RULES AND REGULATIONS

OF THE MEDICAL STAFF

KAPI`OLANI MEDICAL CENTER FOR WOMEN & CHILDREN
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April 21, 2021

RULES AND REGULATIONS
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A. ADMISSION AND DISCHARGE OF PATIENTS

1. A patient may be admitted to the hospital (acute inpatient care) only by a provider with admitting privileges. Types of cases to be admitted include:
   a. Obstetrical (maternity care with or without medical or surgical complications).
   b. Gynecological (with or without medical or other surgical complications).
   c. Pediatric medical or surgical cases through age twenty-one (21) years of age (less than twenty-two (22) years of age) and as defined in the Medical Staff Bylaws, Definitions, Pediatrics.
   d. Adult non-OB-GYN patients may be admitted according to policies approved by the Medical Executive Committee.
2. All providers shall be governed by admitting policies and procedures. Every hospital patient shall be under the medical care of a credentialed provider. All inpatients must be seen by a credentialed provider with admitting privileges every 24 hours or daily, and on the date of discharge, with appropriate documentation in the medical record. The exception to this is an uncomplicated postpartum patient who had a vaginal delivery and has been seen every 24 hours or daily, prior to the date of hospital discharge; such a patient does not need to be seen on the discharge date. Exceptions to this requirement also include patients established as subacute or skilled nursing facility (SNF) levels of care. Provider establishment of level of care and minimum provider visits will follow Hawaii Administrative Rules. For subacute patients, providers with admitting privileges visits and documentation must be at least weekly during the first month and a minimum of once every two weeks thereafter until stability of the patient's condition allows for monthly visits. For SNF level patients, the provider with admitting privileges visits and documentation must be at least monthly.

   The provider with admitting privileges shall be responsible for the prompt completion and accuracy of the medical record and for necessary special instructions.
3. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, the provisional diagnosis shall be recorded as soon as possible.
4. In an emergency case in which it appears that the patient will have to be admitted to the hospital, the provider shall contact the House Supervisor.
5. Each provider with admitting privileges shall designate in writing and be responsible to obtain the signatures of two or more alternates with comparable admitting privileges who are willing to serve as alternates and credentialed at the Medical Center. Whenever a designated alternate is not available, the chair of the department or the Chief of Staff shall be called. He/she shall have the authority to have any provider with comparable privileges called in such an event.

   The Medical Executive Committee in its sole discretion will determine which privileges satisfy the requirements of this section as "comparable" privileges. Upon written request by the provider, the Medical Executive Committee in its sole discretion may waive any and/or all requirements of this section for good cause.

6. The House Supervisor will work with the Hospitalist and/or admitting provider to screen and admit patients on the basis of the following order or priorities:
   a. Emergency Admissions: Emergency admissions are patients requiring immediate hospitalization and treatment.

b. Urgent Admissions: This category includes those so designated by the attending provider and shall be reviewed as necessary to determine priority when all such admissions for a specific day are not possible.
c. Preoperative Admissions: These include all patients already scheduled for surgery. If it is not possible to handle all such admissions, the chair of the department or the Chief of Staff may determine the urgency of any specific admissions.
d. Routine Admissions: These include elective admissions involving all services.

7. Areas of restricted bed utilization and assignment of patients shall be as designated by the House Supervisor. Patients may be admitted without regard to the above restrictions only after consultation with the Administrator On-Call (AOC) or his/her designee, of the area to which the patient is to be admitted. It is understood that when deviations are made from assigned areas as indicated above, the House Supervisor will correct these assignments at the earliest possible moment in keeping with transfer priorities.
8. Patients diagnosed as having a communicable disease shall only be admitted when appropriate isolation room can be provided. The provider with admitting privileges shall be responsible for furnishing information and ordering the patient to be isolated. Proper isolation technique must be carried out on all patients with infectious diseases or conditions, as specified by the Infection Control Committee.
   a. Patients shall be transferred on the basis of the following priorities:
      1) Emergency Room to appropriate patient bed.
      2) From obstetric patient care to general care area, when medically indicated.
      3) From Intensive Care Unit to general care areas.
      4) From temporary placement in an inappropriate geographic or a clinical service area for that patient.
   b. No patient will be transferred without such transfer being approved by the responsible provider.
9. The admitting provider shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause.
10. If, following admission, a patient should become seriously disturbed, disorderly, unmanageable, and detrimental to himself/herself and/or others, the hospital reserves the right to call its own consultant. Such a patient shall be transferred to an institution with facilities for psychiatric care upon request to the Chief Executive Officer or his/her designated alternate.
11. For the protection of patients, the provider and nursing staff, and the hospital, the principles detailed in the Suicidal Patient Management Policy, shall be followed.
12. Patients Discharged:
    a. Patients shall be discharged only on orders of the provider. 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 and he/she or his/her guardian will be asked to sign this release of responsibility. Should he/she refuse to sign a release, a witnessed statement to that effect shall be placed in the patient's chart.
    b. Patients may be discharged by the resident only with the approval of the attending physician.
13. It shall be the responsibility of the provider to discharge patients by the time of day designated by hospital policy.
14. In the event of a hospital death, the deceased shall be pronounced dead by the attending provider or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a provider or his/her designee. Completion of the Death Certificate is required by the pediatrician if a pediatrician or pediatric

resident attends a delivery where a neonate dies. If there is no pediatrician or pediatric resident in attendance, the attending obstetrician must sign the Death Certificate. Residents are allowed to complete the death note in the medical record, but an attending physician is required to sign the Death Certificate. (Refer to Post Mortem Packet for instructions and Second Trimester Intentional Termination of Pregnancy Policy.)

15. Providers shall be encouraged to secure autopsies. 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/her designee. Provisional anatomic diagnoses shall be recorded on the medical record and the complete protocol should be made a part of the record.

    Residents may secure permission for an autopsy.

16. In a disaster situation such as loss of electrical power, water and telephone service, and when the attending provider or his/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.
17. The Medical Center will provide On-Call Schedules listing appropriate specialty physician and subspecialists services for all patients whose conditions can be effectively treated within the scope of services offered by the Medical Centers. On Call lists are available in the Medical Staff Services Office or through the hospital operator. Refer to the Emergency Medical Treatment and Active Labor Act (EMTALA) Policy.

B. MEDICAL RECORDS

1. The attending provider shall be responsible for the preparation of a complete and legible medical record for each patient which shall contain sufficient information to identify the patient, to support the diagnosis, to justify the treatment, and to document the results accurately. The documentation should at all times clearly show the clinical state of the patient and management. All clinical entries in the medical record must show date and time and proper authentication. All paper records must be authenticated by the provider; however, for the purpose of legibility, stamps bearing the provider's printed name may be used in conjunction with the provider's signature. Electronic signatures through the electronic medical record system are acceptable. Authorized users shall be responsible for the authenticity of the reports and the exclusive use of their electronic signatures. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. The resource for symbols and abbreviations is available electronically on the HPH Intranet through the Medical Library Resources webpage. (Refer to the hospital policy regarding the Joint Commission official list of unapproved abbreviations.)

   The provider may send and receive facsimile (FAX) medical record documents. Information transmitted via facsimile will be considered as the intended original document and is acceptable for inclusion into the medical record.

