ALAMEDA HEALTH SYSTEM

MEDICAL STAFF

RULES AND REGULATIONS

5/2019

ALAMEDA HEALTH SYSTEM

MEDICAL STAFF

RULES AND REGULATIONS

TABLE OF CONTENTS

ARTICLE 1 - PREAMBLE

All terms used in these Rules and Regulations shall have the same meaning as used in the Medical Staff Bylaws, unless otherwise herein defined.

ARTICLE II - ADMISSION OF PATIENTS

2.1 General

Each patient shall be under the general care and supervision of a member of the Medical Staff, and, if applicable, a member of the House Staff, and shall be admitted to the department or division which has expertise in the treatment of the disease which necessitated admission. Supervision of House Staff is governed by Article XVIII of these Rules and Regulations and current **Medical Staff Policy and Procedure: House staff Supervision**.

2.2 Provisional Diagnosis

The admitting physician shall provide a provisional diagnosis prior to admission to the Medical Center.

2.3 Clinics

All clinics shall be staffed by an assigned medical staff member who shall serve as the attending physician and be physically present at all times the clinic is in operation.

2.4 Discrimination

No patient shall be denied admission to the Health System on the basis of race, color, creed, national origin, sex, sexual orientation, disability, or ability to pay.

2.5 Infection Control

In case of communicable diseases or suspected communicable disease, appropriate isolation and infection control procedures must be followed, and the Infection Control Coordinator must be notified.

2.6 Psychiatric Admissions

Any patient known or suspected to be suicidal shall be offered a psychiatric consultation by a member of the Psychiatry staff. In any case where consultation is not obtained, the reason, such as patient refusal, must be documented in the patient's medical record. Patients suspected to be suicidal in intent, who meet the criteria for involuntary detention and psychiatric evaluation as authorized in Section 5150 of the Welfare and Institutions Code, shall be placed on a 5150 hold by a provider duly authorized to order such holds.

2.7 Emergency Admissions

Any member of the Medical Staff with appropriate clinical privileges may admit a patient with an emergency or urgent condition if the physician has determined such admission is indicated.

ARTICLE 3- CONSENTS

3.1 Conditions of Admission

Unless an emergency exists Consent for Treatment/Conditions of Admission Form signed by the patient or the patient's surrogate decision-maker shall be obtained at the time of admission by appropriate Health System personnel. When due to unusual circumstances it is not obtained at such time, it should be obtained as soon as possible after admission.

3.2 Informed Consent Defined

Informed consent is a process whereby the patient, or his or her surrogate decision-maker, is given information which will enable him or her to reach a meaningful, informed decision regarding whether to give consent for the complex treatment or procedure which is proposed.

3.2-1 The information provided should include a description of:

a. the nature of the recommended treatment;
b. its expected benefits or effects;
c. the associated risks and possible complications;
d. any alternative procedures and their expected benefits or effects and associated risks and possible complications;
e. any independent economic interests a physician may have which may influence his or her treatment recommendations; and
f. risks of not performing the procedure.

3.3 Who May Give Informed Consent

Consistent with any limitations or exceptions provided by law, before any patient undergoes surgery or any complex diagnostic or therapeutic procedure, the responsible practitioner including House Staff members, shall obtain the patient's (or if the patient does not have decision-making capacity, the patient's surrogate decision-maker), informed consent to the surgery or procedure.

Discussion of the procedure shall be in lay terms, such that the patient is able to fully comprehend. The Health System shall make all reasonable efforts to provide interpreter services to its non-English speaking, limited English speaking, and deaf patients for informed consent discussions. Whenever the circumstances warrant less than a full informed consent, the practitioner shall fully document those circumstances in the progress notes.

3.4 Physician Documentation of Informed Consent

3.4-1 The physician or house staff member involved in securing informed consent shall document in the progress notes of the patient's medical record, their discussions regarding the proposed procedure and whether they secured informed consent.

3.4-2 The documentation related to an emergency situation shall be entered in a progress note by the physician or house staff member and must describe:

a. the nature of the emergency;

b. the reasons consent could not be secured from the patient or a surrogate decision- maker; and
c. the necessity of treatment, including the probable result if treatment would have been delayed or not provided.

3.5 Particular Legal Requirements

Special consents must be obtained as required by law. Special consents shall be obtained where required for at least the following: blood transfusions; elective sterilization procedures; hysterectomies; use of investigational drugs or devices; participation in human experimentation; reuse of hemodialysis filters. Special consents for SNF patients must also be obtained, as required by law, for use of psychotropic medications, physical restraints and the prolonged use of a device that may lead to the inability to regain use of a normal bodily function. Special consent must be secured by a physician in the manner specified in the law applicable to these particular procedures. When appropriate, Health System personnel shall verify that appropriate special consent has been obtained. The laws related to special consents are described in the CHA Consent Manual.

3.5-1 The attending physician, or designee, is responsible for seeing that consent for the special procedure is secured in the manner required by law, and that required forms, waiting periods, and certifications have been completed.

3.5-2 Verification of Authorization for and Consent to Surgery or Special Diagnostic or Therapeutic Procedures Consistent with any limitation or exceptions provided by law, appropriate Health System personnel shall secure the signature of the patient or the patient's surrogate decision-maker on the Verification of Authorization Form and Consent to Surgery or Special Diagnostic or Therapeutic Procedure Form, verifying that the patient's attending practitioner obtained the patient's or the patient's surrogate decision-maker's informed consent to surgery or complex diagnostic or therapeutic procedure.

ARTICLE 4 - DEATHS

4.1 Pronouncement of Death

A physician or house staff member shall pronounce the patient dead within a reasonable period of time. An authenticated entry of the pronouncement of death must be made in the patient's medical record prior to release of the patient's remains. Nurses may pronounce death only pursuant to the Nursing Policy, "Pronouncement of Death by a Registered Nurse".

4.2 Death Certificate

A death certificate and copy shall be prepared by the Admissions department for completion by the pathologist after the autopsy. If no autopsy is to be performed, the death certificate is completed by the Admissions department, signed by the physician last in attendance, and sent, via the electronic death record system (EDRS), to the Vital Statistics Department.

4.3 Autopsy

The two major objectives of the autopsy are the establishment of final diagnoses, and when

possible, determination of cause of death. The autopsy is the "gold standard" for evaluating the accuracy of diagnosis and outcome of therapy.

