing quality of life for the patient.

Healthcare Provider: Individuals authorized to participate in the provision of care to patients.

Informed Consent: Informed consent is the permission given by a patient who has capacity to make healthcare decisions (or, in the case of a patient who does not have such capacity, by an appropriate surrogate decision maker) to undertake or discontinue any recommended medical or surgical intervention; provided, that such permission is given only after the patient (or surrogate) has been given sufficient information regarding the potential benefits and risks of the proposed action and of reasonably available alternative courses of action to rationally evaluate the proposed action.

Member: A Physician, Dentist, or Podiatrist, who is a member of the Professional Staff of Providence Saint Joseph Medical Center of Burbank.

Surrogate: Any individual who is: 1) A person's agent pursuant to an Advance Healthcare Directive, 2) The legally appointed guardian or conservator having the authority to make healthcare decisions.

In the absence of one of the foregoing, anyone who has had an ongoing relationship with the patient so that he or she is able to convey the patient's values and probable choices. Priority is given in the following order: a) spouse, b) a registered domestic partner as defined in the California Family Code, c) an adult son or daughter, d) a custodial parent, e) an adult brother or sister, f) an adult grandchild, g) an available adult relative with the closest degree of kinship.

If there is no agreement among surrogates of the same priority, the Member should follow the procedures in Section VII, Conflict Resolution.

II. GENERAL PRINCIPLES

A. Preamble

These Principles of Medical Ethics are set out to serve as guides for Members and other Healthcare Providers in their care and treatment of patients at Providence Saint Joseph Medical Center of Burbank ("PSJMC").

They are founded in the ethical principals underlying the mission of the Sisters of Providence and the recognition that PSJMC is administered in accordance with the Ethical and Religious Directives for Catholic Health Facilities. The Mission of the Sisters encompasses the core values of respect for the dignity of persons, justice, compassion, excellence and stewardship. The principles of beneficence and avoidance of harm impose an obligation at all times to provide appropriate care, never inappropriate care. The principles of justice require that care which has become inappropriate be terminated.

The principles are applicable at all times and in every circumstance without exception. Each Member must apply

them in each situation in light of the Member's best judgement in view of the circumstances, as the Member understands them. No threat, criticism, or attacks of any kind or from any source can justify a deviation from the application of these principles. It is recognized that situations will arise in which a member will decide that following a course of action demanded by a patient or the patient's Surrogate would not be consistent with these principles. In such situations the proper course of conduct will be for the Member to follow the procedures set out in Section VII. Conflict Resolution.

B. The Member's Goal in Providing Medical Care

Quality of Medical Care: The Members are responsible for the quality of medical care in PSJMC. The individual Member's primary goal is to restore or maintain the patient's well being, relieve pain and suffering, provide appropriate and compassionate care for the terminally ill and assist the patient in achieving the patient's desired quality and duration of life. It is recognized that despite the most appropriate treatment not all patients will recover or achieve their goals.

These principles are designed to assist the Member in the appropriate use of life-sustaining courses of treatment interventions. Based on ethical principles, such intervention should be part of the effort to restore or maintain a patient's well being; it should not have as its sole goal the unqualified prolongation of a patient's biological life.

Biological life need not be preserved at all costs. There are times when it is more in keeping with respect for life to let it go than to cling to it.

Duty to Provide Physical, Spiritual and Emotional Comfort: A decision to withhold or withdraw treatment, including life support systems, does not mean the medical staff has abandoned patients, but rather represents the time to intensify the efforts to provide physical, spiritual and emotional comfort.

Regardless of a living patient's diagnosis or prognosis, it is always necessary to provide hygienic care, relieve discomfort, respect the patient's dignity and provide psychological support and spiritual care. While these treatments will not prolong the act of dying, they will contribute to the patient's comfort and should be emphasized.

C. Role of the Health Care Professional

Members have a professional, ethical, and legal obligation to assist their patients, or their patients' surrogate decision-makers, to make well-informed and careful healthcare decisions.

While Members have an obligation to consider and explain the potentially beneficial treatment alternatives, they have no obligation to propose or participate in the performance of any treatment or intervention, which is clearly futile.

Healthcare professionals may decline to participate in a particular option under these guidelines because that choice may violate their conscience or professional judgment. In doing so, the declining professional must make arrangements to transfer that part of the care of the patient to another health professional who accepts responsibility for that care.

D. Patient Autonomy and Best Interests

Every adult patient with capacity to make healthcare decisions has the right to be informed of his or her medical condition and prognosis; the right to be informed of the advantages and disadvantages of beneficial alternative treatments; and the exclusive right to grant, withhold, or terminate his or her consent to any proposed treatment or intervention, including the institution or termination of life support systems or treatments. This does not imply a patient's right to dictate treatment or procedures to be done.

Where a patient lacks healthcare decision-making capacity, the patient's healthcare decisions must be made by one or more surrogate decision-makers. If such a patient has executed a valid Advance Healthcare Directive, the agent designated in that document is authorized to make any decision regarding the patient's care which a patient with healthcare decision-making capacity could make unless limited by the directive. If such a patient has executed a valid and binding Directive to Members, the patient's healthcare provider and the designated surrogate decision-maker should comply fully with the patient's intentions as expressed in that document.

Where a patient without decision-making capacity has not executed a binding Durable Power or Directive to Members applicable to the circumstances, the patient's healthcare should be directed by a surrogate decision-maker. In such cases, the surrogate decision-maker should be guided by available evidence as to what the patient himself or herself would have preferred under the circumstances and by their best judgment of what course of action would be in the best interests of the patient from the patient's perspective. This process involves a balancing of benefits and burdens

from the patient's perspective.

When decisions are made to withhold or withdraw life support, appropriate efforts should be made to include spiritual care and social services in the decision process and in efforts to assist the patient and family members. The Bioethics Committee should be consulted whenever concern exists as to whether a decision to withhold or withdraw life support is proper or whether these guidelines have been followed.

III. CONFIDENTIALITY

Confidentiality, a duty at least as ancient as the Hippocratic Oath, is rooted in respect for the ethical principles of Autonomy, the right to privacy and physician fidelity. A patient has an autonomous right to determine who has access to the medical and personal information revealed to a physician. Society has a two-fold interest in the confidentiality of medical information:

A) Without confidentiality, a lack of trust results in withholding essential facts, compromising the medical process and patient care;
B) Other entities, without the patient's knowledge, may profit from or otherwise use the information without benefit to and with possible harm to the patient.

Policy

Physicians have an obligation to respect the patient's reasonable expectations of privacy and confidentiality. Confidential communications or information should not be revealed without the express consent of the patient unless mandated or permitted by law as reporting contagious disease, child abuse, elder abuse, gunshot wounds and serious danger to third parties. Furthermore, such information is not permitted to be inappropriately divulged by others to whom it might be professionally known. Patients must be informed of the limits and exceptions to the duty of confidentiality. The ethical principle applies to all medical records, including computerized records.

IV. FUTILITY DETERMINATION

Ethical Principles:

Physicians have an obligation to their patients to maintain or attempt to restore their well being and to avoid harm. The goal of medical intervention is the improvement of the patient's health, well being, comfort, and prognosis, not as its sole goal the prolongation of biological life.

The physician is obliged to inform the patient/surrogate what effect a specific intervention will have including not only positive or beneficial effects, but when it may have little, transient, or no effect on the patient's condition or further the goals of treatment. The provision of interventions that are clearly inappropriate (futile) undermines professional integrity and personal accountability, and is contrary to the ethical goals defining medical practice.

Physicians are obligated to adhere to high standards of scientific competence, claiming neither more nor less than what medicine can actually deliver. Physicians are justified in risking harm to patients only when the potential benefit outweighs the risk. If the benefit is practically zero, there can be no justification for any risk of harm, especially if the futile treatment causes pain or other discomfort.

Appropriate medical decisions must be made in the best interest of the patient, not the physician, the hospital, the legal system or some other entity. The best interests of the patient do not require that life support be continued in all circumstances such as when the patient is terminally ill and suffering, particularly where there is no hope of recovery or sustaining of cognitive function. Physicians are not required to provide treatment that is ineffective or will provide no benefit or is outside generally accepted standards of medical care (California Probate Code CH 4 Sections 4734-4736)

Policy

A. A treatment or intervention is futile if it cannot achieve the goals of the action no matter how often repeated or provides no meaningful extension of life or other benefit to the patient. It is harmful when additional suffering and harm inflicted on the patient is greatly disproportionate to any possibility of benefit.
B. A patient does not have an unqualified right to extraordinary procedures or artificial support in order to achieve or sustain mere vegetative survival, or where such procedures serve only to prolong the dying process in a patient with a terminal illness.
C. There are occasions when intensive interventions that are ultimately futile offer the patient the opportunity to achieve limited goals in accordance with the patient's own values.
D. Futility determinations are made on a case-by-case basis within the context of a particular patient's clinical circumstances, the attending physician's evaluation, diagnosis and prognosis and an individualized understanding of the patient's values, needs and preferences.
E. Neither the physician nor the hospital is required to provide care that is not medically indicated or outside generally

accepted standards of medical practice.

F. Futility determinations will not be based on:
   1. Cost of treatment
   2. The "worthiness" of the patient or the patient's responsibility for his/her condition
   3. Absence of family or friend to be a strong advocate
   4. The physician's and other care givers personal reaction to the patient's situation

G. Futility determinations will not be avoided by unwillingness to address end-of-life issues.

Procedure

A. The preliminary judgment of whether the interventions, treatment or attempted resuscitation would be either futile or harmful is made by the attending physician, and confirmed in the progress notes by consultation with an appropriate specialist.

B. Consideration of futility is appropriate where:
   1. The patient is in irreversible coma
   2. Terminal illness with expected imminent death as confirmed by appropriate consultation.
   3. Progressive multiple organ failure, or clear and convincing data indicate that acute interventions will not reverse the process or materially alter the ultimate outcome.
   4. Treatment would only serve to prolong the dying process and/or bring no relief of the patient's suffering without hope of improvement.

