

LOMA LINDA UNIVERSITY BEHAVIORAL MEDICINE CENTER



LOMA LINDA
UNIVERSITY

BEHAVIORAL
MEDICINE CENTER

Rules and Regulations

2020-2021

Loma Linda University Behavioral Medicine Center
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Loma Linda University Behavioral Medicine Center

2020-2021 Medical Staff Rules and Regulations

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PART II: MEDICAL STAFF RULES AND REGULATIONS

These rules and regulations are incorporated by reference into the Medical Staff Bylaws. Accordingly, all definitional terms set forth in the Bylaws shall apply with respect to these Rules and Regulations. The Rules and Regulations are intended to clarify standards of professional practice and the conditions of appointment to the Medical Staff. To the extent that any conflict exists between these Rules and Regulations and the Medical Staff Bylaws, the Bylaws shall govern.

A. Admissions

A patient may be admitted to the Behavioral Medicine Center (BMC) by a member of the Medical Staff with privileges to admit. An AHP may collaborate with a member of the Medical Staff on admissions.

B. Admission Standards

All admissions must meet the BMC's admission criteria as defined in these Rules and Regulations.

1. **Admission Criteria:** The following standards provide criteria to determine when an individual may be admitted, and to provide quality professional care within the means and circumstances during the patient's prescribed length of stay.
 - a. The patient must exhibit signs and symptoms of a specific psychiatric or chemical dependency disorder and be likely to benefit from hospitalization.
 - b. The patient must have an appropriate acute psychiatric or chemical dependency diagnosis, a chronic diagnosis with exacerbated symptoms, or be in an acute episode based on the current version of the "Diagnostic Statistics Manual".
 - c. Patients should be able to substantially participate in their own care and should be ambulatory with assistance. "Ambulatory" would include the use of mechanical devices; e.g., walkers, crutches, and wheelchairs.
2. **Assignment:** Patients shall be admitted to an age-appropriate unit. Requirements of California law applicable to separate housing and separate treatment arrangements for minors and adults shall be met in all units.
3. **Inappropriate Admissions:** The following patients are inappropriate for admission at the BMC:
 - a. Patients who are medically unstable.
 - b. Developmentally disabled persons or with chronic conditions, e.g. autism (due to the required level of care), with the exception of those experiencing acutely psychotic episodes, as appropriate.
 - c. Imminently terminally-ill patients.
4. **Patients Without An Assigned Physician:** Patients applying for admission who have no attending physician shall be referred to members of the Active Medical Staff.

5. **Admitting Practitioner:** Patients may be treated only by Medical Staff members and/or Allied Health Professionals who have been granted specific privileges/practice-privileges.
6. **Psychiatric Evaluation:** A psychiatric evaluation shall be obtained by a physician within 24 hours of admission for all inpatients and 48 hours of admission for partial hospital/intensive outpatients. When a psychiatric evaluation has been completed within 30 days before the patient was admitted or readmitted, an interim psychiatric evaluation reflecting any subsequent changes may be used in the medical record provided the original information is available for reference.
7. **History and Physical:** A medical history and physical evaluation shall be obtained by a physician within 24 hours of admission for inpatients. The history and physical should contain at a minimum: history of present illness (HPI), physical exam, neurological screening, impression and plan, and should be based on the complexity of the patient. When a history and physical examination has been completed within 30 days before the patient was admitted or readmitted, an interim history and physical examination reflecting any subsequent changes may be used in the medical record, provided the original information is available for reference. (See Article III, 3.2-3.d)
8. **Admission Studies:** The attending physician shall be responsible for ordering admission studies. These orders must include clinical indications for the studies. These may include, but not be limited to, blood and urine examination, x-ray, electrocardiogram and electroencephalogram. The attending physician may delegate this responsibility to an appropriate Staff consultant.
9. **Assessment:** In the case of a patient who has recently had an evaluation (e.g., history and physical examination, psychiatric evaluation, neurological examination, laboratory studies) done elsewhere, it is the responsibility of the attending physician to ensure the following:
 - a. That the evaluation was comparable to the admission evaluations provided by the Behavioral Medicine Center for other patients.
 - b. That the evaluation was completed within seven (7) days prior to admission.
 - c. That the patient's course since the evaluation has been medically uncomplicated.
 - d. That a copy of the original information is in the patient's chart within 24 hours of admission.
 - e. That additional evaluation is ordered as indicated by the patient's presenting condition.
10. **Patient Transfers:** The attending physician has medical, legal, and management responsibilities for the patient's treatment. The responsibilities of the attending physician may be transferred to another physician as outlined below:
 - a. In the case of out-of-facility transfer (including temporary transfer), the receiving physician shall be identified by a written order and a notation in the progress notes.