4.3-1 The Attending physician must first consult with the designated staff pathologist to determine if the autopsy can answer the clinical question(s). The designated staff Pathologist shall determine if the autopsy request is justified and appropriate based on information received from the Attending Physician caring for the deceased. Justification may require additional confirmation or support from data obtained from the clinical record.

4.3-2 If the autopsy is deemed appropriate, the pronouncing physician shall obtain permission for performance of an autopsy in accordance with the Autopsy Policy and Procedure of the Health System. The persons who may consent to autopsies are identified by California law.

4.3-3 The patient's medical record, including all volumes and the completed Consent and Authorization for Autopsy Form, shall be forwarded to the Admissions department, as soon as possible, following final documentation and compilation by ward staff or as per policy.

4.3-4 Except in coroner's cases, all autopsies shall be performed by the Health System pathologist or his or her designee.

4.3-5 Data from the autopsy may be presented at a department conference and reviewed as part of the Performance Improvement activities.

ARTICLE 5 - DISCHARGE OF PATIENTS

5.1 Discharges

5.1-1 Discharge Planning

The Discharge Planning Policy (Hospital and Administrative Policy) shall be followed for each patient.

a. Discharge planning begins upon admission and is on-going throughout the patient's stay.
b. All disciplines are responsible for documenting any discharge instructions provided to the patient, family and/or caregivers.
c. On discharge, patient's condition and status of current patient problems are assessed and documented in the medical record.

5.1-2 Leaving Against Medical Advice (AMA)

a. AMA is defined as an inpatient or outpatient who demands to leave or be discharged from the Health System before the completion of treatment or contrary to the advice of the patient's physician.

b. If a patient indicates that he or she will leave the Health System without a discharge order from the attending physician or designee, the nursing staff shall contact the patient's attending physician or designee to arrange for the patient to discuss his or her plan with the attending physician or designee

before the patient leaves.

c. The attending physician or designee shall discuss with the patient the implications of leaving the Health System against medical advice including the risks involved and the benefits of remaining for treatment, as necessary to meet the standard of informed refusal of treatment. The patient who insists on leaving against medical advice shall be asked to sign the form titled "Leaving the Hospital Against Medical Advice" in the presence of at least one witness. If the patient cannot be located or refuses to sign the form, the nursing staff who witnessed the refusal, shall sign the form and document in the patient's medical record the facts surrounding the patient's departure.

5.1-3 Absent Without Leave (AWOL)/Elopement

a. A patient who leaves the Health System without notifying any healthcare worker prior to departure is considered AWOL.

b. When it has been determined that a patient is AWOL, the immediate area shall be searched, and the patient shall be paged overhead. The attending physician or designee will be notified.

c. Documentation of the circumstances, time and date of the incident shall document by the nurse in the medical record.

d. **Elopement (Emergency Department)**
Any patient that has been seen by the Triage Registered Nurse, had a triage assessment initiated and/or been placed in a treatment area but left prior to completion of an evaluation by the Emergency Department provider is deemed to have eloped. The procedure for documentation is pursuant to the Emergency Department Policy and Procedure "Patient Elopement from the Emergency Department".

.

5.1-4 Reporting

An Occurrence Report shall be completed when a patient has left against medical advice or is considered to have left AWOL or has eloped. An attempt will be made to notify the patient of known or suspected medical conditions that warrant further follow-up. The contact or attempted contact with the patient will be documented in the progress notes.

ARTICLE 6 - MEDICAL CARE OF PATIENTS

6.1 Medication Orders

Orders for drugs shall be written by a person lawfully authorized and credentialed to prescribe and shall conform with the United States Pharmacopeia or National Formulary, with the exception of drugs used in bona fide approved clinical investigations or newly approved medications that are not listed but have been approved by an appropriate Health System Committee. Exceptions shall be approved by the Medical Executive Committee

in accordance with all current applicable regulations.

6.2 Review of Drug Orders/Automatic Stop Orders

6.2-1 Each physician is expected to review all medications for all patients regularly to ensure discontinuation of all orders that are no longer needed.

6.2-2 Automatic Stop Orders

For reasons of patient safety, certain categories of drugs will automatically be stopped at certain established times according to the Health System Automatic Stop Order Policy and Procedure.

6.2-3 The pharmacist shall notify the attending or ordering physician whenever an automatic stop order is to occur by placing a notice in the medical record at least 48 hours in advance of the pending Automatic Stop Order.

6.2-4 An automatic stop order does not apply when the prescriber specifies the number of doses or an exact and reasonable period of time.

6.2-5 Orders for drugs will automatically stop and any new or continuing drugs must be reordered when:

a. a patient goes to surgery; or

b. a patient's level of care is changed. For example, when the patient goes from:

- outpatient setting to inpatient setting
- ICU to medical surgical unit, medical surgical unit to ICU, labor and delivery to post-partum
- acute medical surgical unit to acute rehabilitation or long-term care.

6.3 Drugs and Medications Brought from Home

All drugs and medications brought to the Health System by patients will be sent home with the patient's family whenever possible. The Patient's Own Medications: Medications Brought into the Hospital by Patients Policy shall be followed.

6.4 Preprinted Orders

Preprinted orders for any treatments may be used for a specific patient when authorized by a person licensed and credentialed to issue the specific orders. A copy of preprinted orders for a specific patient must be dated, promptly authenticated, and included in the patient's medical record.

These preprinted orders must:

a. specify the circumstances under which the orders are to be carried out;

b. specify the medical conditions to which the orders are intended to apply;

c. be specific as to the orders that are to be carried out, including all of the relevant information that usually is given in an order; and

d. be initially approved and reviewed annually by the appropriate Medical Staff Committee.

6.5. Verbal/Telephone Orders

a. Orders dictated to a licensed person by a physician or house staff member are known as verbal orders. Verbal orders may be given only in an emergency situation or when the physician is physically unable to write the orders.

b. Orders received via telephone by a licensed person from a physician or house staff member are known as telephone orders.

c. Within the scope of their practice, Registered Nurses, Pharmacists, Clinical Dieticians, and Respiratory Therapists may accept verbal/telephone orders from a physician; house staff member, Physician Assistant and/or Nurse Practitioner.

d. All verbal/telephone orders are repeated back to the practitioner who verifies correctness of information before the conversation is ended. Read back the frequency and/or instructions for use in the non-abbreviated format. Example: If an order is received for BID frequency, the receiver will read the order to the prescriber as "to be administered twice daily, or two times per day".

e. Record the verbal/telephone order immediately in the patient's medical record or, for pharmacists, on a prescription form as appropriate.

f. Indicate either telephone or verbal order in the written record.

g. Verbal or telephone orders for medications must be countersigned by a physician within forty-eight (48) hours.

