Loma Linda University Medical Center
2021-2022 Medical Staff Rules and Regulations

TABLE OF CONTENTS

PART II
MEDICAL STAFF RULES AND REGULATIONS

A. RECOGNIZING THE RELIGIOUS AFFILIATION OF THE MEDICAL CENTER

Activities of the Medical Center are to be conducted in a manner consistent with the ethics, principles, and philosophy of the Seventh-day Adventist Church. Thus, the conduct of Medical Staff members, including conduct within the Medical Center, in any circumstance in which a member is acting as an official representative of the Medical Staff or the Medical Center, and in all settings in which the member's actions or conduct could reflect adversely upon the Medical Center, should not be in conflict with such ethics, principles, and philosophy, including, but not limited to, the following:

1. While there are no Seventh-day Adventist Church rules that forbid the *surgical interruption of a pregnancy* when clinically indicated, nevertheless, in all such instances there must be a full compliance with the rules established by the Medical Center and the Medical Staff for proper consultation. Performance of *sex change s*urgical procedures and similar treatments shall also be subject to such prior consultation requirements.
2. The use of *alcoholic beverages, tobacco* and illicit drugs on Medical Center premises is not permitted.
3. *Hypnosis* is not permitted.
4. The Medical Center encourages whenever possible, the use of *lacto-ovo vegetarian diet*, and attempts to educate all patients regarding the reasons for such a diet, as appropriate.
5. It is the conviction of the Medical Center that, as an educational institution, every patient entering should have the opportunity to learn the laws of health. Accordingly, the Medical Center conducts *educational programs* for Medical Center patients in better living, and the counsel of the Medical Staff is solicited in order to keep such programs scientifically sound and accurate.
6. It is recognized that sickness and pain know no hours, sacred days, or holidays. Members of the Medical Staff will be available to provide all essential services at all times. However, in accordance with Seventh-day Adventist Church beliefs concerning the observation of the *Sabbath as a sacred day*, certain services and therapies are not routinely scheduled from sundown Friday evening until sundown Saturday evening.
7. The Medical Center makes an effort to encourage and develop in its employees, Medical Staff members and other persons who are also privileged to provide patient care related services in the Medical Center, an attitude of kindness, compassion, spiritual concern, and service consistent with the Judeo-Christian tradition. *Chaplains* are provided and clergy of all creeds are welcome to visit patients, and, to the extent reasonably possible, full cooperation is extended to them in religious rites and practices.

B. GENERAL CONDUCT OF CARE AND CLINICAL PATHWAYS

1. The Medical Center shall accept patients for care and treatment for all categories of disease. Patient care and related activities in the Medical Center are to be conducted in a manner consistent with the standards of *The Joint Commission.*
2. A patient may be admitted to the Medical Center only by the order of a member of the Medical Staff who has the prerogative or *privilege to admit patients*. The Medical Staff member may order the admission only to his/her own clinical service. All Medical Staff members shall utilize the procedures established by the Medical Center for processing admissions. The Medical Staff member ordering the admission is responsible for providing a provisional *("admitting") diagnosis and tentative plan of care*.
   When a patient known or suspected to be *suicidal in intent is admitted* to the Medical Center as an inpatient, the attending Medical Staff member shall order continuous observation and supervision and shall order *psychiatric consultation*. The attending Medical Staff member shall notify appropriate Medical Center staff of any information s/he has and deems necessary to protect the patient him/herself, other patients and/or Medical Center staff.
   When a patient known or suspected to be *suicidal in intent is seen in the Emergency Department,* the Emergency Department physician shall request a Psychiatric consultation. The Psychiatrist will evaluate the patient for the appropriateness of a transfer from the Medical Center to a mental health facility or unit.
   When a patient known or suspected to be *suicidal in intent is seen in other Out-patient areas* of the Medical Center, the staff should contact the clinical supervisor who will contact a person qualified to evaluate the patient for a 5150 hold.
3. All patients admitted to the Medical Center shall have a member of the Medical Staff with the prerogative or privilege to admit patients who is identified as the "*Attending"* (or "Attending Medical Staff member" or "Attending Practitioner") responsible for their (the patient's) medical care. The Clinical Service responsible for the patient shall be the clinical service of the attending practitioner. This Medical Staff member and the corresponding clinical service shall be explicitly identified at the time of admission. The *responsibility of the attending* Medical Staff member includes but is not limited to: the providing of or arranging for the providing of clinical services on a continuous basis, the prompt and accurate completion of the medical record and the communication with others as directed by the patient. Under any circumstances where the attending practitioner is unable to care for a patient, the Chief of Service, President of the Medical Staff or Administrator shall have the authority and responsibility *to appoint a substitute attending practitioner.*
4. The responsibility of being the attending practitioner may be *transferred from one Medical Staff member to another*. The actual transfer of responsibility shall occur after the transferring member (or resident acting under the supervision of the transferring member) writes an order for the transfer and the receiving member (or resident acting under the supervision of the transferring member) writes an order accepting the transfer. When a patient is transferred from one Clinical Service to another, both the original Clinical Service and the accepting Clinical

Service shall document the circumstances causing the transfer in the progress notes and shall order the transfer and the accepting of transfer in the orders. Inter-hospital transfers will be handled according to normal admission and discharge policies and procedures of the Medical Center. Patients should be informed of the need for transfer.

5. The attending Medical Staff member at the time of discharge shall be *responsible for completion of the medical record.*
6. For outpatients, a "Clinic Note" or "Emergency Department Note" containing all elements of a History and Physical Examination that are pertinent to the patient's Clinic or Emergency Department visit shall be promptly recorded in the patient's medical record. For admitted patients and observation patients, an *admitting history and physical examination* ("H&P") pertinent to the reason for admission shall be performed within twenty-four (24) hours after admission or up to thirty (30) days prior to admission. This H&P shall be performed by the "Attending" or by a resident physician acting under the supervision of the Attending or by an Allied Health Professional practicing within the scope of his/her profession and acting under the supervision of the Attending. If the H&P is performed prior to admission or if a delay in the H&P being available in the medical record is anticipated, an interval "Admission Note" that includes all pertinent changes to the history and any changes in the physical examination shall be performed and placed in the medical record within twenty-four (24) hours of admission. If the H&P and/or Admission Note is not performed by the Attending, the Attending will indicate in a separate note that he/she has reviewed and concurred with the accuracy of the H&P and/or Admission Note.
7. All patients hospitalized on one of the Clinical Services shall *be seen and re-evaluated daily* by the Attending medical staff member or his/her medical staff member designee. This re-evaluation shall be documented in a progress note in the medical record.
8. *Progress notes for inpatients* shall be entered into the medical record daily. *Progress notes for outpatients* shall be entered into the medical record each time the patient is seen. Progress notes may be entered into the medical record by the "Attending" or by a resident acting under the supervision of the Attending or by an Allied Health Professional practicing within the scope of his/her profession and acting under the supervision of the Attending. Only the individual who produced the progress note should sign it. Progress notes must reflect the involvement of the attending physician in the patient's care.
9. Consultations:
    a) *Residents acting* under the supervision of a Medical Staff member can provide consultations.
    b) *Consultations are required* under the following circumstances:
        - Whenever a patient is known or suspected to be suicidal in intent, a consultation by a psychiatrist shall be obtained.
        - Whenever the specific knowledge or skill of another practitioner is needed to improve the quality of care of a patient, consultation by a practitioner possessing that specific knowledge or skill shall be obtained.