- b. In the case of intra-facility transfer (service-to-service), the responsibilities of the attending physician may be transferred from one medical staff member to another. This shall occur after the transferring physician writes an order for the transfer and a notation in the progress notes, and the receiving physician writes an order accepting the transfer. The attending physician at the time of discharge shall be responsible for the completion of the medical record.
 - c. This shall occur after the transferring physician writes an order for the transfer and a notation in the progress notes.
 - d. The receiving physician writes an order accepting the transfer along with treatment and medication orders. The receiving physician shall write these orders at the time of the actual transfer.
 - e. The attending physician at the time of discharge shall be responsible for the completion of the medical record.
 - f. When a patient is transferred between units and the attending physician remains the same, the attending physician shall write an order indicating the change of unit and/or level of care.
11. ***Residing Outside Close Proximity to Facility:*** Each member of the Medical Staff who does not reside in the area shall name a member of the Medical Staff who resides in the area, who may be called to attend patients in an emergency. In case of failure to name such associate, or in the event the designated physician cannot be located, the Medical Director of the BMC shall have the authority to call any Medical Staff member should this be considered necessary.
 12. ***Psychosocial Evaluation:*** A psychosocial evaluation shall be on the chart within 48 hours of admission.
 13. ***Treatment of Self or Family:*** 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 LLUBMC. 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 Charge Nurse or Patient Care Manager of the unit 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 or the Administrator for resolution.

C. Resident Staff

1. ***Inclusive Statement:*** 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 GME 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 patient 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 residents care of the patient. Supervision is the single most important element in providing graded and progressive responsibility.

3. ***Independent Practice Privileges:*** 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 resident 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 or record. The supervising Medical Staff member shall document that supervision by making timely and pertinent entries in the medical record.

4. ***Limitations:*** Residents in accredited training programs and special fellows will not usually 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. 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. ***Prerogatives:*** 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 documentation as required by the LLUBMC Corporate Compliance Policy):
 - a. Perform and document a complete history and physical examination including the history and physical examination as a part of the 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 (no separate documentation of supervision required);
 - d. Perform basic cardiopulmonary resuscitation;
 - e. Write or dictate progress notes including the final progress notes, consultations, including the final progress note or Discharge Summary;
 - 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 (supervision documented by countersignature of the order).

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. ***Levels of Supervision:*** 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 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.
 - c. Indirect Supervision with Direct Supervision available – the supervising physician is not physically present within the confines of the site of patient care, but is immediately available by means of telephonic and/or electronic modalities, and is available to provide Direct Supervision.
 - d. Oversight – the supervising physician is available to provide review of procedures/encounters with feedback provided after care is delivered.
 - e. PGY-1 Resident – must be supervised either directly or indirectly with direct supervision immediately available.
 - f. Senior Resident or Fellows – may serve in a supervisory role of junior residents, as defined by each resident 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.
 - g. 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. **Residency Program Director:** The residency Program Director (as designee of the LLUMC 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 LLUBMC. All residents and fellows authorized to perform specific procedures without direct supervision will be so indicated in the LLUBMC information system.
8. **Assuring Scope of Supervision:** If a member of the nursing staff or other LLUBMC employee has reason to question the proposed level of supervision, he/she will check the LLUBMC information system to ascertain whether the resident is authorized to perform the procedure without direct supervision.
9. **Emergency Situations:** 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.

D. Allied Health Professionals

All AHPs must meet the applicable qualifications and requirements as outlined in Articles III and V.