   Contents: All medical records shall include, but not be limited to, the following:
   a. Identification Data: When not obtainable, the reason shall be entered in the record.
   b. Reason for admission of care, treatment, and services.
   c. Historical Data: History of presenting illness and pertinent past medical history.
   d. Physical examination.
   e. Provisional diagnosis or diagnostic impression.
   f. Diagnostic and therapeutic orders, including results for special services.
   g. Evidence of appropriate informed consent; when consent is not obtainable, the reason shall be entered in the record.
   h. Progress notes, including clinical observations, current patient status and results of or response to care, treatment and services.
   i. Reports of procedures, tests, consultations.
   j. Conclusions at termination of hospitalization or visit, including summary of hospital course, final diagnosis and disposition.
   k. Allergies to food and/or medicines.
   l. Every medication ordered or prescribed.
   m. Goals of treatment and treatment plan.
2. History and Physical Examination
   A history and physical examination is required:
   -for all inpatient admissions
   -prior to surgery or procedures requiring anesthesia or sedation services.
   a. A history and physical examination must be performed and documented no more than thirty (30) days prior to or no more than twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia or sedation services. The history and physical examination older than thirty (30) days cannot be updated. A new history and physical examination must be completed prior to surgery or a procedure requiring anesthesia or sedation services.

      A history and physical examination done prior to admission or registration must also have an update. This update must be documented within twenty-four (24)

hours after admission or registration, but prior to surgery or procedure requiring anesthesia or sedation services.

b. A medical history and physical examination and update if required must be done for each patient by a doctor of medicine or osteopathy, oral maxillofacial surgeon, advanced practice registered nurse or physician assistant who is licensed in accordance with State law.
   i. If this is performed by a resident, the attending physician shall countersign it unless the attending physician has already entered a history and physical examination. The attending physician is fully responsible for providing this documentation.
   ii. If the required history and physical examination is independently completed by the attending physician, attending physician co-signature of the history and physical examination performed by the resident will not be required. Countersign means a second signature by a physician with admitting privileges which validates the physician's acknowledgment that he/she has read the entry. If there are no amendments, additions, or revisions of the entry present, a countersignature will be interpreted to mean that the physician agrees with the entry.

c. History and physical data, shall include, but not be limited to, the following:
   i. Reason for admission or care, treatment and services.
   ii. Historical Data: History or presenting illness and pertinent past medical history.
   iii. Physical examination relevant to chief complaint.
   iv. Provisional diagnosis or diagnostic impression.

d. When the history, physical examination and necessary laboratory reports are not recorded prior to an operation or procedure, the procedure may be cancelled unless the attending provider states in writing that such delay would be detrimental to the patient.

3. Admission Orders and Notes
   The provider with admitting privileges, resident or physician assistant shall record admission orders and notes within twenty-four (24) hours of admission and should clearly indicate the primary reason for admission. Admission orders and notes by residents, advanced practice registered nurses without admitting privileges and physician assistants must be authenticated by countersignatures by physician.

4. Patient Care Orders
   Orders are given by providers to direct patient caregivers. Authentication of an indirect order (e.g., verbal and telephone order) is to verify the accuracy and appropriateness of that order.
   a. All patient care orders must be entered on the computerized charting or legibly written showing date, time and provider's signature. No attempt will be made to interpret illegible orders without clarification from the provider.
   b. The patient, drug, dose, and dosage route shall be identified and confirmed immediately prior to administration of any drug.
   c. All medication orders must be authenticated and dated.
   d. Telephone orders shall be accepted only by a licensed registered nurse, pharmacist, respiratory therapist or physician. Persons receiving telephone verbal orders shall sign, date, and time the order. All telephone orders must be authenticated within 48 hours by the practitioner or authenticated by another practitioner responsible for the care of the patient. All telephone orders for medications must be authenticated within 24 hours by the prescribing practitioner or authenticated by another practitioner responsible for the care of the patient.

e. Face-to-face patient verbal orders will only be allowed in emergencies or conditions in which the practitioner does not have immediate access to the medical chart (e.g., practitioner performing a procedure or chart not available) and shall be accepted only by a licensed registered nurse, pharmacist, respiratory therapist or physician. Persons receiving the order shall document the order that includes the time the order was received. Face-to-face patient verbal orders for non-medications given in an emergency must be authenticated within 48 hours by the practitioner or another practitioner responsible for the care of the patient. Face-to-face patient verbal orders for medications must be authenticated within 24 hours by the prescribing practitioner or authenticated by another practitioner responsible for the care of the patient.
f. If the attending practitioner transfers the care of a patient to another practitioner, there shall be an order authorizing the transfer of responsibility on the order sheet.
g. Residents are authorized to write orders, give telephone orders and give face-to-face patient verbal orders. All orders by residents shall be reviewed by the attending or consulting physician.
h. Residents, advanced practice registered nurses without admitting privileges and physician assistants are authorized to write transfer orders and must be authenticated by countersignatures by physician.
i. Fourth-Year medical student sub-interns as defined by the University of Hawaiʻi, John A. Burns School of Medicine, are authorized to write orders and must be authenticated by countersignatures by attending physician as a final order prior to be carried out.

5. Informed Consent
The medical record shall contain evidence of informed consent for procedures and treatments for which it is required by the policy developed by the Medical Staff and governing body and consistent with legal requirements.
6. Clinical Observations
   a. Progress Notes: Progress notes made by the provider 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 written on a daily basis, with the exception of patients established as subacute or skilled nursing facility (SNF) levels of care.
   b. Consultations: Each consultation report shall contain a written opinion by the consultant that reflects, when appropriate, an actual examination of the patient in the patient's record.
      i. The attending provider is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant.
      ii. The attending provider will provide written authorization to permit the consultant to attend or examine his/her patients except in an emergency. All providers, including residents, requesting consultation must do so by initiating an order on the usual Provider’s Order Form in the patient’s chart or computer charting.
      iii. Appropriate Consultation Requests/Reports should be used for patients on computer charting. Consultant’s Report may be dictated.
      iv. 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.

c. Reports of procedures, tests, and the results: All diagnostic and therapeutic procedures shall be recorded and authenticated in the medical record. This may also include any reports from facilities outside of the hospital, in which case the source facility shall be identified on the report.
d. The responsible provider is required to record and authenticate a preoperative diagnosis prior to surgery.
e. A full operative or other high-risk procedure report must be in the chart or dictated upon completion of the operative or other high-risk procedure and before the patient is transferred out of recovery/post anesthesia care unit. The full operative or other high-risk procedure report must include the following information:
    1) The date of surgery.
    2) The name(s) of the surgeon who performed the procedure and his or her assistant(s).
    3) The name of the procedure performed.
    4) A description of the procedure
    5) Findings of the procedure.
    6) Any estimated blood loss.
    7) Any specimen(s) removed.
    8) The pre-operative and post-operative diagnosis.
    9) The type of anesthesia administered.
    10) Complications, if any.
    11) The indications for procedure.
f. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the operation or procedure, a postoperative note must be entered in the medical record before the patient is transferred out of recovery/post anesthesia care unit. This note must include the following information:
    1) The name(s) of the surgeon(s) who performed the procedure and his or her assistant(s).
    2) The name of the procedure performed.
    3) A description of each procedure finding.
    4) Any estimated blood loss.
    5) Any specimen(s) removed.
    6) The postoperative diagnosis.