C. Consideration must be given to the patient's goals and value system as evidenced by the patient's culture, religion, family circumstances and stated goals and values.

D. The attending physician will inform the competent patient or the incompetent patient's representative of the futility determination, carefully explaining the nature of the ailment, option, prognosis and which treatment or procedures are considered futile and will explain which futile treatments/procedures will not be offered or will be discontinued.

E. The physician will emphasize that treatment measures for comfort, palliation, dignity, hygiene, psychological, and spiritual support will continue. Palliative Care consultation will be offered.

F. Adequate time is allowed the patient/family/surrogate to consider the information. Consideration will be given to reactions of denial, guilt and need to grieve. The assistance of chaplains**,** social services and palliative care services will be offered. Those departments will be notified.

G. The attending physician will accommodate and assist the family/surrogate if there is a wish for independent consultation for an opinion concerning the futility determination.

H. When treatments, procedures or interventions are determined to be futile and a family conference has been called to discuss the situation, the physician shall document the substance of the discussion in the patient's record. With the decision maker's concurrence, appropriate orders may then be written discontinuing procedures found to be no longer appropriate as well as other tests. Orders for appropriate supportive and comfort care shall be entered.

I. Should further clarification be needed, where the patient/surrogate expresses lack of understanding and/or unwillingness to accept the decision of the attending physician, The Bioethics Committee will be called to assist with continuing efforts to enhance communication and negotiate mutual understanding.
   1. Where the Committee concurs with the futility determination, the attending physician and medical center are not required to, and should not institute or continue futile treatment.
   2. Where there is no consensus on the committee regarding the futility determination, there should be a presumption in favor of providing treatment.

J. The patient/family/surrogate retains the right to transfer care to another facility and physician if possible, who will accept the patient and carry out the patient/family/surrogate wishes. The physician will assist in arranging such a transfer.

K. Where no alternative care provider can be identified or transfer is refused, the physician will consult with the Bioethics Committee, Hospital Administration, and Legal Counsel to determine the course of action.

L. In the event of disagreement between the primary physician and other caregivers about the futility of treatment, the issue may be brought to the Bioethics Committee and to the attention of the appropriate department chairperson.

M. The physician may withdraw from the case after transferring care to another physician if the recommendations and ultimate course of action violates his/her personal, moral/ethical standards or values.

V. STEPS IN THE HEALTHCARE DECISION-MAKING PROCESS

Members and other healthcare providers have a professional and ethical obligation to assure that an appropriate process is followed to make healthcare decisions. This is especially true regarding decisions to forego (that is, either to discontinue or not to initiate) life support systems. Typically, that process will include the following:

A. Making an accurate diagnosis of the patient's medical condition
B. Identifying the patient's goals'
C. Establishing a realistic prognosis based on the diagnosis and available treatment possibilities
D. Identifying beneficial treatment alternatives
E. Formulating and communicating to the patient/surrogate a recommended treatment plan or course of action based

on a professional evaluation of the expected benefits and burdens of the beneficial alternatives; the healthcare professional is not obligated to recommend treatments which are clearly futile;

F. Identifying the appropriate healthcare decision-maker(s):
   1. This will be the patient, if the patient has healthcare decision-making capacity;
   2. This will be a court-appointed conservator or guardian if one has been appointed;
   3. If a patient lacking healthcare decision-making capacity has executed a valid Advance Healthcare Directive for Healthcare, which is in effect, the agent identified in that document is the decision-maker;
   4. Otherwise, one or more appropriate surrogate decision-makers should be identified (see definition).

G. After deliberation, as described above, if there is a disagreement or conflict regarding these recommendations, a conference may be called with the patient/decision-maker/family/attending physician. If no progress is made in resolving the problem the issue may be referred to the full Bioethics Committee.

VI. C0NFLICT RESOLUTION

Conflict in the hospital arises out of patient/family issues, staff issues, institutional issues, legal issues, and ethical issues. Most conflicts are multifactorial and require a systematic approach to identify the nature of the conflict and facilitate resolution.

If a conflict arises involving patients, caregivers, family, or surrogates, a committee appointed by the Chair of the Bioethics Committee of designee will evaluate the problem. The committee shall consist of but is not limited to representatives from: Bioethics Committee, Department Representatives, Clinical Social Work, Spiritual Care, Nursing and Administration. The committee will obtain and review information relative to the conflict and deliberate for an effective solution. After deliberation, a conference may be called with the patient/decision-maker/family/attending physician. If adequate progress is not made in resolving the problem, the conflict may be referred to the full Bioethics Committee.

VII. PAIN

In accord with the Mission of the Sisters of Providence and the Sisters of Little Company of Mary, the relief of pain and suffering is a pressing goal of care at Providence Saint Joseph Medical Center.

Unaddressed and unrelieved pain is a complication of care.

Providence Saint Joseph Medical Center supports the pain management precepts established by the World Health Organization, the Agency for Health Care Policies and Research, and the American Pain Society.

A. Pain Control:
   1. Is a legitimate therapeutic goal and moral obligation consistent with respect for the patient.
   2. Contributes significantly to the patient's spiritual and emotional well being.
   3. Ranks high in the priorities of patient care.
   4. Is patient controlled in terms of assessment of pain and methods used, consistent with safety.

B. The Patient has a right:
   1. To decide duration and intensity of pain he/she is willing to endure or tolerate.
   2. To be informed of all possible methods of pain relief possible as well as positive and negative consequences.
   3. To choose which pain control method he/she wishes to try, consistent with accepted medical practice.
   4. To choose to live with or without pain.
   5. To choose comfort over function even if life is shortened as an unintended effect.

C. Addiction: In treating patients who have an addiction to drugs, the primary concern should be the alleviation of pain. Such treatment may require the use of drugs to which the patient is addicted and use in amounts greater than would be required in patients not so addicted.

D. Guidelines for Provision of Pain Control:
   1. Assess each patient's signs and symptoms and their individual needs, then prescribe, treat, and adjust medication dosage and type. Include other therapies according to desired outcomes.
   2. Believe the patient's self-report using a "zero-to-ten" pain scale and recorded with the vital signs. Believe also that for those patients who are either too young or too infirm to express their pain level analgesics should be prescribed.
   3. A multi disciplinary approach to the evaluation and treatment of pain provides the patient the best therapeutic options and results.
   4. Clinicians must be aware of the effects and potential hazards of pain medications and other therapies and avoid using the term "addicted" for patients who are psychologically dependent upon narcotics.
   5. Consider pain to be a medical emergency.
   6. Placebos will not be used for pain control.

VIII. DECISIONS TO FOREGO THE USE OF LIFE SUPPORT SYSTEMS

A. Life Support Systems: The term "Life Support Systems" as used in this section refers to those measures accepted to be extraordinary in a specific clinical setting. These include, but are not limited to, respirators, dialysis, drugs, enteral and parenteral feedings, and blood products.

B. Decisions to Withhold or Withdraw Medical Treatment: Questions of when to withhold or withdraw medical treatment involve personal values and ethical consideration as well as medical issues. Therefore, the Member should not make decisions in these matters alone. The competent adult patient is the primary decision-maker for his/her healthcare, and has the legal and ethical right to consent to or withhold consent for any medical intervention regardless of the consequences. When decisions are made to withhold or withdraw life support, spiritual care and social services will be notified and included in the process and in efforts to assist the patient and family members.
The Bioethics Committee should be consulted whenever concern exists in a Member's mind as to whether a decision to withhold or withdraw life support is proper or whether these guidelines have been followed.

C. Decision by Surrogate: The legal surrogate of a patient without decision-making capacity may authorize the withholding or withdrawing of any treatments provided it is in keeping with the patient's known wishes or best interests.

D. Parties Involved: The decision to forego Life Support Systems should involve the patient or appropriate surrogate, attending Member, consultants, nurses, and family.

E. Life Support Systems Need Not be Continued Indefinitely: Life Support Systems, once they are initiated, are not required to be continued Indefinitely solely because they were started at an earlier time.

F. Recording Life Support Decisions: The attending Member will summarize in the record and for the decision-maker, the diagnosis, prognosis, available treatment alternatives, and the risks and benefits of both treatment and non-treatment.

G. Life Support Criteria: Life Support Systems will not be initiated or will be discontinued by the attending or responsible Member if the circumstances meet one or more of the following criteria:
   1. It has been determined and recorded in the Patient's Medical Record that the patient has suffered irreversible cessation of all functions of the whole brain, including the brain stem;
   2. The patient having Decision-Making Capacity to make healthcare decisions has given an adequate informed consent regarding omission or discontinuance of life support systems and this is documented in the medical record; or
   3. A patient lacking healthcare decision-making capacity has signed a valid and binding Directive to Physicians in accordance with the California Healthcare Decision Law (Probate Code Section 4600-4805) and the clinical circumstances are appropriate (copy of this must be included in the medical record);
   4. A patient lacks capacity for making healthcare decisions and an appropriate surrogate agrees with the attending and consulting members that initiation or continuation of life support systems would be contrary to the patient's known wishes or would not be in the best interest of the patient.

H. If a patient lacks decision-making capacity and no appropriate surrogate can be identified, see Section XII. "Patients without Surrogates."

I. Conditions for Additional Evaluation and Consideration: Additional evaluation and consideration including the Medical Director, Hospital Administration and legal counsel, when appropriate, is required if:
   1. The patient's condition stems from an injury which appears to be the result of a criminal act or medical accident,
   2. The patient is pregnant,
   3. The patient is a minor or,
   4. The patient has sole custody of or responsibility for minor children.
   5. The patient lacks decision-making capacity and there is no known surrogate (See Section XII "Patients Without Surrogates")

J. Parties Involved in Discontinuance of Life Support Systems: The discontinuance of life support systems should be done by the Member and should be witnessed by at least one registered nurse or another Member. When this is not a viable option, the physician of record may write an order for the R. N. and R.C.P. caring for the patient to remove the life support systems.

