ANTELOPE VALLEY HOSPITAL MEDICAL STAFF

GENERAL RULES AND REGULATIONS

2015 EDITION

	Approved	Revised/ Reviewed	Revised/ Reviewed	Revised/ Reviewed	Revised/ Reviewed	Revised/ Reviewed	Revised/ Reviewed
MEC	11/06/12	10/01/13	06/02/15				
General MS	11/13/12	11/12/13	09/08/15				
Board	11/27/12	11/25/13	09/30/15				
	Approved	**Revised/ Reviewed**	**Revised/ Reviewed**	**Revised/ Reviewed**	**Revised/ Reviewed**	**Revised/ Reviewed**	**Revised/ Reviewed**
MEC							
General MS							
Board							

_____
Bylaws Committee Chair 2015
Ravi Shankar, M.D.

_____
President, Medical Staff 2015
Pramod Kadambi, M.D.

Original signed documents are maintained in Nursing Administration

Table of Contents

MEDICAL STAFF GENERAL RULES AND REGULATIONS

A. ADMISSION AND TREATMENT OF PATIENTS:

1. ADMISSION ORDERS: Patients shall be admitted upon the electronic order of a member of the Medical Staff (see exceptions in section M.1). Patients may be admitted to this hospital and treated only by physicians, dentists, podiatrists and psychologists who have filed written application, submitted proper credentials, and have been duly appointed to membership on the Medical Staff and granted admitting privileges by the Board of Directors. All practitioners shall be governed by the official admitting policy of the Hospital.

   Patients shall be admitted under the joint responsibility of the admitting podiatrist, dentist or psychologist and the attending physician who shall be designated prior to the patient's admission. The attending physician shall perform a medical evaluation (history and physical) of the patient on admission, and shall be responsible for the patient's general medical condition throughout the hospital stay.

2. CARE OF PATIENTS: The Hospital shall be primarily for the care of patients with acute conditions. The Hospital shall admit patients suffering from all types of conditions except the following:

   a. BURNS: Severe burns shall be transferred to another facility as soon as possible after stabilization.
   b. PEDIATRIC PATIENTS: Pediatric patients with mental health diagnoses who are under the age of 18 years.
   c. INADVISABLE FOR CARE: Other diseases deemed inadvisable for care as may be determined by either the President of the Medical Staff, Chair of Department or the Chief Executive Officer.

3. PROVISIONAL DIAGNOSIS: Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible. Handwritten admission notes on patients indicating admitting diagnosis and reason for admission should be entered within twenty-four (24) hours of admission.

4. PATIENT INFORMATION: Medical Staff members admitting patients shall be responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever or to assure protection of the patient from self harm.

5. RESPONSIBILITY FOR CARE: A member of the Medical Staff shall be responsible for the medical care and treatment of each patient admitted to the Hospital, for the prompt completeness and accuracy of the medical record and for necessary special instructions to the patient or guardian.

6. UNASSIGNED OBSTETRICAL PATIENTS: An obstetrical patient who does not have a physician or whose physician does not have Antelope Valley Hospital privileges will be assigned to the Obstetrical Hospitalist upon the patient's arrival to the Labor and Delivery

Unit. Should a patient remain undelivered past the assigned physician's on-call shift, the next Obstetrical Hospitalist will assume the care of the patient.

7. THERAPEUTIC ABORTIONS: Therapeutic abortions will be performed in the Operating Room under sterile conditions with gestational age at less than 20 weeks. An ultrasound and obstetrician/gynecologist is required on all patients with gestational age at 14 weeks or beyond.

8. PESTICIDE ILLNESS: Any physician who knows, or has reasonable cause to believe that a patient is suffering from pesticide poisoning or any disease or condition caused by a pesticide shall promptly report such fact to the local health officer.

9. COMMUNICABLE DISEASES: It is the responsibility of the attending physician to notify Admitting/Outpatient Registration if a patient is coming to the Hospital for treatment with a potential communicable disease. The physician must indicate precautions that should be taken. Admitting/Outpatient Registration is responsible to notify Infection Control.

10. PEDIATRICS:

    a. Patients under thirteen (13) years of age and younger, shall be admitted to the Pediatrics Service with the following exceptions:

        1. Patients requiring obstetrical nursing care;
        2. If beds are not available, patients three (3) years of age and younger shall have admission priority and four (4) years of age to sixteen (16) years of age surgical/orthopedic patients may be admitted to medical/surgical services.
        3. When the admitting physician orders patients to another area of the Hospital and provisions for appropriate care can be provided.
        4. Patients beyond the age of 13 shall not be admitted to or cared for in spaces approved for pediatric beds unless approved by the pediatrician in unusual circumstances and the reason documented in the patient's medical record. [Ref.: Title XXII, Section 70537 (d)].

    b. A pediatric patient who does not have a physician, who does not have a physician preference, or whose physician does not have Antelope Valley Hospital privileges will be assigned to the Pediatric Hospitalist upon the patient's admission to the hospital. Should a patient remain past the assigned physician's on-call shift, the next Pediatric Hospitalist will assume the care of the patient.

11. MENTAL HEALTH: The Hospital operates a Mental Health Services Department. The Medical Staff has approved specific admitting criteria, discharge criteria, and policies and procedures maintained in the Mental Health Policy and Procedure Manual for reference.

12. SPECIAL CARE UNITS: In order to assure that the facilities of Antelope Valley Hospital's Critical and Progressive care units and monitored bed units are available to those patients whose medical conditions require them, a means must be provided to resolve questions which may arise as to whether a given patient's admission to those units is necessary and appropriate. Therefore, while it remains the Hospital's practice to give

every due consideration to the opinion of the attending physician as to whether his patients should be admitted to or discharged from such a unit. When there is a dispute, the Medical Director of the Critical Care Unit or designee, may intervene.

13. SERVICES AVAILABLE TO PATIENTS:

    a. Incoming Services: Outside equipment shall not be used on inpatients and persons not holding clinical privileges to practice at hospital shall not treat inpatients, without the approval of the Chief Executive Officer and the President of the Medical Staff or their designee. Such requests shall be made through a privileged member of the Medical Staff in good standing. In addition, all electrical, hydraulic, and/or pneumatic equipment to be used on inpatients must have prior approval by Engineering.

    b. Outside Services: Inpatients will not be sent to another hospital or to a physician's office to receive a treatment or test if the treatment or test is offered at the Hospital.

    c. Services Not Offered: In the event that a physician orders a specific test or treatment for an inpatient that is not available and which cannot wait to be done until after discharge of the patient, an inpatient may be released to an outside facility or doctor's office to obtain the ordered test or treatment with the patient's written consent. The patient's medical record shall not leave Antelope Valley Hospital. Blank Doctor's Order Sheets and Progress Notes may be sent with the patient.

    d. Medical records of Mental Health patients requiring an appearance at Mental Health Court are sent with the staff in attendance of the patient.

14. CONTINUED HOSPITALIZATION: The attending physician is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Management Performance Improvement Subcommittee of this Hospital and approved by the Medical Executive Committee of the Medical Staff. This documentation must contain:

    a. An adequate written record of the reason for continued hospitalization; a simple reconfirmation of the patient's diagnosis is not sufficient.
    b. The estimated period of time the patient will need to remain in the Hospital.
    c. Plans for posthospital care.

B. <u>ALLIED HEALTH PROFESSIONALS:</u>

1. GENERAL:

Any individual who is neither an employee of Antelope Valley Hospital nor a member of its Medical Staff, and who wishes to examine, treat or in some other way, render care to patients at Antelope Valley Hospital, shall be considered an allied health professional and will be governed by the contents of these Rules and Regulations as well as other pertinent Medical Staff policies.

There are two categories of allied health professionals, which include the following types of health care professionals:

a. Independent Allied Health Professionals (granted admitting and clinical privileges):

- Clinical Psychologist

b. Dependent Allied Health Professionals:

- Audiologist
- Clinical Nurse Specialist/Neonatal Services
- Clinical Nurse Specialist/Wound and Ostomy Services
- Dental Assistant
- Mental Health Registered Nurse
- Licensed Practitioner Surgical Assistant
- Physician's Assistant
- Nurse Practitioner
- Physician's Registered Nurse
- Registered Nurse First Assistant

Since there is, at the present time, no demonstrated or documented need for the following non-contracted professionals at Antelope Valley Hospital, the Medical Staff will not accept the following applications:

- Biofeedback Technician
- Certified Registered Nurse Anesthetists (CRNA)
- Certified Registered Nurse Midwife
- Neonatal Assessment Specialist
- Hemapheresis Nurse
- Hemodialysis/Hemoperfusion Nurse
- Marriage and Family Therapist or Licensed Clinical Social Worker
- Medical Information Manager/Scribe
- Orthopedic Technician
- Pacemaker Specialist
- Perfusionist
- Perfusion Assistant
- Psychological Assistant
- Sleep Technician
- Speech/Language Pathologist
- Student rotations or clerkships. Exempted from this policy are all students enrolled in teaching programs located outside of the Hospital with whom the Hospital has a contractual arrangement for clinical training.

2. MEDICAL SUPERVISION:

Independent Allied Health Professionals:

Allied health professionals who are granted clinical privileges (Clinical Psychologists) are required to co-admit with an M.D. or D.O. At the time of application for clinical privileges, the Clinical Psychologist must provide the names of two physicians on the Medical Staff willing to perform the history and physical examinations for their patients.

Dependent Allied Health Professionals:

Dependent allied health professionals must be under the direction of a member of the Medical Staff of Antelope Valley Hospital who possesses clinical privileges in the area in which the allied health professional will practice. The Medical Staff member must agree in writing to assume full legal and medical responsibility for the actions of the allied health professional. Any patient care services granted under this, and like policies, are contingent upon the continued Medical Staff membership of the sponsoring physician. Furthermore, it is the responsibility of both the applicant and the sponsoring physician to notify the Hospital, specifically Medical Staff Services, in writing, of any changes in physician sponsorship that may occur at any time during the applicant's tenure at Antelope Valley Hospital. All allied health professionals given permission to provide patient care services at Antelope Valley Hospital shall, at all times, wear a distinctive name badge identifying that individual. Failure to notify Medical Staff Services of changes in sponsorship will constitute grounds for termination of access to Antelope Valley Hospital.

Nonemployee allied health professional job descriptions will be limited to the standards, procedures and freedom to act authorized by Antelope Valley Hospital job descriptions for similar licensed or certified classifications. All nonemployee allied health professionals will be accountable to the medical director of the department, the director of the nursing unit, or charge nurse of the particular unit. Nonemployee allied health professionals will report to the charge nurse upon arriving and departing from the unit. All allied health professional notations regarding the care rendered or observations made in the patient's chart will be made on the Health Team Record. All telephone orders must be received by licensed Hospital employees only. Allied health professionals will not be authorized to receive telephone orders unless they are employees of the Hospital, with the exception of Hemodialysis/Hemoperfusion Nurses or vendor technicians.

3. APPLICATION PROCESS:

   a. All applications for allied health professionals at Antelope Valley Hospital shall be in writing, shall be signed by the applicant, and shall be submitted on a form supplied by the Hospital. The application shall require the following information:

      1. The applicant's professional qualifications, education, work experience, continuing education, scope of services to be provided, and the signature of the responsible physician(s);
      2. Documented proof of current certification in cardiopulmonary resuscitation;
      3. Current licensure or certification where appropriate;

4. IDENTIFICATION**:** A picture identification card issued by a hospital (verifiable) or state or Federal agency (e.g., driver's license or passport) for verification of his identity;
5. Other documentation as specified in related Medical Staff policies; and
6. Liability insurance as specified by the Medical Staff Bylaws or policies established by the Board of Directors.

b. The completed application will be submitted through Medical Staff Services to the appropriate department chair for review and recommendations with regard to scope of services. The application and chair's recommendations will be submitted to the Interdisciplinary Practices and Credentials Committee(s) of the Medical Staff. The application with the department chair's recommendation is then forwarded to the Medical Executive Committee and the Board of Directors who will make the final determination.

4. TEMPORARY APPROVAL: Upon submission of a completed application, after initial review by the Credentials Committee and verification of the applicant's license, if applicable, current CPR certification, and evidence of professional liability coverage in the amount of $1 million/$3 million, the Chief Executive Officer or designee, with written concurrence of the appropriate department chair or designee, and the President of the Medical Staff or designee, may grant temporary permission to practice as an allied health professional, to the applicant.. These privileges will only be granted in special circumstances and not on a routine basis for convenience of the applicant or physician sponsor. Temporary approval shall be reviewed every 90 days and is renewable until final disposition is made by the Board of Directors of the Hospital.

5. RENEWAL PROCESS: On a schedule arranged so as to coincide with the Medical Staff reappointments, the department chair, Interdisciplinary Practices and Credentials Committee(s), and Medical Executive Committee shall review all pertinent information available on each allied health professional for the purpose of determining recommendations for renewal of permission to practice for the ensuing two-years, and shall transmit said recommendations in writing to the Board of Directors. Where nonrenewal or a change in scope of services is recommended, the reasons for such recommendations shall be stated and documented.

