WILCOX MEMORIAL HOSPITAL

dba: Wilcox Medical Center

3-3420 Kuhio Highway
Lihue, HI 96766-1099

MEDICAL STAFF RULES AND REGULATIONS

Revised 4/22/2021

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A. Admission and Discharge of Patients

1. The hospital shall accept patients for care and treatment of all disease categories.
2. A patient may be admitted to the hospital only by a Member of the medical staff or Allied Health Professional (AHP) with admitting privileges.
3. All providers shall be governed by the admitting policies of the hospital.
4. A member of the medical staff or AHP (attending provider) shall be responsible for the medical care and treatment of each patient in the hospital. All inpatients must be seen daily by their attending provider or covering provider, with appropriate documentation entered into the medical record.
5. A Member of the medical staff or AHP shall be responsible for the prompt completion, comprehensiveness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring provider.
6. Each medical staff member or AHP must assure timely, adequate professional care for his patients in the hospital by being available or having available through his office, an eligible alternate provider with whom prior arrangements have been made and who has at least equivalent clinical privileges/practice prerogatives at this hospital. Failure of an attending provider to meet these requirements will result in loss of clinical privileges/practice prerogatives.
7. Except in an emergency, no patient shall be admitted to the hospital until provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such provisional diagnosis shall be recorded as soon as possible.
8. Patients with Behavioral Health Conditions:
    i. For the protection of patients, staff and the hospital, precautions are to be taken in the care of the potentially suicidal, or patients who may be suffering from the results of alcoholism, drug abuse, or other emotional illnesses.
    ii. Any patient whose primary diagnosis is suicidal intent shall not be admitted. The patient shall be referred, if possible, to another institution where suitable facilities are available. Psychiatric consultation or psychiatric referral is recommended in all cases of suicidal attempt seen within the hospital.
    iii. When referral to another institution is not possible, the patient may be admitted or treated per hospital policy “Psychiatric, Substance Abuse or Psychological Care”.
9. Admissions to the Intensive Care Unit:
    i. If any questions as to the validity of admission to or discharge from the intensive- care unit should arise, that decision is to be made through consultation with the appropriate Department Chair or the intensive care unit Medical Director.
    ii. The attending provider or covering physician must evaluate patients not evaluated by the attending provider or covering physician in the

Emergency Department within two (2) hours of admission to the intensive care unit.

10. The attending provider is required to document the need for continued hospitalization after specific periods of stay as identified by the utilization review plan of this hospital which has been approved by the Medical Executive Committee.
11. Patients shall be discharged only by order of the attending provider or designee. Should a patient leave the hospital against the advice of the attending provider, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
12. Final diagnosis shall be recorded in full, in the last progress note and/or discharge summary, by the provider responsible for care at the time of discharge.
13. Patients shall not be admitted and discharged without being seen during that admission by the attending provider or designee, with the exception of normal obstetric patients.
14. Deceased Patients:
    i. In the event of a hospital death, the decedent shall be pronounced dead by the attending provider or designee within a reasonable time. The decedent shall not be released until an entry has been made and signed in the medical record of the decedent by a member of the medical staff.
    ii. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of the decedent shall conform to local law.
    iii. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist or his designee. Provisional anatomic diagnoses shall be recorded in the medical record and the complete protocol should be made a part of the record.
15. In a disaster situation such as loss of electrical power, water and telephone service, and when the attending provider or his or her alternate cannot be contacted, the chair of the appropriate department, the Chief of Staff or their designee may assume interim management of the patient, including transfer or discharge. Every effort shall be made to inform the attending provider of action taken as soon as possible.

B. <u>Medical Records</u>

1. The attending provider shall be responsible for the preparation of a complete and accurate medical record for each patient. The medical record shall contain sufficient information to identify the patient, to support the diagnosis/condition, to justify the care, treatment and service, and to document the course and results of care, treatment and service, and promote continuity of care among providers.
2. Timeframes for countersignature as outlined below will commence at the time of signature by the AHP, resident or medical student with the exception of verbal orders, which must be dated, timed and authenticated by the attending or covering

physician's signature within twenty-four (24) hours of the time the order was recorded.