6.6 Surgical Procedures

6.6-1 A complete history and physical examination, in accordance with *Article IX, Section 9.4-1*, of these Rules and Regulations and with the Medical Staff "History & Physical" Policy & Procedure shall be in the medical record of every patient prior to surgery.

6.6-2 Assistants in Surgery

a. An operating surgeon shall have a qualified physician serving as an assistant at all major operations.

b. Any member of the Department of Surgery holding appropriate surgical privileges shall be deemed to have "surgical assist" privileges. Members of other departments requesting surgical assisting privileges must provide evidence of current competence and appropriate professional liability insurance coverage. Requests for such privileges shall be reviewed and approved as provided in Article V of the Medical Staff Bylaws.

c. Appropriately credentialed Allied Health Professionals may act as surgical assistants.

6.6-3 Ambulatory Surgery

The Chief of Surgery shall review the policies and procedures for outpatient surgery, including identification of those procedures that are appropriate to be performed on an outpatient basis, and submit revisions to the Medical Executive Committee as needed.

6.7 Restraint Policy Adherence

All physicians, dentists, podiatrists, psychologists and APPs shall be responsible for adhering to the policies and procedures regarding the use of restraints as defined in the Alameda Health System Administrative Manual.

6.8 Intravenous Sedation

Any department or division member wishing to administer moderate or deep sedation in a setting outside of the operating room or post-anesthesia recovery, will adhere to the Alameda Health System policy as developed by the Department of Anesthesiology for the administration of such intravenous agents by a privileged practitioner. Medical Staff members who wish to administer intravenous sedation shall apply for and be granted privileges by their department.

6.9 Do Not Resuscitate Orders

6.9-1 All patients are to receive full cardiopulmonary resuscitation unless specific orders limiting treatment are written.

6.9-2 The “Do Not Resuscitate” (DNR) Order must be completed by the most senior resident on the team or the attending physician or designee responsible for the patient, along with a progress note documenting the rationale for the order. The order should be reconsidered with any change in clinical status.

6.9-3 The decision to limit cardiopulmonary resuscitation procedures does not necessarily limit other procedures. “Do Not Resuscitate” Orders are compatible with full intensive care unit care and palliative surgery. Resuscitative efforts for immediate surgical or anesthetic complications during palliative surgery should be discussed with the patient or surrogate decision-maker prior to surgery. The “Do Not Resuscitate Order” may be suspended during surgery by an order signed by the attending physician or designee.

6.10 Basic Life Support (BLS) and Other Certifications

All Medical Staff members granted privileges shall be encouraged to undergo training in BLS on a biennial basis. The decision to require BLS, ACLS, ATLS, PALS, NPR, etc. certification shall be left to the prerogative of each Department. Certification may also be required for specific clinical privileges and will be monitored by the Medical Staff Services Department. The Chair of each Department that decides to require BLS or other certification shall be responsible for assuring certification is verified and documented.

ARTICLE 7 - CONSULTATIONS

7.1 Consultation Requirements

Any qualified practitioner with clinical privileges can be called for consultation within his/her area of expertise and within the limits of clinical privileges that have been granted.

7.1-1 Required Consultation

a. Except in an emergency, consultation with a member of the Medical Staff s encouraged for cases in which, according to the judgment of the attending physician or designee, the patient is not a good medical or surgical risk;

b. the diagnosis is obscure;

c. there is doubt as to the best therapeutic measures to be utilized;

d. specific skills of other practitioners may be needed;

e. the patient exhibits severe psychiatric symptoms and is not receiving psychiatric help; or

f. there is doubt as to the capacity of the patient to give informed consent.

g. The Department Chair may establish additional policies regarding consultation for the Department and may require consultation:

1) when he/she deems it necessary, or
2) when requested by the patient or the patient’s surrogate decision maker.

7.1-2 Emergency Consultations

The process for requesting an emergency consultation for those sites for which the clinical service has resident staff, will be in accordance with the applicable policy for that site and service. If the site and clinical service does not have a resident staff, the attending practitioner is primarily responsible for requesting consultation when indicated and any qualified practitioner who has been granted appropriate clinical privileges at this Hospital may be called upon to provide the consultation within his or her area of expertise.

7.1-3 Consultant's Report

Consultation entries shall show evidence of a review of the patient's record by the consultant, pertinent findings on the examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record and shall comply with Article IX, Section 9.4-7 of these Rules and Regulations. A limited statement, such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the

operation or procedure. At the discretion of the requesting physician, consultation reports may be verbal or electronic. In the case of a verbal or electronic consultation report, the requesting physician shall document the occurrence, time, and recommendations received from the consultant.

ARTICLE 8 - COVERAGE

Chairs of the Department and Division Chiefs shall be responsible to ensure that physician coverage is provided as required.

ARTICLE 9 - MEDICAL RECORDS

9.1 Patient Medical Records

Accurate Medical Records must be maintained for all patients who receive treatment at the Health System, including inpatients, outpatients and emergency patients. The Alameda Health System medical record is defined as a hybrid health record including either electronic or paper documents and manual and electronic processes.

9.2 Timely Completion of the Medical Record

9.2-1 A medical record lacking any required elements or required authentication is considered incomplete.

Medical records which are incomplete for any reason fourteen (14) days after discharge are considered delinquent. If the physician fails to complete his or her medical records within fourteen (14) days of discharge, actions including possible suspension of admitting privileges will be initiated pursuant to the **Medical Record Delinquency and Medical Staff Suspension Policy and Procedure.**

9.3 Removal of the Medical Record

Medical Records are the property of the Health System. Nothing may be removed from the medical record. Records are to be maintained at all times in the Medical Record Department or in the custody of a Health System employee, Medical Staff member, or APP member at the Health System who is providing patient care. Medical records may be removed by the Custodian of Records or designee from the Health System's jurisdiction and safekeeping only in accordance with Health System policies for storage, court order, subpoena, or statute.