    The full operative or other high-risk procedure report must be in the chart or dictated by 9:00 a.m. on the second post procedure day.
g. If the operative or other high-risk procedure report is performed by a resident, the attending shall countersign it.
h. When an organ is obtained for transplantation purposes from a brain-wave death patient, the medical record of the donor shall include the date and time of brain-wave death, documentation by and identification of the practitioner who determined the death and patient for organ donation, as well as an operative report.

7. Residents: Residents in training provide patient care in all areas.
   Services provided by residents are always under the supervision and responsibility of the physician. The responsibility for care and the level of supervision required is dependent upon the policies of the individual department. Residents are authorized to write patient care orders. This does not prohibit a member of the Medical Staff from writing orders. In all hospital areas, responsibility for the quality of care, proper supervision, review of chart notes, and review of

orders written by residents is the responsibility of the physician. Medical Staff members have the option of not participating in the teaching program without jeopardizing their privileges.

Only the following performed by residents must be authenticated by countersignatures by physicians in accordance to timelines described in Section 11. Disciplinary Actions, b. Failure to complete inpatient medical records:

1) Medical History and Physical Examination (If the required medical history and physical examination is independently completed by the physician, physician countersignature of the medical history and physical examination performed by the resident will not be required. Refer to Section 2. History and Physical Examination.)
2) Admission Orders and Notes (Refer to Section 3. Admission Orders and Notes.)
3) Transfer Orders (Refer to Section 4. Patient Care Orders, h.)
4) Operative or high-risk procedure report Refer to Section 6. Clinical Observations, g.
5) Discharge Summary or Final Progress Note (Refer to Section 8. Termination of Hospitalization, b.)

8. Termination of Hospitalization:
    1) Final Diagnosis: At the time of discharge, all relevant diagnoses and complications, as well as all operative procedures performed, shall be recorded using acceptable disease and operative terminology that include findings and etiology as appropriate. All relevant diagnoses and complications must be recorded. This must be authenticated by the attending provider.
    2) Discharge Summary or Final Progress Note: Each medical record shall contain either a discharge summary or a final progress note. When this summary or note is written by a resident, it must be countersigned by the attending physician.
        i. Any hospitalization that exceeds forty-eight (48) hours requires a discharge summary except for routine obstetrical and newborn cases.
        ii. Any death (except stillbirths) requires a death summary which indicates reason for admission, findings, course in hospital and events leading to death.
        iii. The discharge summary (clinical resume) should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent.
        iv. A final progress note may be substituted for the discharge summary in the case of patients who require less than a forty-eight (48) hour period of hospitalization and in the case of normal obstetrical deliveries and normal newborn infants. The medical record should include any instructions given to the patient and/or family.
        v. Residents, advanced practice registered nurses without admitting privileges and physician assistants are authorized to write discharge summaries or final progress notes and must be authenticated by countersignatures by physicians unless the attending physician has already completed such a note.
    3) Autopsy Report: When an autopsy is performed, provisional anatomic diagnoses should be recorded in the medical record within three (3) days and the complete protocol should be made a part of the record as soon as possible.
9. Accessibility of Medical Records
    a. Current providers shall have access to records of their patients.
    b. In the case of readmission of the patient, all previous records shall be available for the use of the attending provider. This shall apply whether the patient is attended by the same provider or not.

c. Former providers may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

10. Permanent Filing of Records
A medical record shall not be permanently filed until it is completed by the attending provider or is administratively closed. The Health Information Services Manager (or designee) may determine to administratively close a record in the event the provider involved is deceased, has his/her hospital privileges permanently suspended, has moved out of the state, is no longer a practicing provider or for other reasons rendering the provider involved incapable of completing the medical record.

11. Incomplete Medical Records
Providers must complete their patient's medical records within fourteen (14) days following the date of the patient encounter. Medical records that the provider fails to complete within fourteen (14) days will be considered delinquent. In unusual and extenuating cases, a waiver of the requirement may be considered by the Medical Executive Committee.

Notification Procedures to Incomplete Medical Record:

a. The medical record shall be made available to the responsible provider for completion during hospital care and upon patient discharge.

b. If the provider has not completed the medical record within seven (7) calendar days, the provider or provider office shall be notified by phone call of impending suspension.

c. Automatic suspension will be imposed if records remain incomplete seven (7) calendar days thereafter. Suspension will be lifted as soon as records are complete.

d. Provider must communicate any vacation, short term out of office or leave of absence (Refer to Medical Staff Bylaws, Article III, Section 3.7) to the Medical Records designee to set an Out of Office status and defer their deficiencies. The provider will have forty-eight (48) hours after return to complete the medical records, whereby suspension procedures will resume.

e. The suspended provider may:
   1) Continue to care of his/her patient(s) already hospitalized.
   2) Refer his/her patients, including emergencies, to another provider for admission to the hospital. The admitting provider then is responsible for the total care of that patient.
   3) Not admit patients, scheduled elective inpatient/outpatient surgical cases or see patients in the outpatient departments.

For medical records, it is recommended that whenever possible and when clinically appropriate, documentation or dictation should be completed immediately after the encounter; complete documentation shall include any and all data that is available at the time of the encounter; an addendum can be added following receipt of test and/or procedural results.

12. Disciplinary Actions (Refer to Medical Staff Bylaws, Article IX, Performance Improvement and Corrective Action, 9.6.5 Medical Records)
   a. Providers will be placed on automatic suspension for the following:
      1) Failure to comply with the twenty-four (24) hour requirement for an admission note or a history and physical examination. (Refer to Section 2. History and Physical Examination)
      2) Failure to write or dictate a formal operative report immediately after a surgical or diagnostic procedure. (Refer to Section 6. Clinical Observations, e. and f.)
      3) Failure to complete the Pre-Anesthesia Evaluation prior to patient proceeding to OR, except in an emergency (American Society of Anesthesiologists (ASA)

Classification “E”) (Refer to General Rules regarding Surgical Care, 2. Non-Emergency Cases).

4) Failure to complete hospital medical records within the time limits of the bylaws and rules and regulations.

b. The Admitting Office, Operative Services and Hospital Administration shall be notified immediately of all automatic suspensions. Subsequently, they shall be notified as soon as such suspensions are removed.

c. A monthly listing of all automatic suspensions shall be submitted to departmental committees showing dates when suspensions are removed. Problem providers may be referred to the Medical Executive Committee.

C. PHARMACY SERVICES

1. The pharmacist shall maintain a comprehensive supply of drugs in general use. If the prescribed drug is not in stock, the provider ordering it shall be requested to prescribe a reasonable substitute. Only if a reasonable substitute is not available will the pharmacist be authorized to secure it on the outside and charge it to the patient.
2. The dispensing and storage of investigational or experimental drugs shall be in compliance with established pharmacy policy and procedures.
3. Emergency and routine pharmacy services shall be in compliance with established pharmacy policy and procedures.

D. RADIOLOGY SERVICES

1. All radiology procedures shall be done only on order of a provider. Exceptions may be made only with the approval of the Medical Executive Committee.
2. X-ray procedures involving the abdomen and pelvis in female patients in the child bearing ages shall be in compliance with established radiation policies and procedures.
3. The requisition for radiologic service must include a short pertinent history and medical indication for the requested services. Performance of the requested examination may be postponed if this information is not provided.
4. Emergency as well as routine radiologic services shall be in compliance with established radiology policy and procedures, maintained by the hospital radiologist.
5. Providers desiring to perform arteriographic procedures shall be required to provide evidence of competence and shall be placed on observation for at least three (3) procedures. A current list of observers will be provided by the appropriate department and the list kept in the Diagnostic Imaging Department.