3. Abbreviations:
   i. Standard abbreviations, symbols, and acronyms may be used based on references available electronically through the Medical Library Resources, as approved by the Medical Staff.
   ii. A list of unacceptable abbreviations shall be established, as approved by the Medical Staff.
4. Contents:

Records contain patient-specific information, as appropriate, to the care, treatment, and services provided. Inappropriate entries in the medical record will be reviewed by the Medical Records/Medical Informatics Committee with recommendations made to the Department Chair who will determine the consequences. All medical records shall include, but not be limited to, the following:

   i. Identification data; when not obtainable, the reason shall be entered in the record;
   ii. Chief complaint and/or reason for admission;
   iii. Historical data (presenting illness, personal history, family history);
   iv. Physical examination including provisional diagnosis;
   v. Diagnostic and therapeutic orders;
   vi. Evidence of appropriate informed consent; when consent is not obtainable, the reason shall be entered in the record;
   vii. Progress notes, including clinical observations, current patient status and results of or response to therapy;
   viii. Reports of procedures, tests, consultations; and
   ix. Conclusions at termination of hospitalization or visit, including summary of hospital course, final diagnosis and disposition.

5. History and Physical Examination:
   i. A complete dictated, written or entered in the EMR admission history and physical examination shall include, except as indicated in (ii) and (iii) below, but not be limited to the following:
      a) Chief complaint;
      b) Details of present illness;
      c) Relevant past medical history;
      d) Relevant and social and family history;
      e) Review of systems;
      f) Relevant physical examination;
      g) Current medications;
      h) Conclusions or impressions drawn from the history and physical exam;
      i) Provisional diagnosis or diagnostic impression; and
      j) Goals of treatment and treatment plan.
      k) For pediatric patients, a history and physical examination will also include developmental age, length or height, weight, and immunization status.

ii. A history and physical examination must be documented for procedures done under moderate sedation, deep sedation and for procedures done under monitored anesthesia care (MAC). These reports should include all pertinent findings resulting from an assessment of all the systems of the body. A shorter history and physical exam may be used for endoscopies, cardiac procedures and interventional radiology as long as it meets the following minimum requirements:
   a) Chief complaint;
   b) Details of present illness;
   c) Relevant past medical history;
   d) Relevant physical examination;
   e) Current medications;
   f) Conclusions or impressions drawn from the history and physical exam;
   g) Provisional diagnosis or diagnostic impression; and
   h) Goals of treatment and treatment plan.

iii. A consultation note that contains all of the elements may serve as a history and physical.

iv. A durable, legible copy of a patient's current obstetrical record which shall include a complete prenatal record may be used in lieu of the admission history and physical examination. The obstetrical/prenatal record may be a copy of the attending provider's office record, transferred to the hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

v. A history and physical examination must be completed by a doctor of medicine or osteopathy, a podiatrist, an advanced practice registered nurse, or, for patients admitted only for oral maxillofacial surgery, by an oral maxillofacial surgeon who has been granted such privileges by the medical staff in accordance with State law, within thirty (30) days prior to the hospital admission or outpatient surgery, or within twenty-four (24) hours of admission. If the history and physical examination is older than thirty (30) days, the attending provider prior to the admission/surgery/procedure must complete a new history and physical exam.

vi. A Provider who directly refers a patient to the Hospitalist Service will be required to submit, or make available in the EMR, a complete list of the patient's medications and an history and physical or most recent office note, or otherwise assist the admitting physician as needed to ensure preparation of a complete history and physical, within twenty-four (24) hours of admission.