6. SCOPE OF SERVICES: Only those patient care services specifically requested in the application and as outlined in the applicable standard may be granted. Clinical activities in any field, other than those specifically authorized, are expressly prohibited.

7. CORRECTIVE ACTION:
   a. Whenever the activities, professional conduct, or professional practice of any allied health professional are considered to be lower than the acceptable standard, or to be disruptive to the operations of the Hospital, corrective action against such allied health professional may be taken by the President of the Medical Staff, by the chair of the department in which the allied health professional functions, by the Chief Executive Officer, or by the Medical Executive Committee of the Medical Staff or the Board of Directors.

b. Corrective action may consist of summary suspension of all patient care services performed by the allied health professional. Any of the above named individuals may request that at its next regularly scheduled steering committee meeting, the appropriate department review the privileges of the allied health professional. The department shall review the circumstances warranting the corrective action and shall then recommend whatever action it deems appropriate, including written reprimand, probation, suspension, curtailment or termination of patient care services, or restoration of patient care services to the Medical Executive Committee. The Medical Executive Committee will then review the department's findings and recommendations, and shall submit its recommendations to the Board of Directors for final determination.

8. DOCUMENTATION OF EDUCATION CREDITS: Allied health professionals must biennially provide documentation of continuing education credits in the area that is related to the allied health professional's professional practice for which the allied health professional provides patient care services at this hospital as outlined in each individual category. The continuing education documentation should be submitted at the same time as each allied health professional requests renewal of his/her permission to practice.

C. CONSENT FOR MEDICAL AND SURGICAL PROCEDURES:

1. GENERAL CONSENT FORM: A general consent form, signed by or on behalf of every patient admitted to the Hospital must be obtained as the patient is admitted.

2. INFORMED CONSENT: It is the treating physician's responsibility to obtain informed consent prior to the performance of certain procedures/treatment. For a patient to give informed consent, the patient should be provided with an explanation of the procedure/treatment, its risks, complications, expected benefits or effects, an explanation of any alternatives to the procedure with its risks and benefits and any possible use of blood or blood products. Duration of Informed Consent (in general) may be considered to have continuing force and effect until the patient revokes the consent or until circumstances change so as to materially affect the nature of, or the risks of, the procedure and/or the alternatives to the procedure to which the patient consented.* All complex procedures and treatments require informed consent. Procedures and treatments that are labeled "simple and common" do not require an informed consent. The following procedures/treatments require documentation of informed consent in the medical record:

   a. all surgical procedures done in the operating room
   b. all procedures requiring general anesthesia
   c. procedural sedation
   d. investigational drug use
   e. surgical cutdown
   f. subclavian line/central venous lines/arterial lines/umbilical catheterization, exclusive of those inserted in surgery and those lines inserted by specially trained nursing staff such as PICC or Midline catheters, which are governed by nursing policies on informed consent
   g. bone marrow aspirations
   h. incision & drainage
   i. angiography
   j. cardiac catheterization

k. thoracentesis-paracentesis
l. elective cardioversion
m. nerve block
n. initial dialysis
o. chest tube insertion
p. transvenous pacemaker insertion
q. endoscopies
r. biopsies, e.g., kidney, liver, lung, thyroid, pleural, etc.
s. laparoscopies
t. *cytotoxic agents/neoplastic drugs/chemotherapy (treatment for cancer/newly diagnosed)
u. initial transfusions
v. psychotropic medication in the Mental Health Services Department
w. bronchoscopy
x. tracheostomy
y. Hickman catheter insertion
z. Swan-Ganz insertion
aa. lumbar puncture
bb. urethral dilation

The duty to provide the information and obtain informed consent is the exclusive duty of the treating physician. Documentation in the medical record should indicate that a discussion was held with the patient and informed consent was obtained. **The practitioner will not be permitted to perform surgery or complex procedures/treatments as listed above until such time as documentation of informed consent is duly recorded on the patient's chart. In life-threatening emergencies, the practitioner shall document the reason to proceed with the procedure/treatment.**
The Hospital's role in the consent process should be limited to obtaining and verifying the appropriate signature on the consent form.

3. EMERGENCY SITUATIONS:

In the case of an emergency where delay would result in immediate danger to the life and health of the patient, and where it is impossible to obtain the consent of the patient or his/her legal representative, a physician may certify in the medical record on a consent form, that such an emergency exists and surgical procedures to correct or treat the emergency condition only may be performed without said consent.

Per California State law, there is no legal requirement that a physician consult a second physician to confirm the existence of an emergency. It is a matter of discretion for the treating physician to determine if a consultation is advisable to confirm the existence of the emergency.

D. CONSULTATIONS:

1. RESPONSIBILITY FOR CONSULTATION:

The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness and the question of doubt as to the diagnosis and treatment rests with the physician responsible for the care of the patient.

2. REPORT OF CONSULTANT:

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made part of the patient's record. A limited statement such as, "I concur," does not constitute an acceptable report of consultation. Except in an extreme emergency, preoperative consultation shall be recorded prior to the operation.

3. CONSULTATION TIME FRAMES:

Any practitioner with clinical privileges in this Hospital may be called for consultation within his/her area of expertise.

Consultation shall be done within twenty-four (24) hours whenever possible. If consultation cannot be done in that time frame, another consultant should be requested. The primary care physician shall enter an order for the consultation in the electronic order entry system (see exceptions in section M.1). **When requesting a consultation, it is the responsibility of the attending physician to document the request for consultation and supply the consultant with pertinent information concerning the patient and the reason for the consultation.** Whenever possible, the physician requesting the consultation should communicate directly with the consultant himself.

4. CONSULTATION REQUIREMENTS:

Except in an extreme emergency, consultation is recommended in the following situations:

a. When the patient is at great risk for operation or other invasive treatment;
b. if good medical practice dictates consultative services;
c. when the diagnosis is obscure after ordinary diagnostic procedures have been completed;
d. where there is doubt as to the choice of therapeutic measures to be utilized;
e. in instances in which the patient exhibits severe psychiatric symptoms;
f. when the chair of the clinical department or Chief of Staff determines the patient will benefit from consultation;
g. SPECIFIC CONSULTATION REQUIREMENTS:

- Suicide attempt - all patients seen in the Emergency Department as well as patients admitted to the medical floors with a suicide attempt, or an injury resulting from an unintentional self-destructive act, shall have a psychiatric consultation OR a Mental Health Unit preadmission assessment completed before discharge or other disposition.
- Obstetrical patients - to ensure the optimum care of an obstetrical patient of twenty weeks gestation or greater who is not admitted to the Perinatal Department, a consult with a primary obstetrical physician is required.

E. DEATHS:

1. PRONOUNCEMENTS:

In the event of a hospital death, the deceased shall, within a reasonable time, be pronounced dead by the attending physician or a physician's designee. However, a registered nurse is authorized to pronounce death when the patient's condition is considered terminal and the

attending physician or his/her designee has written a NO CPR or do not resuscitate (DNR) order. If a patient is a DNR a Registered Nurse may pronounce death even if it is a Coroner's case.

2. CORONER'S CASES:

It is the responsibility of the attending physician to check with the Nursing Office regarding current Coroner requirements. If there is any doubt, the physician should contact the Coroner.

3. AUTOPSIES:

a. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without proper written consent. All autopsies, except Coroner's cases, shall be performed by the Hospital pathologists or by a physician delegated this responsibility. Autopsies should be considered in the following circumstances:

- Death under age 50;
- deaths within 48 hours of a surgical invasive or high-risk treatment or procedure, including radiology procedures;
- death associated with drug reaction;
- death associated with an adverse patient occurrence while under treatment;
- death in the Emergency Department and in the Hospital outpatient setting when patient's known diagnosis would not be expected to result in death; and
- all Hospital deaths when the admission diagnosis would not be expected to result in death.

b. The Pathologist or his/her designee shall notify the attending physician of the date/time of the impending autopsy to enable the physician to be present if he/she so chooses. Documentation of said notification shall be noted by the Pathologist.

c. Provisional and anatomic diagnoses shall be recorded on the medical record within 72 hours of death, and the complete report, reflecting date of dictation, shall be part of the record within 60 days. The Medical Staff autopsy report should be distributed to the attending physician and become a part of the patient's record. The autopsy findings of clinically relevant cases shall be incorporated in the continuing medical education and quality improvement programs of the Hospital.

d. Efforts to obtain permission to perform an autopsy and for which the family and/or guardian refuses to grant permission should be documented in the medical record.

4. NOTIFICATION OF NEXT OF KIN:

The physician will inform the family unless special circumstances exist and the physician requests the nurse to do so. The nursing unit will inform Admitting and Nursing Administration as in usual protocol for death; inform mortuary selected by the family.

F. <u>DISASTER ASSIGNMENTS</u>:

1. There shall be a plan for the case of mass casualties at the time of major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community in accordance with the Environment of Care Manual.

2. The disaster plan should make provisions within the Hospital for:

    a. an efficient system of notifying and assigning personnel;
    b. unified medical command under the direction of a designated physician (the chairs of committees or designated substitutes);
    c. prompt transfer when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive case;
    d. a special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he/she is moved; and
    e. procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy.

3. All physicians shall be assigned to posts, and it is their responsibility to report to their assigned stations. The President of the Medical Staff and Chief Executive Officer or their designees, will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, the President of the Medical Staff or designee will, during the disaster, authorize the movement of patients.

4. Disaster privileges may be issued in conjunction with the provision for Emergency Privileges/Contingency Plan in the Event of a Catastrophic Event as described article 5.5 (Emergency/Disaster Privileges) of the Medical Staff Bylaws.

5. The disaster plan shall be rehearsed at least twice a year, occasionally as part of a coordinated drill in which other community emergency service agencies must participate.

G. DISCHARGE OF PATIENTS:

1. Patients shall be discharged only on an order in the electronic order entry system (see exceptions in section M.1.) placed by a Medical Staff member. The Medical Staff member shall see that the record is complete, state the final diagnosis, and sign the record.

2. INSTRUCTIONS ON DISCHARGE: Appropriate instructions for care are given to the patient or family using current hospital format and a copy is retained in the medical record.

3. DISCHARGE/FINAL DIAGNOSIS: The discharge or final diagnoses, procedures and complications should be recorded upon discharge. All relevant diagnoses established at the time of discharge, as well as all procedures performed, are recorded using acceptable disease and operation terminology.

4. Patients who leave the Hospital against the medical advice of the attending physician shall sign a release of responsibility provided by the Hospital and the release shall become part of the patient's medical record.

5. The Chief Executive Officer or his designee, may request the attending physician discharge a patient from the Hospital who at any time refuses treatment, becomes insubordinate or in any way becomes an unfit patient following a three-step process for managing patients with behavioral-related problems as detailed per process, Managing Behavioral Related complaints (APPENDIX A).

6. A patient shall be transferred to another medical care facility only upon the order of the attending practitioner, only after arrangements have been made for admission with the other facility, including its consent to receiving the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to ensure continuity of care must accompany the patient.

7. Minors shall be discharged only to the custody of his/her parent(s) or to his/her legal guardian or custodian, unless such parent or guardian shall direct otherwise in writing. This shall not preclude minors legally capable of contracting for medical care from assuming responsibility for himself/herself upon discharge.

8. Discontinuing the care of the patient in inpatient settings:

   Once a physician accepts the patient for admission under his/her service, the physician generally is under both an ethical and legal obligation to provide services in the inpatient setting as long as the patient continues to require acute care.

   From time to time, circumstances arise when a physician may feel it necessary to discharge a patient from his or her care. Such situations may arise from persistent non-compliance, abusive or disruptive behavior or other conditions evidencing a breakdown in the basic patient-physician relationship.

   Discontinuing a patient's care should not be considered without first exploring all other reasonable alternatives. Efforts should be made to resolve any disagreement or other obstacles that may prevent the physician from continuing the care of the patient. Abrupt withdrawal from patient care without sufficient prior notice or failure to follow accepted protocols can be construed as patient abandonment.

   The procedure recommended by the Medical Board of California comprised of the following:

   a. Review: With the patient the patient's current medical conditions and treatment plan and how the non-compliance or behavior can adversely affect the outcome of care.
   b. Recommend: Outline the choice of proposed treatment options and explain how and why they are in the patient's best interest.
   c. Inform: Patient must be informed about the commonly recognized risks associated with the proposed course of treatment and the risks of not following the treatment plan.
   d. Continuity: Offer a list of physicians who have privileges in the hospital who are qualified to deal with the patient's condition or obtain the department chair's help in properly transferring the care of the patient.
   e. Confirm: With the patient why you found that such an action was necessary.
   f. Document: Thoroughly your performance of all the relevant procedural steps in the patient's medical record.

   The attending physician **should not** stop following the patient without transferring the patient to another provider. If the physician is a consultant on the case, he or she should not refuse to take care of the problems pertaining to his or her specialty. A consultant may refuse to consult or can sign off of the case but should not refuse to help in emergent or life-threatening situations. If a physician's private patient requires admission in the hospital (providing he or she has privileges) refusing to take care of the patient without finding suitable alternatives can be construed as abandonment

If the patient does not want a physician, it is not the physician's responsibility to find another physician for the patient but it is ethical to offer to take care of the patient until a suitable alternative is available.