E. PATHOLOGY SERVICES

1. All laboratory procedures shall be performed only on orders of a provider.
2. Laboratory procedures which cannot be performed in the hospital shall be referred to an outside certified laboratory.
3. All emergency and routine laboratory services shall be in compliance with established policy and procedures maintained by the Laboratory Services.

F. DIETETIC (CLINICAL NUTRITION) SERVICES

1. Nutritional care is the responsibility of all team members in the health care system.
2. Inpatients will receive nutrition therapy/intervention, nutritional support and education as assessed upon admission and identified throughout their hospital stay.
3. Inpatients will be screened for the need for nutrition intervention/ assessment.
   Inpatients receiving oral medications designated by the medical staff shall be counseled regarding potentially significant food-drug interactions.
4. Review of clinical policies and procedures and the diet manual are reviewed by the Pharmacy & Therapeutics Committee.

G. GENERAL CONDUCT OF CARE

1. General consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission.
2. All orders for treatment shall be authenticated. Verbal or dictated orders shall be signed by the provider or by another provider.
3. All standing orders shall be authenticated by the appropriate provider.
4. All orders must be entered clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until re-entered or understood by the nurse. The use of "Renew", "Repeat", and "Continue" orders are not acceptable except for routine postpartum orders.
5. All previous orders are terminated when patients go to surgery. If applicable, the DNR status must be discussed and reaffirmed with the patient or legal guardian prior to surgery.
6. All orders for controlled substances will automatically be discontinued after ninety-six (96) hours unless reordered by the provider. All other medication orders, including p.r.n. medications, will automatically be discontinued after seven (7) days unless reordered by the provider. Attending providers must be notified of any impending expiration of a medication order twenty-four (24) hours prior to expiration.
7. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopeia, National Formulary, American Hospital Formulary or AMA Drug Evaluations. Exceptions are drugs for bona fide clinical investigations. However, these shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.
8. All medications brought into the hospital by the patient shall be relinquished to the nurse on admission. These medications shall be dispensed only upon written orders of the attending provider.
9. Any qualified provider with clinical privileges in this hospital may be called for consultation within his/her area of expertise.
10. Except in an emergency, consultation is encouraged in the following situations:
    a. When the patient is a poor risk for operation or treatment.
    b. Where the diagnosis remains obscure after ordinary diagnostic procedures have been completed.
    c. Where there is doubt as to the choice of therapeutic measures to be utilized.
    d. In complicated situations where specific skills or other providers may be needed.
    e. In instances in which the patient exhibits severe psychiatric symptoms.
    f. When requested by the patient, family or guardian.
11. In the event of a complication arising which demands procedures beyond the scope of the staff member's privileges, a consultation with a qualified staff member is mandatory. In those cases in which a provider does not have privileges covering a specific complication or procedure, the consultant involved shall be responsible for the active management of that complication or procedure for which he/she was called.
12. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall follow the Chain of Command policy.
13. In cases where the resident feels a consultation is necessary, he/she shall so state his/her opinion to the attending physician. If consultation is then refused, the chair of the department involved shall be notified by the resident.

H. GENERAL RULES REGARDING SURGICAL CARE

1. The Medical Staff through its appropriate departments shall be responsible for the development of policies and guidelines subject to the approval of the Medical Executive Committee. Policies shall be established governing the following areas:
   a. Scheduling operations:
      1) Priority
      2) Scheduling periods including change of schedule
      3) Assignment of priority
      4) Loss of priority
   b. Elective surgery
   c. Emergency surgery
   d. Preoperative and anesthesia requirements, i.e.:
      1) Identification of patient
      2) Preoperative evaluation and documentation
         i. Medical record content, including diagnosis
         ii. Laboratory procedures
         iii. Informed consent forms
         iv. A single surgical preoperative note specifically identifying the surgical procedure to be done and the anatomic location signed or initialed by the surgeon
         v. The anesthetic site for unilateral procedure requiring unilateral anesthesia will be initialed by the anesthesiologist
         vi. A separate acknowledgment either directly or by reference in a separate preoperative note by the anesthesiologist
      3) Time of admission
   e. Outpatient (ambulatory) surgery
   f. Efficient utilization of operating rooms
   g. Contaminated cases
   h. Conductivity and environmental control
   i. Radiation safety
   j. Other
2. Non-Emergency Cases:
   a. An appropriate preoperative assessment must include a review of the patient's medical, anesthetic and medication history, a physical examination, appropriate diagnostic laboratory and imaging tests with their results, and any indicated consultations.
   b. Additionally, a written signed informed consent shall be recorded with a preoperative diagnosis or indication for surgery, the planned operative procedure with the risks and benefits, and the likelihood of the need to administer blood or blood products.
   c. These must be recorded in the medical record before the patient can be transported to the Operating Room.
   d. There should also be a Pre-Anesthesia Evaluation completed prior to patient proceeding to OR, evidencing a review of the patient's past and present medical, medication and anesthesia history, an assessment of the patient's physical status with assignment of an American Society of Anesthesiologists' classification, a review of any preoperative diagnostic studies or consultations, and a discussion of the plan for anesthesia.
3. Emergent Cases:
   a. In emergent circumstances, where any significant delay in the operative or invasive

procedure could jeopardize the patient's life or the chance for recovery without significant injury or disability (e.g., rupture of ectopic pregnancy or internal viscera), a brief note must be recorded in the patient's record including any pertinent medical, anesthetic or medication history and evaluation of the heart and lungs and any of the pertinent physical findings and the results of any available preoperative tests or consultations.

b. A written, signed, informed consent outlining the planned procedure and associated risks and benefits should be obtained from the patient if possible or from the guardian or relatives if they are available. If such consent cannot be obtained in person or via some mode of telecommunication and if time permits, the concurrence of a second consulting physician should be documented in the record.

c. Prior to the administration of anesthesia, the anesthesiologist or anesthetist should at a minimum document a brief review of the medical history, physical evaluation including heart and lungs and any available diagnostic tests and consultations, if possible. The ASA classification should be documented along with the plan for anesthesia.

4. A complete anesthesia record shall be maintained throughout the operative or invasive procedure.
5. Postoperatively, the patient’s status must be documented, including any unusual postoperative events or complications in their management.
6. All tissues and/or foreign bodies removed shall be sent to the hospital pathologist who shall make examinations as he may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made as part of the patient's medical record. However, for certain specimens as specified in the hospital Specimen/Pathology policy, exemptions to undergoing pathological examination can be made at the discretion of the surgeon, providing the surgeon documents appropriately in the medical record.
7. Special Conditions for Dental Privileges:

a. The scope and extent of surgical procedures that each dentist may perform shall be specifically delineated and granted in the same manner as all other surgical privileges.

b. Surgical procedures performed by dentists shall be under the overall supervision of the Chair of the Department of Perioperative Services or his/her designee.

c. Patients with medical problems admitted to the hospital by qualified oral surgeons and patients admitted for dental care by other dentists shall receive the same basic medical appraisal as patients admitted for other services.

1) Dentists shall be responsible for:
    - i. A detailed dental history justifying hospital admission;
    - ii. A detailed description of the examination of the oral cavity and a preoperative diagnosis;
    - iii. A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissues, including teeth fragments, shall be sent to the hospital pathologist for examination.
    - iv. Progress notes as are pertinent to the oral condition; and
    - v. Clinical resume (or summary statement).