- Whenever the Medical Staff has imposed upon a member a requirement that consultation be obtained under specified circumstances, consultation shall be obtained if/when those specified circumstances are present.
- Whenever required by the member's Service Rules and Regulations.
- Whenever required by Law.

c) The *attending medical staff member is responsible* for ensuring that the order requesting the consultation is written.

d) The consulting medical staff member is responsible for;
- Responding promptly to the request for consultation
- Reviewing the medical record and examining the patient
- Providing an opinion regarding the patient's condition and recommendations regarding the management of the condition for which consultation was requested
- Recording his/her findings, opinion(s) and recommendation(s) in the medical record.
- Communicating urgent, unexpected findings directly to the attending medical staff member

e) The consulting medical staff member is not responsible for:
- Writing orders implementing his/her recommendations
- Assuming responsibility for the patient's ongoing care unless he/she accepts that responsibility after being requested to accept that responsibility by the attending medical staff member.

10. *Informed consent* shall be obtained from patients prior to submitting to a procedure in which consent is required. The process of obtaining the informed consent and the content of the informed consent shall be documented in the medical record.

11. *Individuals that are authorized to write orders are outlined in LLUMC Hospital Policy M-12*. All orders for patient care, diagnostic studies, and/or treatment shall be recorded or transmitted electronically when CPOE is available or in writing (in the case of computer downtime and verbal orders) when CPOE is not available. *Verbal orders* only may be accepted in emergency situations when, because of the emergency, the physician cannot physically write the order or enter into CPOE. Emergency verbal orders and telephone orders also may be accepted from a physician who is present but, due to his/her involvement in a patient care procedure or treatment, is unable to write the order or enter into CPOE himself/herself (for example, in the Operating room, cardiac catheterization lab, etc.) Verbal orders will be entered into CPOE by the authorized person receiving the order. Handwritten orders shall be written clearly, legibly and completely. *Illegible orders will not be implemented and the ordering physician will be notified.* The use of "renew", "repeat" and "continue" orders will only be used when the complete order is also rewritten. A *verbal or telephone order* shall be considered to be in writing if dictated to a registered nurse or to another medical center employee qualified by law to receive and/or record orders. All verbal or telephone orders for drugs/medications-shall be authenticated by the individual

who gave the order or, for non-CPOE orders in his/her absence, by a practitioner who is involved in the patient's care:

a) within 48 hours in inpatient/observation areas
b) within 10 days in outpatient areas

12. *Residents may give orders.*
13. *Allied Health Professionals* (AHPs) and Medical Center employees may give orders for specific patients when the AHP or Medical Center employee is acting within their legal scope of practice and under the supervision (including supervision by way of a Standardized Procedure and/or Delegation of Service Agreement previously approved by the Medical Staff and the Governing Body) of a member of the Medical Staff. The AHP or Medical Center employee giving the order shall identify the supervising Medical Staff member as a part of the order.
    a) Orders given under these circumstances do not require authentication by a physician.
14. For the protection of patients or Medical Center employees, or members of the Medical Staff, it may become necessary to use *patient restraints*. The ordering of patient restraints by members of the Medical Staff shall be in conformity with Medical Center Policy.
15. When *patients change clinical service,* all currently active orders are to be continued until the physician who assumes care for the patient on the new clinical service has completed an initial evaluation. All orders must then be re-written by the physician who is assuming responsibility for care.
16. If the attending physician feels that a patient is *terminally ill and that resuscitation efforts will only temporarily prolong the patient's life*, s/he will document this impression in the medical record. If the patient is competent, the physician will be guided by the patient's stated desires *regarding resuscitation* including *advance directives*. If the patient is not competent and had not made his or her desires known, the physician's decision regarding resuscitation will be guided by the patient's legal representative (if one has been designated) or by the patient's family. The physician will continually re-evaluate the patient's condition relative to the appropriateness of resuscitative efforts. In any case, the information guiding the physician and his/her decision regarding resuscitation will be recorded in the medical record.
17. All *previous orders* are suspended when patients go to the Operating Room.
18. Patients shall be *discharged only on the order of the attending practitioner*. Should a patient leave the Medical Center against the advice of the responsible Medical Staff member, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
19. In the event of a *patient's death,* the deceased shall be pronounced dead by a licensed physician within a reasonable time. The body shall not be released until a *progress note attesting* to the death has been entered and signed in the medical record of the deceased by a licensed physician. Policies with respect to releases of the body shall conform to state law. The death of the patient must be certified in the manner required by state law and this certification must be recorded in the medical record.
20. It is expected that all Medical Staff members will *request an autopsy* whenever appropriate in accordance with Medical Center Policy. An autopsy may be

performed only with consent in accordance with state law. All autopsies shall be performed by the Medical Center pathologist, or by a physician delegated this responsibility. Provisional anatomic diagnoses shall be recorded in the medical record on completion of the autopsy and the complete protocol shall be made a part of the medical record within sixty (60) days.

21. If a nurse has any reason to doubt or *question the care provided to any patient*, the nurse shall bring the matter to the unit Medical Director (if applicable), then to the attention of the Chief of the Clinical Service wherein the Medical Staff member has clinical privileges. Where circumstances are such as to justify such action, the Chief of the Clinical Service shall arrange for the patient's continuing care.

23. The Medical Staff may adopt *"Clinical Pathways"* as a mechanism to encourage less variability in the processes of care for specified clinical conditions.
    a) The development, or proposed revision, of a "Clinical Pathway" may be initiated by a Service Chief or by a Chair of a standing committee or by a Medical Staff Officer.
    b) The "Clinical Pathway" shall be developed by a multidisciplinary group of "stakeholders" appointed by the Patient Safety and Reliability Committee (PSRC) with input from the services with relevant expertise such as medical, nursing, pharmacy, et cetera.
    c) All "Clinical Pathways" that incorporate entries into the Medical Record shall be reviewed by the Health Information Management Committee or by a subset of the Health Information Management Committee.
    d) All "Clinical Pathways" that incorporate an order set that includes pharmaceuticals shall be reviewed by the Pharmacy and Therapeutics Committee or by a subset of the Pharmacy and Therapeutics Committee.
    e) All "Clinical Pathways" shall be reviewed by the Patient Safety and Reliability Committee (PSRC). The PSRC shall determine which if any additional committees need to review the "Clinical Pathway" before presentation to the Medical Staff Executive Committee (MSEC).
    f) In the interest of expedient pathway development, the reviews of the pathways by PSRC may be conducted by electronic means, such as e-mail. The reviews may qualify as meeting "subsets" of committees in (c) and (d) provided the chair of those committees participates in the review and positively affirms support (e.g. by a yes vote); otherwise the pathway will need formal review by the respective committee. The committees should be notified of pathways approved in this manner. Pathways approved in this fashion may be provisionally implemented with notification of the pathway to the Medical Staff Executive Committee at the next routinely scheduled meeting for ratification or modification.
    g) The Patient Safety and Reliability Committee shall maintain the file of approved "Clinical Pathways".
    h) The PSRC shall review each "Clinical Pathway" as often as necessary but no less than every two years to determine if it (the Pathway) continues to reflect current recommended practice. The PSRC may delegate this responsibility to a group representative of the original stakeholders.
    i) Given that clinical updates of pathways may be urgent, changes to approved pathways, including discontinuation, may be implemented by

PSRC with notice to the Medical Staff Executive Committee at the next routinely scheduled meeting for ratification or modification.

j) The minutes of the MSEC shall be the official repository of approval of Clinical Pathways.