1. **Professions:** Those professions approved by the MSEC and by the Governing Body for delineated practice privileges/Standardized Procedures within the scope of their licensure are: Pain Management Specialist, Nurse Practitioner, Art Therapist, Licensed Clinical Social Work, Licensed Educational Psychologist, Clinical Psychologist, Marriage, Family Therapist, Music Therapist, Speech and Language Pathologist. Other professions may be granted temporary, one-patient-only practice privileges with the approval of the Medical Staff President in conjunction with the Administrator, in accordance with the requirements of Section 7.4 of the Medical Staff Bylaws.
2. **Coordination of Care:** When a physician and an AHP collaborate in providing treatment, the Allied Health Professional will be responsible for those aspects of care covered in the scope of the licensure of that AHP category, and for fully cooperating with the physician and other members of the Treatment Team. The attending physician shall be responsible for all aspects of patients' treatment.
3. **Determining Need for Admission:** When an Allied Health Professional determines that a patient under his or her care may need admission, the AHP may contact either an Active staff member to participate in the admission process, or may contact the Hospital's Assessment and Referral Department to have such a physician assigned to the patient's care.

4. **Coordinating Admission:** Both the attending physician and the collaborating AHP will participate in the admission process, with the physician carrying out the legal responsibility for admission, including contact with the patient either individually or jointly with the Allied Health Professional and writing admission and medical orders on the day of admission.
5. **Physician Responsibility:** The attending physician shall be responsible for coordinating treatment and writing orders.
6. **Nurse Practitioners (NP):** NPs may write orders and provide treatment under the following conditions:
 - a. They have been granted the practice privilege in accordance with Article V to write orders and provide treatment.
 - b. **Writing Orders:**
 - 1) The Attending Physician shall have previously written an order authorizing the writing of orders on that specific patient by a specific NP. This authorizing order shall not be a verbal order transmitted through the NP. As an alternative, the Attending Physician who is the Supervising Physician, may present to Medical Staff Administration a document indicating his/her authorization and acceptance of responsibility as the Supervising Physician for specifically named NPs for whom he/she is willing to take responsibility under the Standardized Procedures (SP) referred to in item 2) below.
 - 2) The order is a verbal order or the order is congruent with and controlled by a standardized procedure previously approved by the MSEC and the Governing Body. The NP writing the order shall confirm that the standardized procedure is being utilized and identify the name of the “Supervising Physician” under which the NP is performing patient care services.
 - c. **Provide Treatment:**

The treatment is congruent with and controlled by a Standardized Procedure (SP) previously approved by the MSEC and the Governing Body. The NP providing treatment shall confirm that the SP is being utilized and identify the name of the “Supervising Physician” under which the NP is performing patient care services.
 - d. **Supervision of Nurse Practitioners (NP):**

Regardless of the NP practicing under a Standardized Procedure, in-patient care continues to require daily physician contact as outlined in the Rules & Regulations I. Documentation of Progress Notes.

 - 1) The scope of professional service rendered by the NP shall be explicitly described in the applicable Standardized Procedure.
 - 2) The identification of the supervising physician(s) is included in the Standardized Procedure. The supervising physician(s) has been explicitly granted the privilege to supervise the NP.
 - 3) The NP and the supervising physician(s) are each individually responsible to ensure compliance with the supervisory role.
 - 4) Should a nurse or physician have a question regarding the level of supervision of any NP for any treatment, he/she will check the level that is outlined in the applicable Standardized Procedure.

7. ***Changes in Medication/Treatment:*** The attending physician shall be responsible for medications and other medical treatment, but is expected to discuss anticipated changes in medication and/or medical treatment with the collaborating Allied Health Professional and the Treatment Team. The collaborating Allied Health Professional is expected to discuss anticipated changes in treatment with the attending physician and the Treatment Team.
8. ***Course of Treatment:*** The attending physician and collaborating Allied Health Professional shall be available for discussion of treatment as needed. The patient's treatment plan will be developed collaboratively by all members of the Treatment Team at the Treatment Team meetings and approved by the attending physician.
9. ***Discharge Planning:*** The attending physician shall participate in discharge planning and is responsible for the discharge of the patient.
10. ***Medical Record Completion:*** The collaborating Allied Health Professional is responsible for completing all appropriate records and correspondence. The attending physician is responsible for assuring that the patient record is complete and that appropriate reports are sent.