2) Physicians involved shall be members of the Active, Courtesy or Consultant Staff and shall be responsible for:
    - i. Medical history pertinent to the patient's general health;
    - ii. A physical examination to determine the patient's condition and overall risk prior to anesthesia and surgery; and
    - iii. Supervision of the patient's medical health status while hospitalized.

a. A qualified oral surgeon who admits a patient without medical problems may complete an admission history and a physical examination and assess the medical risks of the procedure to the patient. Criteria to be used in identifying such a qualified oral surgeon shall include:
    i. Successful completion of postgraduate program in oral surgery accredited by a nationally recognized accrediting body approved by the U.S. Office of Education.
    ii. Evidence (as determined by the Credentials Committee) that the oral surgeon is currently competent to conduct a complete history and physical examination to determine the patient's ability to undergo the proposed oral surgical procedure.
    iii. Has admitting privileges

I. GENERAL RULES REGARDING OBSTETRICAL CARE

1. The policies and guidelines will be the responsibility of the department chair and Department of Obstetrics Committee.
2. The Department of OB-GYN will establish policies governing the following areas:
    a. Prenatal records. The current obstetrical record shall include a complete prenatal record. The prenatal record shall be a legible copy of the attending physician's office record transferred to the hospital by the 37th week of gestation. Pertinent additions in the physical findings shall be written on admission. For patients who have not had prenatal care or who do not have a prenatal record, the transfer note or summary and the history, physical examination and assessment performed on admission shall satisfy this requirement.
    b. Admission of patients;
    c. Admission orders;
    d. Examination and progress notes;
    e. Use of induction/cervical ripening agents;
    f. Presence of nonmedical personnel in the Labor and Delivery Room;
    g. Delivery Room technique;
    h. Operative delivery and identification:
    i. Forceps
    j. Vacuum extraction
    k. Cesarean section
    l. Care of Newborn (Newborn care will be consistent with Department of Pediatrics policies):
    m. Intrapartum care;
    n. Postpartum care:
    o. Care of antepartum patients;
    p. Care of high-risk patients;
    q. Adoption.
    r. Pediatric attendance at Cesarean sections to be coordinated with the Pediatrics Department.
3. When a delivery takes place outside of the delivery suite, the mother and baby may be admitted to the Delivery Room for an examination.

J. GENERAL RULES REGARDING CARE OF PEDIATRIC PATIENTS

1. The policies and guidelines will be the responsibility of the department chair and the Department of Pediatrics.
2. The Department of Pediatrics will establish policies governing the following areas:
    a. Admission of babies to the nursery;
    b. Assignment of low birth weight babies to appropriate nursery;
    c. Assignment of transfer patients to appropriate nursery;
    d. Disposition of a sick infant;
    e. Pediatric attendance at Cesarean sections to be coordinated with the OB-GYN Department.
3. The attending provider or his/her alternate shall examine the newborn within twenty-four (24) hours following delivery and exam recorded in the chart.
4. All neonates must be examined by the attending provider and the exam recorded in the chart within 24 hours prior to discharge.
5. If care for a newborn infant has been provided exclusively in the normal newborn nursery, a discharge summary is not required. Rather, a final progress note will be written within 24 hours of discharge.
6. Intramuscular Vitamin K is to be given to all neonates unless the attending provider documents in the patient's medical record the reason not to administer Vitamin K.
7. House formula is to be used on all patients in the Nursery, with the exception that individual providers may use alternative formulas if they prescribe them for each of their individual patients, and each state in each medical record the reason for the change. Discharge formula packs will be given out only by the providers or under their direct order.
8. There will be no minimum lab requirements (Admission CBCs/UAs) for pediatric patients. Lab tests should be ordered on an individual, case-by-case basis.
9. Only pacifiers that are approved by the U.S. Consumer Product Safety Commission may be used in Pediatrics.
10. Exchange transfusions must be performed by a provider with this clinical privilege or by his/her designee under his/her observation. Exchange transfusions may be performed by a member of the neonatal fellowship program qualified (by the neonatologist) to supervise an exchange transfusion. Post-exchange transfusion observation will include cardiac and respiratory monitoring. Areas where an exchange transfusion may be performed include NICU and PICU.

K. GENERAL RULES REGARDING ANESTHETIC CARE

1. The policies and guidelines will be the responsibility of the department chair and the Department of Anesthesiology.
2. The Department of Anesthesiology will establish policies governing the following areas:
   a. Admission and discharge of patients to the Recovery Room;
   b. Assignment of patients to the Recovery Room;
   c. Preoperative evaluation;
   d. Postoperative evaluation;
   e. Intraoperative evaluation;
   f. Anesthetic records.
3. Any patient having anesthesia in the Operating Room will have a credentialed sedation/anesthesia provider in attendance.
4. All patient orders will be completed before the Anesthesiologist leaves the Post-Anesthesia Care Unit (PACU). This should include, but is not limited to, pain medication, antiemetic therapy, fluid therapy, and O_2 therapy.
5. Patients admitted for surgery will remain in their respective area until notification is made from the Operating Room. Patients in SurgiCenter or the Recovery Room will be monitored and observed.
6. All patients who have received anesthesia are to be recovered according to the appropriate post-anesthesia discharge criteria, i.e., Post-Anesthesia Discharge Criteria or SurgiCenter Discharge Criteria at the discretion of the Anesthesiologist regardless of location.

L. GENERAL RULES REGARDING EMERGENCY SERVICES

1. 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 the delivery of such services, including the delineation of clinical privileges for all practitioners who render emergency care.
2. The Emergency Department will submit quality review summaries to appropriate departments.

M. GENERAL RULES REGARDING INFECTION CONTROL ISOLATION PROCEDURES

1. The provider with admitting privileges will be promptly notified of the decision to isolate his/her patient.
2. If the above action is not approved by the provider with admitting privileges, the Chair of the Infection Control Committee, or his/her designee, will be contacted.
3. If the chair and the provider with admitting privileges are still in disagreement after conferring about the need to institute control procedures, the Chief of Staff or the chair of the appropriate department will be contacted.
4. The provider with admitting privileges may request a special meeting with the Infection Control Committee (with a quorum of physician members present) within twenty-four (24) hours.
5. A patient may be removed from the isolation by the provider with admitting privileges or nursing service when the patient is no longer considered infectious according to specific hospital policies or, when no local policy exists, according to the guidelines in the current Center for Disease Control (CDC) Manual.

N. ALLIED HEALTH PROFESSIONALS

1. Allied Health Professionals shall document, within the medical record, services provided to the patients of their sponsor or referring physician and shall make signed entries containing pertinent, meaningful observations and information as to the extent of such services provided. Entries into the medical record shall follow hospital policies established by the Medical Staff.
2. Allied Health Professionals shall, at all times when present within the hospital, wear identification badges issued by the institution.
3. The Allied Health Professionals shall participate as appropriate in patient care audit and other quality review, evaluation and monitoring activities required of the staff.
4. Additional Rules and Regulations for Clinical Psychologists applying for Independent status:
    a. Clinical Psychologist should hold a current license to practice in the State of Hawaii.
    b. Clinical Psychologist should provide evidence of receipt of a Ph.D. or a Psy.D. from an accredited program in clinical psychology.
5. If this condition is not met, at least one of the following must apply:
    a. American Board of Professional Psychology Diplomat in Clinical Psychology.
    b. Satisfactory completion of an American Psychological Association (APA) accredited clinical psychology respecialization program with completion of an APA-accredited internship.
    c. Psychologists who do not meet Criteria 4a-4b are considered dependent and must be sponsored by a member of the Medical Staff with appropriate privileges.