24. *Point Of Care Testing:* Members of the Medical Staff who wish to perform Point of Care Testing (POCT) on LLUMC patients must have a current Certificate of Competency for the test(s) they wish to perform. The Certificate of Competency is issued by the Medical Director of the LLUMC Clinical Laboratory. The Medical Director of the LLUMC Clinical Laboratory is solely responsible for the criteria used to issue a Certificate of Competency. The process to obtain this Certificate of Competency is:
    a) The physician who wants to perform POCT must bring to the laboratory a list of the specific types of POCT they wish to perform.
    b) The physician who wants to perform POCT must set up a date and time to be trained.
    c) The physician who wants to perform POCT must maintain Quality Control and other documentation within standards set by the laboratory.
    d) At all of the competency updates (at 6 months and one year during the first year and yearly thereafter) the physician who wants to perform POCT must be responsible for obtaining any required training or assessment of competency.
    e) A physician who fails to follow this rule will have their Certificate of Competency revoked.
25. *Clinical Pharmacists* who are employees of the Medical Center may record orders for pharmaceuticals, laboratory tests for therapeutic drug level monitoring and for toxicity detection:
    a) After obtaining authorization from the attending physician or designee. Such orders require authentication by the attending physician or designee.

    Or

    b) When implementing protocols to assist the attending with the management of pharmaceuticals when such assistance is requested by an order recorded in the Medical Record by the attending or by another authorized individual acting under the supervision of the attending. The process for the implementation of this Rule is:
        1) The Pharmacy and Therapeutics Committee (and other Medical Staff Committees that are stake holders in the process [such as the Infection Control Committee for protocols involving the use of antibiotics]) develops and approves the protocol.
        2) The Medical Staff Executive Committee approves the protocol.
        3) The attending (or other authorized individual acting under the supervision of the attending) chooses to implement the processes by recording an order for the Clinical Pharmacist to initiate the protocol. This initiating order must include the diagnosis that the protocol is intended to treat and any targeted benchmarks (such as target therapeutic drug level) that the protocol is intended to achieve.

4) The Clinical Pharmacist records in the Medical Record the order(s) necessary to implement the protocol. These orders must include lab orders, drug name, drug dose, administration route, administration frequency, and intended duration of therapy.
5) The implementing orders recorded by the Clinical Pharmacist do not require authentication by the attending.

26. Disruptive Behavior-Reporting and Documenting:
While this regulation outlines several meetings with and warnings to the practitioner, if the conduct at issue is egregious, corrective action or summary suspension under the Medical Staff Bylaws may be pursued immediately. Any employee, physician, patient, visitor, resident physician or student who observes unprofessional conduct/disruptive behavior by a member of the medical staff or allied health professional (practitioner) may report the incident.

The report should be in writing and should include, but not be limited to:
a) Date and time of the alleged disruptive behavior
b) Name of the patient, employee or other person(s) involved
c) Circumstances that preceded the alleged disruptive behavior
d) A factual, objective description of the alleged disruptive behavior
e) Remedial steps taken including date, time, place, actions(s) and name(s) of those intervening

Submission of the Report: The report may be submitted to the supervisor of an employee, who shall forward it to the Patient Safety and Reliability Department, to the Service Chief of the practitioner, to the President of the Medical Staff, to the Administrator, or submitted electronically as a report of staff concern. The Service Chief, the President of the Medical Staff and the Administrator shall be promptly notified of the report. Every effort will be made to maintain confidentiality of all individuals. Retribution by the practitioner involved or the complainant(s) will not be tolerated.

Evaluation of the Report: The Service Chief shall evaluate the report and may recommend to the President of the Medical Staff that the report is unfounded. If unfounded, the report shall be dismissed and the person initiating the report so apprised. If the Service Chief has a conflict of interest relating to the practitioner, the President of the Medical Staff or designee shall evaluate the report. This evaluation is not to be construed as a formal investigation. Reports will be stored by the Service Chief for consideration during OPPE and reappointment.

Graded Response:
a) Meeting with the Practitioner: For the first confirmed report of disruptive behavior, the Service Chief and/or President of the Medical Staff or designee shall meet with the practitioner and advise him/her to take immediate steps to end the behavior. A copy of the LLUMC Physician Code of Conduct will be given to the practitioner.

b) Written Admonition: If it appears to the Service Chief, President of the Medical Staff or designee that a pattern of disruptive behavior is developing, one or more of these individuals shall discuss the matter with the practitioner, emphasizing that if the behavior continues; formal action will be taken to stop it. After the meeting, a letter shall be sent to the practitioner stating that the practitioner is required to behave professionally and cooperatively.
All meetings with the practitioner shall be documented. Informal meetings with the practitioner do not constitute a "hearing" subject to the procedural requirements of the Medical Staff Bylaws; however, the practitioner may submit a rebuttal to the complaint.

c) Final Warning: If the disruptive behavior of the practitioner continues, the President of the Medical Staff or designee or Board of Trustees Chair or designee shall meet with and advise the practitioner that such conduct must stop. This constitutes the practitioner's final warning. After the meeting, a letter shall be sent to the practitioner reiterating the warning. This letter shall become part of the practitioner's permanent file. This letter shall state what behavior is unacceptable and that the consequences of further unacceptable behavior will include suspension or termination of privileges in accordance with the Medical Staff Bylaws.

27. Medical Screening Examinations: All patients who present to the Emergency Department shall be offered an emergency medical screening examination and evaluation by a qualified individual to determine if any emergency medical condition exists. For the purpose of this section of the Rules and Regulations, a qualified individual is defined as a physician, physician assistant, or a nurse practicing under an applicable Standard Procedure under the supervision of a physician, or a nurse operating within his/her scope of practice.

28. "Except under emergency conditions, members of the Medical Staff *may not self-treat,* treat or perform surgery on members of their immediate families, or prescribe medications for them when admitted to LLUMC. Immediate family includes: husband or wife; natural or adoptive parents, child or sibling; stepparent, stepchild, stepbrother or stepsister; father-in-law; mother-in-law, son-in-law, daughter-in-law, brother-in-law, sister-in-law; grandparent or grandchild; spouse of grandparent. (Ref. CMS 42 CFR §411.12)

In the event that a member of the Medical Staff is out of compliance with this rule, the Service Chief, Medical Staff President, or Chief of Staff, should inform the member of the Medical Staff of this rule and assist the member of the Medical Staff in finding an alternate member of the Medical Staff to provide care. If the situation remains unresolved, the appropriate Service Chief or Medical Director of the unit should be contacted. If still unresolved, the matter should be referred to the President of the Medical Staff for resolution."

C. PROFESSIONAL PRACTICE EVALUATION: GENERAL, FOCUSED, ONGOING

1. Purpose:
   To define, determine, maintain and evaluate the competency of members of the Medical Staff and Allied Health Professionals.
2. Policy:
   It is the policy of the Medical Staff at Loma Linda University Medical Center (LLUMC) to define, determine, maintain and evaluate the competency of members of the Medical Staff and Allied Health Professionals. Competency includes the ability to provide care, treatment and service in accordance with the credentialing and privileging processes and requirements of the Medical Staff. This responsibility will be implemented by the Service Chief, Credentials Committee, Medical Staff Executive Committee, and the Medical Staff President.
3. Procedure:
   There are a number of methods for collecting the data required for Professional Practice Evaluation. They are utilized according to the type of evaluation that is being conducted: General Competency Evaluation, Focused Professional Practice Evaluation or Ongoing Professional Practice Evaluation.

General Competency Evaluation (GCE)

Applicants and members of the medical staff must satisfactorily exhibit the qualifications as outlined in the Bylaws at the time of appointment and reappointment. The **general competencies** of the practitioner can be ascertained in several ways:

1. Peer references that affirmatively attest to the general competencies of the practitioner, along with a positive recommendation for appointment, reappointment, and on an ongoing basis.
2. The decision of the Department, Credentials Committee, and the Medical Staff Executive Committee (MSEC) that the practitioner exhibits the general competencies based on the practitioner's relevant education, training and experience and known information about the practitioner's clinical performance.
3. Specific information that may arise out of ongoing and/or focused evaluation of a practitioner that affirmatively or adversely speaks to that practitioner's general competencies.