E. Admission and Treatment Orders

1. ***Admitting Physician:*** Patients shall be admitted or discharged only on the written order of a Medical Staff member with admitting privileges. The admitting order shall include a provisional diagnosis.
2. ***Orders:*** All orders shall be in writing. Face-to-face verbal orders may be given only in the case of medical or psychiatric emergencies. When the attending physician or consulting physician is away from the Hospital, orders may be given by telephone. These orders shall be received by a licensed nurse and shall be signed with the name of the Medical Staff member and the nurse. The order shall be signed by the respective physician within forty-eight (48) hours.

An emergency circumstance shall exist when all of the following apply:

- a. A patient demonstrates physical discomfort and/or emotional distress as assessed by the unit charge nurse.
 - b. The attending physician is not available on the grounds.
 - c. Asking the patient to wait without chemical or other intervention would endanger the patient's well-being and/or increase the patient's emotional distress.
3. ***Countersignature:*** Medical student orders must be countersigned by a Resident or by the attending physician before being acted upon.
 4. ***Resident Orders:*** Resident Staff may write orders.
 5. ***Medication Orders:*** Medication orders may be issued only by the Attending Physician, Consulting Physician, or by Residents, and shall be received only by a

licensed nurse or pharmacist. Medication orders shall be within limits of privileges granted to the respective Staff member.

6. **Treatment Orders:** Orders for medical treatment may be issued only by the Attending Physician or Consulting Physician, and shall be received only by a licensed nurse. No practitioner shall issue an order for any medical treatment, which is not within the limits of the privileges granted or not permitted within the scope of his/her respective licensure, registration or certification status. All medical orders given shall be written in the medical record by the Medical Staff member or Resident, and shall be signed, dated, and timed. All orders must be identified with date, time and the full name of the person promulgating the order.
7. **Authentication:** All orders must be authenticated by the author. All signatures on orders must be identified with titles.

F. Medication Protocol

1. **Medication Use:** Drugs used shall meet the standards of the United States Pharmacopoeia National Formulary, New and Non-Official Drugs with the exception of drugs for bona fide clinical investigation.
2. **Orders for Controlled Substances:** All medication orders for controlled substances (schedule II, III, IV, V drugs) and antibiotics should include the length of treatment desired.
3. **Automatic Stop Orders:** Medication orders that do not include a specified duration will automatically stop at 30 days with the following exceptions:
 - a. 3 days for meperidine (Demerol)
 - b. 5 days for warfarin (coumadin)
 - c. 5 days for ketorolac (Toradol)
4. **Indication for Use:** All orders for routine medications must include an indication for use.
5. **PRN Orders:** All PRN [“as needed”] medication orders must have indications for use and the total amount must not exceed the maximum allowable dosage in a 24-hour period.

G. Treatment Plans

1. **Patient-specific Treatment Plan:** An individual comprehensive treatment plan, based on an inventory of the patient's strengths and limitations, is to be included in the patient's medical record. The treatment plan shall include a working diagnosis in accordance with Diagnostic Statistical Manual IV short term and long range goals, the specific treatment approach and interventions, the responsibilities of the Treatment Team members, and discharge planning. The treatment plan will be initiated by the attending physician, or the collaborative efforts of the attending physician and an Allied Health Professional, and will incorporate changes as