In an inpatient setting, a patient cannot be left without a physician in charge. If the attending physician is unable to find a suitable alternative, he/she should get the help of the Department Chair and/or Administration for the proper transfer of care to avoid legal repercussions and charges of abandonment.

Once again, discontinuing a patient's care should not be done abruptly or without prior consideration of other means of resolving the issues. Close attention to proper protocol will lessen the exposure to charges of patient abandonment.

H. DUES AND APPLICATION FEES:

1. APPLICATION FEES:

Due to the considerable time and effort expended in the processing of both Medical Staff applications and applications for allied health professional practice privileges, a processing fee in the amount of $1,000 is required from all applicants for membership on the Medical Staff, and in the amount of $300 for applicants for allied health professional practice status. This fee is a nonrefundable processing fee.

2. STAFF DUES:

The annual dues for all members of the Medical Staff are $100. Members of the Consulting and Honorary staffs are exempt from paying dues as are members exercising senior responsibilities.

I. EMERGENCY DEPARTMENT:

1. EMERGENCY DEPARTMENT CALL PANEL:

The President of the Medical Staff or designee shall be responsible for the development of an equitable call schedule for each specialty area assigned to each respective department in accordance with the guidelines established by the department and as noted in the Medical Staff Bylaws to ensure the highest standard of care for patients presenting at the Hospital for emergency treatment and as a supplement to the care provided by the Emergency Department physicians. When on emergency call, physicians shall make themselves available for consultation as needed.

If so directed, the Medical Staff Services Department will develop call schedules as follows: Medical Staff members will be assigned in alphabetical rotation. Each Medical Staff member assigned to a call schedule shall be on call and available by telephone for a 24-hour time period beginning at 0700 hours on the date noted and ending at 0700 hours the following day. If a Medical Staff member cannot assume his/her call responsibility for a specific date as assigned, the member must personally make arrangements with another physician who holds the same clinical privileges, to cover the call for that day and shall also notify the Emergency Department and Medical Staff Services Department of the change in call within 24 hours prior to the date assigned. The ultimate responsibility for coverage on that specific day shall remain with the individual originally assigned.

On call physicians shall respond within 30 minutes in person or via telephone if called by Emergency Department personnel to attend a patient. Should the physician on call fail to respond within the specified response time of 30 minutes, Emergency Department personnel may initiate the Medical Staff chain of command beginning with the appropriate department chair.

The department shall establish written guidelines for each specialty call schedule which shall outline the category of membership from which the schedule is developed, criteria for the rotation to be used (daily/weekly/monthly), how the members are to be listed (alphabetically or otherwise), whether or not exceptions are acceptable and how they are to be determined and to whom the responsibility of developing and distributing each call schedule is designated.

Membership on the Medical Staff of Antelope Valley Hospital carries with it certain responsibilities in aiding the Hospital to carry out its obligations to the community. Participation in the call schedule is such a responsibility as outlined in the Medical Staff Bylaws. When requested by the Medical Executive Committee, eligible members who have clinical privileges shall take a minimum of one designated call day/week if necessary, if they wish to exercise their clinical privileges at this Hospital. Failure to participate as requested shall subject the member to possible disciplinary action.

2. EMERGENCY MEDICAL SCREENING EXAMS

   a. PURPOSE: To describe and comply with the Emergency Medical Treatment and Active Labor Act (EMTALA) for physicians and employees and its application to Antelope Valley Hospital and to define policies and procedures for compliance.

   b. POLICY:

      (1) Compliance: It is the policy of the hospital to comply with the EMTALA requirements.

      (2) Enforcement: Violations of EMTALA will be reported to CMS, the Office of the Inspector General (OIG) of the U.S. Department of Health and Human Services, other federal and state agencies and to The Joint Commission.

      (3) Sanctions: Failure to comply with EMTALA may result in termination by CMS of the hospital's participation in the Medicare and MediCal programs, as well as civil monetary penalties imposed by the OIG for both the hospital and physicians of up to $50,000 and possible exclusion from Medicare/MediCal. Failure to comply with state laws on emergency services is subject to a licensing enforcement action as well as possible fines imposed by the state for both the hospital and physicians. A violation of EMTALA or the state laws governing emergency services is subject to injunctive relief and civil lawsuits for damages.

      (4) Scope of EMTALA and Definitions:

         (a) Application to the Hospital: EMTALA is applicable to anyone who presents in any area or department of the hospital (including on-campus and off-campus clinics and other departments billed under the hospital Medicare provider number) for primary assessment and treatment, including emergency room, obstetric units, psychiatric services, urgent care and other hospital-based clinics. The EMTALA requirements are applicable to anyone who is on hospital property, including parking lots, sidewalks and driveways.

(b) Application to Physicians: EMTALA is applicable to any physician who is responsible for the examination, treatment or transfer of an individual, including a physician on-call for the care of such an individual.

(c) Discrimination: The hospital will provide emergency services and care without regard to an individual's race, ethnicity, national origin, citizenship, age, sex, sexual orientation, preexisting medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services, except to the extent that a circumstance such as age, sex, preexisting medical condition, or physical or mental handicap is medically significant to the provision of appropriate medical care to the patient.

(d) Resources: The hospital must use its available resources, including on-call physicians, to provide ongoing evaluation and stabilizing treatment as required by law and may not transfer the patient for care that is within the scope of it services, privileges of the medical staff and facilities of the hospital.

(e) Definitions:

((1)) EMERGENCY MEDICAL CONDITION:

((a)) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in either placing the health of the patient (or, with respect to a pregnant woman, the health of her unborn child) in serious jeopardy; serious impairment of bodily functions; or serious dysfunction of any bodily organ or part; OR

((b)) with respect to a pregnant woman who is having contractions, there is inadequate time to effect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman and/or her unborn child.

((2)) LABOR: the process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta; a woman in true labor unless the physician certifies that after a reasonable time of observation, the woman is in false labor.

((3)) COMES TO THE EMERGENCY DEPARTMENT: an individual who presents for emergency services anywhere on the hospital campus, even if the individual presents at a location other than the emergency department. The hospital includes ambulatory services departments located on or adjacent to the campus, as well as hospital parking lots, sidewalks and access roads.

((4)) TRANSFER: the movement (including discharge) of a patient outside of the facility at the direction of any person employed by (or affiliated or associated, directly or indirectly with) the hospital, but does not include such movement of an individual who has been declared dead or leaves the facility without permission of such person.

((5)) STABILIZATION:

((a)) Labor and Delivery Patients – Stabilization is defined as delivery of the child and the placenta. A woman having contractions "may not be transferred unless she, or a legally responsible person acting on her behalf, requests a transfer or if a physician or other qualified medical personnel, in consultation with a physician, certifies that the benefits to the condition of the woman and/or the unborn child outweigh the risks associated with the transfer". (Interpretive Guidelines, A407)

((b)) Medical Patients – Stabilization is defined as, with respect to an emergency medical condition, no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer. A patient is deemed "stabilized" if the treating physician has determined, within reasonable clinical confidence, that the emergency medical condition has been resolved.

If an emergency medical condition has not been resolved, the determination of whether the patient is "stable" will depend on whether the patient is being transferred or discharged:

- Stable for transfer. A patient is considered "stable" for transfer if the transferring physician has determined within reasonable clinical confidence that the patient may be transferred without material deterioration in his/her condition and the receiving facility has the capability to manage the patient's condition and any foreseeable complications of that condition.
- Stable for discharge. A patient is considered "stable" for discharge if the treating physician has determined within reasonable clinical confidence that the patient has reached the point where his/her continued care, including diagnostic work-up and/or treatment, may be reasonably performed on an outpatient basis or a later inpatient basis so long as the patient is given a plan for appropriate follow-up care with the discharge instructions.

((c)) Psychiatric Patients –

- Stable for transfer. A psychiatric patient is considered "stable for transfer" if the patient has been assessed by the treating physician and determined to have no underlying organic basis for the presenting psychiatric symptoms; initial treatment has been provided as indicated; and the patient has been treated sufficiently so the s/he is no longer a threat to themselves or others.

- Stable for discharge. A psychiatric patient is considered "stable for discharge" if the patient is no longer considered to be a threat to him/herself or to others.

(5) General Policies:

(a) Signage: The hospital shall post signs conspicuously in lobbies, waiting rooms, admitting areas and treatment rooms where examination and treatment occurs in the form required by CMS that specifies the rights of individuals to examination and treatment for emergency medical conditions and indicating that the hospital

participates in the MediCal program. Signage shall also state the name, address and telephone number for the State Department of Health Services. Signs shall be posted in the Emergency Department, Labor and Delivery, ambulatory clinics and other locations where patients may present for emergency services.

(b) Central Log: Each department of the hospital that provides medical screening examinations shall maintain a central log recording the names of patients who present for emergency services. The log shall record the name of each patient who presents for emergency services and whether the patient refused treatment, was refused treatment by the hospital or whether the patient was transferred, admitted and treated, stabilized and transferred or discharged. Each department shall establish is own central log policy and procedure for including additional information in the log, timely recording of log entries and the maintenance and expedited retrieval of completed logs.

(c) On-Call Response: The hospital shall maintain a list of physicians who are on-call to come to the hospital to consult or provide treatment necessary to stabilize a patient with an emergency medical condition. On-call physician responsibilities to respond, examine and treat emergency patients are defined in the Medical Staff General Rules and Regulations by reference in this document as thirty (30) minutes or less when requested to respond by the emergency physician. The Emergency Department shall be prospectively aware of physicians who are on-call to the Department. The notification of an on-call physician shall be documented in the patient's medical record and any failure or refusal of an on-call physician to respond to call shall be reported to the appropriate department chair or follow the chain of command.

(d) Maintenance of Records: Medical and other records (such as transfer logs, on-call lists and changes to the on-call list and central logs) shall be maintained in accordance with hospital record-retention policies, but not less than five (5) years.

(e) Disputes: In the event of any concern over emergency services to a patient, of a dispute with another hospital regarding a patient transfer or a concern about the hospital's compliance with EMTALA, the Chief Executive Officer or designee is to be notified immediately.

(f) Reporting EMTALA Violations: The hospital must report to CMS or the State Department of Health Services, within 72 hours if it has a reason to believe that it has received an individual who has been transferred in an unstable emergency condition from another hospital. All hospital personnel who believe that an EMTALA violation has occurred shall report the violation to the Chief Executive Officer or designee.

(g) Retaliation: The hospital shall not retaliate, penalize or take adverse action against any Medical Staff member or hospital employee for reporting violations of EMTALA or State laws to the proper authorities.

(6) Medical Screening Examination:

(a) Policy – A medical screening examination must be offered to any individual presenting for examination or treatment of a medical condition. The examination must be provided within the capabilities of the hospital, including the availability of on-call physicians. The examination must be the same appropriate screening examination that the hospital would perform on any individual with similar signs and symptoms, regardless of the individual's ability to pay for medical care.

(b) Scope – A medical screening examination is the process required reaching, within reasonable clinical confidence, the point at which it can be determined whether an

emergency medical condition does or does not exist. The scope of the examination must be tailored to the presenting complaint and the medical history of the patient. The process may range from a simple examination (such as a brief history and physical) to a complex examination that may include laboratory tests, MRI or diagnostic imaging, lumbar punctures, other diagnostic test and procedure and the use of on-call physician specialists.

(c) Comparison with Triage – Triage is not equivalent to a medical screening examination. Triage merely determines the "order" in which patients will be seen, not the presence or absence of an emergency medical condition.

(d) Continuous Monitoring – The medical screening examination is a continuous process reflecting ongoing monitoring in accordance with an individual's needs. Monitoring will continue until the individual is stabilized or appropriately transferred. Reevaluation of the patient must occur prior to discharge or transfer.

(e) Personnel Qualified to Perform Medical Screening Examinations – The categories of persons qualified to perform emergency medical examinations shall be defined in the General Medical Staff Rules and Regulations.

(f) Department Policies – Each department of the hospital that provides emergency services shall adopt policies and procedures describing the conduct of the medical screening examination in the department and documentation of patients records, and conduct ongoing inservice training of department personnel.

(7) Patient Registration:

(a) Policy – The medical screening examination and/or necessary stabilizing treatment shall be provided without delay and inquiry about a patient's method of payment or insurance status shall occur AFTER the medical screening examination and/or necessary stabilizing treatment.

(b) Patient Registration - Routine registration information may be obtained prior to the medical screening examination as long as it DOES NOT delay the screening examination or necessary treatment. The hospital will not inquire as to the patient's ability to pay prior to providing the medical screening examination and necessary stabilizing treatment.

(c) Prior Authorization – Prior authorization for emergency services (including the medical screening examination) shall be conducted AFTER the medical screening examination.