A practitioner who is unable to satisfactorily exhibit the general competencies outlined in this policy may be subject to the focused evaluation of his or her professional practice, as described in this policy.

Ongoing Professional Practice Evaluation (OPPE)

Ongoing professional practice evaluation is the **continuous evaluation** of the practitioner's professional performance, rather than an episodic evaluation. It is intended to identify and resolve potential performance issues

as soon as possible, as well as foster a more efficient, evidence-based privilege renewal process.

Ongoing professional practice evaluation allows the organization to identify professional practice trends that may impact the quality of care and patient safety. Early identification of problematic performance allows for timely intervention. Ongoing professional practice evaluation results may be shared with the practitioner by the Service Chief, as appropriate.

OPPE requires the Medical Staff to collect, review, and analyze practitioner/specialty specific data according to the following Core Competencies defined by The Joint Commission:

- **Patient Care:** Practitioners are expected to provide patient care that is compassionate, appropriate and effective for the promotion of health, prevention of illness, treatment of disease and managing the end of life.
- **Medical/Clinical Knowledge:** Practitioners are expected to demonstrate knowledge of established and evolving biomedical, clinical and social sciences, as well as the application of their knowledge to patient care and the education of others.
- **Practice-Based Learning and Improvement:** Practitioners are expected to be able to use scientific evidence and methods to investigate, evaluate and improve patient care practices.
- **System-Based Practice:** Practitioners are expected to demonstrate both an understanding of the contexts and systems in which health care is provided and the ability to apply this knowledge to improve and optimize healthcare.
- **Interpersonal and Communication Skills:** Practitioners are expected to demonstrate interpersonal and communication skills that enable them to establish and maintain professional relationships with patients, families and other members of health care teams.
- **Professionalism:** Practitioners are expected to demonstrate behaviors that reflect a commitment to continuous professional development, ethical practice, an understanding and sensitivity to diversity, and a responsible attitude toward their patients, their profession and society.

The information gathered during this process is factored into the Service Chiefs recommendation for continuing and/or changing existing privilege(s).

- OPPE indicators must include patient activity data (i.e. admissions, consults, procedures), and other indicators chosen by Services.
- OPPE reports will be completed at least three times per 24-month appointment cycle in eight month intervals. Reports of OPPE activities will be provided to the Credentials Committee, and will be utilized in the credentialing process to determine whether to continue, limit, or revoke existing privileges.

Focused Professional Practice Evaluation

Focused professional practice evaluation is a process whereby the privilege/procedure-specific competence of a practitioner is evaluated. This process may also be used when a question arises regarding a current practitioner's ability to provide safe, high-quality patient care for which he or she possesses current privileges. The FPPE is not considered a formal Medical Staff investigation, and is not subject to regulations afforded in the investigation process.

When a practitioner is granted privileges for the first time, he or she shall undergo an initial period of focused evaluation called proctoring (as defined in Section 7.4 of the Bylaws and in the Rules and Regulations for each Service).

A focused review of a practitioner's performance may also occur when issues are identified that may affect the provision of safe, high-quality medical care. The following criteria may trigger the need for a focused evaluation by the Service Chief:

1. There is aggregate practitioner-specific data that demonstrates a significant adverse variation from internal or external benchmarks of performance.
2. There is a problematic pattern or trend identified as a result of the ongoing professional practice evaluation of the practitioner.
3. There is a complaint or quality-of-care concern raised against the practitioner that is of a serious nature.
4. There is evidence of behavior, health, and/or performance issues that carries an immediate threat to the health and safety of the patient, public, or other members of the health care team.
5. While the above issues may result in an FPPE, they may also, or alternatively, require action under the Corrective Action provisions of the Medical Staff Bylaws.

The Service Chief/designee shall make the recommendation to assign a period of focused performance monitoring. When there is a conflict that involves the Service Chief, another individual identified by the Medical Staff President shall perform the Focused Evaluation. Criteria for the type of focused performance monitoring is based on the triggering issue and may include the following:

1. Chart review (by internal or external reviewer
2. Direct observation
3. Simulation
4. Discussion with individuals involved in the care of each patient
5. Defined length of time or number of cases

The Performance Improvement Plan that is implemented to resolve the issue(s) must be documented and clearly define the following:

1. Duration of monitoring
2. The requirements
3. Who is accountable
4. How the improvement will be measure and documented
5. Outcome

D. CARE OF PATIENTS UNDERGOING SURGICAL PROCEDURES

Cross reference Bylaws 3.2-3

1. The *preoperative diagnosis* and description of the operative procedure planned shall be recorded in the medical record prior to beginning any procedure or surgery.
2. A *pre-procedure evaluation pertinent to the procedure/surgery being performed* (the "pre-procedure history and physical examination {PPHPE}) shall be required for any surgery or invasive procedure that is performed in the operating room or is performed elsewhere in the Medical Center utilizing general anesthesia or procedure related sedation more intense than light sedation. The PPHPE shall be performed by the "Attending" or by a resident physician acting under the supervision of the Attending or by an Allied Health Professional practicing within the scope of his/her profession and acting under the supervision of the Attending within the twenty-four (24) hours preceding the beginning of the procedure or surgery unless the Attending Medical Staff member *performing the procedure* certifies in the medical record that an emergency exists and that delaying the surgery or procedure to complete the PPHPE would be detrimental to the patient. *However the required PPHPE will be completed immediately following the procedure.* The PPHPE shall be documented in the medical record prior to the start of the surgery or procedure by the operating surgeon or by a resident supervised by the operating surgeon. If the PPHPE or certification of emergency is not present in the medical record before the scheduled time for the surgery or procedure, the surgery/procedure shall be delayed until it can be obtained (OR schedule permitting). Except in emergencies documentation shall be provided of a pre-anesthesia evaluation completed and documented by an individual qualified to administer anesthesia performed within forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services".
3. A surgical operation shall be performed only on *written, informed consent* of the patient, or the parent when the patient is a minor or legal guardian. In emergency situations where valid consent cannot be obtained, an opinion as to the necessity for emergency care shall be recorded and signed by a licensed physician.
4. If the procedure shall be done in the operating room, prior to the patient's entry, the attending Medical Staff member performing the procedure shall assure that *the correct site and side* to be operated upon has been identified whenever the proposed surgical procedure involves laterality or digits.
5. *Marking of the site* shall be done by the attending surgeon or attending physician performing the procedure.
   The *operating surgeon shall bear the ultimate responsibility* for the surgery being performed on the correct site.

6. Marking of the site shall *be done by use of a permanent marking pen to write "YES" on the site* or by the placement of an adhesive sticker or tape on the site if a permanent marker is not appropriate.
7. Verification of site and side shall be obtained by Medical Center personnel prior to the patient's entry into the operating room or procedure location and shall include:
   a) Verification of agreement of all documents relating to the surgical site.
   b) Verification of the site and side with the patient.
   c) Notification of the Medical Staff member performing the procedure/attending physician if there *is a discrepancy in this verification*.
8. Before incision or procedure start, the anesthesia providers, the Medical Staff member or resident performing the procedure, and the circulating nurse, operating room technician and other active participants who will be participating in the procedure from the beginning shall have as *a team verified and documented* in the patient's medical record their verification of:
   a) the patient's identity,
   b) the proposed procedure,
   c) the adequacy of the consent for the proposed procedure,
   d) the accuracy of the site and side identification of the proposed procedure.
   e) an interval medical history and physical examination performed and recorded within the previous twenty-four (24) hours.