O. QUALIFIED MEDICAL PERSONNEL

Qualified Medical Personnel may be designated by their respective Departments to evaluate and manage patients' care under the supervision of a privileged practitioner. The Departments should delineate qualifications and responsibilities for the qualified medical personnel.

P. SUPERVISION OF RESIDENTS

1. The Program Director, clinical faculty and/or attending staff members shall be responsible for the direction and supervision of the onsite and/or day-to-day patient care activities of each trainee, who shall be permitted to perform only those clinical functions set out in curriculum requirements, affiliation agreements and/or training protocols approved by the Graduate Medical Education Committee or its designee. Training programs include the following specialties:

   Child Psychiatry
   Family Practice
   Obstetrics and Gynecology
   Orthopedics
   Pathology
   Pediatrics
   Psychiatry
   Surgery

2. The applicable Program Director shall be responsible for verifying and evaluating the qualifications of each physician in training.
3. Annual reports from the professional graduate education programs are submitted to the Board of Directors through the Medical Executive Committee.

Q. OBSERVATION REQUIREMENTS

All new applicants to the Medical Staff shall undergo observation for their privileges which they have requested. The observation requirements may be removed based on the approved specific criteria described in Item 2., Criteria For the Removal of Observation Requirements. All Active Members with unrestricted privileges should participate in the observation process. In specialties/subspecialties with insufficient number of observers, it may be necessary to require those on Courtesy Staff also participate as observers.

1. Purpose
   The purpose of observation is:
   a. to protect the well-being of the patient;
   b. to assure the competence of the provider;
   c. to provide education or clarification of hospital policies and practices.
2. Criteria For the Removal of Observation Requirements
   The department chair may recommend to the Credentials Committee removal of observation requirements:
   a. for a candidate who has satisfactorily completed his/her training in a residency program conducted at KMCWC;
   b. for a licensed physician who is an active faculty member of a recognized medical school which is affiliated with this hospital's residency training program and is regarded as being outstanding in his/her field;
   c. in exceptional circumstances which leave the Department thoroughly satisfied with the candidate's personal and professional qualifications.
3. Peer Review Observers
   a. While performing the observation duties, the observer shall be afforded primary liability coverage for these activities as long as the actions are performed in good faith and without malice. The Hospital's insurance carrier specifically includes medical staff members or allied health professionals providing supervision, instruction, observation and proctoring within the definition of "insured" persons. The amount of coverage for this activity would be the same as for any other claim.
   b. A different observer should be chosen for each of the provider's observed cases whenever possible.
   c. An observer shall not assist in the operation which he/she is observing.
   d. The observer shall serve without remuneration and shall file a report on the evaluation with the department concerned.
   e. When possible, observers should not be affiliated with the provider being observed either through partnership or group practice arrangement.
   f. Observer should have comparable privileges for which the observed provider is being evaluated.
   g. If the observer feels that the patient's life is endangered by the provider's actions, the observer may intervene in the following manner:
      i. The observer may recommend that an appropriate consultant or alternate be called to take over the case.
      ii. 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 of the provider and designate an alternate to take over the case.

iii, If the situation is urgent and immediate intervention is necessary, the observer may take over the case until the arrival of the consultant, the alternate or the appropriate chair.

h. Approved Observer's 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.

i. The observer's report shall be filed at the Medical Staff Office within one week following completion of the case.

4. Responsibility of Departments

a. Define the types of procedures and number of cases requiring observation and to apply this policy fairly to all applicants.

b. May permit that observation report of cases performed at other hospitals in the State of Hawaii be accepted as long as that observation is provided by a physician member of the Medical Staff who is qualified as an observer.

c. May permit that operative reports of cases performed at other hospitals in the State of Hawai'i be accepted.

d. Submit to the Medical Staff Services Office for appropriate distribution a schedule or panel of observers and any subsequent revisions. It shall be the responsibility of the assigned observer to arrange for an alternate if he is unavailable. The Department Chair may recommend transfer of a physician from Active Staff to another staff membership category, if that practitioner repeatedly fails to fulfill his/her observation responsibility.

e. The Department Chair will review any Observer's Report that is rated unsatisfactory or that contains any unsatisfactory evaluation as soon as possible and within one week after the report is received by the Medical Staff Services Office. The Department Chair may then send a letter to the provider regarding the status of his/her observation requirement and convey in summary any concerns raised.

f. Upon receipt in the Medical Staff Services Office of the required number of observed cases or operative reports, the Department Chair will review all applicable reports and render a recommendation to the Credentials Committee within one month. The recommendations may include whether the provider has satisfactorily completed observation requirements for those particular procedures, whether additional observation is needed, whether additional requirements are indicated, or whether the provider's application for the particular procedure should be denied. If additional observations are recommended, the number and type should be specified, as well as the allowed time to complete. A brief explanation to the provider would be appropriate. 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.

g. If the Department Chair has determined the provider satisfactorily met all observation requirements for the particular procedures and has no significant concerns, he may temporarily remove further observation requirements pending final approval by the Credentials Committee, Medical Executive Committee, and the Board of Directors. Appropriate individuals and hospital departments should be informed.

5. Provider on Observation

a. It is the responsibility of the provider to be observed to select and make arrangements with an observer with comparable privileges to act as an observer. Selection should be made from the respective Department panel of observers if a schedule of observers is not available. Panel and schedule of observers are available from the Medical Staff Services Office.

b. The provider to be observed should make every effort to schedule elective cases at times convenient to the observer, and to notify the observer as soon as possible of the scheduled case. If the case is rescheduled, it is the responsibility of the observed provider to notify the observer of the change.

c. For retrospective case reviews, the provider is to provide a list of cases completed, including Medical Record number, to the Medical Staff Services Office.

6. <u>New Procedures In Which No Other Member of the Medical Staff Has Privileges to Perform.</u>

a. Special credentialing criteria must be developed prior to performing new procedures which shall include a summary of what the new procedure consists of and requirements for competency; documentation of training by the provider requesting to perform a new procedure; approval by the training facility and/or physician. (See Development and Approval to Provide New Clinical Services/Procedures Policy.)

b. Designation of a provider within the same specialty to review literature and become knowledgeable of this new procedure and who will agree to attend the first three procedures performed by the requesting provider.

c. Concurrent evaluation of the first three procedures shall be performed by the Department Chair to determine acceptance of continued performance of the procedure, without observation.

d. When this evaluation is completed and provider is granted full privileges to perform a new procedure, he/she will serve as the observer for future providers who request to perform this procedure.

e. Observer's reports, preferably submitted by physicians who are members of our medical staff, may be accepted from other hospitals in the State of Hawaii.

f. Medical staff members in the same or in other departments with privileges most comparable to those being requested may be asked to provide the observation.

7. <u>Forms</u>

a. Development and modification of Observer's Reports for Invasive Procedures, Observer's Reports for Non-Invasive Procedures and Retrospective Case Review Forms shall be reviewed by the Credentials Committee with approval of the Medical Executive Committee. Appropriate Reports/Forms shall be utilized by all specialties/subspecialties with the exception of pathology and psychiatry that utilizes reports specific to their specialty.

b. All reports shall be retained in the provider's credentials file in the Restricted Component Section and considered confidential. The provider may review the contents of his credentials file, EXCEPT information contained in the Restricted component of the file. (Medical Staff Rules and Regulations, Credentials File Guidelines, 2. Credentials File Contents and 3. Accessing Credentials Files).