K. Care of the Patient Following Discontinuance of Life Support System: When the patient survives, discontinuance of life support systems added emphasis must be placed on the patient's comfort, care and dignity. All other procedures or interventions not related to this may be omitted.

L. Consultation with Bioethics Committee: If there are any questions or concerns about the application of any part of these guidelines, or if any of the participants do not agree that the decision is appropriate or that proper protocol was followed (and if the participants are unable to resolve any concerns) the participants shall consult the Bioethics Committee for assistance.

IX. DECISIONS TO MAKE "DO NOT ATTEMPT RESUSCITATION" ORDERS (DNAR)

A. CPR: CPR is meant to treat unexpected Cardiopulmonary arrest in live patients. It may not be indicated in certain situations such as in cases of terminal and irreversible illness, where death is not unexpected, or where prolonged cardiac arrest dictates the futility of resuscitation efforts.

B. DNAR Orders Not Inconsistent with Ongoing Treatment: DNAR orders are compatible with maximal and aggressive

medical care and do not necessarily imply either that current treatment need be withdrawn or that additional measures may not be initiated. Treatment choices should be based on continuous reassessment of clinical information, regardless of "Do Not Attempt Resuscitation" orders.

C. Use of CPR: CPR will be initiated on a routine basis when a patient suffers an apparent cardiac and/or pulmonary arrest unless the attending or responsible member has written an order to the contrary ("do not attempt resuscitation").

D. Non Use of CPR: CPR shall not be performed for patients who have been pronounced dead (including patients who are brain dead) unless one of the following exceptional circumstances is noted on the patient's medical record:
   1. Ventilatory support or other interventions have been ordered to be continued pursuant to an approved protocol for harvesting organs from the patient; or
   2. A court order is in effect, which prohibits withholding of Life Support Systems.

E. Recording Circumstance: "Do Not Attempt Resuscitation" orders must be recorded in the Patient's Medical Record stating the reason for the order and that the patient having decision making capacity, family members, conservator, or other appropriate surrogate decision-maker, if appropriate, have been included in the discussion and concur with the order. The order must be reviewed with appropriate Members of the nursing staff a completed DNAR form may be used and included in the medical record. If an "Advance Healthcare Directive for Health Care" or other advance directive is used, a copy must be a part of the Patient Medical Record.

F. Telephone "Do Not Attempt Resuscitation" Orders: Telephone "Do Not Attempt Resuscitation" Orders may be given by a Member to the nursing staff charged with the patient's care. When the Member gives a "do not attempt resuscitation" phone order to a registered nurse, it must be witnessed (listening on the telephone) by another licensed professional and must be co-signed, dated and timed by both. The order must be signed, dated and timed by the ordering member within 24-hours and recorded in the Patient's Medical record.

G. Patient Decision Not to Use Cardio Pulmonary Resuscitation: If a patient with Decision making capacity gives an informed consent to a DNAR order, and this informed consent is recorded in the patient's medical record, no other action need be taken.

H. Procedure to be Followed When a Patient Lacks Decision-Making Capacity: If the patient lacks healthcare decision-making capacity and has a terminal and irreversible illness with a limited life expectancy, the responsible family members, appropriate surrogate decision-maker and/or conservator must be involved in the discussion and concur in the decision of a "Do Not Attempt Resuscitation" order. Whenever this decision is made the attending or responsible members must note this in the Patient's Medical Records. When there is no surrogate follow the procedure in Section XII. (Patients without surrogates)

I. Involvement of Los Angeles County Public Guardian: The Los Angeles County Public Guardian will generally not consent to a "Do Not Attempt Resuscitation" order for patients who are wards or conservatees of the Public Guardian. If the Member believes that such orders are otherwise indicated and appropriate for such patients, the Member must contact the Public Guardian to discuss the reasons for a "Do Not Attempt Resuscitation" order for a particular patient and request and submit the forms required to obtain consent for a DNAR order.

J. Situations Requiring Consultation with Bioethics Committee: If there is any question on the part of the attending members, the nursing staff, patient, family, or chief of service as to the application of these guidelines, a representative of the Bioethics Committee designated by the Committee's Chairman may be called in to participate in the discussion. This request will be made by or with the knowledge and concurrence of the attending Members.

K. Circumstances Requiring Reevaluation of "Do Not Attempt Resuscitation Orders": All patients who have "do not attempt resuscitation" orders written must have this status reevaluated when there has been a material change in the patient's status. If there is a change in the clinical status, a new DNAR order shall be written in the chart if appropriate or other orders as indicated.

L. Partial Code Orders: Orders for partial resuscitation measures such as "No Defibrillation" "No Intubation", or "No Chest Compression" may be appropriate. If it is appropriate to use medication, the Member shall specify which drugs are to be used and in what circumstances. For patients in a monitored unit who have a "do not attempt resuscitation" order written, the member must review the standing orders and specify which drugs are to be used.

M. Care of Patients when Death is Imminent: Where death is expected and imminent and a "do not attempt resuscitation" order is written emphasis will be placed on the patient's comfort and care, and all procedures not related to this may be omitted. "Comfort Care" orders will be discussed with the family. Palliative Care consultation may be appropriate.

N. Responsibility of Member: During a code, the responsible Member in attendance shall decide if and when it is appropriate to stop resuscitation measures. If the attending physician is not present, this decision shall be made in consultation with him whenever possible.

X. SURGERY

In accordance with the ethical principles of patient autonomy and best interests and in keeping with the requirements of informed consent: The patient with Decision-Making Capacity or the appropriate surrogate decision-maker will be fully informed of the policies of the Department of Surgery and Anesthesia relative to DNAR orders from the time the patient enters the surgical suite until leaving the Post Anesthesia Recovery Unit.

XI. PATIENTS WITHOUT SURROGATES:

Hospital patients without surrogates who lack health-care decisional capacity retain the right to have ethically and medically appropriate decisions made on their behalf. These decisions, based on sound medical advice, must be made in the best interest of the patient, not the physician, the hospital, the legal system or some other entity. Appropriate health-care decisions include both the provision of needed medical treatment and the avoidance of non-beneficial or excessively burdensome treatment or treatment that is medically ineffective.

The initiation or continuation of life sustaining treatment without a decision that such treatment provides a medical benefit or is in the patient's best interest may subject the patient to indignity and suffering. Physicians are not required to provide such treatment or treatment that is outside generally accepted standards of medical care.

This policy provides guidelines for an advisory process, using surrogate teams, acting as the patient's advocate, to support healthcare providers in making ethically and medically appropriate treatment decisions on behalf of persons who lack health-care decision-making capacity and for whom there is no surrogate decision-maker or advance directive. No hospital consent form is required for such patients when this policy is followed.

This policy is not employed in emergencies where life is endangered or significant morbidity or disability is likely to result due to delays in treatment. In such situations consent is implied by law.

Patient Surrogate Teams

1. The chairman of the Bioethics Committee, with the assistance of the chief of the department involved, if necessary, will appoint the members of the surrogate team to serve for the time required to complete the case under consideration. All team members may be members of the Bioethics Committee.
2. The basic team shall include, at a minimum, a physician not involved in the care of the patient, a non-physician member of the committee and a community member. If a community member is not available within a reasonable time, not to exceed 24 hours, another member of the Bioethics Committee may serve as the third member of the team.
3. The expanded team may be required by the needs and complexity of the patient's case as well as the significance of the decisions to be made and their consequences. In addition to the basic team, it will include, but not be limited to, nursing, clinical social work, spiritual care, risk management and consultants as required.
4. The surrogate team has the authority to review, discuss, suggest modifications and give or withhold consent to the final treatment decisions by unanimous vote.
5. Surrogate teams will function and be accountable in their actions based on the Organized Medical Staff Bylaws and Rules & Regulations.

Medical Treatment Levels

1. Basic medical treatment does not require a surrogate team meeting. This is routine care that any patient would expect to receive, e.g., I.V.s, non-surgical biopsies, non-surgical artificial nutrition, antibiotics, routine radiology and other non-invasive testing procedures.
   The physician will enter in the medical record that the patient lacks decisional capacity, surrogate or advance directive. The physician will record what treatment or procedure is required, why, and what would likely occur if it is not done.
2. Except in emergencies, when explicit signed consent is required, e.g. for the administration of blood or blood products, use of contrast dyes, insertion of central lines etc., the physician will obtain the concurrence of another physician (or one appointed by the chief of service) not involved in the care of the patient. This will be recorded in the medical record. A surrogate team meeting is not required for consent.
3. Major medical treatment that entails significant risk, discomfort, debilitation or invasion of body integrity such as major surgery, chemotherapy, diagnostic procedures requiring anesthesia, etc. requires a basic surrogate team meeting with the patient care team as described below.
4. Decisions about DNAR (do not attempt resuscitation) orders, withholding or withdrawing treatment or possible termination of life sustaining treatment will require an expanded surrogate team conference with the patient care team as described below.

Procedure

1. A determination is made by the primary physician and appropriate consultant (s) assuring that the patient lacks medical decision-making capacity.
2. Diligent search fails to identify a surrogate to act on behalf of the patient: no agent, conservator, or guardian; no health care directive or POLST; no family member or close associate/friend reasonably available and willing to serve as surrogate decision-maker.