vii. All acute hospital admissions and surgeries/procedures must have a history and physical examination dictated, written or entered in the EMR within twenty four (24) hours of admission. Any provider who has not dictated, written or entered in the EMR a history and physical within twenty four (24) hours of admission or surgery/procedure shall be

automatically suspended until the history and physical examination has been dictated, written or entered in the EMR.

viii. If the original history and physical examination was done within thirty (30) days, as set forth in the Bylaws, it must be documented and dated in the patient's medical record that the provider has confirmed there have been no significant changes subsequent to the original examination or documented and dated the changes at the time of admission.

ix. The sponsoring physician shall countersign the history and physical examination and preoperative note when they have been recorded by a dependent AHP, or an approved resident or medical student.

x. When the history and physical examination is not dictated, written or entered in the EMR for moderate sedation, deep sedation or monitored anesthesia care (MAC) before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending provider states in writing that such delay would be detrimental to the patient. A preoperative diagnosis written by the surgeon will be recorded on the chart before anesthesia is administered.

xi. A history and physical examination dictated, written or entered in the EMR by a Physician Assistant (PA) or a dependent AHP must be countersigned by the sponsoring physician within seven (7) days. A history and physical examination for surgical patients must be countersigned by the supervising physician prior to the procedure.

6. Progress Notes:

Progress notes made by the Medical Staff or AHPs should give a pertinent chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.

i. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

ii. Progress notes shall be entered in the EMR at least daily.

iii. Progress notes shall be countersigned by the supervising physician within seven (7) days if dictated, written or entered in the EMR by a Physician Assistant (PA), dependent AHP, resident or medical student.

7. Pended Notes:

i. Pended notes made by any provider must be completed by the 14th day of discharge.

ii. Any provider who has not completed a pended note within 14 days of discharge shall receive a warning letter. After 30 days, the provider shall be automatically suspended until the pended note has been completed.

8. Consultations:

Each consultation report shall contain an opinion by the consultant that reflects, when appropriate, an actual examination of the patient.

i. The attending provider is primarily responsible for requesting consultation when indicated.

ii. It shall be the provider's responsibility to see that the consultant is notified. If the consultant is not contacted directly by telephone, it is the requesting provider's responsibility to follow-up to be certain that the consultant is made aware of the request.
iii. The consultation report shall include the consultant's opinion and recommendations.
iv. A limited statement such as "I concur," does not constitute an acceptable report of consultation.
v. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.
vi. For non-operative cases, the consultation note shall be entered in the EMR within forty eight (48) hours of the date and time of consultation.

9. Post-Operative Note:

The Post-Operative note shall be written or entered in the EMR immediately after the procedure and must include the following:

i. Name of primary surgeon and assistant;
ii. Pre-operative diagnosis;
iii. Findings;
iv. Procedure(s) performed;
v. Description of the procedure;
vi. Estimated blood loss, as indicated;
vii. Specimens removed; and
viii. Post-operative diagnosis.

10. Operative Report:

i. Operative reports shall be dictated, written or entered in the EMR immediately after the procedure if a detailed description of the procedure is not included in the Post-Operative Note, and must include the following:
    a) Name of primary surgeon and assistant;
    b) Findings;
    c) Procedure(s) performed;
    d) Detailed description of the procedure;
    e) Estimated blood loss, as indicated;
    f) Specimens removed; and
    g) Postoperative diagnosis.
ii. Any provider who has not dictated, written or entered in the EMR an operative report twenty-four (24) hours following the operation shall be automatically suspended from operative privileges until the report has been dictated, written or entered in the EMR.
iii. The report shall be promptly signed by the surgeon and made a part of the patient's current medical record.

11. Discharge Summary:

i. A discharge summary shall be dictated, written or entered in the EMR on all medical records of patients hospitalized over forty-eight (48) hours.

ii. A discharge summary dictated, written or entered in the EMR by a Physician Assistant (PA), dependent AHP, resident or medical student must be countersigned by a sponsoring physician within seven (7) days.