(8) Transfer of Patients with an Emergency Medical Condition:

(a) Policy – The hospital shall not transfer any patient with an unstable emergency medical condition (including a pregnant patient having contractions, a patient with severe pain, a psychiatric disturbance or symptoms of substance abuse) unless the patient requests the transfer or a physician certifies that the medical benefits reasonably expected from the provision of treatment at the receiving facility outweigh the risks to the patient from the transfer. The hospital shall provide additional examination and treatment as may be required to stabilize the emergency medical condition.

(b) Requirements for Transfer - A patient with an unstable emergency medical condition may be transferred only if the hospital complies with ALL of the following standards:

((1)) The hospital provides medical treatment within its capacity to minimize the risks to the patient's health and, in the case of a woman in labor, the health of the unborn child; the patient record shall reflect the vital signs and condition of the patient AT THE TIME OF THE TRANSFER;

((2)) The receiving hospital has available space and qualified personnel for treatment of the patient; and the receiving hospital and physician have agreed to accept the patient and provide appropriate medical treatment;

((3)) The hospital sends to the receiving facility copies of all medical records available at the time of transfer related to the emergency condition of the patients, including:

((a)) records related to the patient's emergency condition, observations of signs or symptoms, preliminary diagnosis, treatment provided, results of any tests and vital signs at the time of transfer; other records (including pending test results or records not available at the time of transfer) must be forwarded as soon as practicable after the transfer;

((b)) a copy of the patient's informed written consent to transfer or the physician's certification; and.

((c)) the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide necessary stabilizing treatment.

((4)) The transfer is effected using proper personnel and equipment, as well as necessary and medically appropriate life support measures.

(c) Transfer for Off-Site Tests – If a patient who has or may have an emergency medical condition is transferred to another facility for a test with the intention of the patient returning to the hospital after the test, the hospital shall affect an appropriate transfer in accordance with EMTALA standards.

(9) Patient Refusal of Emergency Services or Transfer:

(a) Policy – The patient retains the right to refuse necessary stabilizing treatment and further MEDICAL examination, as well as a transfer to another facility, EXCEPT when placed on an involuntary detention due to a psychiatric condition and danger to self and/or others.

(b) Refusal of Medical Screening Examination – If a VOLUNTARY patient leaves the hospital before receiving a medical screening examination, either with or without notice to staff of his/her departure, staff shall document the circumstances and reasons (if known) for the patient's departure and the time of departure. Staff should make reasonable efforts to encourage all patients presenting for emergency services to remain for their medical screening examination.

(c) Refusal of Further Examination or Stabilizing Treatment – If a VOLUNTARY patient, who has received a medical screening examination refuses to consent to further examination or stabilizing treatment, the hospital must offer the examination and treatment to the patient, inform the patient of the risks and benefits of the examination and treatment and request that the patient sign a form that s/he has refused further examination or treatment.

(d) Refusal of a Transfer – If a VOLUNTARY patient refuses to consent to a transfer, the hospital must inform the patient of the risks and benefits to the patient of

refusing the transfer and request that the patient sign a form that s/he has refused the transfer.

(e) Discharge Against Medical Advice (AMA) – If a VOLUNTARY patient refuses to accept treatment or a transfer, the offered treatment, a summary of the risks and benefits described to the patient as to the refused treatment or transfer shall be documented in the patient's medical record. The patient shall be requested to sign an AMA form.

(10) Acceptance of Patient Transfers:

Policy – The hospital has the obligation to accept an appropriate transfer of a patient with an unstabilized emergency medical condition who requires specialized capabilities or facilities if the hospital has the capacity to treat the individual.

(11) Performance Improvement:

The Hospital, in collaboration with the Medical Staff, shall adopt a monitoring program to evaluate the conduct of the medical screening examinations, patient transfers and compliance with on-call obligations, and initiate corrective action and inservice training when appropriate.

(12) Categories of Non-Physician Personnel Authorized to Perform Medical Screening Exams

Emergency Department:	Nurse Practitioners and Physician's Assistants
Mental Health Unit:	Mental Health Registered Nurses
OB Clinic	Nurse Practitioners
Nursery	Qualified Registered Nurses
L & D	Qualified Registered Nurses
Employee Health	Qualified Registered Nurse or Nurse Practitioner

Refer to Standardized Procedures that have been approved by the Interdisciplinary Practices Committee.

3. EMERGENCY CODES:

Request for assistance in an emergency situation shall be made through the paging system (extension 3333) using established code names. Designated individuals shall respond and remain in area until released by the person in charge.

CODE RED – Fire - First responder implements RACE. Others upon overhead page of the "Code Red" or fire alarm bells: Employees not affected remain in their respective department area and wait for further assignment. Employees out of their departments should remain out of the corridors until "All Clear" is announced.

CODE BLUE – Adult Medical Emergency - If inside a hospital building, the First Responder will activate a Code Blue (Adult) by calling x3333 and the appropriate clinical staff responds. If this occurs outside the hospital, on hospital grounds or in the parking lot, the EMS (call 911) should be activated.

CODE WHITE – Pediatric Medical Emergency - If inside a hospital building, the First Responder will activate a Code White by calling x3333 and the appropriate clinical staff responds. If this occurs outside the hospital, on hospital grounds or in the parking lot, the EMS (call 911) should be activated.

CODE GREEN – Patient Elopement - Immediately notify the Security Department at x3333. A high risk patient is defined as being on a legal hold, gravely disabled, having suicidal ideations, confused or disoriented, lacking mental capacity or is on a patient watch assigned a sitter.

CODE YELLOW – Bomb Threat - First Responder will obtain as much information as possible regarding the bomb, whether is it over the telephone, in the mail, or as a suspicious package. Immediately notify the Security Department at x3333.

CODE PINK – Missing Newborn - Go to nearest stairwell, hospital exit and parking area and watch for a person attempting to exit with a baby or large package/bag/suitcase. Search any vehicles leaving the premises. Call x3333 for Security intervention, if needed.

CODE PURPLE – Missing Child - Go to nearest stairwell, hospital exit and parking area and watch for a person attempting to exit with a child. Call x3333 for Security intervention, if needed.

CODE ORANGE – Hazardous Material Event - Alerts staff to a Hazardous Material spill or exposure. If the hazardous material spill is in the hospital or on the hospital grounds, call X3333 for assistance.

CODE TRIAGE – Emergency Management Plan In Effect - All staff are to wait for further instructions and follow your Department Emergency Response Document.

CODE GRAY – Combative Person - Respond to location called in the overhead page and follow the directions of Clinical Staff or Security Officer in charge of the situation.

CODE SILVER – Person w/Weapon or Active Shooter - Immediately call 3333, calmly provide as much information as possible. Wait for further direction.

The Rapid Response Team will be activated by any staff member in a perceived emergency or any question about patient stability by calling the house supervisor.

J. GENERAL CONDUCT:

1. COVERAGE:

   a. Medical Coverage - In the case of an emergency, when the physician in charge is not available, the President of the Medical Staff or the chair of the appropriate department shall assign a qualified member of the Medical Staff to assume the care of the patient until the patient's physician is available.

   b. Administrative Coverage - Problems involving the Medical Staff shall be referred to the appropriate department chair. If that physician or his designee is not available or not responsive, the matter is to be referred to the Chief of Staff. If the Chief of Staff is not available, other members of the Medical Executive Committee are to be contacted in the following order:

- Vice-President
- Secretary/Treasurer
- Members-at-large
- Other members

All members of the Medical Executive Committee are authorized to take action as appropriate.

2. CODE OF BUSINESS CONDUCT:

While not all provisions of the Antelope Valley Healthcare District (AVHD) Code of Business Conduct apply to non-employee members of the Medical Staff, members of the Medical Staff are expected to be aware of the AVHD Code of Business Conduct in their actions with respect to AVHD.

3. HARASSMENT:

Antelope Valley Hospital is committed to providing a work environment that is free of discrimination. In keeping with this commitment, Antelope Valley Hospital maintains a strict policy prohibiting harassment, including sexual harassment. Harassment includes, but is not limited to that based on sex, race, color, religion, national origin, ancestry, citizenship, pregnancy, age, marital status, sexual orientation, medical condition, or physical or mental disability. The policy applies to **all** agents and employees of the Hospital, including supervisors, nonsupervisory employees, members of the Medical Staff and allied health professionals who have been given permission to practice their profession in the Hospital. Furthermore, it prohibits harassment in any form, including verbal, physical and visual harassment.

4. DISRUPTIVE BEHAVIOR, DISCRIMINATION AND SEXUAL HARASSMENT PROHIBITED:

All members of the Medical Staff are expected to conduct themselves at all times while on Hospital premises in a courteous, professional, respectful, collegial and cooperative manner. This applies to interactions and communications with or relating to Medical Staff colleagues, allied health professional (AHP) staff, nursing and technical personnel, other caregivers, other Hospital personnel, patients, patients' family members and friends, visitors and others. Such conduct is necessary to promote high quality patient care and to maintain a safe work environment. Disruptive, discriminatory or harassing behavior, as defined below, will not be tolerated. All members of the Medical Staff shall read, understand and follow established policies and procedures on the Disruptive Medical Staff member. All members of the Medical Staff shall acknowledge receipt of the Code of Professional Conduct.

a. DEFINITIONS:

"Disruptive Behavior" is behavior manifested through personal interaction with practitioners, Hospital personnel, patients, family members or others, which:

(1) interferes or tends to interfere with high quality patient care or the orderly administration of the Hospital or the Medical Staff; or
(2) creates a hostile work environment; or

(3) is directed at a specific person or persons, causes substantial emotional distress and serves no legitimate purpose.

"Discrimination" is conduct directed against any individual (e.g., against another Medical Staff member, allied health professional, Hospital employee or patient) that deprives the individual of full and equal accommodations, advantages, facilities, privileges, or services, based on the individual's race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex, gender or sexual orientation.

"Sexual Harassment" is unwelcome verbal or physical conduct of a sexual nature, which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings or posters). Sexual harassment includes unwelcome advances, requests for sexual nature when (1) submission to or rejection of this conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) this conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct indicating that employment and/or employment benefits are conditioned upon acquiescence in sexual activities.

b. EXAMPLES OF PROHIBITED CONDUCT:

Examples of prohibited, disruptive conduct may include, but are not limited to, any of the conduct described below if it is found to interfere, or tend to interfere with, patient care or the orderly administration of the Hospital or Medical Staff; or, if it creates a hostile work environment; or, if it is directed at a specific person or persons, causes substantial emotional distress and has no legitimate purpose:

(1) Any offensive striking, pushing, or touching of Hospital staff or others;
(2) Any conduct that would violate Medical Staff and./or Hospital policies relating to discrimination and/or sexual harassment;
(3) Throwing, hitting, pushing, or slamming objects in an expression of anger or frustration;
(4) Yelling, screaming, or using an unduly loud voice directed at patients, Hospital employees, other practitioners, or others;
(5) Refusing to respond to a request by any caregiver for orders, instructions, or assistance with the care of a patient, including, but not limited to, repeated failure to respond to calls or pages;
(6) Use of racial, ethnic, epithetic, or derogatory comments, or profanity, directed at Hospital employees or others;
(7) Criticism of Hospital or Medical Staff personnel (including other practitioners), policies or equipment, or other negative comments that undermine patient trust in the Hospital or Medical Staff in the presence or hearing of patients, patients' family members, and/or visitors;
(8) Use of medical record entries to criticize Hospital or Medical Staff personnel, policies or equipment, other practitioners, or others;
(9) Unauthorized use and/or disclosure of confidential or personal information related to any employee, patient, practitioner, or other person;
(10) Use of threatening or offensive gestures;

(11) Intentional filing of false complaints or accusations;
(12) Any form of retaliation against a person who has filed a complaint against a practitioner alleging violation of the above standard of conduct;
(13) Use of physical or verbal threats to Hospital employees, other practitioners, or others, including, without limitation, threats to get an employee fired or disciplined;
(14) Persisting to criticize, or to discuss performance or quality concerns with, particular Hospital employees or others after being asked to direct such comments exclusively through other channels;
(15) Persisting in contacting a Hospital employee or other person to discuss personal or performance matters after that person or a supervisory person or Medical Staff leader has requested that such contacts be discontinued;
(16) Disrupting or failing to cooperate in Medical Staff credentialing or peer review activities or Hospital quality improvement or utilization management activities.

c. HOSPITAL STAFF RESPONSE TO DISRUPTIVE OR DISCRIMINATORY BEHAVIOR OR SEXUAL HARASSMENT ("WALK AWAY RULE"):

Any Hospital employee or allied health practitioner ("caregiver") who believes that he or she is being subjected to disruptive or discriminatory behavior or sexual harassment by a member of the Medical Staff or allied health professional within the meaning of this policy is authorized and directed to take the following actions:

(1) Discontinue all conversation or interaction with the Medical Staff member except to the extent necessary to transition patient care responsibility safely and promptly from the caregiver to another qualified person;
(2) Promptly contact the caregiver's immediate supervisor to report the situation and to arrange for the transition of patient care as necessary in order to permit the caregiver to avoid conversing or interacting with the Medical Staff member;
(3) Continue work or patient care activity elsewhere as directed; and
(4) Consult with supervisory personnel or with the appropriate Human Resources representative about filing a report of the alleged incident via the electronic event reporting system.

d. ENFORCEMENT:

(1) Allegations:

(a) All allegations of disruptive behavior, discrimination, or sexual harassment as defined above, by a member of the Medical or AHP Staff ("practitioner") involving a patient or involving another member of the Medical or AHP Staff, shall be forwarded, in writing, to the department chair, President of the Medical Staff or other appropriate Medical Staff Officer. If the department chair, President of the Medical Staff or other appropriate Medical Staff Officer determines that the allegations are supported by reliable evidence, he or she shall follow the three-step process for managing behavioral-related problems as detailed per process, Managing Behavioral Related complaints (APPENDIX B).
(b) All other allegations of disruptive behavior, discrimination, or sexual harassment, as defined above, by a Practitioner will be immediately forwarded to the President of the Medical Staff, Chief Executive Officer, and/or their designee(s). In the event the allegations involve the President of the Medical Staff, the allegation will be forwarded to the Vice-President of the Medical Staff or their designee.