3. A bioethics consultant is obtained to review the case for diagnosis, prognosis and care plan to determine the need for a surrogate team meeting and at what level.
4. The surrogate team will meet with the primary care physician and other members of the care team including consultants, as needed, with minimal delay.
5. The team will review the case, the recommendations of the physician in charge of the case and all relevant information. This includes consideration of benefits and burdens, risks, alternatives and possible modifications of the care plan.
6. Goals of care will emphasize relief of pain and suffering, the possibility of improved function and in some cases preservation or recovery of cognitive function. Quality of life issues are part of the discussion.
7. It is not required that life support be continued in all circumstances where treatment is non-beneficial, ineffective or when the patient is terminally ill, suffering and there is no reasonable expectation of meaningful improvement.
8. The surrogate team must be reasonably sure that the recommendations for care are consistent with the patient's wishes, if known, and are in the patient's best interest. They must be consistent with generally accepted standards of medical care and within the range of ethically acceptable treatment alternatives.
9. If the surrogate team cannot reach a unanimous decision to consent or not consent to the recommendations, the matter is referred to the full ethics committee or to the clinical department. It may be referred to the superior court although it is recognized that this is not always practical or desirable.
10. Any implementation of a recommendation to withdraw or withhold life-sustaining treatment will be the responsibility of the primary treating physician.

Special Circumstances

1. The responsible physician may at any time withdraw from the case provided another physician member assumes care of the patient
2. Legal counsel and administration must be consulted if a decision to withhold or withdraw treatment is likely to result in the death of the patient and arises in any of the following circumstances:
   a) the patient's condition appears to be the result of a criminal act;
   b) the patient's condition appears to have been created or aggravated by a therapeutic misadventure;
   c) the patient is pregnant;
   d) the patient has sole custody of, or sole responsibility for support of, a minor child

Documentation

1. The conclusions of the surrogate-care team meeting must be promptly entered into the medical record by both the primary care physician and a member of the surrogate team.
2. The entry will note the patient's lack of decisional capacity and the failure to identify a surrogate or advance directive. The final proposed care plan will be described and the decision to consent or not consent with the reasons for the decision.
3. A report will be submitted to the Ethics committee's professional staff coordinator containing a list of participants, a summary of the case and the final approval or disapproval of the recommendations for care as well as any other relevant information

Review

1. All surrogate team meetings will be reviewed at the next scheduled meeting of the full Ethics Committee and then reported to the Medical Executive Committee.

XII. DECISIONS REGARDING PATIENTS IN A PERSISTENT VEGETATIVE STATE (PVS):

PVS is by definition a condition of irreversible coma characterized by irreparable neocortical damage although brain stem functions persist. In this state respiration and heartbeat may continue indefinitely with no hope ever of return of consciousness or recovery of recognized cortical function.

In principle there is an obligation to provide such a patient with food and water including medically assisted nutrition and hydration.

This obligation becomes morally optional when there is no benefit or the burden out-weighs any benefit. This occurs where there is significant discomfort, co-morbidities or underlying fatal conditions. In these instances medically administered nutrition and hydration is not obligatory due the very limited ability to prolong life or provide comfort.

In such cases it can be morally and ethically justifiable to withdraw artificial nutrition or hydration, as well as other artificial means of life support, allowing the patient to die in the natural course. Once the diagnosis of PVS has been established, all

decision relating to possible termination of life support must be made in consultation with the appropriate decision-maker based on a determination of the best interest to the patient.

XIII. DECLARATION OF DEATH

A. Declaration of Death: All patients who die while hospitalized must be declared dead by a member of the medical staff or, where a DNAR order has been written, by a nurse certified in this procedure as delineated in the nursing policy NSGD.1, Pronouncement of Death No Code Patient, approved by the Medical Executive Committee on 7/16/97. When a question of death arises, the staff registered nurse will call the attending physician.

A patient may be declared dead either under the criteria for clinical death or under the criteria for brain death. (Uniform Determination Death Act) in accordance with accepted medical standards.

B. Criteria for "Clinical Death"
1. Irreversible cessation of circulatory and respiratory function, i.e.:
   a. Absence of heart sound and peripheral pulses
   b. Absence of spontaneous respiration
2. Absence of spontaneous movement
3. Unresponsiveness to externally applied stimuli
4. No elicitable reflexes

A Member attending a patient who has been declared dead will record in the patient's medical record the following:
1. Date
2. Time declared dead
3. A statement pronouncing patient death and criteria used, in the determination of death, etc.

C. The California Health and Safety Code **7180** states:
"An individual who has sustained...irreversible cessation of all functions of the entire brain, including the brain stem, is dead. The determination must be made in accordance with accepted medical standards." Brain death is the absence of clinical brain function when the proximate cause is known and demonstrably irreversible.
1. Clinical or neuro-imaging evidence of an acute CNS catastrophe that is compatible with the clinical diagnosis of brain death
2. Exclusion of complicating medical conditions that may confound clinical assessment (no severe electrolyte, acid-base, or endocrine disturbance)
3. No drug intoxication or poisoning
4. Core temperature ≥ 97 degrees F. (*American Academy of Neurology)*

D. Diagnostic Criteria for clinical diagnosis of Brain Death
The three cardinal findings in brain death are coma or unresponsiveness, absence of brainstem reflexes, and apnea.
1. Coma or unresponsiveness – no cerebral motor response to pain in all extremities (nailbed pressure and supraorbital pressure)
2. Absence of brainstem reflexes
   a. Pupils: No response to bright light, Size: midposition (4mm) to dilated (9mm)
   b. Ocular movement
      i. No oculocephalic reflex (testing only when no fracture or instability of the cervical spine is apparent)
      ii. No deviation of the eyes to irrigation in each ear with 50 ml of cold water (allow 1 minute after injection and at least 5 minutes between testing on each side
   c. Facial sensation and facial motor response
      i. No corneal reflex to touch with a throat swab
      ii. No jaw reflex
      iii. No grimacing to deep pressure on nail bed, supraorbital ridge, or temporomandibular joint
   d. Pharyngeal and tracheal reflexes
      1. No response after stimulation of the posterior pharynx with tongue blade
      2. No cough response to bronchial suctioning
      3. APNEA Testing may be performed as follows:
         a) Prerequisites
            i. Core temperature ≥ 36.5° C or 97° F
            ii. Systolic blood pressure ≥ 90 mm Hg
            iii. Euvolemia. *Option:* positive fluid balance in the previous 6 hours
            iv. Normal PCO_2 > 40 mm hg
            v. Normal PO_2 *Option:* preoxygenation to obtain arterial PO_2 > 200 mm hg
         b. Connect a pulse oximeter and disconnect the ventilator

c. Deliver 100% O_2, 6 1/min, into the trachea. *Option:* place a cannula at the level of the carina
d. Look closely for respiratory movements (abdominal or chest excursions that produce adequate tidal volumes)
e. Measure arterial PO_2, PCO_2 and pH after approximately 10 minutes and reconnect the ventilator
f. If respiratory movements are absent and arterial PCO_2 is > 60 mm Hg (*option:* 20 mm hg increase in PCO_2 over a baseline normal PCO_2), the apnea test result is positive (ie, it supports the diagnosis of brain death)
g. If respiratory movements are observed, the apnea test result is negative (ie, it does not support the clinical diagnosis of brain death), and the test should be repeated
h. Connect the ventilator if, during testing, the systolic blood pressure becomes < 90 mm Hg or the pulse oximeter indicates significant oxygen desaturation and cardiac arrhythmias are present; immediately draw an arterial blood sample and analyze arterial blood gas. If PCO_2 increase is < 20 mm Hg over baseline normal PCO_2 the result is indeterminate, and an additional confirmatory test can be considered.

4. Pitfalls in the diagnosis of brain death
The following conditions may interfere with the clinical diagnosis of brain death, so that the diagnosis cannot be made with certainty on clinical grounds alone. Confirmatory tests are recommended.
a. Severe facial trauma
b. Preexisting pupillary abnormalities
c. Toxic levels of any sedative drugs, aminoglycosides, tricyclic antidepressants, anticholinergics, antiepileptic drugs, chemotherapeutic agents, or neuromuscular blocking agents
d. Sleep apnea or severe pulmonary disease resulting in chronic retention of CO_2

5. Confirmatory tests
Not legally required but desirable in patients in whom specific components of clinical testing cannot reliably be performed or evaluated.
a. Conventional angiography. No intracerebral filling at the level of the carotid bifurcation or circle of Willis. The external carotid circulation is patent, and filling of the superior longitudinal sinus may be delayed.
b. Electroencephalography. No electrical activity during at least 30 minutes of recording that adheres to the minimal technical criteria for EEG recording in suspected brain death as adopted by the American Electroencephalographic Society, including 16-channel EEG instruments.
c. Transcranial Doppler ultrasonography
    1. Ten percent of patients may not have temporal insonation windows. Therefore, the initial absence of Doppler signals cannot be interpreted as consistent with brain death.
    2. Small systolic peaks in early systole without diastolic flow or reverberating flow, indicating very high vascular resistance associated with greatly increased intracranial pressure.
d. Technetium-99m hexamethylpropyleneamineoxime brain scan. No uptake of isotope in brain parenchyma ("hollow" skull phenomenon")
e. Somatosensory evoked potentials. Bilateral absence of N20-P22 response with median nerve stimulation. The recordings should adhere to the minimal technical criteria for somatosensory evoked potential recording in suspected brain death as adopted by the American Electroencephalographic Society.

6. Two physicians, one or both a Neurologist/Neurosurgeon will conduct the clinical evaluations (a 6 hour interval between examinations is recommended but the interval is arbitrary per the American Academy of Neurology) with appropriate confirmatory test, where applicable. They will independently determine and document in the medical record that the patient has/has not suffered a total and irreversible cessation of all brain function.
a. Standard medical record documentation includes:
    i. Etiology and irreversibility of the condition
    ii. Absence of Brain Stem reflexes
    iii. Absence of motor response to pain
    iv. Absence of respiration with PCO2 > 60 mm Hg
    v. Reason for and result of any confirmatory test
b. The determinations shall be made by physicians not involved in any later effort to recover organs or tissue from the deceased.