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

iv. At a minimum the discharge summary shall include the following:
   a) The reason for hospitalization;
   b) Significant findings and discharge diagnoses;
   c) Procedures performed and care, treatment, and services provided;
   d) The patient's condition at discharge; and
   e) Instructions to the patient and family, as appropriate.

v. Hospitalizations resulting in death and transfer to another facility require a discharge summary.

vi. Any provider who has not dictated, written or entered in the EMR a discharge summary within fourteen (14) days shall receive a warning letter. After thirty (30) days, the provider shall be automatically suspended until the discharge summary has been dictated, written or entered in the EMR.

12. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated.

13. Corrections in the medical record, whether hand written or dictated, will be corrected in ink with a single line drawn through the incorrect information. In the EMR, correction will be made by editing and saving the corrected document as an addendum. The person making the correction will time and date the corrected information.

14. A medical record shall not be permanently filed until it is completed by the responsible provider or is ordered filed by the Medical Records/Medical Informatics Committee.

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

16. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed from the premises. Unauthorized removal of charts from the hospital is grounds for suspension of the provider for a period to be determined by the Medical Executive Committee of the medical staff. Patients may obtain copies of records per hospital policies and applicable legal statutes.

C. <u>General Conduct of Care:</u>

1. Whenever possible, orders for treatment should be entered in the EMR. Written orders, when necessary, may be accepted by fax or hand delivery provided that

the identity of the ordering provider is reliably established. All orders dictated, written or entered in the EMR by a Physician Assistant (PA) or a dependent AHP, other than verbal orders, must be countersigned by the sponsoring physician within seven (7) days.

2. Orders dictated to a licensed person by a Medical Staff Member or AHP, including orders dictated over the telephone, are known as verbal orders. Verbal orders should be used infrequently; they may be accepted in emergency situations or when the ordering provider is unavailable to write the order in a timely manner. If the ordering provider is in the hospital and able to write the order, a verbal order shall not be accepted.
3. Verbal orders shall be entered promptly in the patient's medical record, noting the name of the person giving the verbal order and signed by the person receiving it. Verbal orders must be countersigned by the ordering provider except where the ordering provider is not able to authenticate his or her verbal orders in a timely manner. In such cases, the attending or another provider who is responsible for the care of the patient and authorized to give such orders may countersign the ordering provider's verbal orders. A provider who countersigns a verbal order for another provider in such a situation assumes responsibility for the order as being complete, accurate and final.
4. All verbal orders, including telephone orders, shall be dated, timed and authenticated by the attending or covering physician's signature within twenty-four (24) hours of the time the order was recorded[1]. Faxed or electronic signatures may be used to authenticate a verbal order provided that the identity of the provider authenticating the verbal order is reliably established. Failure to do so shall be brought to the attention of the Medical Executive Committee for appropriate action.
5. All previous orders are suspended when patients go to surgery and must be reconciled and reordered post-operatively.
6. Drugs prescribed and administered to patients at Wilcox Medical Center shall be used in accordance with all federal and state laws. The Medical Staff and AHPs shall adhere to the hospital pharmacy department's policies and procedures approved through the Pharmacy and Therapeutics Committee.
7. A patient admitted for dental care is a dual responsibility involving the dentist(s) and physician member of the medical staff.
    i. Dentist's Responsibilities:
        a) A detailed dental history justifying hospital admission.
        b) A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
        c) A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the anatomic number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination.
        d) Progress notes as are pertinent to the oral condition.
        e) Discharge summary.

[1] HAR §11-93-28, c(2)

ii. Physician's Responsibilities:
    a) Medical history pertinent to the patient's general health.
    b) A physical examination to determine the patient's condition prior to anesthesia and surgery.
    c) Supervision of the patient's general health status while hospitalized.
iii. The discharge of the patient shall be on written order of the dentist member of the medical staff.