9.4 Medical Record Content

The Medical Record shall contain:

9.4-1 History and Physical Examination Report

A comprehensive and complete general history and physical examination is required no more than 30 days prior to, or within 24 hours after, registration or inpatient admission, but prior to surgery or a procedure requiring anesthesia service on all Health

System patients. The history and physical shall be dictated or legibly handwritten. The scope and content of the examination must be relevant to the patient's medical history and the clinical findings.

a. The history and physical report shall be prepared by the patient's attending physician unless he or she delegates this responsibility to another physician or he or she is required by the Medical Staff Bylaws or Rules and Regulations to delegate or share this responsibility with another physician.

b. A complete history and physical shall be recorded in the patient's medical record: within 72 hours following admission to the SNF. *(Title 22, 72303);* and/or

c. within forty-eight (48) hours of admission to a sub-acute bed. (Title 22, 51215.5).

9.4-2 Diagnosis

An admitting diagnosis, any changes in diagnoses occurring during hospitalization, and a discharge diagnosis must be contained in the medical record.

9.4-4 Progress Notes

Progress notes shall be entered:

a. daily on the Highland and John George campuses or more often when warranted by the patient's condition;

b. at least three (3) times per week in the Rehabilitation Unit or more often when warranted by the patient's condition;

c. at least two (2) times a week for sub-acute beds in the neuro-respiratory unit or more often when warranted by the patient's condition; or

d. every thirty (30) days in the Skilled Nursing facility unit or more often when warranted by the patient's condition.

9.4-5 Post-Operative Note

a. A postoperative note must be entered into the medical record immediately after surgery and include pertinent information that is necessary for care by any provider who will be attending the patient. Immediately after surgery is defined as "upon completion of surgery, before the patient is transferred to the next level of care", i.e. the Post Anesthesia Unit (PAR).

The postoperative note must include at least the following elements:

1) Primary surgeon and assistant(s);

2) Pre- and postoperative diagnosis(s).

3) Name of specific surgical procedure(s) performed.

4) Description of findings and tissue removed or altered.

5) Prosthetic devices or implants used, if any.

6) Complications, if any.

7) Estimated blood loss.

8) Condition of patient postoperatively.

b. A dictated operative report must be completed within twenty-four (24) hours of each surgery and must contain at least the information described above.

9.4-6. Anesthesia Record

An anesthesia record is required including preoperative assessment and diagnosis, if anesthesia has been administered. The pre-anesthesia record is to completed and documented forty-eight (48) hours prior to surgery or a procedure requiring anesthesia services and the post-anesthesia record no later than forty-eight (48) hours after surgery or a procedure requiring anesthesia services.

9.4-7 Consultation Report

In the case of a written report of the consultation, it shall be written and placed into the patient's medical record within twenty-four (24) hours of the performance of the consultation.

9.4 -8 Discharge Summary

a. At the time of discharge, the physician responsible for the patient shall ensure that the medical record is complete, including final diagnosis.

b. A written discharge summary form must be completed and on the medical record at the time of discharge and a discharge summary must be dictated within forty- eight (48) hours of discharge. All patients transferred from AHS to another healthcare facility must have a discharge summary sent with the patient at the time of transfer. All discharge summaries shall, at a minimum, include the following elements:

1) the reason for hospitalization;
2) the significant findings;
3) the procedure performed and/or, treatment rendered;
4) the patient's condition at the time of discharge;
5) final diagnosis;
6) all complications and co-morbidities;
7) final disposition; and,
8) the instructions given to the patient and/or surrogate decision-maker (*e.g.*, physical activity, medication, diet and follow-up care).

The discharge summary must be reviewed and authenticated by an attending physician.

9.5 Access to Medical Records

Access to all medical records of all patients may be afforded to medical staff members in good standing for bona fide study and research consistent with confidentiality of personal information concerning individual patients as prescribed in applicable state and federal law and Health System policies. Subject to applicable laws, Health System policy and the discretion of the Chief Executive Officer, former members of the Medical Staff may be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Health System.

9.6 Use of Signature Stamp or Computer Key

9.6-1 The medical staff permits the use of electronic signature, per the approved Medical Records Policy and Procedure.

9.7 Use of Symbols and Abbreviations

9.7-1 No symbols or abbreviations may be used on the face sheet.

9.7-2 A list of symbols, abbreviations, acronyms and dose designations which may be used in the medical record shall be approved by the Medical Executive Committee and distributed to the Medical Staff.

9.7-3 A list of symbols, abbreviations, acronyms and dose designations that are prohibited from use in the medical record shall be approved by the Medical Executive Committee and distributed to the Medical Staff.

9.8 Correction of the Medical Record.

In the event it is necessary to correct an entry in a medical record, the authorized person shall line out the incorrect data with a single line in ink, leaving the original writing legible. The person shall note the reason for the change, the date of striking, and sign the note. Appropriate cross- referencing shall be placed in the medical record when necessary to explain the correction. The correction shall never involve erasure or obliteration of the material that is corrected. In addition, all blanks left in dictated reports must be filled in by the dictating physician at the time the report is authenticated. Any cross-outs with or without re-entries in the report should be noted as error, dated, and initialed. No medical record entry shall be removed from the medical record.

9.9 Entries in the Medical Record including Authentication, Dating, and Timing of Entries

9.9-1 The following health care professionals are permitted to make entries in the medical record: Medical Staff members, House Staff members, Medical Students, APPs, Nursing Staff, Dieticians, Occupational Therapists, Speech Therapists, Pharmacists, Physical Therapists, Radiology Technicians, Recreational Therapists, Respiratory Therapists, Social Workers, Health System Clergy, and other health practitioners as designated by the Medical Staff.

9.9-2 Each entry that is made in the medical record shall be signed by the person making the entry, dated, and timed. The date and time shall be the date and time that the

entry is made, regardless of whether the contents of the note relate to a previous date or time.

9.9-3 If the practitioner signing or otherwise authenticating a medical record entry is not a member of the Medical Staff, that practitioner must include their full signature and status in the organization. For example, a resident must include their name, title of resident and current year of training. All Advanced Practice Providers must include their category of Advance Practice Provider status. For example, Robert Jones, MD, PGY II, or Mary Smith, Physician Assistant.