- indicated by the Treatment Team. The attending physician and AHP are both required to attend the weekly treatment planning meetings of all the patients under their care.
2. ***Multi-disciplinary Treatment Plan:*** The multi-disciplinary treatment plan for the patient shall provide the framework for the appropriate services of all members of the Treatment Team including those to be rendered by the Allied Health Professionals. Each Treatment Team member shall be accountable for implementing those parts of the treatment plan that are within his/her domain and shall be responsible to the director of his/her clinical service for the quality of services rendered. Overall responsibility for the treatment plan rests with the attending physician. The attending physician shall sign the treatment plan as evidence of his/her approval.
 3. ***Goals and Objectives:*** The patient's progress and current status in meeting goals and objectives of his/her treatment plan shall be documented in the patient's medical record.
 4. ***Initiation:*** The treatment plan shall be initiated upon admission and updated throughout the patient care treatment. It is the responsibility of the physician to periodically evaluate the therapeutic program and determine the extent to which treatment goals are being realized and whether changes in the direction or emphasis are needed. Such evaluation should be made on the basis of periodic consultations and conferences with therapists, reviews of the patient's medical record, and regulatory scheduled patient interviews. A treatment team summary shall be recorded in the progress notes by a representative of the treatment team to document changes in and/or observations of the patient's condition, treatment plan modification, implementation of the treatment plan, and the results of treatment intervention.

H. Consultation Requests

1. Any Medical Staff member with clinical privileges at the Behavioral Medicine Center can be requested to provide consultation within his or her area of expertise.
2. Residents acting under the supervision of a Medical Staff member can provide consultations.
3. Consultations are made under the following circumstances:
 - a. Whenever the specific knowledge or skill of another practitioner may be needed to improve the quality of care of a patient, consultation by a practitioner possessing that specific knowledge or skill shall be obtained. (e.g., ECT, psychological testing, obstetrics, neurology, cardiology, endocrinology, dentistry, etc.).
 - b. 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. Those circumstances may include:

- 1) An obscure diagnosis.
 - 2) Doubt as to the best therapeutic approach.
 - 3) Treatment risks for the patient.
 - 4) A recommendation made by the Internal Medicine physician for a need identified during the physical examination.
- c. Based on clinical necessity, consultations may be deferred until the patient is discharged and a referral is included in the discharge plan.
4. The attending Medical Staff member is responsible for writing the order requesting the consultation and assuring that the request has been transmitted to the consulting Medical Staff member. The reason for the consultation request is noted on the order and in the progress notes.
5. The consulting medical staff member is responsible for:
- a. Responding promptly to the request for consultation.
 - b. Reviewing the medical record and examining the patient.
 - c. Providing an opinion regarding the patient's condition and recommendations regarding the management of the condition for which consultation was requested.
 - d. Recording his/her findings, opinion(s) and recommendation(s) in the medical record.
 - e. Communicating urgent, unexpected findings directly to the attending Medical Staff member.
6. The consulting Medical Staff member is not responsible for:
- a. Writing orders implementing his/her recommendations.
 - b. 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.

I. Documentation of Progress Notes

1. **Progress Notes:** During hospitalization, acute care patients must be seen daily and assessed by the attending physician and progress notes written. Patients may be seen by Allied Health Professionals. However, this does not preclude the requirement that the attending physician see the patient daily. During partial hospitalization/intensive outpatient treatment, patients must be seen weekly and assessed by the attending physician and progress notes written.

In the event the attending physician is on vacation, or for any reason is incapacitated, then this responsibility will pass to the physician who is taking calls for the attending physician. Documentation shall be written in a manner as to provide a full picture of the therapy administered as well as an assessment of the patient's reaction to it.

2. ***Progress Note Content:*** Progress notes shall be entered in the patient's record and shall include the following:
 - a. Documentation of implementation of the treatment plan.
 - b. Documentation of all treatment rendered to the patient.
 - c. Chronological documentation of the patient's clinical course.
 - d. Descriptions of each change in the patient's condition.
 - e. Descriptions of the response of the patient to treatment, the outcome of treatment, and the response of significant others to important intercurrent events.

A progress note shall be recorded at each visit by the practitioner making the visit. Justification for continued hospitalization must be documented daily unless the patient has graduated to the chemical dependency rehabilitation program. Progress notes involving subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed.