(c) An allegation of disruptive behavior, discrimination, or sexual harassment shall be made in writing and contain the following elements:

- Individual(s) involved;
- Date, time and place of incident;
- A factual description and detailing of the incident;
- All witnesses to the incident including any patient or patient's family member or visitor;
- The immediate effects or consequences of the incident; and
- Any action taken by anyone to intervene or remedy the incident.

(2) Initial Investigation and Mediation:

(a) The President of the Medical Staff, Chief Executive Officer and/or their designees, shall undertake a prompt initial investigation to determine whether the complainant appears to be supported by reliable evidence. The Director in charge of Risk Management and any other Hospital personnel designated by the Chief Executive Officer may participate in the initial investigation. If the complaining party is a Hospital employee, the Chief Executive Officer or designee shall take written statements from the complaining party and from witnesses. The complaining party shall be informed of the process to investigate and respond to such allegations and shall be informed that retaliation for making such allegations will not be tolerated. The complaining party shall also be informed that his written statement may be made available to the Practitioner who is the subject of the allegations. Written statements and other documents produced during the initial administrative investigation may not be protected from discovery.

(b) If the complaint appears to be supported by reliable evidence, the President of the Medical Staff, Chief Executive Officer, or their designee(s), shall promptly contact the Practitioner who is the subject of the complaint. They shall advise the Practitioner of his or her obligations under this policy, that a complaint has been made and that no retaliation against any complaining person, witness or investigator will be tolerated. The President of the Medical Staff, Chief Executive Officer, or their designee(s) shall provide the Practitioner with sufficient information to understand and respond to the allegations made by the complaining party. The Practitioner shall be permitted to respond orally or in writing to the allegations. Any written statement provided by the Practitioner and all documentation of the investigation created during the investigation should be maintained as confidential Medical Staff documents.

(c) Human Resources shall advise the Chief Executive Officer and the Director in charge of Risk Management of the complaint and the status of the investigation, if indicated. Legal counsel may also be consulted.

(d) Human Resources shall take appropriate steps to assure that employees, witnesses and others are protected from discrimination, harassment, sexual harassment or retaliation pending the resolution of the complaint.

(e) The President of the Medical Staff, Chief Executive Officer and/or their designee(s) shall attempt, if feasible, to facilitate an informal resolution of the complaint.

(3) Medical Executive Committee Action:

(a) If the parties are not able or willing to agree to an informal resolution, the Medical Staff Officer shall ask the Medical Executive Committee to initiate a formal corrective investigation of the complaint in accordance with Article VII – Investigation and Corrective Action Policy, Sections 7.1 and 7.2 of the Credentials Policy and Procedure Manual.

(b) If immediate action must be taken in order to prevent or reduce an imminent risk of injury to any person, the Chief Executive Officer or the President of the Medical Staff or both, may act to summarily suspend the Practitioner's Staff privileges in accordance with Article VII, Section 7.4 of the Credentials Policy and Procedure Manual.

(c) If the Medical Executive Committee initiates a corrective action investigation of the complaint, it shall, where feasible, assure that the investigation, although not constituting a hearing, shall include the following elements:

- The Practitioner shall be entitled to review, but not retain, copies of statements made by complaining parties and witnesses. The Practitioner shall also be entitled to receive a summary of other adverse information considered relevant to the investigation.
- The Practitioner shall be entitled to respond to the adverse statements and information and to submit oral or written information in response, subject to such conditions and limitations as the investigating body may determine.
- The investigating body may include one or more Hospital employees, appointed by the Medical Executive Committee, who are not members of the Medical or Allied Health Professional Staff(s).

(d) If the Medical Executive Committee determines that there is substantial evidence that a violation of this policy has occurred, it may do any one or more of the following:

- Issue a written or oral reprimand. If a written or oral reprimand is issued, the Practitioner shall be entitled to reply orally or in writing to the Medical Executive Committee. A copy of any written reprimand and any written reply shall be maintained in the practitioner's credentials file until reappointment. A written reprimand shall not be considered medical disciplinary action, shall not be reported to the Medical Board of California or the National Practitioner Data Bank and shall not entitle the Practitioner to a hearing or appeal under Article X of the Medical Staff Bylaws.
- Recommend that the Practitioner undertake analysis, therapy, counseling or sensitivity training.
- Refer the Practitioner to the Physician Wellness Committee with such conditions and stipulations as the Medical Executive Committee may make.
- Recommend other corrective action in accordance with Article X of the Bylaws.

(e) If the Medical Executive Committee recommends action that would entitle the Practitioner to request a Medical Staff hearing, notice to the Practitioner shall be given in accordance with Article X, Section 10.1 of the Bylaws.

(4) Action by the Chief Executive Officer and Board:

(a) If the Medical Executive Committee elects not to initiate a corrective action investigation, and the decision of the Medical Executive Committee is not in accordance with the weight of the evidence, the Chief Executive Officer shall be entitled to conduct his own investigation of the complaint if it involves an employee and to recommend such corrective action as he may deem reasonable. If the Board of Directors determines that the Medical Executive Committee's action is inadequate, it may take or recommend any of the actions identified in paragraph d (3)(d) above.

5. TOBACCO-FREE CAMPUS:

Any form of tobacco including cigarettes, cigars and smokeless tobacco is not permitted on the AVH campus. This will promote the health and safety of patients, employees and visitors alike.

6. PUBLIC RELATIONS INTERVIEWS WITH NEWS MEDIA:

The President/Chief of Medical Staff, or designee, may speak on matters pertaining to the Medical Staff on behalf of the Medical Staff.

7. ADVANCED CARDIAC LIFE SUPPORT (ACLS):

Advanced Cardiac Life Support (ACLS) classes are scheduled on a quarterly basis. Certification and recertification courses are offered on a rotating basis. ACLS classes are conducted according to the guidelines and standards established by the American Heart Association. Priority will be given to physicians and staff from the Departments of Emergency Medicine, Anesthesia and Critical Care.

8. MEDICAL STAFF MEETINGS - SUBMISSION OF AGENDA ITEMS:

In order to ensure continuity and proper use of department/committee time, agenda items to be reviewed/approved by Medical Staff departments/committees, personnel shall first submit the proposed material to the administrative Vice President or designee responsible to the particular hospital department/committee for review and include a Medical Staff Meeting Agenda Routing cover memo. Once approved by the administrative Vice President or designee, it should be forwarded to Medical Staff Services Department **seven working days** prior to the next regular meeting, for inclusion in the agenda.

Physicians wishing to submit agenda items shall present them to Medical Staff Services Department for inclusion in the agenda of the particular committee **seven working days** prior to the department/committee meeting in question. Items should be approved for inclusion in the agenda by the chair of the department/committee.

K. MEDICAL RECORDS:

1. RESPONSIBILITY/CONTENT:

The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, special reports, such as consultations, clinical laboratory, nuclear medicine and radiology departments, and others; provisional diagnosis, medical or surgical

provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary of discharge note, clinical resumé and autopsy report, if performed and available.

2. HISTORY AND PHYSICAL:

A complete history and physical examination **shall be <u>on the chart</u> within 24 hours of admission** and shall include the admitting diagnosis and treatment plan. If a complete history has been recorded and a physical examination performed within a prior to the patient's admission to the Hospital, a reasonably durable, legible copy of those reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination provided those reports were recorded by a member of the Medical Staff or by a non-member of the Medical Staff provided the individual is a California licensed doctor of medicine or osteopathy who is accountable for the patient's medical history and physical examination.

If a patient is readmitted for treatment of the same or related problem within 30 days following discharge from the Hospital, an interval history and physical examination report explaining subsequent changes may be used in the medical record, provided that the original information is included in the record.

A history and physical examination must be present prior to commencing surgery. If the history and physical was not performed within 24 hours of the surgery an interval note must be present. If a history and physical was recorded in the 30 day timeframe mentioned above then a dated and signed addendum note reflecting any changes must be made upon admission. Prior to the start of surgery or a procedure, even if the history and physical was performed within 24 hours prior to the start of the surgery or procedure, the physician must provide an interval note on the day of the procedure documenting any change in the patient's condition.

When the history and physical examination is not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled. In a life-threatening emergency, the surgeon shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

The full or complete history and physical must include the following items:

- Chief patient complaint
- Details of the present illness or condition including, when appropriate, assessment of the patient's emotional, behavioral, and social status
- Relevant past social and family histories appropriate to the patient's age
- Inventory of body systems
- Physical examination
- Diagnosis or problem list with a plan of care
- For children and adolescents, the history should also include the following:
    - An evaluation of the patient's developmental age
    - Consideration of educational needs and daily activities, as appropriate
    - The parents' report or other documentation of the patient's immunization status
    - The family's and/or guardian's expectations for, and involvement in, the assessment, treatment, and continuous care of the patient.

- The short form H&P typically includes the above six elements for adults and additional four elements for children, with a provision that the information may be abbreviated to include only that which is relevant to the procedure to be performed.

- Procedural or deep sedation requirements

  - In cases involving procedural or deep sedation, the hospital may incorporate (into the short form H&P) documentation required for a preanesthesia/pre-sedation assessment and reassessment. Typically, this would include the following:

    - Pertinent medical and surgical history
    - Personal and family history of sedation/anesthesia complications
    - Physical exam of airway, heart, and lung, and level of consciousness
    - Clinical impression or preoperative diagnosis
    - Operative and other invasive procedure plan
    - Pertinent lab or test results
    - Current medications and dosages-including over-the-counter medications and herbal supplements-allergies, and all past medication reactions

All complex procedures and treatments require a History and Physical prior to the procedure. The following complex procedures/treatments require documentation of a history and physical in the medical record:

a. All surgical procedures;
b. All procedures requiring anesthesia or procedural sedation;
c. Investigational drug use;
d. Angiography;
e. Cardiac catheterization;
f. Cardioversion;
g. Interventional radiology;
h. Transvenous pacemaker insertion;
i. All gastrointestinal procedures;
j. Bronchoscopy.
k. Obstetrical procedures.

(1) The Obstetrical history and physical requirements for normal delivery and emergency cesarean sections shall include that the pre-natal record be present and that the OB Assessment be completed prior to delivery.
(2) A history and physical is required on all Cesarean sections.
(3) A history and physical is required on all emergent Trial of Labor After Cesarean (TOLAC). Nonemergency TOLACs may be performed within the scope of ACOG guidelines and Hospital policy(s).

3. PROGRESS NOTES:

Progress notes shall be documented by the attending physician or his physician designee on a daily basis on all patients, giving a pertinent, chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.

4. OPERATIVE AND PROCEDURE REPORTS:

An operative/procedure note shall be entered in the medical record immediately after an operation or procedure to provide pertinent information for use by any individual who is required to attend the patient. The immediate postoperative/postprocedure note shall include the name of the primary surgeon and assistants, procedure(s) performed and description of each procedure, findings, estimated blood loss, specimens removed, disposition of each specimen and postoperative diagnosis.

Operative/procedure reports shall include the name of the primary surgeon and assistants, procedures performed and description of each procedure, findings, estimated blood loss; specimens removed, disposition of each specimen, and postoperative diagnosis. Operative reports shall be written or dictated immediately following surgery for outpatients as well as inpatients and made a part of the patient's current medical record.

The following complex procedures/treatments require documentation of an operative/procedure note in the medical record immediately after the operation or procedure:

a. All surgical procedures;
b. All procedures requiring anesthesia or procedural sedation;
c. Investigational drug use;
d. Angiography;
e. Cardiac catheterization;
f. Cardioversion;
g. Interventional radiology;
h. Transvenous pacemaker insertion;
i. All gastrointestinal procedures;
j. Bronchoscopy.
k. Obstetrical procedures.

5. DATE AND TIME OF ENTRIES:

All entries into the medical record, including orders and progress notes, **must be dated, timed and signed**

6. ABBREVIATIONS:

Symbols and abbreviations may be used only when they have been approved. An official record of approved abbreviations shall be kept on file in the Medical Records Department. Dangerous abbreviations must not be used as defined in the Medical Staff approved "Do Not Use List."