   In cases in which no anesthesia provider is involved, the verification and documentation shall be done by the Medical Staff member or resident performing the procedure and the support personnel.
9. The Medical Staff member performing the procedure or assistant surgeon must be in the Operating Room *before anesthesia begins*.
10. *Operative reports shall be documented immediately*. When the operative report is not placed in the medical record immediately, brief operative note shall be entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend the patient prior to changing level of care.
11. All *specimens removed at operation* shall be sent to the Department of Pathology and Laboratory Medicine of Loma Linda University Medical Center for such examination as the pathologist may consider necessary for proper diagnosis. If a special examination of the specimen by an approved outside reference laboratory is requested, this request should be arranged through the Department of Pathology and Laboratory Medicine. The pathologist's signed report shall be made a part of the medical record.

E. PATIENTS RECEIVING OBSTETRICAL CARE

1. Hospitalized obstetrical patients shall have urinalysis and a postpartum hematocrit or hemoglobin. Reports of *prenatal laboratory studies*, including blood group and Rh, shall be on the medical record; if such reports are not provided, these studies shall be done.
2. Obstetrical patients shall have a *discharge summary documented unless*:
   a) The hospitalization resulted in a normal spontaneous vaginal term non-operative delivery; and
   b) The infant was normal; and

c) There were no obstetrical or medical complications; and
d) The length of stay was less than 72 hours.

F. CARE OF PATIENTS BY DENTISTS

1. Medical Staff members who are fully trained as Oral and Maxillofacial Surgeons can serve as a patient's attending practitioner.
2. If so privileged, the Attending Oral and Maxillofacial Surgeon may provide the required current history and physical examination.
3. The Attending Oral and Maxillofacial Surgeon shall request consultation and follow up care by an appropriately privileged physician member of the Medical Staff for any medical problems beyond the field of Oral and Maxillofacial Surgery that may be present or arise during hospitalization.
4. The Attending Oral and Maxillofacial Surgeon shall be responsible for the completion of the medical record.
5. Patients admitted by dentists who are not Oral and Maxillofacial Surgeons shall be admitted jointly with a physician member of the Medical Staff.
6. Patients admitted by Pediatric Dentists who are not Oral and Maxillofacial Surgeons shall be admitted jointly with a physician member of the Medical Staff with privileges in pediatrics.
7. The required current history and physical examination of patients admitted jointly by a dentist and a physician shall be the responsibility of the Attending physician.
8. The discharge summary of patients admitted jointly by a dentist and a physician shall be the responsibility of the Attending physician.
9. Dentists who are members of the Medical Staff are responsible for completing chart documentation of the history and physical examination data pertinent to the dental aspects of their patients.

G. CARE OF PODIATRY PATIENTS

Podiatrist members of the Medical Staff are responsible for completing *chart documentation* of the history and physical examination data pertinent to the podiatry aspects of their patients. Additionally, to the extent that the patient's condition is beyond the scope of podiatric practice, the attending podiatrist must obtain appropriate consultation and involvement by a non-podiatrist.

H. CARE OF PATIENTS RECEIVING HEMODIALYSIS

1. All patients in the dialysis unit will be *under the care of a Nephrologist* or a physician working under the direction of a Nephrologist.
2. The medical director of a dialysis unit shall be responsible for the *overall quality of care* of the patients in the unit. The Medical Director shall be appointed by the Chief of Medicine Service and shall be accountable to the Chief of the Nephrology Section and the Chief of Medicine Service.

I. CARE OF PATIENTS IN INTENSIVE CARE UNITS

1. All patients admitted to an Intensive Care Unit shall have as *their attending* physician a member of the Medical Staff with "Intensivist Privileges" or the Attending Physician shall arrange for a member of the Medical Staff with "Intensivist Privileges" to provide concurrent care (in the form of consultation and follow-up visits if needed) throughout the patient's stay in the Intensive Care Unit. The criteria for being granted "Intensivist Privileges" shall be developed by the Credentials Committee in consultation with the Critical Care Committee, and approved by the Medical Staff Executive Committee.
2. A physician shall evaluate the patient *within thirty (30) minutes* after admission to the unit or just prior to admission with accompanying documentation and initial orders shall be written;
3. Physicians must designate a *co-admitter* at the time of admission, who agrees to cover the patients if the admitting physician is not *within 30 minutes travel time* to the institution;
4. A physician shall provide *History and Physical/Admit/Transfer* note documentation on the chart within four (4) hours.

J. CARE OF PATIENTS IN THE EMERGENCY DEPARTMENT

1. All practitioners providing medical service in the Emergency Department shall have obtained the privilege to practice at the Medical Center as defined in the Medical Staff Bylaws.
2. Medical care of patients presenting to the Medical Center Emergency Department shall be the *responsibility of the Emergency Medicine Service* physicians.
3. The physician caring for a patient in the Emergency Department shall provide *documentation in the medical record* of the following:
    a) A pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to arrival at the Medical Center;
    b) A description of significant clinical, and laboratory findings;
    c) A diagnosis best explaining the reason for the care given;
    d) A description of the treatment given;
    e) A description of condition of the patient on discharge or transfer;
    f) The final disposition, including instruction(s) given to the patient and/or patient's family pertaining to necessary follow-up care;
    g) The signature of the Medical Staff member in attendance, who is thereby responsible for accuracy.
4. Once the initial physician *decision to admit* an Emergency department patient to an inpatient service has been made, the search for a suitable bed should begin. The final decision to admit shall be made by a Medical Staff member from the Clinical Service to whom the patient will be admitted. If there is disagreement between the initial admission decision made by the Emergency Medicine attending physician and the Medical Staff member representing the inpatient clinical service to which admission is proposed, the Medical Staff member

representing the inpatient clinical service to which admission is initially proposed must personally evaluate the patient in the Emergency Department and take responsibility for an alternate disposition. In the event that the inpatient service is at or above capacity or capability, alternate admission plans will be made. *Admission orders are to be written by the admitting service representative*, or the patient is to be cleared for discharge from the Emergency Department after evaluation of the patient by the proposed admitting service no later than two (2) hours after the Emergency Medicine attending physician requests to admit a patient. If admission orders are not written, or the proposed admitting Medical Staff member has not evaluated the patient in a timely manner, then it will be deemed that the medical Staff member from the proposed admitting service has admitted that patient to his/her service. The Emergency Medicine Service attending physician must confirm communication with the proposed admitting Medical Staff member of the admission to their service and the patient will be transferred to an inpatient bed. Orders for inpatient care shall be provided by the designated inpatient service.

The Service Chief shall be notified, but immediate notification is not necessary, if this process is utilized to admit a patient. If the service receiving the patient has concerns about the appropriateness of the admission, they may request review by the President of the Medical Staff. If the President of the Medical Staff is a member of one of the services involved, s/he may appoint a designee to conduct the review. The reviewer shall report his/her findings to the Patient Safety and Reliability Committee to consider for submission to the Professional Practice Committee and to the Emergency Medicine Continuous Quality Improvement Committee.

5. Clinical Services shall ensure *that requests for evaluation in the Emergency* Department prior to admission shall be responded to promptly and in compliance with any applicable Medical Staff or Medical Center policies.

K. FLUOROSCOPY

1. In any procedure, multiple specialty teams may be present and involved. The fluoroscopy supervisor/operator is the senior member of the specialty team performing fluoroscopy, who must have a fluoroscopy permit and privilege/authorization.
2. The senior member of the specialty team performing fluoroscopy may be either an attending, resident, or fellow. Residents and fellows may function as the senior team member only when no attending is present from that specialty team.
3. When residents or fellows are functioning as fluoroscopy supervisor/operator using the LLUH internal fluoroscopy training/authorization from GME program, the generally supervising attending must have a current state-issued fluoroscopy permit.