ARTICLE 10 - EMERGENCY MANAGEMENT/DISASTER

10.1 Emergency Management/Disaster Plan

All physicians shall be assigned posts either in the Health System or defined auxiliary areas during a disaster. It is their responsibility to report to their assigned stations. The Chair of the Department of Emergency Medicine and the Chief Executive Officer will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Health System to another or evacuation from the Health System premises, the Chair of the Department of Emergency Medicine or the Emergency Department physician on duty will authorize the movement of patients in consultation with the Chief Executive Officer or A.O.D. (Administrator of the Day) of the Health System during the disaster.

10-2 Credentialing in a Disaster

Licensed Independent Practitioners who are not members of the medical staff of AHS and who do not possess clinical privileges at the Health System, may be granted temporary or emergency privileges during a disaster pursuant to the **Medical Staff Bylaws.**

10.3 Plan for Mass Casualties

The plan for the care of mass casualties shall be updated at least annually and rehearsed at least twice a year by appropriate Health System personnel.

10.4 Fire and Internal Disaster Drills

Fire and internal disaster drills shall be held at least quarterly for each shift and under varied conditions.

10.5 In-House Medical Emergency (Non-Patients)

10.5-1 Inpatient patient care areas

Medical personnel will react as appropriate to the person's needs and, as necessary, bring him/her to the Emergency Department.

10.5-2 Non-patient care areas inside the Health System buildings

The house code blue team will be contacted.

ARTICLE 11 - ADVANCE PRACTICE PROVIDERS

All Advance Practice Providers shall be bound by current Policies and Procedures and other applicable Alameda Health System Medical Staff Bylaws, Rules and Regulations, or Policies and Procedures.

ARTICLE 12 - PERFORMANCE IMPROVEMENT

12.1 Performance Improvement Program

12.1-1 The Medical Executive Committee shall, in conjunction with Health System Administration, develop a Performance Improvement Program for patient care. The plan shall be reviewed annually and shall be subject to the approval of the Board of Trustees.

12.1-2 Performance Based Reappraisal

Each member of the Medical Staff or APP Staff at the time of application for reappointment shall have a performance-based reappraisal profile. The Chair of the Department/Division Chief/Site Director shall review the profile and use the data as a critical factor in determining the practitioner's qualifications for reappointment and for current competence and ability to perform privileges for the specific privileges or practice prerogatives requested.

ARTICLE 13 - REQUIREMENTS FOR PROFESSIONAL LIABILITY INSURANCE

Medical Staff members and APP members shall be required to provide evidence of professional liability insurance in minimum amounts of $1,000,000 per occurrence and $3,000,000 aggregate, evidenced in a written document which specifies amounts and dates of expiration and must name each individual practitioner covered by the policy. Health System employees may meet this burden by providing proof of insurance by Alameda Health System.

ARTICLE 14 - CHAIN OF COMMAND

The mechanism for hospital clinical and administrative staff to communicate with the appropriate medical staff representation regarding clinical and/or administrative concerns is pursuant to the Chain of Command and Stop the Line Policy.

ARTICLE 15 - PRIVILEGES

15.1 Introduction of a New Privilege

New privileges to be performed at the Health System are obtained in accordance with current ***Medical Staff Policy and Procedure: Introduction of a New Privilege for the Medical Staff or a New Privilege for a Specific Department or Specialty***.

15.2 Experimental Procedures

If a procedure is not being performed at the Health System or elsewhere, except on an experimental basis, the applicant shall submit a proposal to the Alameda Health

System Institutional Review Board to perform the procedure under the auspices of a research protocol and Section 15.1 shall apply.

ARTICLE 16 - ON-CALL RESPONSIBILITIES

Duties of practitioners on call to the Emergency Department are described in the EMTALA Policies and Procedures.

ARTICLE 17 - INFECTION CONTROL

17.1 Infection Control Policies and Procedures

All physicians, dentists, podiatrists, psychologists and AHPs shall be responsible for adhering to the infection control policies and procedures as defined in the Infection Control Policy and Procedure Manual for the Health System.

ARTICLE 18 - SUPERVISION OF HOUSE STAFF

18.1 All members of the House Staff are under the supervision of the Medical Staff. Members of the Medical Staff exercise that supervision under the guidelines established by the Graduate Medical Education Program. Medical Staff members who serve as house staff supervisors must be licensed independent practitioners and must hold clinical privileges that reflect the patient care, treatment, and service responsibilities given to the house staff. House Staff, who are approved to provide patient care, may write orders unless otherwise specified in the Bylaws or these Rules and Regulations. Supervising members of the Medical Staff are responsible for the patient care and documentation activities of the House Staff members they supervise. The Graduate Medical Education Committee must provide regular report of the activities of the Graduate Medical Education Program to the Medical Executive Committee, which will communicate this report to the AHS Board of Trustees.

ARTICLE 19 - COMMITTEES OF THE MEDICAL STAFF

19.1 Special Committees

Special committees, other than the below standing committees and as may be required to properly carry out the duties of the Medical Staff, shall be appointed by the President of the Medical Staff and subject to the Medical Staff Bylaws, Article XI, Section 11.1.

19.2 Membership

The Chief of Staff shall determine the membership eligibility, the number of members, purposes and frequency of meetings and shall appoint the Chair in each instance. Members of the House Staff shall be represented on all committees of the Medical Staff. Such committees shall confine their work to the purposes for which they are appointed.

19.3 Standing Committees of the Medical Staff

In addition to the committees established in the Medical Staff Bylaws, the following committees shall be established:

19.3-1 Quorum

A quorum of fifty (50) percent of the voting members shall be required for Medical Executive and Credentials Committee meetings, but in no case less than five (5). For other committees, a quorum shall consist of ten (10) percent of the voting members of a committee, but in no event less than three (3) voting members.

19.3-4 Bylaws Committee

The Bylaws Committee shall be chaired by the Vice Chief of the Medical Staff and be composed of three (3) physicians, the Medical Staff Director and a representative from administration who would be invited by the Chair if there is an issue that they want to discuss.

The duties and responsibilities of the Bylaws Committee shall be to:

a. conduct an annual review of the Medical Staff Bylaws, and Rules and Regulations; and

b. submit recommendations to the Medical Executive Committee for changes in these documents as necessary to reflect current Medical Staff practices.