J. Discharge Procedures

1. ***Discharge Orders:*** Patients shall be discharged only on order of the attending physician or resident physician. Patients shall continue to receive care and treatment until they physically leave the hospital. If a patient does not leave the hospital until the day after a discharge order is written, the physician will rescind the discharge order and will document the reason in the progress note.
2. ***Discharge Summary:*** At the time of discharge, the attending physician shall see that the record is complete and dictate a discharge summary. The discharge summary shall include:
 - a. Identifying information: i.e., patient name, admission date, discharge date, and attending physician.
 - b. Admitting diagnosis (DSM-IV all five axes including GAF score).
 - c. Final diagnosis (DSM-IV all five axes including GAF score).
 - d. Reason for admission (brief history, including mental status).
 - e. Physical findings.
 - f. Results of diagnostic tests.
 - g. Therapy rendered.
 - h. Condition and in-hospital progress of patient.
 - i. Condition of patient upon discharge, including mental status.
 - j. Aftercare instructions, with special attention to follow-up plans.
3. ***Designating Responsibility of Discharge Summary:*** Physicians may delegate the responsibility of dictating the discharge summary to a person previously approved by Administration and the MSEC. The responsibility for the accuracy and content of the discharge summary rests with the attending physician. The procedure by which this policy will be carried out is in the Medical Records Department.

K. Medical Records

1. ***Permanently Filing Records:*** A medical record shall not be permanently filed until it completed by the responsible Medical Staff member or is ordered “filed incomplete” by the Medical Staff Executive Committee.
2. ***Medical Record Completion:*** All medical records for hospitalized patients shall be completed within fourteen (14) days following discharge. The Medical Staff member may be suspended for delinquent medical records as outlined in Article VIII, 8.3-5 “Medical Record Delinquency” of the Bylaws.
3. ***Notification of Suspension:*** Notification that suspension of privileges for delinquent medical records has gone into effect will be provided to the physician via telephone, fax or 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 Admitting Department, Medical Records Department and Hospital Administration.
4. ***Dating and Signing:*** All clinical entries in the patient’s medical record shall be accurately dated and signed.
5. ***Legibility:*** All written entries in the patient’s medical record shall be legible, including the practitioner’s signature.
6. ***Access to Medical Records:*** Records may be removed from the Hospital’s jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital. In case of readmission of a patient, all previous records shall be available for use of the attending physician, consulting physician(s), and Allied Health Professionals providing care to the patient. Unauthorized removal of charts from the Hospital is grounds for corrective action.
7. ***Access to Medical Records by Former Members:*** 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 Hospital, subject to the discretion of the Medical Staff President.
8. ***Physician’s Responsibility:*** 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. All handwritten entries into the medical record shall be in ink.
9. ***Patient Confidentiality:*** Members of the Medical Staff protect the rights and privacy of Hospital patients. By example, they are scrupulous in avoiding any appearance of violating patient privacy. They do not peruse charts or other collections of data for those patients not under their care. By example and direction, they assist those under their supervision and tutelage to develop sensitivity to:
 - a. patients’ rights and need for privacy; and
 - b. practices to be avoided that tend to erode patient confidentiality.

L. Documentation of Death

1. ***Pronouncing Death:*** In the event of a patient's death, the deceased shall be pronounced dead by the attending physician or designee within a reasonable time. A summation statement shall be entered in the medical record in the form of a discharge summary. The summation statement shall include the circumstances leading to the death and shall be signed by the attending physician.
2. ***Release of Deceased Patient:*** The body shall not be released until an entry has been made and signed in the medical record of the deceased by a licensed physician. Policies with respect to release of dead bodies shall conform to state law.
3. ***Autopsy:*** It shall be the duty of all staff members to request autopsies whenever appropriate. An autopsy may be performed only with consent in accordance with state law. The attending physician will be notified when an autopsy is being performed.