8. <u>Failure to Comply</u>

A provider under observation who performs a procedure without an observer, except in an emergency, may be subject to summary suspension upon the recommendation of the chair of the appropriate department.

R. PROCTORING REQUIREMENTS

Proctoring is generally recommended for specialties that perform surgery or invasive procedures. These may include procedures which represent new technology, high risk or are infrequently performed. Physician-sponsored allied health professionals may also be required to undergo proctoring if evidence of sufficient experience is lacking upon initial application or request for new privileges. Upon completion of proctoring, the provider may also be required to undergo observation requirements.

1. Purpose
   The purpose of proctoring is:
   a. to protect the well-being of the patient;
   b. to provide hands-on new/additional experience;
   c. to provide refresher education in performance of privilege.
2. Proctoring
   a. While performing the proctoring duties, the proctor shall be afforded primary liability coverage for these activities as long as the actions are performed in good faith and without malice. The Hospital's insurance carrier specifically includes medical staff members or allied health professionals providing supervision, instruction, observation and proctoring within the definition of "insured" persons. The amount of coverage for this activity would be the same as for any other claim.
   b. A proctor is involved in the privileges being performed and providing patient care (touching the patient).
   c. A proctor may serve with remuneration.
   d. A proctor should have comparable privileges with the proctored provider.
   e. Approved Proctor's Report must be completed by the proctor and submitted to the department concerned.
   f. The Proctor's Report shall be filed at the Medical Staff Office within one week following completion of the case.
   g. When selected as a proctor by the provider requiring proctoring, the proctor cannot serve as an observer for the same provider in performance of same privilege and patient care (touching the patient) to meet observation requirements.
4. Responsibility of Departments
   a. Define the types of procedures and number of cases requiring proctoring and to apply this policy fairly to all applicants.
   b. May define the required experience of proctors for new technology, high risk or infrequently performed procedures.
   c. May permit that observation/proctor report of cases be accepted from other healthcare facilities.
   d. May permit that operative reports of cases performed be accepted from other healthcare facilities.
   e. The Department Chair will review Proctor's Report.
   f. Upon receipt in the Medical Staff Services Office of the required number of proctored cases, observation reports or operative reports, the Department Chair will review all applicable reports and render a recommendation to the Credentials Committee within one month.

g. If the Department Chair has determined the provider satisfactorily met all proctoring/observation requirements for the particular procedures and has no significant concerns, he may temporarily remove further proctoring/observation requirements pending final approval by the Credentials Committee, Medical Executive Committee, and the Board of Directors. Appropriate individuals and hospital departments should be informed.

5. Provider Requiring Proctoring

a. It is the responsibility of the provider to be proctored to select and make arrangements with a proctor with comparable privileges to act as a proctor.

b. The provider to be proctored should make every effort to schedule elective cases at times convenient to the proctor, and to notify the proctor as soon as possible of the scheduled case. If the case is rescheduled, it is the responsibility of the proctored provider to notify the proctor of the change.

c. When the situation exists in which no other physician is qualified or credentialed to serve as a proctor, an outside proctor may be retained and granted temporary privileges.

d. Providers with an educational/teaching license from the State of Hawaii who will be involved in the privileges being performed and will be providing patient care for educational purposes must obtain privileges through the medical staff credentialing and privileging mechanism. (See Educational/Teaching License Credentialing Policy, MEC-71.)

e. Practitioners serving as consultants to the surgeon who will not be involved in the privileges being performed and will not be involved in patient care, e.g., robotic surgery, do not need to be credentialed. A letter of agreement with the Medical Center must be in place in order to serve in this capacity. Qualifications to serve as such will be kept in the Medical Staff Services Office.

7. Forms

a. Development and modification of Proctor's Reports for Invasive Procedures, Observer's Reports for Non-Invasive Procedures and Retrospective Case Review Forms shall be reviewed by the Credentials Committee with approval of the Medical Executive Committee. Appropriate Reports/Forms shall be utilized by all specialties/subspecialties with the exception of psychiatry that utilizes report specific to its specialty.

b. All reports shall be retained in the provider's credentials file in the Restricted Component Section and considered confidential. The provider may review the contents of his credentials file, EXCEPT information contained in the Restricted component of the file. (Medical Staff Rules and Regulations, Credentials File Guidelines, 2. Credentials File Contents and 3. Accessing Credentials Files).

8. Failure to Comply

A provider under proctoring who performs a procedure without a proctor may be subject to summary suspension upon the recommendation of the chair of the appropriate department.

S. APPROVED MALPRACTICE FINANCIAL RESPONSIBILITY

1. All providers shall be required to provide documentation of approved and appropriate malpractice financial responsibility as defined below and consistent with those clinical privileges.

   Professional liability insurance coverage issued by a commercial insurance company, indemnity plan or risk retention group licensed to do business in any state in 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.

2. Documentation attesting to approved malpractice financial responsibility shall contain a provision that the applicable company, institution, organizational or financial institution will notify Kapi`olani Medical Center for Women & Children upon cancellation or amendment, in part or whole, of the provider professional's malpractice financial responsibility. In the event the applicable company, institution or financial institution will not provide a provision, or does not notify Kapi`olani Medical Center for Women & Children, the provider shall be held responsible to ensure that Kapi`olani Medical Center for Women & Children is notified, in writing, of any cancellation or amendment, in part or whole, of his/her malpractice financial responsibility.
3. Failure to provide documentation
   a. No application for clinical privileges will be considered complete unless it includes adequate documentation of malpractice financial responsibility. In lieu of a certificate of insurance, applicants must provide a letter of acceptance from a malpractice carrier to include effective date and the coverage amount. The letter must be approved by the Risk Management Department. If malpractice financial responsibility is approved by the Risk Management Department, the application may be forwarded to the Medical Staff Services Office for the review and approval process.
   b. If the provider's financial liability coverage or any of the other form of financial responsibility as outlined above is canceled or expired, all clinical privileges will automatically be suspended until the deficiency is corrected.
4. Notwithstanding the foregoing requirements, the Board, in consultation with the Risk Management Department may consider and approve conditions of malpractice financial responsibility on a case by case basis based upon unique or extenuating circumstances.
5. On a periodic basis, the Board, in consultation with the Risk Management Department, may review, approve, and/or disapprove any of the entities insuring, indemnifying, or assuming the risks of malpractice liabilities pursuant to this provision.

T. MEDICAL STAFF DUES

1. All providers on the Active, Courtesy, Consultant, Refer and Follow or Allied Health Professional staff shall be required to pay annual Medical Staff dues.
2. Amount of dues shall be established by the Medical Executive Committee biennially (years divisible by two) in January and submitted to the general staff for approval at the Annual Meeting.
3. The Secretary/Treasurer shall be responsible for the collection of dues by August and accounting to the staff.
4. Use of dues are for administrative services provided by the Medical Staff Officers and Department Chairmen and for other uses as determined by the Medical Executive Committee.
5. Failure to pay will result in automatic suspension of Medical Staff membership. Refer to Medical Staff Bylaws, Article 9.6.