7. When it has been determined the patient has suffered irreversible cessation of all brain function including the brain stem, a responsible physician will pronounce the patient dead and make the appropriate entries in the medical record. The family/next of kin are informed. Spiritual Care and Clinical Social Work are notified.
8. The criteria for determination of death by neurological criteria (brain death) and the significance of this finding must be explained to the family by the primary care physician, preferably when first suspected and again when confirmed. The family will also be provided with a written notification of the nature or purpose of the clinical examinations. These matters will be recorded in the medical record. In some instances the family may wish to have a physician of their choice communicate with the primary care physician in order that family members fully understand the medical and legal issues.
9. The family will be provided a reasonable period of accommodation to gather next of kin and others to the bedside from the time the patient is declared dead by brain death criteria prior to the discontinuance of mechanical support systems (Section 1254.4 Health and Safety Code).
   Reasonable efforts will be made to accommodate special religious or cultural traditions surrounding brain death without impacting other patients in need of care.
10. In accordance with HCFA regulations, PSJMC will notify its Organ Procurement Agency (OPA) of all individuals where death is imminent or who have died in the hospital. The hospital is required to work in collaboration with the OPA in notifying families of their right to donate or decline to donate organs of tissues from the deceased.
11. After the family/surrogates have been allowed a reasonable but not excessive time (not to exceed 24 hours unless a special arrangement has been made by the primary care physician in cooperation with Administration) the attending physician shall direct removal of the life support systems unless one of the following exceptional circumstances is noted in the medical record:
    a. Ventilatory support or other interventions have been ordered continued pursuant to an approved protocol for harvesting organs
    b. A court order is in effect which prohibits withholding support measures
    c. The patient's condition appears to be the result of a criminal act (inform Administration immediately)
    d. The patient's condition was created by a medical accident (inform Administration immediately)
    e. The patient is pregnant (inform Administration immediately)

XIV. MATERNAL/FETAL ADVISORY COMMITTEE

A. Maternal/Fetal Advisory Committee: The Maternal/Fetal Advisory Committee is a subcommittee of the Bioethics Committee whose purpose is to give advice where there are ethical issues in providing care or carrying out procedures, including surgery, in the setting of the patient's pregnancy and other issues of possible maternal/fetal conflict. The Committee is advisory only; the Member is responsible for medical care and the Member together with the patient and spouse or appropriate other involved person, make the decisions regarding care and treatment. However, the Members should carefully regard the opinion of the Committee, particularly in the context of Providence Saint Joseph Medical Center as Catholic Health Care Institution and The Ethical and Religious Directives for Catholic Healthcare Services which are foundational to PSJMC ethics.

B. Meetings: The Committee will meet on an as needed basis as issues arise. The chairperson of the OB/GYN Committee will be a member of the Bioethics Committee. Members of the committee will meet on an as needed basis. Which members requested to attend will depend on the issues to be discussed. Not all members of the Committee would be needed in every situation.

C. Membership: Those who may be needed are:
   1. The chairperson, vice-chairperson or designee of the OB-GYN Department, who will serve as chairperson of the Committee;
      a. Director of Mission or Designee
      b. The Director of the Neonatal ICU or his/her designee;
      c. Staff Perinatologist or designee;
      d. The attending Member of the patient being discussed and pertinent consultants;
      e. The Nurse Manager of Labor/Delivery Service;
      f. The Maternal/Child Health Social Worker;
      g. The Maternity Chaplain for the Spiritual Care Department.

D. Reporting Responsibility: The chairperson of the Bioethics Committee will be advised of the meeting, the issue(s), and their resolution. A brief summary will be sent to the Bioethics Staff Coordinator by the chairperson of the M/FAC Committee or by the social worker in attendance.

E. Committee Issues: Members may consult the Committee whenever any of the following issues are present:
   1. Whenever obstetrical deliver is contemplated prior to the time of expected fetal viability

2. When caesarian hysterectomy is contemplated
3. Issues related to tubal ligation during c-section
4. Other issues of maternal/fetal conflict

XV. THE INFANT CARE REVIEW COMMITTEE (ICRC)

The Infant Care Review Committee (ICRC) will be a subcommittee of the Bioethics Committee whose purpose is to give advice in those situations where there are ethical questions about provisions for and continuation of life-support systems. The ICRC is an advisory group only; the physician is responsible for medical care and the parents are ultimately responsible for making decisions regarding care and treatment of the child. However, the physician(s) should give due regard to the opinion of the ICRC. The Chairman of the ICRC will be a member of the Bioethics Committee.

The ICRC will meet on an as-needed basis to discuss cases where non-provision of intensive support is being considered. Membership of the ICRC will consist of the following persons:

1. The Chairman of the Pediatric Department, or his/her designee, who will serve as Chairman of the ICRC.
2. The Medical Director of the Intensive Care Newborn Nursery (ICNN) or his/her designee.
3. The attending physician of the patient being discussed and all pertinent consultants.
4. The Nurse Manager of the ICNN or his/her designee.
5. The maternal/child health social worker.
6. The Maternity Chaplain for the Spiritual Care Department.

If required by state or federal statutes, the Chairperson of the Social Services Department shall serve as liaison between the Hospital and Child Protective Services for the purpose of coordination, consultation, and notification activities.

XVI. GUIDELINES FOR PROVISIONS OF LIFE SUPPORT IN NEWBORNS

A. As a general policy, all live born infants at Saint Joseph Medical Center regardless of condition, prognosis or viability will be given basic support and care. Basic care consists of warmth, oxygen as indicated, hydration, nutrition as indicated, pain relief as indicated and social contact including contact with parents. There will be no exceptions to this polic.

B. Intensive (or "heroic") support is defined as the provision of CPR, artificial ventilation, cardiotonic/pressor drugs, and invasive procedures. In general, intensive support will be given any infant who requires it. There are however, rare circumstances where provision of intensive support may not be appropriate. These guidelines are meant to address those specific circumstances.

C. The following indications should be considered in any decision to discontinue intensive support:
   a. The provision of such treatment would merely prolong dying.
   b. Would not be effective in ameliorating or correcting all of the infant's life threatening conditions.
   c. Or otherwise be futile in terms of the survival of the infant.
   d. The provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane. A consultation with the Infant Care Review Committee is mandatory for an advisory opinion before discontinuation of support.

D. If the attending physician and the managing/consulting physician(s) agree that intensive support should not be provided, and if the parents of the child concur, the ICRC must be consulted.

E. The ICRC may meet as a group or the individual members may be contacted by phone, at the discretion of the requesting physician. It is acceptable for the ICRC to be consulted before the parents have decided, in order to appraise the committee of an impending situation. In NO circumstances should intensive support be discontinued without concurrence by the parents. The ICRC should also be consulted if the physician(s) or the parent's desire further input on appropriate levels of care. This shall be initiated by contact with any member of the ICRC who shall contact the Department Chair.

F. Two physicians must independently determine and document in the chart the hopelessness of the medical condition. The decision to discontinue therapy may not be made by physicians involved in any later effort to transplant organs or tissue from the deceased infant.

G. If intensive support is not to be provided, the physician shall document the discussions with the parents and the ICRC. The physician will then write appropriate orders on the order sheet. "No Code" orders will not be accepted because of lack of specificity; the physician must write specific instructions (i.e., "no hand bagging, or CPR") so all personnel will have clear responsibilities.

H. Non-provision of intensive support in no way bears upon provision of "basic care". All infants will be given basic care and support as defined in these guidelines. If an infant survives the discontinuance of life-support systems, emphasis should be placed on the infants comfort and care, and all procedures not related to basic care may be omitted.

I. If brain death has occurred, the process of terminating treatment is no different than under the more familiar circumstances when death is established by cessation of heart beat and breathing. All treatment may be discontinued when a diagnosis of brain death is made. The family's concurrence is extremely important. It may be appropriate to

continue life support briefly until the parents have had the opportunity to spend a last time with their infant. If the family is unable to accept the diagnosis of brain death and the decision to withdraw life support, support should be continued and the ICRC consulted.

J. Consultation with the ICRC is NOT necessary to withdraw support from an infant who cannot be stabilized even with maximal intensive support and who is dying. This is a clinical decision left to the physician caring for the infant. However, this in no way relieves the physician(s) from their responsibility to communicate with the parents and to honor their requests.

XVII. DELIVERY ROOM RESUSCITATION OF NEWBORNS

In general, all live born infants will receive full resuscitation measures as needed. Possible exceptions to this policy are as follows:

A. Infants known to have anomalies or abnormalities well documented by ante-partum testing, that is incompatible with survival. The abnormality (-ies) and the parental concurrence with plans not to resuscitate the infant must be documented in the mother's chart PRIOR TO DELIVERY and in the infant's chart after delivery. It is recommended that the Obstetrician notifies the Pediatrician when such a situation is identified, and that Social Services and Spiritual Care be consulted to provide family support. Communication between Obstetrics and Pediatrics is ESSENTIAL so that everyone is aware that a non-viable infant is being delivered, and that the parents have elected NOT to opt for intensive support.

In the absence of adequate documentation of the fetal diagnosis or parental decisions, full resuscitative measures will be required. The Chairperson of the Department of Obstetrics must be notified in each case to ensure that the proper procedure has been followed.

B. Extremely immature, "non-viable" infants: These babies are less than 23 weeks gestation and USUALLY weigh less than 500 gms (1 lb 2 oz.). Gestational age must be well documented by serial ultrasound, and weight must be determined at the time of delivery before a final decision is made not to resuscitate.

Below 500 gms, life support usually should not be instituted unless there is good evidence for intra-uterine growth retardation with gestation at least 23-24 weeks; above 600 gms, life support is usually indicated unless there is good evidence that the baby is in fact less than 23~~-24~~ weeks gestation and the weight is due to edema or anomalies.
Appropriately grown infants between 500 and 600 gms are a particular problem, and no firm guidelines can be made. Parental wishes must play a very strong role in these situations.