M. Special Treatment Procedures

1. ***Seclusion Protocol***
 - a. A patient is placed in seclusion only when exhibiting behavior which threatens harm to self or others and the patient fails to respond to less restrictive interventions. Placement in seclusion shall never be used for punishment, the convenience of staff, or as a substitute for a less restrictive alternative form of treatment.
 - b. The attending physician shall adhere to and assure staff's compliance with the Hospital's Policies and Guidelines.
2. ***Restraint Protocol***
 - a. A patient is placed in restraints only when exhibiting behavior which threatens harm to self or others, and the patient fails to respond to less restrictive interventions. Placement in restraints shall never be used for punishment, the convenience of staff, or as a substitute for less restrictive alternative forms of treatment.
 - b. The attending physician shall adhere to and assure staff's compliance with the Hospital's Policies and Guidelines.
3. ***Electroconvulsive Therapy Protocol (Performed at LLUMC only):***
 - a. Electroconvulsive therapy shall not be used for a child or adolescent except in special circumstances. Prior to initiating electroconvulsive therapy for a child or adolescent, two qualified child psychiatrists who are not directly involved in the treatment of the patient shall:
 - 1) Examine the patient;
 - 2) Consult with the attending physician responsible for the patient;
 - 3) Document in the medical record their concurrence with the decision to administer the therapy.

- b. In all cases involving adults, the attending physician must obtain concurrence in the decision for electroconvulsive therapy from at least one additional psychiatrist not directly involved in the care of the patient.
4. ***Psychosurgery:*** Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental or a behavioral disorder will not be performed at this facility.
5. ***Behavioral Modification:*** Behavioral modification procedures that use aversive conditioning will not be performed except under special circumstances and with the approval of the MSEC.

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 Behavioral Medicine Center capabilities in conjunction with other emergency facilities in the community.
2. All Medical Staff members shall be assigned duties and it is their responsibility to perform these duties at the time of a disaster.
3. The Medical Staff is expected to comply with the Behavioral Medicine Center policies and procedures regarding safety and security matters.

O. Privacy/Patient's Rights

Members of the Medical Staff protect the privacy of BMC 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 BMC patients for teaching, they clear such use ahead of time with the physician caring for the patient. When using BMC patient information for research purposes, they support the following BMC 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 BMC 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.

P. 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 Behavioral Medicine (BMC) 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.
4. **General Competency Evaluation (GCE)**
 - a. 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:
 - b. 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.
 - c. 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.
 - d. 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.
 - e. 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.
5. **Ongoing Professional Practice Evaluation (OPPE)**
 - a. 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.
 - b. 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.
 - c. 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:
 - i. **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.
 - ii. **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.

- iii. **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.
 - iv. **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.
 - v. **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.
 - vi. **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.
- d. The information gathered during this process is factored into the Service Chiefs recommendation for continuing and/or changing existing privilege(s).
 - e. OPPE indicators must include patient activity data (i.e. admissions, consults, procedures), and other indicators chosen by Services.
 - f. 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.

6. ***Focused Professional Practice Evaluation (FPPE)***

- a. 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.
- b. When a practitioner is granted privileges for the first time, he or she may 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).
- c. 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:

- i. There is aggregate practitioner-specific data that demonstrates a significant adverse variation from internal or external benchmarks of performance.
 - ii. There is a problematic pattern or trend identified as a result of the ongoing professional practice evaluation of the practitioner.
 - iii. There is a complaint or quality-of-care concern raised against the practitioner that is of a serious nature.
 - iv. 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.
- d. 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.
- e. 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:
- i. Chart review (by internal or external reviewer)
 - ii. Direct observation
 - iii. Simulation
 - iv. Discussion with individuals involved in the care of each patient
 - v. Defined length of time or number of cases
- f. The Performance Improvement Plan that is implemented to resolve the issue(s) must be documented and clearly define the following:
- i. Duration of monitoring
 - ii. The requirements
 - iii. Who is accountable
 - iv. How the improvement will be measured and documented
 - v. Outcome

Q. Review/Revisions of the Rules and Regulations

These Rules and Regulations and other policies of the Medical Staff of the BMC shall be reviewed and revised as necessary in accordance to Article XVII of the Medical Staff Bylaws.

APPROVAL OF RULES AND REGULATIONS

RECOMMENDED by the Medical Staff

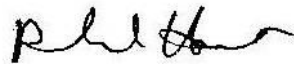


Carolina Osorio, MD, BMC Medical Staff President



William Murdoch Jr., MD, BMC Medical Director

APPROVED by the Governing Board



Richard Hart, MD, Governing Board Officer

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