8. Written, signed, informed surgical consent shall be obtained by the surgeon prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian, next of kin or authorized decision-maker, these circumstances should be fully explained on the patient's medical record by the operating surgeon. Written documentation of the circumstances in such instances is desirable before the emergency operative procedure is undertaken, if time permits.
9. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. A post anesthesia evaluation is completed and documented by an anesthesiologist or anesthetist no later than 48 hours after a surgery or procedure requiring anesthesia services. The anesthesiologist or anesthetist is also responsible for the discharge of patients from the recovery area.
10. Except in an emergency, specialty consultation is encouraged in the following situations:
    i. When the patient is a poor risk for the treatment or procedure.
    ii. Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed.
    iii. Where there is doubt as to the best therapeutic measure to utilize.
    iv. In instances of suicidal attempt seen within the hospital.
    v. In complicated situations where specific skills or other providers may be needed.
    vi. When requested by the patient, family or guardian.
    vii. Non-obstetrician providers are required to obtain an obstetrical consultation on all patients requiring cesarean section and complicated obstetrical procedures. Responsibility for obtaining consultations shall rest with the attending provider.
11. If a nurse has a strong reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he shall call this to the attention of his superior, who in turn may refer the matter to the Chief Nurse Executive. If warranted, the Chief Nurse Executive may bring the matter to the attention of the Chair of the Division or Department wherein the provider has privileges/practice prerogatives. Where circumstances are such as to justify such action, the Chair of the Division or Department may himself request a consultation after notification of the attending provider.

D. General Rules Regarding Surgical Care:

1. Collective policies, rules and regulations regarding surgical services should cover at least the following:
    - i. General considerations.
    - ii. Scheduling operations.
        - a) Priority.
        - b) Scheduling periods.
        - c) Assignment of priority.
        - d) Loss of priority.
    - iii. Reservations for operations.
    - iv. Information required to make reservations.
    - v. Change of schedules.
    - vi. Emergency operations.
    - vii. Requirements prior to anesthesia and operation.
        - a) Identification of patient, site of procedure and type of procedure.
        - b) Preoperative evaluation and documentation.
            - 1) Medical record content, including diagnosis.
            - 2) Laboratory procedures.
            - 3) Informed consent forms (consent must be obtained by the operating surgeon).
        - c) Time of operations.
    - viii. Starting time of admission.
    - ix. Ambulatory operations requiring general anesthesia.
    - x. Care and transport of patients.
    - xi. Efficient utilization of operating rooms.
    - xii. Contaminated cases.
    - xiii. Conductivity and environmental control.
    - xiv. Radiation safety.
2. The collective policies, rules and regulations regarding surgical services shall be formulated by the Department of Surgery with input from the Chief Nurse Executive, the Director of Perioperative Services, and others deemed necessary by the Chair of the Department of Surgery.
3. Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency, the provider shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.
4. Assisting at Surgery:
    - i. During any surgical procedure with appreciable morbidity or mortality risk, a qualified surgical assistant must be present and scrubbed.
    - ii. According to the degree of difficulty of the contemplated surgical procedure, an assistant must be selected with consideration for the expeditious and timely completion of the case.
5. All tissues removed during surgery, with the exception of those listed on the approved non-tissue list, shall be sent to the hospital pathologist who shall make

such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

6. The pathologist will participate in performance improvement activities addressing all significant discrepancies between pre-operative and post-operative diagnoses.

E. General Rules Regarding Obstetrical Care:

1. Policies, rules and regulations relating to the obstetrical suite shall be formulated by the Department of Obstetrics/Gynecology/Pediatrics with input from anesthesia and nursing services, and from hospital administration.
2. The Division of Obstetrics and Gynecology may designate qualified medical personnel to evaluate and manage patients' care under the supervision of a medical staff member or AHP with active privileges/practice prerogatives. The Division of Obstetrics and Gynecology should delineate qualifications and responsibilities for the qualified medical personnel.