The Bylaws Committee shall meet as often as necessary but at least annually.

19.3-5 Committee on Interdisciplinary Practice (CIDP)

The Committee on Interdisciplinary Practice shall include the Chief Executive Officer (or his/her designee), the Chief Nursing Executive (or his/her designee), an equal number of physicians appointed by the President of the Medical Staff, two registered nurses appointed by the Chief Nursing Executive, and the Chief Medical Officer. One or more APPs who practice at the Health System shall be appointed to serve on the CIDP by the President of the Medical Staff. The Chair of the CIDP shall be a physician.

The duties of the CIDP shall be to:

a. evaluate and make recommendations regarding the need for and appropriateness of the performance of services in the Health System by APPs;

b. evaluate and make recommendations to develop policies and procedures relevant to the formation and approval of standardized procedures;

c. periodically review and approve all standardized procedures and clinical protocols utilized by nurses practicing in expanded roles and/or practitioners providing clinical services utilizing protocols under the supervision of a medical staff member;

d. evaluate and make recommendations regarding the qualifications and credentials of Advanced Practice Providers who are eligible to apply for and provide services either utilizing standardized procedures or protocols; and

e. evaluate and make recommendations regarding the qualifications and credentials of

each APP applying for initial appointment and reappointment and ensure that an appraisal is performed on each Advanced Practice Provider at the time of reappointment to the Advanced Practice Provider Staff.

f. The CIDP shall maintain a permanent record of its proceedings and shall submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The CIDP shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-6 Continuing Medical Education Committee (CME)

The Continuing Medical Education Committee shall be composed of physicians (one (1) physician representative from each program series that awards Category 1 credit), nurses, administration and other assigned members as may be necessary and appropriate.

The duties of the CME Committee shall be to:

a. prepare and approve a CME budget for each fiscal year;

b. formulate the educational needs of the Medical Staff;

c. evaluate individual CME activities as they occur as well as evaluate the overall CME program admission at least annually;

d. write and update CME policies and forms;

e. ensure all CME standards for Category 1 activities are met;

f. be responsible for approving all Category I Credit Activities; and

g. maintain a permanent record of its proceedings and submit periodic and timely reports of its activities and recommendations to the Medical Executive Committee.

The CME Committee shall meet as often as necessary at the call of the Chairperson.

19.3-7 End of Life Committee

The End of Life Committee shall be composed of physicians, nurses, social workers, administration and other assigned members as may be necessary and appropriate.

The duties and responsibilities of the End of Life Committee shall be to:

a. participate in the development of guidelines to address physical, psychological and spiritual concerns for patients at end of life and with life threatening illness;

b. develop and implement procedures for the review of such cases;

c. develop and/or review institutional policies regarding care and treatment of such cases;

d. retrospectively review cases for the evaluation of palliative care and end of life

services;

e. develop and support the Palliative Care Consult Service to assist patients, families and treatment teams to facilitate excellent symptom management, decision making and communication and aid in providing psychosocial support and discharge planning;

f. educate the Health System staff and house staff on end of life and palliative care matters; and

g. maintain a permanent record of its proceedings and submit periodic and timely reports of its activities and recommendations to the Medical Executive Committee.

The End of Life Committee shall meet as often as necessary at the call of its chairperson.

19.3-8 Ethics Committee

The Ethics Committee shall be composed of physicians, nurses, administration, and other assigned members as may be necessary and appropriate. It should include diverse members, such as lay representatives, social workers, chaplains, other clergy, ethicists and/or an attorney.

The duties and responsibilities of the Ethics Committee shall be to:

a. participate in the development of guidelines for consideration of cases having bioethical implications;

b. develop and implement procedures for the review of such cases;

c. develop and/or review institutional policies regarding care and treatment of such cases;

d. retrospectively review cases for the evaluation of bioethical policies;

e. consult with concerned parties to facilitate communication and aid bioethical conflict resolution;

f. educate the Health System staff on bioethical matters; and

g. maintain a permanent record of its proceedings and submit periodic and timely reports of its activities and recommendations to the Medical Executive Committee.

The Ethics Committee shall meet as often as necessary at the call of its chairperson.

19.3-9 Graduate Medical Education Committee

The Graduate Medical Education Committee shall be composed of physicians, which include, at a minimum, the, Designated Institutional Official (DIO), the Program Directors, Program Associate Directors of Medicine, Emergency Medicine and Surgery, representatives of faculty, and resident physicians, and other assigned members as may be necessary and appropriate.

The duties of the Graduate Medical Education Committee shall be to:

a) oversee and direct all graduate medical education activities at the Health System;
    1. establish and implement policies and procedures regarding the quality of education and the work environment for the residents of AHS

b) To review at least annually the salary and benefits afforded to the resident physicians employed by AHS

c) To establish and implement formal written policies and procedures to ensure compliance by all programs and institutions utilized in GME for AHS with all aspects of the ACGME duty hour requirements;

d) To regularly monitor compliance of programs and institutions with the established duty hour requirements.

e) To ensure that resident physicians have appropriate supervision for all patient care and educational activities within the program curriculum.

f) To establish and monitor policies for the selection, evaluation, promotion and dismissal of resident physicians at AHS;

g) To ensure that all programs have both a written curriculum and a formal evaluation system based on the established ACGME core competencies;

h) To review and approve all communications with the ACGME for all programs including but not limited to:
    1. applications for new programs
    2. requests for changes in resident complement,
    3. changes in length of training
    4. changes in participating institutions
    5. appointments of all program directors
    6. requests for either inactive status or reactivate status
    7. requests for voluntary withdrawal
    8. and appeals of adverse action

i) regularly review ethical, socio-economic, medical/legal, and cost containment issues that affect graduate medical education;

j) act as a forum for communication between the graduate medical education program, the Medical Staff, Health System Administration, and the Board of Trustees related to the monitoring and improvement of graduate medical education programs;

k) maintain a permanent record of its proceedings and submit biannual reports of its activities and recommendations to the Medical Executive Committee and an annual report to the Board of Trustees regarding safety, quality of patient care, and

l) To conduct internal self-study and review for all programs at approximately mid-cycle of scheduled ACGME site visits and review reports and make recommendations to the program directors to address areas of concern and ensure

substantial compliance with the institutional, common program and specialty specific requirements.