L. DRUGS AND MEDICATIONS

1. *All drugs and medications administered to patients* except for those drugs being administered through a research protocol, shall be those listed in the latest edition of United States Pharmacopeia, National Formulary, American Hospital

Formulary Service, or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be accepted. These shall be used in full accordance with the "Statement of Principles Involved in Use of Investigational Drugs in Hospitals" and all regulations of the Food and Drug Administration.

2. There shall be a *Medical Center Formulary* established by and approved by the Medical Staff Executive Committee after recommendation by the Pharmacy and Therapeutics Committee. Drugs included in the Medical Center Formulary shall be readily available for prescribing or ordering. Criteria for selection of drugs to be included in the Medical Center Formulary shall include:
   a) Need, given the diseases and conditions treated in the Medical Center
   b) Effectiveness
   c) Risk
   d) Cost
3. The Medical Staff Executive Committee may *place restrictions* on the use of some drugs (both formulary and non-formulary). Such restrictions may make some drugs (both formulary and non-formulary) more readily available to some specialties. Although the use of non-formulary drugs is discouraged, non-formulary drugs may be used by members of the Medical Staff when the Medical Staff member communicates to the Medical Center Pharmacy the specific reason for the use of the non-formulary drug. Use (and reasons for use) of "non-formulary" drugs shall be reviewed by the Pharmacy and Therapeutics Committee and by the Clinical Services.
4. The following classes of drugs are considered to *pose special potential hazards* to patients:
   a) *Parenteral anticancer chemotherapeutic agents* - An attending member of the Medical Staff or nurse practitioner specifically granted practice privileges, approved by the MSEC, must authenticate drug orders for parenteral anticancer chemotherapeutic agents (in accordance with Medical Center policies).
   b) *Parenteral potassium* – when concentration exceeds 40 mEq/liter or infusion rate exceeds 10 mEq/hour.
   c) *The order* (verbal, dictated or written) for these drugs *must be authenticated* by a member of the medical staff or by a licensed member of the resident staff before the drug is administered to a patient.
5. *Automatic stop orders* on narcotics and dangerous drugs shall be determined by the Medical Staff Executive Committee after recommendation by the Pharmacy and Therapeutics Committee.

M. UTILIZATION/BED MANAGEMENT

1. Whenever the Medical Center's beds are utilized or expected to be utilized at a level which requires the *restriction of admissions* in order to most efficiently accommodate requests for Medical Center services, a priority admissions procedure shall be implemented. The determination of the availability of beds and the priority of admissions to those beds shall be made by the Administrator, or designee(s), in consultation with the President of the Medical Staff, and with due consideration of available information provided by Medical Center

Administration. Factors which should be taken into consideration in making such determinations include, but are not limited to:

a) The average patient census in the affected Clinical Service(s) during the most recent weekly period and the projected census based on scheduled admissions for the period for which implementation of the priority admissions procedure is being considered;
b) The volume and types of surgical procedures and elective admissions that have been scheduled;
c) The requirements of the Medical Center's emergency department for beds; and
d) Such other relevant information affecting the demand for or the availability of Medical Center beds and services as may be provided by Medical Center administration.

2. Upon a determination that the Medical Center's beds are utilized at such a level as to *require restriction of admissions* by Medical Staff members or otherwise require restrictions to most efficiently accommodate requests for Medical Center services, or designee(s), may institute any one or all of the following actions, as appropriate, for such time as the high level of utilization shall continue:
   a) *Cancellation of Surgical Procedures and/or Related Admissions*. The CEO/Administrator, or designee(s), in consultation with the Chief of Surgery Service, may cancel surgical procedures and/or related admissions, which have been scheduled upon giving notice by telephone to the Medical Staff member who scheduled the procedure or admission. Whenever possible, such notice shall be given sufficiently in advance of the canceled admission(s) to permit time for appropriate notification of the affected patient(s) and avoid an unnecessary Medical Center admission or extension of a patient's Medical Center stay.
   b) *Cancellation of Other Admissions*. Scheduled elective admissions to clinical services other than Surgery may be canceled by the Administrator or designee(s) in consultation with the Chief(s) of the Service(s) to which the admissions are scheduled. Such cancellation shall be effective upon giving notice by telephone to the Medical Staff member who scheduled the admission. Whenever possible, such notice shall be given sufficiently in advance of the canceled admission(s) to permit time for appropriate notification of the affected patient(s) and avoid an unnecessary admission or extension of a patient's Medical Center stay.
   c) *Intensified Utilization Review*, The Administrator, or designee(s), in consultation with the President of the Medical Staff, may request the appropriate Medical Staff committee members and Medical Center staff to institute an intensified utilization review and to increase efforts to have patients discharged when they are first medically fit for discharge and to screen admissions to ensure that patients who most urgently need the beds are given priority of admission.
   d) *Priority Admission*. In the event it is necessary, the Administrator, or designee(s), in consultation with the President of the Medical Staff, shall establish admission priorities in accordance with a prioritization system consistent with the following guidelines:

1) Priority shall be given to Active Medical Staff members.
2) When the weekly average Medical Center occupancy reaches or is scheduled to reach approximately eighty percent (80%), the number of admissions by Provisional and Courtesy Staff members will be limited to not more than twenty-five percent (25%) of the number of beds reasonably expected to be available during the relevant period.
3) When the weekly average Medical Center occupancy level reaches or is scheduled to reach approximately ninety percent (90%), admissions by Provisional and Courtesy Staff members shall be limited solely to critical admissions that cannot be cared for in another hospital, as determined by the Administrator, or designee(s), in consultation with the President of the Medical Staff, on the basis of such factors as listed in Item 4 below.
4) All determinations of priority shall take into account the nature of the patient's condition and the admitting diagnosis and, whenever possible, shall not result in the cancellation of permission to admit a patient. To this end, priority determination shall be consistent, insofar as possible, with giving preference to those Medical Staff members who first scheduled the procedure or admission. In no event, however, shall there be discrimination against Medi-Cal patients in determining such priorities, nor shall the priority admissions system limit the Medical Center's obligations to provide or arrange for inpatient services for Medi-Cal patients.

N. SAFETY AND DISASTER PLAN

1. There shall be a plan for the care of *mass casualties* at the time of any major disaster, based upon the Medical Center's capabilities in conjunction with other emergency facilities in the community. The Safety and Disaster Plan shall be developed by a Disaster Control Committee working in conjunction with an administrative committee of the Medical Center and/or the University.
2. All physicians shall be *assigned duties* which they are expected to perform at time of a disaster.
3. The *disaster plan* should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administrative, nursing and other Medical Center personnel. Actual evacuation of patients during drill is optional. There should be a written report and evaluation of all drills.
4. The Medical Staff is expected to comply with *Medical Center policies* and procedures regarding safety and security matters.