In situations where gestation is estimated to be 22 weeks or more, the obstetrician must discuss delivery room care of the baby with the family; consultation with a neonatologist is strongly recommended. This discussion with family must be documented in the mother's chart, along with whatever decision has been made concerning delivery room care. The obstetrician must inform the obstetrical nursing staff of the plans, and must also inform the Neonatal Intensive Care Unit staff. If the decision has been made not to resuscitate an extremely immature liveborn baby, the infant will be given comfort care (warmth, swaddling, contact with parents as requested by them) until he or she expires. All liveborn infants, regardless of gestation or condition, will require a birth certificate and death certificate.

A neonatologist should attend the delivery of all extremely immature infants at 22 weeks gestation and beyond. A final decision on resuscitation should be made at the time of delivery based upon birthweight and estimated gestation.

C. Review of Life Support Measures for Newborns in Nursery: Provision of life support measures in the Delivery Room does not necessarily imply indefinite continuation of these measures in the nursery. Continuation of these measures is subject to ongoing review according to the criteria discussed in "Guidelines for Provisions of Life Support in Newborns."

D. The Departments of Pediatrics and OB/GYN must review all cases to ensure compliance with this Protocol

RADIATION SAFETY

Radioactive materials may only be used in the Medical Center with the approval of the Radiation Safety Committee and in accordance with the Radiation Safety Program Manual (Radioactive Materials) of Providence Saint Joseph Medical Center.

Professional Staff members who use an x-ray machine or fluoroscope (conventional unit or C-arm) and/or supervise authorized technicians in the use of such equipment in the hospital, must have a copy of their current California Department of Health Services-issued radiography supervisor and operator permit and/or fluoroscopy supervisor and operator permit or temporary permit on file in the

Professional Staff Office.

RESEARCH PROJECTS

Any investigational procedures or drugs must be submitted to the System Research/IRB Committee for clearance in accordance with the rules and regulations of the Medical Center and the Professional Staff Bylaws.

AUTOPSY CRITERIA

Autopsy Criteria will follow Government Code section 27490 – 27512, the office of the coroner. The Hospital will contact the Office of the Coroner for all deaths meeting the criteria below. It is the duty of the coroner to determine the:

1. Circumstances, manner, and cause of all violent, sudden, or unusual death, unattended death where a person has not been attended to by a physician or nurse for 20 days prior to their death
3. Deaths related to suspected self-induced or criminal abortion, alleged rape
4. Suspected homicide, suicide or accidental poisoning, death related to an accident (old or recent)
5. Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, aspiration, suspected sudden infant death syndrome
6. Deaths due to contagious disease constituting a public hazard, occupational diseases or hazards
7. Death that occur while incarcerated or in a state mental hospital serving the mentally disabled and operated by the State Department of State Hospitals

Physician may request a private autopsy's for:

1. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
2. All deaths in which the cause of death is not known with certainty on clinical grounds.
3. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnosis procedures and/or therapies.
4. All unanticipated neonatal and pediatric deaths.
5. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
6. Deaths of patients who have participated in clinical trials (protocols) approved by the Institutional Review Board.
7. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival, deaths occurring in the hospital within 24 hours of admission and deaths in which the patient sustained or apparently sustained an injury while hospitalized.
8. Deaths known or suspected to have resulted from environment or occupational hazards.

(Physician and family requests for private autopsy's not meeting the coroners criteria will be referred to an outside agency at the expense of the family.)

PROFESSIONAL STAFF CONFLICT OF INTEREST POLICY

All members of the Professional Staff are expected, as a matter of general professional ethics, to avoid business and financial arrangements which, because of personal gain, are likely to influence their judgment in the care of patients. Collusion for personal gain against the interests of patients is morally reprehensible and professionally unacceptable.

In the discharge of their peer review responsibilities, all members of the Professional Staff are expected to act in the best interest of quality patient care and professional practice. No peer review action or recommendation should be motivated by personal, financial or competitive factors. Any individual who seeks or accepts leadership responsibility in the Professional Staff has a special obligation to disclose, at the earliest practical time, any financial, business, personal or competitive interest which is reasonably likely to affect his or her judgment or actions as a Professional Staff leader. No such leader shall vote or take any action regarding a matter as to which he or she has such a conflicting interest. The requirements of this paragraph shall apply to all Professional Staff Officers, Clinical Departmental Chairmen and Vice Chairmen, and the Chairmen and members of all Professional Staff Committees.

Failure of any Professional Staff member or leader to comply with the requirements of this Policy shall constitute grounds for corrective action or removal from office.

ORGANIZED HEALTHCARE ARRANGEMENT

PROVIDENCE CALIFORNIA REGION ORGANIZED HEALTHCARE ARRANGEMENT
Providence St. Joseph Medical Center, as part of the Providence California Region, and the Professional Staff members have established a California Region Organized Health Care Arrangement under 45 CFR 164.51, as a clinically integrated health care setting, including all Providence Health System facilities, services and programs, the Providence employees, and practitioners and other clinicians who are members of the Professional Staff and/or who otherwise have Professional Staff privileges at the Hospital or other Providence facilities,

services, or programs in the Providence California Region ("Providence OHCA"). Under the Providence OHCA, all of the members, including members of the Professional Staff, may rely on a Joint Notice of Privacy Practice and Acknowledgement. Further, members of the Providence 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 Professional Staff shall be required to use and conform to the terms of the Joint Notice of Privacy Practice developed and used by the Providence California Region with respect to protected health information created or received as part of each Professional Staff member's participation in the Providence PHCA and to comply with all applicable Providence, Professional Staff and HIPAA requirements, policies and procedures relating to the confidentiality of protected health information.

Each Professional Staff member is responsible for his or her own compliance with applicable state and federal laws relating to protected health information. The establishment of the Providence OHCA shall not in any way create additional liabilities by or among the members of the Providence OHCA or cause one or more Providence OHCA members to assume responsibilities for the acts or omissions of any other member of the Providence PHCA, and each member of the Providence PHCA shall be individually responsible for his or her 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 Professional 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.

PROTECTION OF HOSPITAL/PATIENT INFORMATION

All workforce and non-workforce members (eg. Physicians) are assigned a unique login and password for accessing data. Under no circumstances are new or existing users allowed to inherit or use the login and password of another user or share this information with anyone else.

Non-workforce members with access to Providence data, systems or devices are required to comply with Providence security polices and standards when utilizing Providence systems and devices or accessing Providence information

FEE SPLITTING

The practice of division of fees under any guise whatsoever shall be prohibited, and any such division of fees shall be cause for exclusion from the staff.

HARASSMENT/DISRUPTIVE BEHAVIOR PROHIBITED

Harassment by a medical staff member against any individual (e.g., against another staff member, hospital employee or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation shall not be tolerated.

'Sexual harassment' is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, or posters).

Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or others aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.
All allegations of discrimination, harassment, or disruptive behavior shall be immediately investigated.

Furthermore, disruptive behavior or conduct which is felt to be disruptive and unprofessional which is displayed in the hospital is likewise to be prohibited. Such issues may involve: personal or irrelevant attacks on staff, patients, or other physicians that go beyond the bounds of fair professional comment; impertinent and inappropriate comments written (or illustrations drawn) in a patient's medical record or other official documents; nonconstructive criticism delivered in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity or incompetence; participation in committee or departmental affairs only on his or her own terms or doing so in a disruptive manner; idiosyncratic requirements imposed on the nursing staff that have nothing to do with better patient care.

PROFESSIONAL STAFF IMPAIRMENT POLICY

The Professional Staff of Providence Saint Joseph Medical Center (PSJMC) is committed to having all its Members and AHPs provide patients with quality care, free from the potential hazards created by physical or mental health issues. Therefore, it is the policy of the Professional Staff that it's Members and AHPs shall not assume responsibility for patient care when there is potential impairment of judgment or performance.

PROCEDURE

The following procedure will be followed if a Member or AHP comes to PSJMC to provide patient care, and the Member's or AHP's behavior or physical condition or appearance raises a reasonable likelihood or perception that (a) patient care or safety may be compromised, (b) hospital operations may be disrupted, (c) the community's confidence in the hospital may be compromised, or (d) that the physician's judgment may be impaired. For purposes of this procedure, examples of behavior, physical condition or appearance that may give rise to the implementation of this procedure are, without limitation:

1. Slurred/incoherent speech;
2. Uncharacteristic moodiness;
3. Undue aggressiveness or disruptive conduct;
4. Lack of dexterity;
5. Dizziness;
6. Alcohol on breath

When one or more of these factors appears to be present and raises concern regarding the Member's or AHP's ability to provide quality and safe patient care, the observing staff person shall notify the Nursing Supervisor. The supervisor will assess the situation; if they concur that the Member's or AHP's judgment and/or performance may be compromised the concern will be shared with the Member or AHP. If the Member or AHP concurs he/she will leave the hospital; if necessary, transportation and/or medical care may be provided for the Member or AHP. If the supervisor is uncertain as to the potential impairment of judgment or performance or the Member or AHP insists on continuing to provide care, the supervisor will contact the Chairman (or designee) of the Department of which the Member or AHP is a member, or the Chief or Vice Chief of Staff.

The Chairman or Officer will immediately institute an evaluation, either in person or may ask another physician to assess the Member or AHP in question and determine ability, or lack of same, to safely provide care.

If the evaluation determines that the Member or AHP should not provide care at that time, or if the Member or AHP refuses to be evaluated, the Chairman or Officer will notify the Member or AHP that he/she cannot provide care. Where necessary, the Member or AHP will be given an opportunity to arrange substitute care, or the Chairman or Officer may do so, and the Member or AHP will be directed to leave the hospital premises. If the Member or AHP refuses the Chairman or Chief of Staff may initiate summary suspension. If necessary, transportation and/or medical care may be provided for the Member or AHP.