The GME Committee meeting shall meet at a minimum quarterly or as needed.

19.3-10 Health Information Management Committee

The Health Information Management Committee shall be composed of physicians, nurses, House Staff, administration including a member from the Medical Records Department, and other assigned members as may be necessary and appropriate.

The duties of the Health Information Management Committee shall include:

a. review and make recommendations for Medical Staff and Health System policies, Rules and Regulations relating to Medical Records, including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;

b. review and evaluate medical records, or a representative sample, to determine whether the information contained in the medical record is complete, accurate and recorded in a timely manner;

c. provide liaison with Health System Administration and Health Information Management personnel in the employ of the Health System on matters relating to medical record practices including the development of and adherence to policies maintaining appropriate access to and confidentiality of patient medical information; and

d. maintain a permanent record of all actions taken and submit quarterly reports and recommendations to the Medical Executive Committee.

e. ensures the integrity of the medical record is maintained

f. serves as a forum to identify important health information management issues and develops plans to address these concerns

The Health Information Management Committee shall meet bi-monthly or as often as necessary at the call of its Chairperson.

19.3-11 Human Subjects Protection Committee/Institutional Review Board (HSPC/IRB)

The HSPC/IRB Committee shall be composed of physician, nurses, administration and other assigned members including lay representation as may be necessary and appropriate.

The duties of the Human Subjects Protection/IRB Committee shall be to:

a. monitor research involving human subjects and compliance with State and Federal laws pertaining to such research by reviewing, evaluating, and approving or

disapproving all research protocols prior to initiation;

b. formulate and implement written procedures for conducting the initial and continuing review of research protocols;

c. evaluate and act on requests for access to and/or of individually identifiable health information for research purposes pursuant to regulations published under the Health Insurance Portability and Accountability Act of 1996.

d. maintain a permanent record of its proceedings and shall submit periodic and timely reports of its research activities and recommendations to the Medical Executive Committee.

The HSPC/IRB shall meet as often as necessary at the call of its chairperson and at least annually.

19.3-12 Infection Control Committee

The Infection Control Committee shall be composed of physicians, nurses including the Infection Preventionist, administration, other representation from the Infectious Disease Service and individuals employed in a surveillance or epidemiological capacity, and other assigned members as may be necessary and appropriate.
The duties of the Infection Control Committee shall include:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Infection Control program;

b. develop a Health System wide infection control program and maintain surveillance over the program;

c. develop a system for reporting, identifying and analyzing the incidence and cause of healthcare associated infections, and assign responsibility for the ongoing collection and analytic review of such data, and follow-up activities;

d. develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing and evaluating aseptic, body substance precaution and sanitation techniques;

e. develop written policies defining special indications for body substance precaution;

f. act on recommendations related to infection control received from the President of the Medical Staff, the Medical Executive Committee, the departments and other committees;

g. review susceptibility of organisms specific to the Health System and its campuses; and

h. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Infection Control Committee shall meet at least quarterly or as often as necessary at the call of its Chairperson.

19.3-13 Interdepartmental Professional Practice Committee (IPPC)

The Medical Executive Committee has delegated the oversight of the individual QRC's to the Interdepartmental Professional Practice Committee. The IPPC's voting members shall include at least one member from each medical staff departments. The IPPC's non-voting members may include representatives from administration and such other assigned individuals as the Chief of Staff may determine are necessary or appropriate for the IPPC to fulfill its functions.

The duties and responsibilities of the IPPC shall be to:

a. Assure that a fair and just culture is maintained in the functioning of all the QRC's

b. Monitor the effective identification of systems issues identified during the process.

c. Oversee to the Ongoing Professional Practice Evaluation / Focused Professional Practice Evaluation process as well as other provider performance reviews.

d. Maintain a permanent record of its proceedings and submit reports of its activities and recommendations to the Medical Executive Committee.

The Interdepartmental Professional Practice Committee shall meet at minimum quarterly or as needed.

19.3-14 Morbidity and Mortality (M&M) Conference Committees

Each department of the Medical Staff may form a Morbidity and Mortality (M&M) Conference Committee. The M&M Conference Committee may be a combined meeting of the divisions of the department or the divisions may meet separately.

The M&M Committee, if formed, shall be a subcommittee of the Quality Review Committee of the department. The chairperson of the M&M Conference Committee shall be the Chair of the Department or the appropriate Division Chief unless the Chair of the Department appoints a chairperson who is a member and holds clinical privileges in the appropriate department/division.

The M&M Conference Committee shall be composed of physician members who hold clinical privileges in the department/division, house staff and other assigned members as may be necessary and appropriate.

The duties of the M&M Committees shall be to:

a. review patient care activities related to the department/division;

b. develop practice management guidelines related to the department/division;

c. report and recommend practitioner specific cases with significant concerns in patient care to the appropriate departmental QRC;

d. maintain a permanent record of its proceedings and submit periodic and timely

reports to the departmental QRC.

The M&M Conference Committee shall meet as often as necessary at the call of the Chairperson.

19.3-15. Pharmacy, Therapeutics and Nutritional Care Committee (P&T)

The Pharmacy, Therapeutics and Nutritional Care Committee shall be composed of physicians, nurses, House Staff, administration (including representation from Pharmacy Services, and Nutrition Care) and other assigned members as may be necessary and appropriate.

The duties of the Pharmacy, Therapeutics and Nutritional Care Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for professional practices and policies regarding nutrition care and the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and all other matters relating to drugs in the Health System, including antibiotic usage;

b. review and recommend to the Medical Executive Committee, relevant policy, procedures, and protocols that may be necessary for the operation of medication usage and nutritional care programs;

c. evaluate and improve the quality of patient care provided to patients related to medication usage and nutritional care;

d. advise the Medical Staff and Pharmacy Services on matters pertaining to the choice of available drugs;

e. make recommendations concerning drugs to be stocked on the nursing unit floors and by other services;

f. annually review and revise, as necessary, the formulary or drug list for use in the Health System.

g. evaluate clinical data concerning new drugs or preparations requested for use in the Health System;

h. monitor and review adverse drug reactions;

i. to review aggregate data relevant to medication errors;

j. to oversee clinical care related to the nutritional needs of patients; and

k. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee

The Pharmacy, Therapeutics and Nutritional Care Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-16 Provider Wellness Committee

The Provider Wellness Committee shall be composed of physicians, residents, nurses, administration and other assigned members as may be necessary and appropriate.