Final diagnosis shall be recorded in full, without the use of symbols or abbreviations.

7. AUTHENTICATION:

a. All clinical entries in the patient's medical record shall be accurately dated and authenticated by the responsible practitioner. Authentication means to establish authorship by written signature, or identifiable initials. Use of a rubber stamp signature is **not** acceptable.

b. Electronic signature authentication:

All entries into the medical record shall be authenticated. Electronic signature authentication (ESA) of medical record documents are acceptable when conforming with policy/procedure as described in accordance with the Medical Staff Bylaws, Federal, State and accrediting agency requirements.

The purpose is to maintain the integrity of the medical record as a legal document; to assure that electronic signatures and/or computer-generated signature codes are secure from unauthorized persons; to facilitate the flow of medical information to caregivers and appropriately sanctioned parties; to reduce clerical and financial backlogs.

Procedure:

- Physician participation in electronic signature authentication is required for all documents in the Electronic Health Record (EHR). All physicians participating must sign all reports electronically; reports that are in the EHR cannot be signed manually.
- Physicians must have on file with Administration, a signed statement that he/she is the only individual using and in possession of, the confidential signature code.
- The physician will be assigned a default password, which will allow initial access to the Electronic Signature Authorization program. At the first login, the physician will then personally select and enter a password known only to that individual. The confidential code will not be viewable on the screen at any time. A physician may change his/her password at any time.
- The computer will verify the physician's identification number with his/her password and allow access if both are correct.
- Each transcribed report is individually authenticated by the physician on the computer screen. After viewing each report, the physician has the following options that may be exercised and reference is made to the procedure outlined in the policy in the Health Information Management Manual.
- When review and signatures are completed for the session, the physician will exit and sign off from the system. Automatic security time-out is also provided to further protect against inadvertent viewing of confidential patient information and electronic signature access by unauthorized individuals.
- Policies and procedures on confidentiality of patient health information are adhered to at all times. The user's assigned identifier will be terminated if misused. "Misused" means that the user has allowed another person to use his/her confidential code or that the code has otherwise been inappropriately used. Signatures, manual and electronic are equivalent, and any willful disregard of same by allowing unauthorized individuals to use the electronic password will result in disciplinary action, such as suspension of privileges.

8. DISCHARGE SUMMARY/FINAL PROGRESS NOTE/TRANSFER SUMMARY:

A discharge or transfer summary shall be written or dictated for all discharges or transfers of patients.

A final progress note may be substituted for the discharge summary in the case of patients with problems of a minor nature who require hospitalization of less than a 48-hour period, in the case of normal newborn infants, and in uncomplicated obstetrical deliveries.

The discharge summary should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient upon discharge, and any specific instructions given to the patient and/or the family.

9. HIPAA COMPLIANCE:

As a condition to the receipt or continued exercise of clinical or practice privileges, each practitioner shall agree, in writing, to comply with any policy, procedure or rule approved by the Medical Executive Committee and the Board of Directors relating to the confidentiality of medical records or other protected health information. Without limitation, this obligation includes compliance with the Hospital's HIPAA Notice of Privacy Practices and Organized Health Care Arrangement agreement together with amendments.

Patient medical information shall be maintained in confidence and shall not be used or disclosed except as is expressly permitted by Hospital policy.

10. RELEASE OF INFORMATION:

Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

11. REMOVAL OF RECORDS:

Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, statute, or when a Mental Health patient is escorted to Mental Health court. All records are the property of the Hospital and shall not otherwise be taken away. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee of the Medical Staff.

12. ACCESS TO MEDICAL RECORDS:

Access to medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

13. PERMANENT FILE:

A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Records Performance Subcommittee.

14. INCOMPLETE MEDICAL RECORDS:

All medical records shall be **completed within fourteen (14) days following discharge** of the patient from the hospital. A copy of the chart completion requirements shall be retained in the Health Information Management and Transcription Department.

Medical Staff members who do not complete records within the specified time frames will receive a temporary suspension of privileges as outlined in the Medical Records Chart Completion Policy and Procedure. The Health Information Management and Transcription Department will be responsible for instituting this policy.

15. LIMITED LICENSE PRACTITIONER RECORDS:

a. An adequate medical history, physical examination and laboratory work is required before dental or podiatric surgery.
b. A complete oral examination or podiatric examination, an oral history by the admitting dentist or podiatrist, shall be on the chart as soon after admission as possible.
c. A complete mental status examination is required within 24 hours of admission on mental health patients.
d. Progress notes shall be written by the attending dentist or podiatrist as well as the attending physician.

L. MEDICATION ORDERS:

1. All drugs and medications administered to patients shall be those approved for listing in the latest edition of Facts and Comparisons, American Hospital Formulary Service of AMA Drug Evaluations.

2. FORMULARY STANDARDS:

The Hospital Formulary System is a method whereby the Pharmacy Department and the Hospital's Medical Staff, working through the Pharmacy and Therapeutics Performance Subcommittee, evaluates, selects and approves from the available medicinal agents and dosage forms, those that are considered the most therapeutically effective (with cost containment one of the considered factors).

The Antelope Valley Hospital Pharmacy Department shall have what is termed a "closed formulary." It will be limited to the present inventory and a restriction placed upon the number of drug items within each therapeutic classification.

In emergency situations, a Medical Staff member may order medications that are not a part of the Formulary if the desired drug is recognized by the Formulary Service and has been so listed for at least one year. A request will then be honored for one time, one patient use, if the desired drug is shown not to present a duplication of a drug already in the Formulary.

3. GENERIC SUBSTITUTIONS:

a. The Pharmacy and Therapeutics Performance Subcommittee will establish a list of nonproprietary substitutions of medications ordered by the proprietary name. The addition of any drug to the list must be approved by this subcommittee, and presented to the Quality

Management and Safety Committee to recommend to the Medical Executive Committee for final approval. The Pharmacy will review the manufacturer, availability, cost and bioavailability, where available.

b. Any drug which is approved for addition to the list may be substituted for a drug that has been ordered by trade (proprietary) name, so long as:

- it is equivalent chemically to the trade name drug;
- it does not differ significantly in clinical effect from the trade name drug (both in efficiency and bioavailability); and
- the physician issuing the original drug request does not specifically prohibit such substitution.

c. Substitution of medications shall occur, in accordance with the list approved by the Medical Staff departments and the Medical Executive Committee. The Pharmacy Department will be obligated to inform the Nursing Staff of any substitutions made in the medical record. The Pharmacy Department shall document same on the medical record in order to maintain clear communications and prevent medication errors.

4. PREPRINTED & ELECTRONIC ORDER SETS:

Preprinted order sets may be used when the CPOE is not functional or the order set does not exist in the CPOE system. Order sets for medications may be used for specified patients when authorized by a person licensed to prescribe. The order set must be approved by the respective department(s) and Forms Committee.

Preprinted & electronic order sets shall:

a. Specify the circumstances under which the medication is to be administered;
b. specify the type of medical conditions of patients for whom the preprinted orders are intended;
c. be approved by the Pharmacy and Therapeutics Performance Subcommittee and the respective department(s) before being used and reviewed by the Subcommittee periodically; and
d. be specific as to the medication, dosage, route and frequency of administration.

Standardized Orders for medication or PRN Orders for indication approved by the Medical Executive Committee may be used by Registered Nurses and Pharmacists.

5. AUTOMATIC STOP POLICIES:

All medication orders for dangerous medications not specifically prescribed for an exact number of doses and/or duration of days to be administered, must be renewed after 72 hours, by the attending practitioner. There should be a reminder on the chart regarding the need for review prior to discontinuing the medication. These orders may include:

a. All Drug Enforcement Agency (DEA) controlled substances;
b. antibiotics - oral and injectable;
c. anticoagulants;
d. antifungal agents - oral and injectable;
e. antihypertensives with severe side effects;
f. antineoplastic agents;

g. Cortisone and Cortisone synthetic derivatives - oral and injectable;
h. diuretics;
i. psychotherapeutic agents.

All medication orders are canceled when a patient goes to surgery and must be reordered postoperatively.

6. ADVERSE DRUG REACTIONS/MEDICATION ERRORS:

Medication errors and adverse drug reactions shall be reported immediately to the attending physician and/or prescribing physician. An entry of the medication administered, time and dosage, is to be documented on the patient's medication administration record and/or Health Team Record. The standard protocol will be followed by the Pharmacy Department.

7. HOME MEDICATION BROUGHT IN BY PATIENT:

The Hospital cannot accept responsibility of administering medications brought in by the patient and it should not be done. For exceptions, consult the Pharmacy Department's policy and procedure entitled, "Home Medication Brought in by Patient."

8. SELF-ADMINISTRATION OF MEDICATION BY PATIENTS:

For patient safety, self-medication by patients is strongly discouraged. However, certain exceptions are made. Those exceptions have been approved by the Medical Staff and are referenced in the Pharmacy Department's policy and procedure entitled, "Self-Administration of Medication by Patients."

9. PERSONNEL AUTHORIZED TO PRESCRIBE:

The ordering of medication for hospitalized patients at Antelope Valley Hospital shall be limited to the following, who must be:

a. Licensed to practice under the laws of the State of California;
b. granted clinical privileges at Antelope Valley Hospital;
c. acting only within the scope of his/her license or specialty; and
d. duly registered with the Drug Enforcement Agency:

(1) Doctor of Medicine - M.D.;
(2) Doctor of Dental Surgery - D.D.S./D.M.D.;
(3) Doctor of Podiatric Medicine - D.P.M.; or
(4) Doctor of Osteopathy - D.O.

10. INVESTIGATIONAL DRUGS:

Practitioners prescribing investigational drugs must coordinate the prescription with the Director of Pharmaceutical Services. Investigational drugs will be under Antelope Valley Hospital Investigational Drug Protocols and Federal Administration regulations.

M. ORDERS:

1. COMPUTERIZED PHYSICIAN ORDER ENTRY (CPOE):

The medical staff, in the interest of patient safety, will directly enter all orders through the hospital electronic order entry system. Handwritten, verbal or telephone orders are not to be given to nursing/ancillary staff with the following exceptions:

1.) The order entry system is not functional or configured for a given type of order.
2.) A patient emergency precluding the practitioner from directly entering his/her orders.
3.) The practitioner is in the process of performing a clinical procedure (e.g. in the Operating Room, Cardiac Cath Lab, etc.)
4.) The practitioner is on the hospital campus where practitioner computer access is not available.
5.) The practitioner is physically remote from the hospital and does not have access to the order entry system.

2. ORDER WRITING:

When CPOE is not available per Section M.1, all practitioners' written orders shall be written clearly, legibly and completely. Open-ended orders are not acceptable. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse. Multiple therapeutic options for the same condition will not be accepted without proper documented guidelines for nursing to choose one medication over the other. The sole use of "renew" and "continue order" is not acceptable.

3. TELEPHONE ORDERS:

A telephone order will be considered to be in writing if given to a registered nurse, respiratory therapist, pharmacist, medical technologist, physical therapist, registered dietitian, or a licensed vocational nurse; functioning within his/her scope of practice and signed by the attending physician. All orders given over the telephone shall be signed, dated and timed by the appropriately authorized person to whom given, with the name of the physician per his/her own name. The person receiving the telephone order will enter into the electronic order entry system or write down the information provided and “read back” all orders to the prescriber to ensure accuracy and improve patient safety and so document same on the medical record. The responsible practitioner or attending physician shall authenticate medication orders within 48 hours. In situations where the physician who gave the telephone order is unavailable, the physician who is covering for the physician may authenticate the orders on his behalf. Failure to do so shall be brought to the attention of the appropriate department chair for appropriate action.

4. SURGERY ORDERS:

All previous orders are canceled when patients go to surgery, or are transferred to any special care unit.

5. PREPRINTED & ELECTRONIC ORDER SETS:

a. Routine preprinted and electronic order sets (hereby referred to as “order sets”) shall be those orders that are utilized by individual practitioners for specific conditions/procedures. Order sets will be permitted in the Hospital under the following circumstances:

- The order sets must be approved by the appropriate clinical department and Medical Executive Committee.
- Practitioners are encouraged to utilize evidence based electronic order sets in the CPOE system.
- Preprinted order sets may be used when the CPOE is not functional or the order set does not exist in the CPOE system.

N. ORGAN DONATION:

The physician is required to abide by State law with respect to organ donation. It is the attending physician's responsibility to speak with the family about the imminent death of their loved one. At **NO** time during this discussion shall the subject of organ donation be discussed with the family by Antelope Valley Hospital physicians or staff. After recognition of imminent death, it is the responsibility of nursing staff to notify One Legacy, who will approach the family.

O. OUTPATIENT SERVICES:

The Outpatient Treatment Center is a specially equipped unit, designed to provide services to those patients scheduled for outpatient medical or surgical procedures.

1. ORGANIZATION:

a. Administration and proper functioning of the unit is the joint responsibility of Administration, the Medical Staff and Nursing Services.
b. The policies and protocols of the unit will be approved by the Departments of Anesthesia and Surgery. Other Medical Staff committee approval will be obtained as indicated. All physicians treating patients in the Outpatient Treatment Center are expected to adhere to the rules and regulations of the unit.
c. Medical care is the responsibility of the attending physician and designated consultants.
d. The Director and/or designee will attend the Department of Anesthesia meetings for evaluation of service and recommendations.