O. MEDICAL RECORDS

1. The *attending* Medical Staff member shall be responsible for the preparation of a complete, pertinent, current, and legible medical record documenting the care provided to each patient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis, treatment and end result. *This record shall include* identification data; statement of reason for admission; provisional diagnosis; history and physical examination; progress notes; orders; consultation reports; reports of laboratory studies and of the examination of pathology specimens; reports of radiologic studies and consultations; reports documenting diagnostic and therapeutic procedures; reports of the activities of the nursing staff and of all others involved in the clinical care of the patient; a discharge summary of the hospitalization course and discharge program and autopsy report when performed. *All handwritten entries* into the medical record shall be in ink.
2. *Progress notes* shall be entered into the medical record daily. Progress notes shall give a pertinent chronological report of the patient's course in the Medical Center and should reflect any change in condition, the results of treatment and plans for future care. Progress notes must reflect the involvement of the attending physician in the patient's care. *Consultation* reports shall be a part of the patient's medical record and 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, the consultant's recommendations, and the signature of the consultant.
3. The current *obstetrical record* shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Medical Staff member's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
4. When a patient is to be *transferred between services*, the attending Medical Staff member shall sign an order to that effect.
5. All clinical entries in the patient's medical record shall *be accurately dated, timed, and signed*. An *electronic signature* is the equivalent of a regular signature. Passwords allowing for *electronic signature* are not to be used by anyone other than the person issued the password.
6. The *final diagnosis* shall be recorded in the medical record. This entry shall be separately authenticated when required by policy of the Health Information Systems Committee.
7. A *Discharge Summary ("Final Progress Note")* shall be entered into the medical record at time of discharge for all patients. It shall include that information needed for the immediate post-discharge care of the patient. The required content of the Discharge Note shall be determined by the Health Information Systems Committee. The Discharge Note shall be recorded without the use of symbols and abbreviations. A Discharge Summary shall be documented immediately following the patients discharge from the hospital. Some types of admissions may be

excluded from the requirement for a discharge summary by action of the Medical Staff Executive Committee. The Discharge Summary shall include:

a) Patient identifying information,
b) Attending practitioner(s) identifying information,
c) Dates of hospitalization,
d) Reason for admission,
e) Principal diagnosis (that one diagnosis that best explains the patient's admission),
f) Other diagnoses that impacted the patient's care during hospitalization, including new problems that arose during hospitalization,
g) Procedures performed during hospitalization,
h) A description of the management of the patients medical problem(s) during the period of hospitalization,
i) A description of the plan for the continuing management of the patient's medical problem(s) following discharge, including instructions given to the patient at the time of discharge.
j) The Discharge Summary shall be authenticated by the Attending physician.

8. *Release of private / confidential patient information* shall be guided by Medical Center policies that have been approved by the Medical Staff Executive Committee.
9. *Records may be removed from the Medical Center's jurisdiction and safekeeping* only in accordance with a court order, subpoena or statute. All records are the property of the Medical Center. In case of readmission of a patient, all previous records shall be available for the use of those caring for the patient. Unauthorized removal of charts from the Medical Center is grounds for corrective action.
10. *Access to medical records* for research purposes shall be consistent with Medical Center policies approved by the Medical Staff Executive Committee regarding preservation of the confidentiality of personal information concerning individual patients.
11. *Former members* of the Medical Staff shall be permitted access to information from the medical records of their patients covering periods during which they were involved in the care of such patients in the Medical Center.
12. A medical record shall not be permanently filed until it is completed by the responsible Medical Staff member or is ordered "*filed incomplete*" by the Health Information Systems Committee.
13. Medical Record Completion:
    a) A *history and physical* shall be provided *within 24 hours after admission or within 4 hours of admission to the ICU.* A chart shall be delinquent if the history and physical is not documented on the chart within 24 hours of admission. The history and physical should contain at a minimum: history of present illness (HPI), physical exam, impression and Plan, and should be based on the complexity of the patient.
    b) All Medical Staff members are required to *complete medical records in a timely manner*. The time frame for completion of various components of the Medical Record shall be set by the Health Information Systems

Committee and approved by the Medical Staff Executive Committee. Failure *to complete all available records in a timely manner may result in corrective* action.

c) In case of an *emergency which prevents completion* of all available medical records in a timely manner, the Medical Staff member is expected to work out a completion schedule with the Medical Center Department of Health Information Management. Failure to meet this schedule to complete all available records may result in corrective action.

d) Prior to any *period of absence of five (5) working days* or longer from the Medical Center, physicians are expected to complete all available medical records. Before extended absence, Medical Staff members are expected to notify the Health Information Management Department of their planned absence and expected date of return.

14. When a physician is identified as out of compliance with respect to completion of medical records s/he will be notified by Health Information Management (HIM) and the enforcement process will be instituted.

Timeline for notification of noncompliance with respect to medical record completion and enforcement process:

Time = 0: The physician is identified by HIM as out of compliance with medical record completion requirements. No specific notification of the physician is provided beyond flagging the electronic medical record.

Time = Eleven (11) days after the physician is identified as out of compliance with medical record completion requirements, Health Information Management (HIM) will notify the following via email, pager or phone call of the pending suspension of privileges for delinquent medical records: the physician, the Service Chief, the Service's Administrative Assistant, and Medical Staff Administration (MSA). Community physicians will be notified via the appropriate method.

Time = Fourteen (14) days after the physician is identified as out of compliance with medical record completion requirements, HIM will evaluate the medical record and if appropriate HIM will notify MSA that privileges should be suspended. Within 24 hours of receipt of notice from HIM, MSA will suspend the physician's privileges (as outlined in Bylaws Section VIII).

Notification that suspension of privileges for delinquent medical records has gone into effect will be provided to the physician via telephone, and email. Upon suspension of privileges Medical Staff Administration will also notify the Medical Staff President, the Chair of the Credentials Committee, the Service Chief, the Operating Room and Admitting/Pre-Admitting that suspension will begin the following day, and to cancel any surgeries scheduled by the physician for the day after the suspension begins.

All delinquent records must be completed and a fine paid before privileges will be reinstated. (Fine: on a rolling calendar year, 1st suspension $100, 2nd $200, 3rd $400 and continues to double.)

If the physician CONTESTS the incomplete or delinquent record designation, then representatives from Medical Staff Health Information Systems Committee and HIM will jointly investigate the physicians claim(s) and make a final determination. The timeline for pending suspension of the physician will be stopped until such determination is made."

P. SUPERVISION OF RESIDENT STAFF

1. These rules and regulations *apply to all residents (*physicians appointed to and functioning in Graduate Medical Education [GME] programs accredited by the Accreditation Council on Graduate Medical Education [ACGME] or dentists appointed to and functioning in graduate dental programs accredited by the Council on Dental Accreditation [CODA]) and clinical fellows (physicians or dentists not separately appointed to medical staff membership, but appointed to and functioning in programs not accredited by the ACGME) in programs sponsored by Loma Linda University Health Education Consortium and other special fellows under the supervision of the LLUMC GME Committee (GMEC).
2. Key Principles of Resident Supervision:
   a) Residency is an essential dimension of the transformation of the medical student to the independent practitioner along the continuum of medical education. This requires residents to assume personal responsibility for the care of individual patients while under the guidance and supervision of faculty. As residents gain experience and demonstrate growth, they are encouraged to assume roles that permit them to exercise those skills with greater independence. This concept of graded and progressive responsibility is one of the core tenets of graduate medical education.
   b) Supervision in the setting of graduate medical education has three primary goals: the safety and quality of care rendered to patients today; the safety and quality of care rendered to patients in the future by our residents in independent clinical practice, and a safe and humanistic education environment that establishes a foundation for continued professional growth. Supervision balances patient safety and resident education with Whole Person Care for resident physicians.
   c) Supervision is defined as the provision of monitoring, guidance and feedback on matters of personal, professional, and educational development in the context of the resident's care of the patient. Supervision is the single most important element in providing graded and progressive responsibility.
3. Residents and fellows *who have not been granted independent practice privileges* shall be subject to supervision by a member of the Medical Staff. Supervision of resident physicians shall be performed as required by the Graduate Medical Education Committee Policy and by the specific policies of the various residency programs. In all cases the responsibility for the supervision of residents who have

not been granted independent practice privileges lies with the supervising Medical Staff member. The supervising Medical Staff member must be available to participate in the care of patients as if residents were not involved; the presence of residents to "cover" patients on in-patient services or provide care in ambulatory settings does not diminish the standard of availability required of the supervising physician of record. The supervising Medical Staff member shall document that supervision by making timely and pertinent entries in the medical record.