U. CREDENTIALS FILE GUIDELINES

1. <u>One Credentials File/Location.</u>
There shall be one credentials file kept for each provider. The credentials files shall be deemed confidential and the property of Kapi'olani Medical Center for Women and Children. The hospital Administration shall provide a secure environment within the Medical Staff Office. Within a computerized information system, the credentialing module shall be deemed a part of the credentials files and safeguards installed. The Medical Staff Supervisor shall serve as custodian of these files.

2. <u>Credentials Files Contents.</u>
The credentials files shall have four components described below:
   a. <u>The Documentation Component</u> shall contain:
      1) The initial and reappointment application(s) and required documents such as verification of professional and postgraduate training, board certifications, licensures, health status, CME data, malpractice information (refer to Medical Staff Bylaws, Article 6).
      2) Correspondence relating to appointments, clinical privileges granted, staff status.
      3) Information relating to elected positions within the Medical Staff organization, committee and other hospital appointments/activities.
      4) Information of professional special commendations, honors and awards.
      5) Copies of routine requests for verification of staff status, privileges from medical centers, insurance carriers, state licensing boards shall not be part of the credentials files.
   b. <u>The Confidential Component</u> shall contain:
      1) Information received from the National Practitioner Data Bank.
      2) Any quality review information submitted to and reviewed by the appropriate department (filed after the practitioner's QA profile has been sent to him/her and he/she has had an opportunity to rebut any portion of it).
      3) Peer review material after the practitioner has had an opportunity for due process and a disposition made or actions taken.
      4) Copy of the Adverse Action Report submitted to the National Practitioner Data Bank through the State Board of Medical Examiners.
   c. <u>The Restricted Component</u> shall contain documents such as confidential letters of reference, peer recommendations, observers' reports and other documents sent to the hospital in strict confidence.
   d. <u>The Preliminary Component</u> shall contain quality review, peer review material and other documents requiring review and final action.

3. <u>Accessing Credentials Files.</u>
Access of the credentials file shall require a written request on a prescribed form available in the Medical Staff Office. All requests shall require the approval of one (1) Medical Staff Officer (Chief of Staff, Vice Chief of Staff, Secretary/Treasurer or the Past Chief of Staff). An officer may not approve his own request. No material contained in the file may be altered or removed. No new material may be added at this time by the person accessing the file. Request may be made by:
   a. <u>Medical Staff Officers/Chairs/Committees</u>: Access of the credentials file of an individual practitioner shall be limited to Medical Staff Officers, chair, and members of Medical Staff committees whose perusal of the file is based solely

on the need to discharge official Medical Staff responsibilities. These involve credentialing and peer review/quality of care functions.

b. Provider. The provider may review the contents of his/her credentials file, EXCEPT information contained under the "Restricted" component of the file. The file may be reviewed only in the presence of a Medical Staff Officer or the custodian of the credential files.

c. Administration. The hospital administration may review the credentials file of any provider as long as the established procedure for requesting the credentials file is followed.

The Risk Management and Quality Management Departments may receive written information contained in the file when such information is pertinent in the course of performing their responsibilities and when information is required to conduct reviews requested by a Medical Staff peer review committee.

In legal action (subpoena), the Administration will release appropriate portions of a credentials file to the appropriate attorney.

4. Insertion of Material.
Insertion of material to the credentials files (not mentioned in #2) shall be made only by the Chief of Staff and the Medical Executive Committee.

Insertion of information relating to adverse decisions, or those which result in involuntary restriction, curtailment or reduction in Medical Staff privileges shall be made only after the provider has been notified of the adverse decision and has been given an opportunity for due process proceedings in accordance with Articles 9 and 10 of the Medical Staff Bylaws.

5. Deletion or Correction of Material.
A request for deletion or correction of material in the credentials file shall be in writing and submitted to the Chief of Staff and the Medical Executive Committee, and the reasons for deletion or correction clearly stated. Deletions or corrections will be made by the Chief of Staff and the Medical Executive Committee.

6. Disclosure of Information.

a. Confidential, Restricted and the Preliminary Components: These sections will not be disclosed.

b. Documentation Component: Information contained in the documentation component may be disclosed either internally or externally with the provider's written consent except as required by State or Federal laws, by the hospital administration or their designee. Information is usually disclosed, on request to other health care institutions, professional licensing boards or specialty boards, professional liability underwriters. Information disclosed by the custodian shall include verified information, such as membership, clinical privileges, adverse actions, if any, based on information in the credentials files.

7. Reporting Guidelines to the National Practitioner Data Bank (NPDB).

a. Reportable actions to the National Practitioner Data Bank are:

1) Professional review action, based on reasons relating to professional competence or conduct, adversely affecting clinical privileges for a period longer than thirty (30) days; or voluntary surrender or restriction of clinical privileges while under, or to avoid investigation.

2) Examples of actions that are NOT reported to the National Practitioner Data Bank are:

a) Provider voluntarily restricts or surrenders his clinical privileges, when professional competence and/or conduct is not under investigation. The provider must complete a Voluntary Resignation and Privileges Reduction Form which will be filed in his credentials file.
b) Provider's privileges are suspended for medical record delinquency, no documented malpractice coverage, nonpayment of Medical Staff dues.
c) Voluntary admission to a program for impaired practitioners.
d) Based on assessment of professional competence, an observer or proctor is assigned to supervise the provider, but the proctor does not grant approval before medical care is provided by the provider.

3) Confidentiality.
a) Information received from the National Practitioner Data Bank shall be considered confidential and will be used only for the purpose of carrying out professional review activity within the Medical Center.
b) Limitation on Disclosure. Information reported to the Data Bank is considered confidential and shall not be disclosed outside the Department of Health and Human Services, except as specified in the Title IV Regulations. Persons and entities which receive information from the Data Bank either directly or from another party must use it solely with respect to the purpose for which it was provided. Nothing in this paragraph shall prevent the disclosure of information which is authorized under applicable State law. Accordingly, the Federal law prohibits disclosure of information from the National Practitioner Data Bank and any person in violation shall be subject to a penalty of up to $10,000 for each violation.

4) Verification of the Data Submitted to the National Practitioner Data Bank: The Medical Center will be responsible for the accuracy of information which is reported to the Data Bank. The Report Verification Document sent to the Medical Center will be reviewed for accuracy and completeness in compliance with time frame established by National Practitioner Data Bank regulations. If errors or omissions are found in the reported information, a correction or addition will be submitted.

8. <u>Unauthorized Insertion, Deletion or Disclosure of Information.</u>
Unauthorized insertion or deletion of material or disclosure of information from the file will result in disciplinary action by the Medical Executive Committee or, when appropriate, by the hospital administration.

9. <u>Official Log.</u>
An official log shall be maintained by the custodian of the credentials files. The log shall be reviewed monthly by the Credentials Committee, with any suspected or actual violations of these regulations reported to the Medical Executive Committee and when appropriate, to the hospital administration. The log shall record 1) the types of requests made, 2) who approved them, 3) name, time and purpose of person making the request and 4) the name of the officer or the custodian of the files (when required).
<u>Types of Requests:</u>
a. Access to Restricted, Confidential and Preliminary Components.
b. Insertion and deletion of information into the Restricted and Confidential components.
c. Report to the National Practitioner Data Bank (log to document that report was sent by certified mail, return receipt requested, and date of receipt of verification document

received by the Medical Center; date of submission of a "Correction or Addition" Report).

04/21/2021km