2. MEDICAL STAFF RESPONSIBILITY:

a. It is the physician's responsibility to discuss the operative and/or medical procedure with the patient. This is to include indications for, and any inherent complications.
b. The physician will provide written postoperative instructions for the patient prior to discharge.
c. The physician will inform the patient that admission to the Hospital may be necessary in the event of medical need. If the patient does require admission to the Hospital, it will be the responsibility of the physician to provide appropriate orders.

- If the patient is admitted, the medical record must be in compliance with Hospital policies.
- All unanticipated admissions from the outpatient treatment center will be considered for peer review by the respective departments.

P. FOCUSED PROFESSIONAL PRACTICE EVALUATION:

In accordance with the Joint Commission regulations, the Medical Staff has established a systematic process for evaluation and confirmation of the current competency of practitioners' performance of privileges at Antelope Valley Hospital. *Focused professional practice evaluation* (FPPE) is defined as a time-limited period during which the organized medical staff evaluates and determines a practitioner's professional performance of privileges. FPPE will occur in all requests for new privileges and when there are concerns regarding the provision of safe, high quality care by a current medical staff member, as recognized through the peer review process or through the Ongoing Professional Practice Evaluation (OPPE) process. Each individual department will be responsible for developing FPPE guidelines for that specific department.

1. WRITTEN POLICIES:

   Focused Professional Practice Evaluation shall apply to ALL new Medical Staff members and those members requesting additional privileges or to evaluate infrequently used privileges, regardless of specialty or category of membership, so long as direct patient care is involved.

2. METHODS OF FOCUSED EVALUATION:

   a. During the period of focused evaluation, every case shall be observed.
   b. Every effort shall be made to have direct, concurrent observation by an approved proctor. Retrospective evaluation of performance may be utilized as a supplement, but cannot substitute for direct observation.
   c. The minimum duration of evaluation shall be specific, either in terms of time or in the number of cases to be proctored in accordance as specified in the respective department's rules and regulations.
   d. Evaluation by direct observation of a number of cases requires a sufficient sampling, depending upon the scope of clinical privileges requested by the applicant.
   e. The evaluator shall prepare a written report to be submitted to the department chair to be used in delineating the applicant's privileges. The report shall describe the case proctored and an evaluation of the applicant's performance.
   f. The evaluation report shall be maintained in the applicant's confidential file and shall be taken into consideration at the time the applicant is considered for completion of the evaluation requirement.
   g. Proctoring shall involve the evaluation of all aspects of the management of the case.
   h. Supervision shall include concurrent chart review, direct observation in the case of invasive procedures, and monitoring of diagnostic and treatment techniques.

3. QUALIFICATIONS OF PROCTOR:

   a. A proctor shall have sufficient expertise to judge the quality of work being performed.
   b. A proctor shall always be identified as a member of a department of the Medical Staff established in the Medical Staff Bylaws as having the responsibility for proctoring as one of its peer review functions.
   c. It is not necessary for a proctor to have the same specialty qualifications as the individual being proctored. For example, surgical technique in a number of specialties can be adequately observed by a surgeon of another specialty.
   d. A proctor should not expect to receive compensation for time of proctoring services.
   e. In a situation where no member of the Medical Staff is deemed qualified to proctor the work of an applicant, the Medical Staff should consult its local medical society, the most closely

related society to the applicant's profession, or the California Medical Association, for assistance.

4. RECIPROCAL PROCTORING ARRANGEMENTS:

In compiling the required number of proctoring reports to comply with requirements as outlined in the Credentials Policy and Procedure Manual as well as in these Rules and Regulations, and more specifically in the specific departmental rules and regulations, the applicant for the requested clinical privileges/procedures may, under certain special circumstances submit proctoring reports from other hospitals.

The following conditions should be considered by the clinical department chair:

a. The proctor utilized must be a member in good standing of the Medical Staff of Antelope Valley Hospital who has current privileges to perform the privilege or a related privilege to be proctored and who has been approved by the department chair or designee.
b. Outside proctored cases/procedures may be accepted in lieu of proctored cases/procedures performed at AVH, provided that there is an insufficient number of cases performed at AVH. However, every attempt must be made to perform the required number of cases/procedures at AVH before submitting cases from other hospitals. Only cases submitted from Joint Commission accredited hospitals where the applicant holds unrestricted clinical privileges will be accepted.
c. In no instance will cases/procedures proctored at other hospitals comprise more than 50 percent of the total proctoring reports required.
d. If procedures proctored at other hospitals are to be submitted, the applicant must release all proctored cases done at the other hospital(s) supplying those reports.

5. SPECIAL PROCTORING ARRANGEMENTS:

a. In the case of a new procedure where no member of the medical staff holds privileges to perform, an external proctor may be obtained. The external proctor's current license, activity reports and training will be verified by the Medical Staff Services Department. The Department Chair will review and approve the proctoring arrangement.

b. Robotic Surgery: Upon approval of the department chair, Chief Executive Officer and President of the Medical Staff, proctoring for the daVinci Robotic Surgery Platform may be performed remotely if the proctor is unable to perform in person. The proctor is able to remotely control the robot should intervention be required.

Q. PROFESSIONAL LIABILITY INSURANCE:

All practitioners with clinical privileges must carry a minimum of $1million/$3 million liability insurance coverage.

R. PROTECTION OF CONFIDENTIALITY OF MEDICAL STAFF RECORDS:

This policy applies to all records maintained by, or on behalf of the Medical Staff of Antelope Valley Hospital, including the records, reports and minutes of all Medical Staff departments and committees and the credentials and peer review files for all individual practitioners.

1. Purpose:

   The Medical Staff recognizes that it is important to maintain the confidentiality of Medical Staff records for both legal and policy reasons. Accordingly, disclosure of Medical Staff records shall only be permitted under the conditions set forth in this section.

2. Location/Security Precautions:

   All Medical Staff records shall be maintained in the Medical Staff Services Department, access to which is strictly controlled. Such records shall be maintained in locking file cabinets in the custody of the Director of Medical Staff & Credentialing or employee designees. These files shall remain locked except during those times as the above personnel are physically present and able to monitor access in accordance with this section.

3. Access by Employees/Medical Staff:

   All requests for Medical Staff records shall be made to and recorded by the Director of Medical Staff & Credentialing or designee, who shall be responsible for preserving the confidentiality of the records. Requests by persons as described in paragraph 4., shall be noted by Medical Staff Services personnel and disclosure may be authorized by that individual. Requests by other persons will be forwarded by Medical Staff Services personnel to those persons or committees empowered to determine disclosure under this policy. Unless otherwise stated, a person permitted access under this section shall be given a reasonable opportunity to examine the records being requested and to make notes requiring them, but will not be permitted to remove them from Medical Staff Services or to make copies of such records. Removal or copying of records shall only be upon the express written permission of the Chief Executive Officer or his designated representative.

4. Access by Persons Performing Official Hospital or Medical Staff Functions:

   Medical Staff officers, Medical Staff department/committee chairs, Medical Staff department/committee members, members of the Board of Directors, consultants, the Director of Medical Staff Services and subordinates, and the Chief Executive Officer or his designated representative, shall have access to Medical Staff records to the extent necessary to perform official functions, specifically as follows:

   a. Medical Staff officers:

      Shall have access to all Medical Staff records that pertain to the Medical Staff.

   b. Medical Staff Department/Committee Chairs:

      Shall have access to all Medical Staff records pertaining to the activities of their respective department/committees; and to the credentials and peer review files of those practitioners in their respective departments whose competency or performance he/she is reviewing in his official capacity as department chair for the purposes of assessment of performance either for initial credentialing or renewal/reappointment, or in the event a performance improvement issue is being addressed.

   c. Medical Staff Department/Committee Members:

Shall have access to the files of the department/committees on which they serve; and to the credentials and peer review files of those practitioners whose competency or performance their respective department chair is reviewing if they have been designated by the chair to do so in his behalf. Credentials and peer review files of practitioners in their respective departments may not be accessed for any other reason than that noted above.

d. Consultants:

Consultants (who may or may not be members of the Medical Staff) reviewing a practitioner's performance at the request of a department chair, shall have access to the credentials and peer review files of the practitioner being reviewed and to any other pertinent Medical Staff committee records that may assist him in completion of his assigned task.

e. Chief Executive Officer/Designated Representative:

The Chief Executive Officer or his designated representative shall have access to all Medical Staff records.

5. General Access by Practitioners to Medical Staff Records:

a. Credentials and Peer Review Files:

A practitioner shall have access to the credentials and peer review files of other practitioners only as set forth in paragraph 4. A practitioner may have access to his own file and may request copies of any documents in his file that he personally submitted, i.e., application for membership, request for reappointment, privileges being requested, or personal correspondence from him), or which were addressed to or copied to him.

b. Medical Staff Committee Files:

A practitioner shall be allowed access to Medical Staff department/committee files (including department/committee reports/minutes) only if, following a written request by the practitioner, the Medical Executive Committee and either the Board of Directors or the Board's designated representative grants written permission for good cause.

6. Access by Persons or Organizations Outside the Hospital or Medical Staff:

a. Credentialing or Peer Review at Other Hospitals/Surgery Centers/Health Maintenance Organizations/Managed Care Organizations/Insurance Companies:

<u>Routine Requests for Information</u>:

If a practitioner has not encountered disciplinary or peer review problems at the Hospital, or has not been denied membership or clinical privileges at the Hospital, then the Director of Medical Staff & Credentialing or designee, the Chief Executive Officer, the Chief of Staff, or Chair of the Credentials Committee may release information contained in his/her credentials and peer review file in response to a written request from another hospital or its medical staff, surgery centers, health maintenance organizations, managed care organizations or insurance companies. Such request shall include notification that the practitioner is a member of that hospital's medical staff, exercises privileges at that hospital

or facility, is an applicant to or member of a health maintenance organization or managed care group, or is applying for or is affiliated with an insurance plan. The request shall be accompanied by a signed release from the practitioner. Disclosure shall be limited to the information approved for disclosure by the Medical Staff and in accordance with regulations specified by The Joint Commission, i.e., affiliation, dates of affiliation, specialty and competence.

Nonroutine Requests for Information:

If a practitioner has encountered disciplinary or peer review problems at the Hospital, or he has been denied privileges at the Hospital, then no information shall be released until clearance is received from the Hospital's legal counsel. All such requests must be in writing as outlined above.

Other Requests:

All other requests by persons or organizations outside the Hospital for information contained in the Medical Staff records shall be referred to the Chief Executive Officer or his designated representative. The release of any such information shall require the concurrence of the Medical Executive Committee or its designated representative and the Board of Directors or its designated representative. The Medical Executive Committee and Board of Directors may enact disclosure applying to specific types of requests, i.e., Medical Board of California, California Medical Review, Inc., Department of Health Services, etc. When such disclosure is enacted, they shall be appended to the Rules and Regulations and shall take precedence.

Subpoenas:

All subpoenas of Medical Staff records shall be referred to the Chief Executive Officer or his designee, who shall consult legal counsel.

7. Responsibilities of members of the medical staff:

Recognizing the importance of preserving the confidentiality of this information, all members of the Medical Staff will respect the confidentiality of all information obtained in connection with their responsibilities as Medical Staff members. This requirement of confidentiality extends, not only to the information contained in the physical files of the Medical Staff members and their departments/committees, but to the discussions and deliberations which may take place within the confines of Medical Staff departments/committees.

S. RESTRAINTS:

It is the policy of the Hospital to minimize the use of restraints through prevention and use of alternative strategies. The determination of the interventions to be used will be based on the patient's assessed needs and the immediacy of those needs. The patient's medical history will also be reviewed and taken into account.

Treatment staff shall identify previous, appropriate interventions that have assisted in meeting the patient's behavioral or care management needs. Documentation of all previous, appropriate interventions taken prior to the application of any restraining devices, as well as the rationale for

using the restraining device due to the inadequacy of these intervention techniques shall be included in the patient's medical record.

Restraint shall not be used as aversive therapy, punishment, or for the convenience of staff, and shall not be a part of the patient's treatment plan. Staff shall not threaten the use of restraint in an attempt to gain compliance from a patient.

A patient in restraints retains all his/her rights as outlined in Administrative Policy #RI.1., entitled, "Patients Rights and Responsibilities."

Staff shall ensure the patient's rights; protection from the unnecessary, excessive and/or punitive use of restraints; and that restraints are used and documented as required by regulations and professional standards as outlined in the Patient Care Manual.

RESPONSIBILITIES AND DUTIES OF THE PHYSICIAN/PSYCHOLOGIST:

1. There shall be a written evaluation of the patient by a physician/psychologist at the time of initiating the order for behavioral restraint of a patient or when authenticating a telephone order for same.

   The physician/psychologist's accompanying progress note shall identify and make comment on the patient's physical and medical condition, medication(s), and treatment plan.