As soon as possible, and in less than three working days, the Department Chairman and/or Chief of Staff will cause the Professional Ethics and Advisory Committee ("Committee") to evaluate the situation and make further recommendations. If the Committee concurs with the action taken but feels no further investigation or action is necessary, it will document that decision in the minutes of the Committee and close the matter. If the Committee feels further evaluation and/or actions are necessary, it will make such recommendations to the Clinical Department of which the Member or AHP is a member. Any further action by the Clinical Department will be taken in accordance with the Professional Staff Bylaws. If the Committee feels that the actions taken appear excessive, it will so notify the Member or AHP, the Department Chairman or Chief of Staff and the staff person and Nursing Supervisor who initiated and assessed the concern; in this case, no documentation will be recorded in the Member's or AHP's file. If a summary suspension was initiated, further action will be taken in accordance with the Professional Staff Bylaws.

CLINICAL FUNCTION PROTOCOLS

Clinical Departments may develop protocols related to defined clinical functions by personnel meeting the licensure, training and competency requirements as in the protocol (example: Triage Nurse in the Emergency Department; Discharge Nurse in Day Surgery). After approval by the Department, the protocol shall be submitted to the Interdisciplinary Practice Committee for review and approval. The protocol shall then be submitted to the Patient Care Committee for review and approval.

The protocol shall then be submitted to the Executive Committee for approval.

CHARGES OF THE CANCER COMMITTEE

CANCER COMMITTEE

The Cancer Committee shall be a standing committee of the Professional Staff. It will report to the Patient Care Committee and may have access directly to the Executive Committee. It shall be a multi-disciplinary committee whose composition, duties, and responsibilities shall be delineated in the General Rules and Regulations.

A. Composition:

The Cancer Committee Chairman is appointed by the Chairman of the Patient Care Committee. Within the limits of those

disciplines available to the institution, the Committee shall consist of board certified physicians representing all medical specialties involved in the care of patients with cancer. Required to be included are Board Certified physician representatives from Surgery, Medical Oncology, Diagnostic Radiology, Radiation Oncology, and Pathology. Other disciplines should be included as appropriate, such as internal medicine and family practice. In selection of other disciplines, the Cancer Committee should consider the major sites that are diagnosed and treated at the institution and include representatives from the specialties that manage these types of cancers, for example, gynecology, urology, thoracic surgery, and otolaryngology.

The committee also must include the Cancer Center Director (Cancer Liaison Physician) and the Cancer Registrar, who serves as staff to the Cancer Committee in coordinating the cancer program; they shall be permanent non-voting members.

The Committee must also include the American College of Surgeons Field Liaison(s).

Administration, nursing, social services, and to provide liaison between the Cancer Committee and Cancer Data Service (tumor registry), Quality Assurance must also be represented. Whenever possible, nursing should be represented by an oncology-certified nurse. Other specialties may be represented such as Pharmacy, Nutrition, Medical Records, Clergy, Rehabilitation, Home Health/Hospice, or other departments as required by the committee.

B. Duties:

1. Meet at least quarterly with documentation of the policy-advisory function.
2. Make certain that cancer conferences include all major cancer sites yearly and are primarily patient oriented and prospective.
3. Ensure that consultative services are available to patients with cancer through multidisciplinary physician attendance at conferences.
4. Monitor and evaluate the quality of care of patients with cancer, either directly or by interaction with and review of audit data from other committees.
5. Re-evaluate the effectiveness of the patient care evaluation program.
6 Actively supervise the cancer registry for quality control of abstracting, staging, and reporting.
7. Publish and distribute the annual report.
8. Serve as registry physician-advisor(s).
   Objectives: With clearly defined objectives, a committee course of action and a system of periodic evaluation, the Cancer Committee can establish and maintain an exemplary cancer program that will benefit the community. The Cancer Committee must:
9. Organize, publicize, conduct, and evaluate regular educational and consultative cancer conferences that are multidisciplinary, institution-wide, and patient oriented.
10. Plan and complete a minimum of two patient care evaluation studies annually, one to include survival data and, if available, comparison data.
11. Make certain that cancer rehabilitation services are available for use.
12. Encourage a supportive care system for all patients with cancer.
    The Cancer Committee shall have the overall responsibility to oversee the multidisciplinary and comprehensive activities relative to the cancer programs on prevention, diagnosis, treatment, its quality assurance program, and longitudinal follow-up of cancer patients.
13. Conduct and maintain a functioning Tumor Board with minutes of its meetings, including, but not limited to, maintaining a functioning Tumor Registry with a regular and ongoing analysis of the data, and an annual report of the activities and analysis of the data to the Professional Staff. Be responsible for ongoing patient care/evaluation programs as related to the Cancer Center and its components. Oversee the multi-disciplinary educational cancer conferences.
14. Serve in an advisory capacity to the Professional Staff and Medical Center Administration on matters pertaining to the purchase of new equipment and the construction of facilities relating to the Medical Center.
15. A member will be designated by the Chairman to Chair the Protocols Subcommittee which will be responsible for the review of cancer-related protocols. The Protocols Subcommittee recommendations will be forwarded to the Research Committee.
16. A member will be designated by the Chairman to Chair the Tumor Board Committee which will be responsible for coordinating various Tumor Board activities.
17. In concert with Administration, approve and administer the disbursement of funds donated to the cancer and/or research funds for matters or projects related to the Cancer Program in accordance with the Providence Saint Joseph Medical Center Foundation policies.

C. Meetings:

The Cancer Committee shall meet at least quarterly, or more often as needed. A quorum will be called at the discretion of the Chairman. Findings and recommendations of the Committee shall be reported to the Patient Care Committee and to the Executive Committee.

PEDIATRIC RULES - PATIENTS LESS THAN 13 YEARS OF AGE

It is the goal of Providence Saint Joseph Medical Center to offer the safest, most efficient, highest quality care that can be given to our Pediatric patients by the following rules:

A. Outpatient Surgery
   1. Any pediatric case with chronic cardiac, GU, CNS, renal or pulmonary disease or unstable condition must preoperatively have:
      a. A complete history and physical or consultation by the Providence Saint Joseph Medical Center Pediatrician.
      b. A Pediatrician or a covering Pediatrician must be available for postoperative management and/or care if needed.
   2. Patients converted postoperatively to an inpatient basis:
      a. Require notification of a Pediatrician within one (1) hour and prompt consultation (within six [6] hours).
      b. ICU admission requires a visit by the Pediatrician within four (4) hours. The transfer of a patient to a PICU will be the responsibility of the Pediatrician and Surgeon with input if necessary from the Chief of Staff or his designee.

B. Inpatient Surgery
   1. Neonates and small infants less than 28 days of age are candidates for admission to the NICU. Individual cases must be discussed with the neonatologists. The patients will be managed jointly by the Surgeon and the Neonatologist.
   2. Other than infants admitted to the NICU, no inpatient surgery will be done on infants less than 36 months of age except for emergencies.
   3. Unstable patients require preoperative consultation by the Pediatrician or intraoperative or postoperative consultation if a life-threatening situation requires surgery prior to the Pediatrician's arrival, or if delay in surgery will have a serious adverse impact on the patient.
   4. Any pediatric case with chronic cardiac, GU, CNS, renal, pulmonary disease, or a patient NPO greater than 36 hours must have a preoperative complete history and physical or consultation by a Providence Saint Joseph Medical Center Staff Pediatrician.
   5. Postoperative ICU admissions require a Pediatric visit within four (4) hours. Timely transfer of patients to a PICU will be the responsibility of the Pediatrician and Surgeon with input if necessary from the Chief of Staff or his designee.

C. Nonsurgical Pediatric Admissions
   1. Children requiring inpatient care for medical problems such as asthma, croup, dehydration, seizures, serious infection, diabetes out of control, etc., are to be referred to a full-service Pediatric Center for admission.

D. Pediatric Emergency Department Patients
   1. Transferable trauma cases will be stabilized as necessary and transported to a Pediatric Center as soon as it can be accomplished safely.
   2. Nontrauma surgical cases may be transported to a Pediatric Center or admitted to Providence Saint Joseph Medical Center at the discretion of the attending Surgeon and the Pediatrician. Inpatient surgery guidelines as stated above will apply to PSJMC admissions.
   3. Pediatric Emergency Department patients requiring hospitalization for medical indications are to be transported to a full-service Pediatric Center.
   4. In the Emergency Department, unassigned patients will be referred to the EDAP Pediatrician Panel. These physicians in turn will have preference cards for which surgeon they designate be called to see such patients.

E. Transporting Patients from Other Facilities
   1. PSJMC will not accept pediatric admissions from other hospitals except direct admissions to the NICU which must be approved by a neonatologist.

Clarification of Pediatric Surgical Rules.

Please Note the Following Regarding Pediatric Surgery:

1. Patients less than 36 months of age should not have inpatient surgery except in emergencies. An emergency case is defined as a nontransferable patient. These cases require preoperative consultation by a Pediatrician unless a life-threatening situation or a significant adverse impact will occur if the patient is not promptly taken to surgery. If this exists, this requires either an intraoperative or an immediate postoperative consultation by the Pediatrician.
2. Appendicitis is considered a nontransferable situation and this is mandated by the Department of Health Services. Appendicitis, therefore, requires immediate surgical intervention and patients so diagnosed should receive such at Providence Saint Joseph Medical Center. A patient under 36 months of age with this diagnosis is an emergency surgery. Any admission or observation of the patient under 36 months of age must have immediate Pediatric consultation.

HOSPITAL EMERGENCY RESPONSE TO NATURAL DISASTER

Effective: July 2009

(Reference Professional Staff Bylaws Section 6. Emergency Privileges Subsection 1. Disaster Privileges)
(Administrative/Departmental Policy: Professional Staff - Emergency/Disaster Privileges revised 07/09)

ADMISSION AND DISCHARGE

1. A patient may be admitted to the Medical Center only by Professional Staff members who have admitting (general) privileges. It is the admitting physician's responsibility to obtain appropriate specialty consultation as may be required by the patient's condition and for writing an order on the patient chart giving the name of the consultant.