F. General Rules Regarding Call Coverage:

Pursuant to the Wilcox Medical Staff Bylaws, Medical Staff Members with clinical privileges shall participate in Department and Emergency Department specialty coverage when required by the Department Chair and Chief of Staff. This requirement shall not exceed ten (10) days per month; a Member could elect to provide additional coverage if desired.

G. General Rules Regarding Emergency Services:

1. Policies, rules and regulations relating to the emergency services area shall be formulated by the Division of Emergency Medicine with input from nursing services and from hospital administration.
2. The medical staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the hospital's basic plan for delivery of such services, including the delineation of clinical privileges for all providers who render emergency care. The Division of Emergency Medicine shall have overall responsibility for emergency medical care.
3. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record. This record shall include:
    i. Adequate patient identification.;
    ii. Information concerning the time of the patient's arrival, means of arrival and by whom transported;
    iii. Pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his arrival at the hospital;
    iv. Description of significant clinical, laboratory and imaging findings;
    v. Diagnosis;
    vi. Treatment given;
    vii. Condition of the patient on discharge or transfer; and
    viii. Final disposition including instructions given to the patient and/or his family for necessary follow-up care.

4. All Emergency Department notes shall be signed or completed within twenty-four (24) hours of Emergency Department discharge.
5. Each patient's medical record shall be signed by the provider in attendance who is responsible for its clinical accuracy.
6. The records of all patients dying within twenty-four (24) hours of admission to the Emergency Department should be routinely reviewed.
7. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by the Disaster Planning Committee, which includes department representatives.
    i. Providers shall be assigned to posts (either in the hospital or in the community) and it is their responsibility to report to their assigned stations. The Chief of Staff, Chairs of the Departments and the Chief Executive Officer of the hospital will work as a team to coordinate activities and directions.
    ii. In cases of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the triage provider will authorize the movement of patients. All physicians on the Medical Staff and AHPs specifically agree to relinquish direction of the professional care of their patients to the triage provider in case of such an emergency. All policies concerning direct patient care will be the responsibility of the triage provider or his designee.

H. General Rules Regarding Special Care Units:

For Special Care Units including, but not limited to, recovery rooms, intensive care units of all kinds, and newborn nurseries, appropriate committees of the medical staff should adopt specific regulations and policies. These regulations and policies should be subject to approval of the Medical Executive Committee and the governing body.

I. General Rules Regarding Clinical Departments:

1. Each Department is expected, within its framework, to adopt various procedural rules that fit its needs. Essential organizational commitments dictate that these must include rules to implement the credentials function and the ongoing medical care evaluation activities of the Medical Staff.
2. A Vice Chair of each Division and Department will be appointed by the respective Department Chair, after consultation with the Chief of Staff, at the start of each term. The Vice Chair will serve as the Department/Division Chair's delegate/designee in the respective Chair's absence.
3. It is expected that each Department's representative on various multi-specialty or multi-disciplinary committees concerned with patient care, shall regularly report such activity of these groups as is pertinent to the maintenance and improvement of high professional standards.
4. Policies, rules and regulations for clinical Departments of Medicine, Surgery, and Obstetrics/Gynecology/Pediatrics, when approved by the Medical Executive Committee and the Board, shall be appended to this document.

J. General Rules Regarding Meetings:

Meeting attendance requirements may be imposed by each Department, Division and/or Committee. When such requirements are imposed, the Vice Chief of Staff, in conjunction with the Medical Staff Office, shall consider and grant or deny requests from members for excused absences. When absence from a meeting is compelled for a staff member due to illness, vacation or educational activities, he may be excused by notifying the medical staff services office, stating the reason for absence. All other requests for excused absences will be reviewed by the Vice Chief of Staff who will decide whether a member is either absent or excused for good cause.