2. The physician/psychologist's order shall specify the following:

   a. Type of restraint to be used;
   b. description of the patient's need for restraint;
   c. the less restrictive alternatives considered and tried;
   d. the maximum duration of time the patient may be restrained. The order for care management restraints SHALL NOT EXCEED twenty-four hours unless the order is reevaluated and renewed. The order for behavioral management seclusion/restraints shall not exceed the following timeframes:

      (1) Adult – four hours;
      (2) Adolescent (9-17 years of age) – two hours; and
      (3) Child (less than 9 years of age) – one hour.

   e. measures to be taken to protect the rights, dignity and well-being of the patient, including required monitoring, reassessment and attention to patient's needs;
   f. the date and time the order is entered; and
   g. the physician/psychologist's signature.

3. P.R.N. orders for restraints are prohibited.
4. A new physician/psychologist's order must be obtained if a patient has been released from restraints for more than a thirty (30) minute period of time and the patient again shows a need for such restraints, and when alternative or less restrictive means have been exhausted or are not sufficient to maintain the patient's body posture, alignment, balance and/or safety.
5. The physician/psychologist shall review and evaluate a patient in care management restraints who remains in such restraints for more than twenty-four (24) hours.

The treating physician/psychologist shall review/evaluate the use of restraints with his/her patients daily. Necessary changes in the patient's treatment plan shall be made as soon as possible. This review/evaluation shall be documented in the patient's medical record.

6. Continuing orders greater than eight hours for behavioral management seclusion and/or restraints require an order for a psychiatric consult or a second psychiatric opinion with a face to face evaluation of the patient.

T. PROCEDURAL SEDATION:

The purpose of procedural sedation is to provide safe and effective management of all patients during the delivery of medications for sedation and analgesia by physicians during diagnostic or therapeutic procedures outside of the Operating Room. This includes assessing the patient, planning care and interventions, implementing appropriate interventions and evaluating the plan of care. Patient care measures include identifying factors that modify the intended interventions, identifying and managing untoward side-effects, providing patients/significant others with education, relieving discomfort, reducing anxiety and assuring patient safety.

1. Affected areas/departments:

   a. Critical Care, Emergency Department, Outpatient Treatment Center (OPTC), Pediatrics and Radiology. If the patient cannot be transferred, OPTC will respond to all areas with the exception of Critical Care and Emergency Department.

2. Outcome criteria:

   a. Maintain independent airway;
   b. maintain spontaneous respirations;
   c. retain protective reflexes;
   d. maintain purposeful response to verbal or tactile stimuli
   e. maintain stable vital signs;
   f. reduce anxiety;
   g. minimize physical discomfort;
   h. enhance cooperation; and
   i. return to preprocedure status safely.

3. Definitions (for clarification):

   a. **LIGHT SEDATION**: The administration on nonparenteral pharmacological agents for the reduction of anxiety. The patient maintains stable vital signs, independently maintains his/her airway with intact protective reflexes and has adequate, spontaneous respiration.
   b. **PROCEDURAL SEDATION**: A medically controlled state of depressed consciousness achieved through the administration of pharmacological agents for the purpose of providing sedation and analgesia by a physician during diagnostic or therapeutic procedures outside the Operating Room. The patient retains the ability to continuously and independently maintain airway reflexes and responds purposefully to physical stimulation and/or verbal commands.
   c. **DEEP SEDATION**: A medically controlled state of depressed consciousness or unconsciousness achieved through the administration of pharmacological agents from which the patient is not easily aroused. It may be accompanied by a partial or complete loss of protective reflexes (defined as coughing and gag) and may include the inability of the patient

to maintain a patient airway independently and/or responds purposefully to physical stimulation or verbal commands.

d. **SAFETY**: Procedural sedation may be administered by either a credentialed physician or a registered nurse under the supervision of the credentialed physician. Staffing will include a minimum of two people - one performing the procedure (MD or DO) and one to monitor the patient (RN). It is the responsibility of the physician performing the procedural sedation to obtain informed consent from the patient/guardian for sedation and to document it in the patient's medical record.

4. Privileges: Individuals wishing to apply for clinical privileges must do so in accordance with the procedure outlined in the Credentials Policy and Procedure Manual in addition to being tested for competency through the completion of a brief examination administered by Medical Staff Services.

U. STANDARDS FOR GRANTING OF MULTISPECIALTY PRIVILEGES:

1. FLUOROSCOPY:

Practitioners who operate fluoroscopic equipment must be certified by the State of California, Department of Health Services, as Certified Supervisors and Operators. Copies of the Supervisors and Operators Certificates are kept on file in the Medical Staff Services office.

2. LASER SURGERY:

a. Basic requirements: The applicant shall present documented evidence that he/she has completed an approved formal residency training program that includes specific training in laser surgery, which may be confirmed by a letter from the program director, or the applicant shall present documented evidence of a minimum of 12 hours of continuing medical education training which shall include laser fundamentals, tissue biophysics and hands-on laboratory training.

e. Clinical requirements: A minimum of two proctored cases is required. Additional cases may be required at the discretion of the department chair until such time as the applicant has demonstrated current competence.

c. Equipment inservice: The applicant must provide documentation of his/her inservice on laser associated equipment owned or leased by the Hospital.

V. ADMISSION, TRANSFER AND DISCHARGE:

1. ADMISSION:

a. Patients will be admitted upon order and under the care of a member of the Medical Staff who has been granted privileges to diagnose, prescribe and treat patients.
Patients will be admitted chronologically, taking diagnosis and acuity into account. Pathways for admission may be through the Postanesthesia Care Unit (PACU), Emergency Department or from the physician's office. PACU admissions will usually have priority. Patients from the physician's office may wait for admission at home. A physician should examine direct admit patients within 7 days prior to admission. If the patient's vital signs are unstable, the patient will be transported to the Emergency Department and the physician notified.

b. Patients will be admitted to the nursing unit that is able to provide the appropriate level of care based on patient needs.

c. Patients will be provided with an identifying wristband to include the name, hospital number and name of the physician.
d. Patients will be provided with information regarding advanced directives and their rights and responsibilities as patients while in the Hospital.

2. TRANSFER:

a. To provide the appropriate level of care, upon receipt of a physician's order, patients may be transferred within the facility.
b. Transfers of patients to other healthcare facilities will be made when there is confirmation of an accepting physician and accepting facility.

3. DISCHARGE:

a. Discharges are ordered by the admitting physician or his designee.
b. Legally competent patients will not be detained in the hospital against their will, including emancipated minors.
c. Minors may only be discharged to the custody of their parent(s), legal guardian, or legally authorized caregiver, unless CHA Consent Manual form 10-1 "Authorization for Release of a Minor," is completed by the parent, guardian, or caregiver and on the medical record.
d. Upon discharge of a child less than six years of age or weighing less than 60 pounds, child safety seat information and a list of low cost purchase loan programs shall be given to the parents or person to whom the child is released. The parent or person to whom the child is released shall sign the acknowledgment of receipt at the top of CHA form 10-4. A copy of the form shall be placed in the patient's medical record.
e. Discharged patients and/or their families will receive sufficient healthcare education to provide for their immediate healthcare needs after discharge.
f. Discharged patients and/or their families will be referred to appropriate community referrals to assist them in providing for their immediate healthcare needs after discharge.

W. SURGERY:

1. GENERAL REQUIREMENTS:

a. A copy of the clinical privileges of practitioners who maintain membership on the Medical Staff or who hold temporary privileges shall be kept in the Operating Room. The original privileges are maintained by the Medical Staff Services office and an additional copy is maintained in the Nursing Office.
b. Emergency equipment and supplies shall be available in the Operating Room suite.
c. The operative procedures that require an assistant surgeon shall be determined by the Department of Surgery.
d. Prior to commencing surgery, a procedural pause (time-out) will occur immediately before starting the procedure in the location where the procedure will be performed. It must involve the entire operative team, using active communication, be documented, and at the very least shall include: The correct patient identity; correct side and site of the procedure; correct procedure to be performed; correct patient position; and availability of correct implants and any special equipment or special requirements. The person responsible for administering anesthesia, or the surgeon if a general anesthesia is not administered, shall verify the patient's identity, the site and side of the body to be operated on, and ascertain that the history and physical, appropriate screening tests, and informed consent appear in the patient's medical record.

e. A register of operations shall be maintained.
f. All anatomical parts, tissues and foreign objects removed by operation shall be delivered to the pathologist. A report of the pathology findings shall be filed in the patient's medical record.

2. NONPHYSICAN SURGICAL PRIVILEGES:

Nonphysician surgical privileges may be granted to podiatrist and dentist Medical Staff members.

3. STARTING OF CASES:

Surgeons shall be in the Operating Room suite before the scheduled time of surgery. In the event that a surgeon is detained by an emergency, he/she shall notify the Operating Room. When an emergency case will delay the schedule, the Operating Room shall attempt to contact surgeons who will be delayed. If a surgeon has not made an appearance or contacted the Operating Room within 20 minutes of the scheduled procedure time, his/her case will be moved to the end of the schedule. If the surgeon has several cases scheduled serially, surgeons in other rooms will have the time made available to them.

4. CHART REQUIREMENTS PRIOR TO SURGERY:

Prior to surgery, all charts for inpatients and outpatients shall contain:

a. A History and Physical and informed consent must be present on the chart, before the patient will be taken to surgery.
b. An interval note documenting any changes in the patient’s condition on the day of and prior to the surgery or procedure.
c. As deemed necessary, PT, BMP, CBC, and UA should be performed within one week, unless specifically ordered not to be done.
d. EKG within 30 days of surgery on all patients over the age of 40 undergoing general or regional anesthesia unless the physician has specifically ordered no EKG.
e. Chest x-ray when ordered by the physician.
f. Pregnancy test results for all patients scheduled for therapeutic abortion.
g. Consultations should be considered for:

- Cases in all departments in which there is a clear indication that:

  - The patient is not a good medical or surgical risk;
  - the diagnosis is obscure; or
  - there is doubt as to the best therapeutic measures to be utilized.

5. OBSERVATION IN SURGERYAND/OR OTHER CLINICAL AREAS:

a. Observation in the Operating Room will be extended to the following with appropriate consent and notification: Coaches during a Cesarean section as governed under obstetrical protocol; or vendors/medical manufacturers’ representatives when medically necessary as determined by the treating physician/surgeon, governed under and approved by the Operative and Other Procedures Performance Subcommittee. Premedical students and other nonphysicians who wish to shadow a physician for educational purposes will be subject to requirements as outlined in protocol below.

b. Visiting Observer Protocol:

1. Pre-medical students and other non-physicians, who wish to observe a physician and visit the Hospital to observe the practice of medicine, shall obtain permission from the physicians they plan to observe and from the hospital. Observers must be over the age of 16 and provide government issued photo ID at the time of application. Observers under the age of 18 are required to provide parent/guardian consent.
2. Applicants should seek formal or informal permission from the appropriate department chair(s).
3. One week prior to visit, the Hospital will need to be informed of the visit, duration and purpose through the Medical Staff Services Department - Telephone (661) 949-5545, FAX - (661) 949-5578, EMAIL credentialing@avhospital.org
4. The observer will maintain a professional demeanor whenever present in the Hospital, show respect for the policies and procedure of the Hospital, and show respect for patient care and rights.
5. Before walking to a patient's bedside, the sponsoring physician will seek the patient's permission to have the observer present. If the patient refuses, the observer will not proceed into the room.
6. The observer must be accompanied by a physician sponsor at all times.
7. The observer shall maintain compliance with HIPAA regulations, particularly with regard to patient privacy and confidentiality of patient records. The observer shall not discuss patient issues with anyone other than with the medical personnel caring for the patient and shall not copy any records without prior authorization.
8. CONFIDENTIALITY: Information regarding the names of individuals, and/or treatment they are undergoing must be treated in strict confidence and must not be communicated in any manner. Any person participating in the Shadowing Program must adhere to the confidentiality statement of Antelope Valley Hospital. Any unauthorized viewing, discussion, or disclosure of a patient's information could result in litigation and/or prosecution.
9. Antelope Valley and its affiliates believe that all medical, financial and personal information is confidential and is protected from unauthorized viewing, discussion and disclosure. Any unauthorized viewing, discussion or disclosure will provide grounds for immediate termination of the visit and any future visits. Whenever it is questionable as to what information is confidential it is my responsibility to discuss the matter with your sponsoring physician before any breach of confidentiality occurs.
10. Any violation of the above guidelines shall lead to termination of the individual's observation status.

X. UTILIZATION MANAGEMENT PLAN, QUALITY ASSESSMENT AND IMPROVEMENT PLAN AND INFECTION CONTROL PROGRAM:

The Utilization Management Plan, Quality Assessment and Improvement Plan and the Infection Control Program, are all hospital-wide plans that have been approved by the Medical Staff.

Y. REVIEW/REVISIONS OF RULES AND REGULATIONS:

These General Rules and Regulations shall be reviewed/revised on a biennial basis at a minimum or more frequently as the need is identified. The Medical Staff will be informed of any revisions.