4. Residents in accredited training programs and special fellows *will typically not be granted membership in the Medical Staff.* Clinical fellows in certain non-accredited training programs may apply for independent practice privileges as members of the Medical Staff in the Provisional category. Clinical fellows granted membership in the Medical Staff shall have their clinical privileges defined and granted by the Medical Staff as described in the Medical Staff Bylaws.
5. Based on the prerequisites for appointment to a residency program, all residents, regardless of their level of training, are *allowed to perform the following activities without direct supervision* (subject to confirmation and additional documentation as required by the LLUMC Corporate Compliance Policy):
    a) Perform and document a complete history and physical examination including the history and physical examination as a part of a consultation;
    b) Perform venipuncture;
    c) Place a cannula for intravenous infusion in a peripheral vein of the upper extremity of adult patients not receiving hemodialysis;
    d) Perform basic cardiopulmonary resuscitation;
    e) Write or dictate progress notes, consultations, including the final progress note or Discharge Summary (supervision documented by countersignature or separate note);
    f) Write diagnostic and therapeutic orders on behalf of the attending physician.
    g) Request consultations by members of the Medical Staff on behalf of the attending physician.

    If there is a procedure that the Resident is allowed to perform without the direct supervision of the supervising Medical Staff member, the supervising Medical Staff member will not be responsible for the signature required for chart completion.
6. All procedures shall be subject to supervision as described by the following categories:
    a) Direct Supervision: The supervising physician is physically present with the resident and patient.
    b) Indirect Supervision:
        i. with Direct Supervision immediately available:
        The supervising physician is physically within the confines of the site of patient care, and is immediately available to provide Direct Supervision.
        ii. with Direct Supervision available:
        The supervising physician is not physically present within the confines of the site of patient care, but is immediately available via

phone and/or electronic modalities, and is available to provide Direct Supervision.

c) Oversight: The supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.

d) PGY-1 residents must be supervised either directly or indirectly with direct supervision immediately available.

e) Senior residents or fellows may serve in a supervisory role of junior residents, as defined by each residency program. In all cases the final responsibility for the supervision of residents and fellows who have not been granted Medical Staff privileges lies with the supervising Medical Staff member. This responsibility includes ensuring the quality of care provided to patients, patient safety and provision of high quality education.

f) Each resident is responsible for knowing the limits of his/her scope of authority and the circumstances under which he/she is permitted to act with conditional independence.

7. The *residency program director* (as designee of the Medical Center Chief of Service) may authorize a resident or fellow to perform procedures without direct supervision after the resident or fellow has demonstrated this capability. This determination is subject to review and revision at the sole discretion of the Chief of Service and is not subject to appeal. This authorization is in no way to be construed as being credentialed by or having privileges at the Medical Center. All residents and fellows authorized to perform specific procedures without direct supervision will be so indicated in the Medical Center information system.
8. If a member of the nursing staff or other Medical Center employee has reason to question the proposed level of supervision, s/he will check the Medical Center information system to ascertain whether the resident is authorized to perform the procedure without direct supervision.
9. It is stipulated that this policy will be superseded in emergency situations where all physicians are expected to do their utmost to render lifesaving treatment. In such an event, the resident shall note in the medical record that such a situation existed and prompted the procedure.

Q. SUPERVISION OF ALLIED HEALTH PROFESSIONALS

1. The following categories of Allied Health Professionals (AHPs) are eligible for Practice Privileges in the Medical Center.
   a) Limited License Independent Practitioners (AHP-LLIP):
   b) Dependent Practitioners (AHP-DP):
2. These rules apply to *all Allied Health Practitioners* (AHPs) authorized to perform services for patients as provided for under Article V of the Medical Staff Bylaws.
3. The AHP-LLIP exercising practice privileges under Article V of the Medical Staff Bylaws shall be *under the general supervision of a Medical Staff member*
4. *The AHP-DP* exercising practice privileges under Article V of the Medical Staff Bylaws shall be under the direction and supervision of an authorized Medical Staff member *at all times* while performing these functions (Bylaws 5.1).

5. The *scope of each and every professional service* and/or practice privileges and/or Standardized Procedure rendered by the AHP shall be explicitly described in the privileging documents. These privileging documents may be in the form of a job description, a privilege description, a standardized procedure, or other format as accepted by the Medical Staff Credentials Committee and the Medical Staff Executive Committee.
6. Every professional service provided by an AHP-LLIP shall be consistent with the practice privileges granted to that AHP-LLIP and shall be under the general supervision of the medical staff member ordering the service who shall be available in person or by telephone.
7. The scope of supervision required for each and every professional service and/or practice privilege and/or Standardized Procedure rendered by the AHP-DP shall be explicitly described in the privileging documents using the following Levels of Supervision:
   Level 1 Supervision: The supervising Medical Staff member has approved the need for the procedure and is physically present for the significant portions of the procedure. The identification of the supervising physician is included in the privileging documents. The supervising physician has been explicitly granted the privilege to supervise the AHP performing the specified procedure.
   Level 2 Supervision: The supervising Medical Staff member has approved the need for the procedure and can respond to be physically present within 5 minutes. The identification of the supervising physician is included in the privileging documents. The supervising physician has been explicitly granted the privilege to supervise the AHP performing the specified procedure(s).
   Level 3 Supervision: The supervising Medical Staff member has approved the need for the procedure and is available by telephone or in person to consult with the AHP as needed
8. The AHP and the supervising Medical Staff member are each individually responsible to ensure compliance with the supervisory role.
9. Should a nurse or Medical Staff member have a question regarding the level of supervision of any AHP for any procedure, s/he will check the level that has been assigned to that procedure on the advanced practice protocol.

R. CONFIDENTIALITY

Members of the Medical Staff protect the confidentiality of their patient's data by abiding by the confidentiality statement signed as part of the application for Medical Staff membership. They are particularly careful to protect the privacy of patients from unwarranted intrusion by other Staff members, faculty, students and institutional employees. By supervision, example, and direction, they help assure that those under their supervision and tutelage respect and develop sensitivity to patient's rights and the need for privacy and identify those practices to be avoided as tending to erode patient privacy.

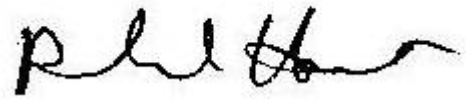
S. PRIVACY/PATIENT'S RIGHTS

Members of the Medical Staff protect the privacy of Medical Center patients. By example they are scrupulous in avoiding any appearance of violating patient privacy. They do not peruse charts or other collections of patient data of those not under their care. When using Medical Center patients for teaching, they clear such use ahead of time with the physician caring for the patient. When using Medical Center patient information for research purposes, they support the following Medical Center policies controlling access, review and use of patient information. They are particularly careful in protecting the privacy of those most vulnerable, other Staff members, faculty, students and institutional employees who become Medical Center patients. By example and direction, they assist those under their supervision and tutelage to develop sensitivity to patient rights and need for privacy and to those practices to be avoided that tend to erode patient privacy.

APPROVALS:

These Medical Staff Rules and Regulations were approved by the Medical Staff Executive Committee, and by the Governing Board, on the dates listed below, as attested to by these signatures (Bylaws 15.1-1).

ADOPTED by the Medical Staff on June 23, 2021. 
Jason Gatling, MD, President of the Medical Staff

Tait Stevens, MD, Chair of the Bylaws Committee
APPROVED by the Board on August 31, 2021 
Richard Hart, MD, Board Officer