ORDERS

1. Verbal/Telephone orders may be accepted and recorded by a licensed nurse; nurses may accept medication orders only from a person lawfully authorized to prescribe. Verbal orders are ONLY accepted in emergent situations.

CONSULTATION

1. Specialty consultation shall be required for any patient having significant or serious medical condition which is not within the scope of practice of the attending physician
2. Specialty care consultation shall be required with disease processes that are unresponsive to therapy
3. Critical Care consultation shall be required for patients admitted to the ICU with severe sepsis or septic shock within 4 hours of admission

RULES AND REGULATIONS FOR PHYSICIANS ASSISTANT

DEFINITION

A Physician Assistant, subsequently called PA, is a person who is a graduate of a program of Instruction for Physician Assistants recognized and approved by the Physicians Assistants Examining Committee of the State of California, licensed by the Physicians Assistants Examining Committee and who is currently certified by the National Commission for the Certification of Physicians Assistants.

Physicians Assistants must work with a Supervising Physician. A Supervising Physician must hold "like" privileges in the specialty of supervision. The Supervising Physician must be an unsupervised Active or Associate member in good standing at Providence Saint Joseph Medical Center (PSJMC). The physician will assure that the PA will be supervised in accordance with the written supervisor guidelines required by Section 1399.545 "Supervising Physicians Responsibility for Supervision of Physicians Assistants."

QUALIFICATIONS

The PA must:
1. Provide proof of current licensure issued by the Physicians Assistants Examining Committee of the State of California.
2. Retain the above license in order to continue to provide services at PSJMC and shall notify the Professional Staff upon termination of the license.
3. Provide proof of malpractice insurance coverage in the minimum amount approved by PSJMC.
4. Have completed an accredited training program as a Physicians Assistant.
5. Have an appropriate physician sponsor.
6. Demonstrate competence in the privileges/procedures requested. These will be reviewed on a regular basis, i.e. annually or biennially.

QUALIFICATIONS OF THE SUPERVISING PHYSICIAN

The Supervising Physician must:
1. Currently be licensed in the State of California.
2. Be an Active or Associate member in good standing at PSJMC.
3. Have a written delegation of the service agreement with the PA and supply an up-to-date copy of this to the PSJMC Professional Staff.
4. Provide continuing quality assessment of the PA's performance and skills.
5. Agree in writing to notify PSJMC:
    a. Of any revocation, suspension, modification, or termination of his/her privileges to supervise PA's.
    b. If the PA leaves his/her employment or is no longer supervising that PA at which point the PA's privileges will be suspended.
    c. That the PA and Supervising Physician are in full compliance with all Medical Board regulations regarding PA's and Supervision of PA's.

CONDITIONS OF STANDARD OF PRACTICE

The PA shall:
1. Practice only under the direction and supervision of a Supervising Physician. The method for providing adequate supervision

may be satisfied by:
   a. Examination of the patient and a written note by the supervising physician the same day as care is given by the physician assistant; or
   b. Countersignature and dating, timing and signing of all medical records written by the physician assistant within thirty (30) days that the care was given by the physician assistant.
2. Perform only those functions and procedures permitted by law for his/her specialty as designated in Section 1399.500 of Title XVI of the California Administrative Code.
3. Act within the scope of practice and the realm of functions as set by his/her service agreement with the Supervising Physician approved by the Medical Executive Committee at PSJMC.

DUTIES AND TASKS WHICH MAY BE PERFORMED BY PHYSICIANS ASSISTANTS

The PA's privileges may be divided up into the following two areas:
1. General privileges
2. Specific procedures that are department/section specific.

General privileges include:
   a. Ability to take a history, perform a physical examination and make an assessment and diagnosis based on the information from above.
   b. Initiate and review treatment and therapy plans within the scope of approved privileges.
   c. To record and present the data in an appropriate manner to the Supervising Physician for his/her approval and counter-signature, including date and time.
   d. Convey an order for therapeutic diet, physical therapy, occupational therapy, respiratory therapy, radiological procedures, other diagnostic procedures and nursing services as outlined in the designation of services contract.
   e. Assist in the written documentation of admissions and provide continued documentation of the patient care under the supervision of the Supervising Physician.
   f. Recognize and evaluate situations which call for immediate attention or action by the physician or if necessary institute emergency procedures to protect the life of a patient.
   g. Instruct and counsel patients and their families when appropriate regarding matters pertaining to their physical and mental health.
   h. Initiate and facilitate referral of patients to appropriate health facilities, agencies or resources in the community.
   i. Administer or order medications for a patient under the direction of the Supervising Physician. The PA may order medications on a patient specific protocol using the appropriate criteria for any specific medical therapies. A PA shall not provide any drug or transmit any prescription for a drug other than the drug specified on the protocol without a patient specific order from the Supervising Physician.

RULES AND REGULATIONS FOR NURSE PRACTITIONER

DEFINITION

A Nurse Practitioner, subsequently called NP, is a person who has active licensure as a registered nurse in California, has completed a program of study for Nurse Practitioners which conforms to the standards of the California Board of Registered Nurses as set forth in section 1484 of the Nurse Practice Act, and has valid certification as a nurse practitioner from the California board of Registered Nursing.

Nurse Practitioners must work with a Supervising Physician (or physician group). A Supervising Physician is a physician currently licensed by the State of California. The Supervising Physician must be an unsupervised Active or associate member in good standing at Providence Saint Joseph Medical Center (PSJMC).

The physician (or physician group) will assure that the NP will be supervised in accordance with the written Standardized Procedures required by Article 7, sections 1470-1474 of the Nursing Practice Act.

QUALIFICATIONS

The NP must:
1. Provide proof of current RN licensure issued by the Board of Registered Nursing of the State of California.
2. Provide proof of current Nurse Practitioner certification by the Board of Registered Nursing of the State of California.
3. Retain the above license and certification in order to continue to provide services at PSJMC and shall notify the Professional Staff upon termination of the license.
4. Provide proof of malpractice insurance coverage in the minimum amount approved by PSJMC.
5. Have completed an accredited training program as a Nurse Practitioner.
6. Have an appropriate physician sponsor.

a. When the physician sponsor(s) leave the Medical Center, the Nurse Practitioner's privileges will be terminated.
b. If the physician sponsor(s)' privileges are in any way limited, the Nurse Practitioner's privileges may be automatically modified by the Executive Committee of the Professional Staff consistent with the change in the privileges of the sponsoring physician(s).

7. Demonstrate competence in the privileges/procedures requested. These will be reviewed on a regular basis, i.e. annually or biennially.
8. Possess a Master of Science Degree in Nursing (or related field).
9. Be an Allied Health Professional approved by the Professional Staff to exercise active privileges at Providence Saint Joseph Medical Center.

QUALIFICATIONS OF SUPERVISING PHYSICIANS

Supervising Physicians must:

1. Currently be licensed in the State of California.
2. Be an Active or Associate member in good standing at PSJMC.
3. Provide continuing quality assessment of the NP's performance and skills.
4. Agree in writing to notify PSJMC:
   a. If the NP leaves his/her employment or he/she is no longer supervising that NP, at which point the NP privileges will be terminated.
   b. That the NP and Supervising Physician are in full compliance with all Medical and Nursing Board regulations regarding NP's and supervision of NP's.

CONDITIONS OF STANDARD OF PRACTICE

The NP shall:

1. Practice only under the guidelines set forth in the Standardized Procedures in accordance with Article 7, Sections 14-70-1474 of the Nursing Practice Act.
2. Perform only those functions and procedures permitted by law for his/her specialty as designated in Nursing Practice Act.
3. Act within the scope of practice and the realm of functions as set by the Standardized Procedures, approved jointly by administration, supervising physicians and nurse practitioners.
4. Assure that all data summaries, progress notes, and written information will be completed and reviewed in accordance with the guidelines set forth in the Standardized Procedures.

DUTIES AND TASKS WHICH MAY BE PERFORMED BY THE NURSE PRACTITIONER

The NP's privileges may be divided up into the following two areas:

1. General privileges.
2. Specific procedures that are department/section specific.

General privileges include:

a. Ability to take a history, perform a physical examination and make an assessment and diagnosis based on the information from above.
b. Initiate and review treatment and therapy plans within the scope of approved privileges as delineated in the Standardized Procedures.
c. To record and present the data in an appropriate manner to the Supervising Physician for his/her approval.
d. Convey an order for therapeutic diet, laboratory studies, physical therapy, occupational therapy, respiratory therapy, radiological procedures, other diagnostic procedures, and nursing services as outlined in the Standardized Procedures.
e. Assist in the written documentation of admissions and provide continued documentation of the patient care.
f. Recognize and evaluate situations which call for immediate attention or action by the physician or, if necessary, institute emergency procedures to protect the life of a patient.
g. Instruct and counsel patients and their families when appropriate regarding matters pertaining to their physical and mental health.
h. Initiate and facilitate referral of patients to appropriate health facilities, agencies, or resources in the community.
i. Administer or order medications for a patient under the guidelines of the Standardized Procedures and the Furnishing guidelines outlined in Section 2836.1-2836.3 of the Nursing Practice Act. A NP shall not provide any drug or transmit any prescription for a drug other than those included in the Standardized Procedures without a patient specific order from the Supervising Physician.

These Professional Staff General Rules and Regulations incorporate all modifications approved through **March 18, 2020** by the PHS, SFVSA Community Ministry Board of Providence Saint Joseph Medical Center, Burbank, California.

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Sasan Najibi, M.D.
Chief of Staff

Raymond H.M. Schaerf, M.D.
Vice Chief of Staff

Signature Update: 2017: 2019
sp:ProfStaffServsR&R\04.19.12 APPROVED WORKING DOCUMENT
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09/14:09/15: 01/15/20, 01/22/2020
Approved by Board: 04/19/12: 07/16/12: 09/18/13: 11/13/13: 09/10/14: 10/15/15:02/18/16
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