K. General Rules Regarding Medical Students and Residents:

Policies, rules and regulations for medical students and residents, when approved by the Medical Executive Committee of the medical staff and the governing body, shall be appended to this document.

L. Observation Requirements:

All new applicants to the Medical Staff requesting privileges or AHPs requesting practice prerogatives and existing members/AHPs requesting a modification of or additional clinical privileges/practice prerogatives shall undergo focused observation for those privileges/practice prerogatives which they have requested. It is highly recommended that the first procedure or admission in the hospital be observed. The observation requirements may be removed based on the approved specific criteria described in Item 2, Criteria for the Removal of Observation Requirements. The performance of all members of the Medical Staff and AHPs shall be evaluated semi-annually as part of the Ongoing Professional Practice Evaluation (OPPE) Program; these evaluations will be reviewed at the time of reappointment. All providers with unrestricted privileges/practice prerogatives may serve as observers in the observation process.

1. Purpose:

   The purpose of observation is:

   i. To protect the well-being of the patient;
   ii. To assure the current competence of the provider; and
   iii. To provide education or clarification of hospital policies and practices.

2. Criteria for the Removal of Observation Requirements:

   The Department or Division Chair may recommend to the Credentials Committee removal of specific observation requirements in circumstances which leave the Department or Division Chair thoroughly satisfied with the provider's personal and professional qualifications, provided each named privilege has been observed at least once.

3. Peer Review Observers:

   i. A different observer should be chosen for each of the provider's observed cases whenever possible.

ii. An observer shall not assist in the operation or procedure which he or she is observing whenever possible.

iii. The observer shall complete an observation report and submit to the Medical Staff Office for further review by the Department/Division Chair.

iv. Observers should not be affiliated with the provider being observed either through partnership or group practice arrangement whenever possible.

v. The observer should have comparable privileges/practice prerogatives for which the observed provider is being evaluated.

vi. If the observer feels that the patient's life is endangered by the provider's actions, the observer may intervene in the following manner:

a) The observer may recommend that an appropriate alternate provider be called to take over the case.

b) If the provider refuses, the observer shall call the Chair of the appropriate Department or the Chief of Staff, who have the authority to summarily suspend the privileges/practice prerogatives of the provider and designate an alternate provider to take over the case.

c) If the situation is urgent and immediate intervention is necessary, the observer may take over the case until the arrival of the alternate provider.

vii. An approved observation report must be completed by the observer to evaluate the quality of care provided. It is the responsibility of the observer to report any poor or significant substandard performance made by the provider immediately to the Department Chair and the Chief of Staff.

4. Responsibility of Departments:
The Department/Division Chair will review all applicable observation reports and render a recommendation to the Credentials Committee. The recommendations may include whether the provider has satisfactorily completed observation requirements, whether additional observation is needed, whether additional requirements are indicated, or whether the provider's request for the procedure should be denied. If adverse action is recommended, reference should be made to the Medical Staff Bylaws. If the provider is an Allied Health Professional, the appropriate sponsors or associates should also be informed.

5. Provider on Observation:
It is the responsibility of the provider to be observed to select and make arrangements with an observer with comparable privileges/practice prerogatives to act as an observer.

M. <u>Approved Malpractice Financial Responsibility:</u>

All providers with clinical privileges and Allied Health Professionals with practice prerogatives shall be required to provide documentation of approved and

appropriate malpractice financial responsibility as defined below and consistent with those clinical privileges/practice prerogatives.
Professional liability insurance coverage must be issued by a commercial insurance company, indemnity plan or risk retention group licensed to do business in any state of the United States in the amounts of at least $1,000,000 per occurrence and $3,000,000 in annual aggregate. A certificate of insurance must be provided.

Restated and adopted by the Medical Staff on April 21, 2021.

Carol A. Fujiyoshi, M.D.
Chief of Staff

Restated and approved by the Board of Directors on April 22, 2021.

Jen Chahanovich, FACHE
President and Chief Executive Officer