The duties of the Provider Wellness Committee shall be to:

a. develop and assess wellness activities for the health system through the guiding principle that the professional satisfaction and physical and emotional wellbeing of physicians and other caregivers is inextricably linked to quality, safety and patient-centeredness;

b. plan activities to pursue and promote good health for our caregivers and create a culture of wellness;

c. refer systems issues to the Quality and Safety Committee;

d. develop speaker's series with educational topics that build support for providers;

e. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Provider Wellness Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-17 Provider Wellbeing Committee

The Provider Wellbeing Committee shall be composed of three (3) physician members of the Medical Staff. Members of the Provider Wellbeing Committee shall not serve as active participants on other peer review or performance improvement committees while serving on the Provider Wellbeing Committee.

The committee shall not have disciplinary function with respect to a physician's staff membership or privileges and shall not be responsible for any investigation leading to disciplinary action against staff membership or privileges/practice prerogatives.

The duties of the Provider Wellbeing Committee shall be to:

a. provide education about physician health, addressing prevention of physical, psychiatric, or emotional illness;

b. facilitate confidential diagnosis, treatment, and rehabilitation of physicians who suffer from potentially impairing conditions;

c. aid the physician regaining or retaining optimal professional functioning consistent with protection of patients;

d. educate the Medical Staff and other organizational staff about illness and impairment recognition issue-specific to physicians;

e. allow for self-referral by physicians and referral by other organizational staff;

f. referral of affected physicians to appropriate professional internal or external resources for diagnosis and treatment of physical, emotional, or drug dependency related conditions;

g. maintenance of the confidentiality of the physician seeking referral or referred for assistance except as limited by law, ethical obligation, or when the safety of a patient is threatened;

h. evaluate the credibility of any complaint, allegation, or concern regarding the physical or emotional health of a physician;

i. monitor impaired physicians during programs of treatment and rehabilitation;

j. report to the appropriate Medical Staff committee, at any time during diagnosis, treatment, or rehabilitation, if it is determined that the physician may be unable to safely perform the privileges he or she has been granted;

k. monitor compliance with any mandatory drug treatment programs; and

l. maintain only such records of its proceedings, as it deems advisable and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

m. Initiating appropriate actions when a licensed independent practitioner fails to complete the required rehabilitation program.

The Provider Wellbeing Committee shall meet at least quarterly and as often as necessary at the call of its Chairperson.

19.3-18 Quality and Safety Committee

The Quality and Safety Committee shall be composed of the President of the Medical Staff, the President-Elect and two (2) at large members of the Medical Staff appointed by the President of the Medical Staff. Non-physician members shall include the Chief Medical Officer, Chief Financial Officer, Chief Operations Officer, Chief Nursing Executive, Chief Quality Officer, Ambulatory Quality Services Director, and the Risk Manager. The Committee shall be Co-Chaired by a medical staff member and an administrative member of the committee.

The Quality and Safety Committee has a central role in the initiation, performance and maintenance of the organization's performance improvement program. The fundamental responsibilities and duties of the Quality and Safety Committee shall be to:

a. set priorities for organizational performance improvement activities that are designed to improve patient care processes and outcomes;

b. develop performance improvement training programs for the organization's staff;

c. foster communication among all departments and services;

d. prioritize and select specific performance improvement team projects;

e. receive aggregate reports related to performance improvement activities from Health System support services, Medical Staff clinical function committees and all organizational performance improvement teams;

f. have direct oversight of the following functions:
   1) Improving Organizational Performance
   2) Leadership

g. prepare an annual appraisal of the organization's performance improvement program; and

h. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality and Safety Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-19 Quality Review Committees (QRC)

Each department of the Medical Staff shall have a Quality Review Committee (QRC). Each department's QRC may meet separately or jointly with the QRCs of other departments at the discretion of the Chair of the Department and as approved by the Medical Executive Committee.

Each departmental QRC shall monitor the quality and appropriateness of clinical services provided by those holding clinical privileges in its department related to the divisions represented by the QRC. When requested, the QRC shall also make recommendations to the Credentials and/or Medical Executive Committees related to specific credentialing issues. The Chair of the Department, however, shall have the ultimate duty and responsibility to make recommendations regarding credentialing issues to the Credentials and/or Medical Executive Committees.

The duties and responsibilities of the QRC's shall be to:

a. evaluate and improve the quality of care provided to Health System patients which may include accurate and timely medical record documentation;

b. conduct patient care reviews for the purpose of analyzing and evaluating the quality and appropriateness of care and treatment including practitioner specific data for medication usage, medical records, transfusion review and operative and invasive care, provided by practitioners within the divisions of the departments represented by the QRC;

c. perform peer review and/or other physician specific intensified assessments when indicated or requested by an appropriate Medical Staff committee;

d. identify system problems requiring process improvement activity and make such recommendations to the Quality and Safety Committee;

e. take appropriate actions when important problems in patient care or opportunities to improve patient care are identified;

f. recommend to the Chairperson of the Department, those Medical Staff policies and procedures as may be necessary to conduct patient care and administrative Medical Staff activities;

g. communicate the significant results of peer review and performance improvement activities to relevant practitioners;

h. implement programs that assess compliance with clinical practice guidelines and other recognized standards of care;

i. assume all duties and responsibilities of the departments related to quality assessment, peer review and performance improvement, which have not been otherwise assigned to the Chair of the Department and as may be described in the Bylaws and/or Rules and Regulations; and

j. maintain a permanent record of its proceedings and submit periodic and quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Quality Review Committees shall meet quarterly or as often as necessary at the call of its chairperson.

19.3-20 Stroke Committee

The Stroke Committee shall be composed of the Stroke Team which includes physicians, nurses, administration, other representation from the Emergency Department and Neurology Division and EMS and other assigned members as may be necessary or appropriate.

The duties of the Stroke Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Stroke program;

b. demonstrate conformity with clinical practice guidelines or evidence-based practice

c. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality and Safety Council.

The Stroke Committee shall meet at least quarterly or as often as necessary at the call of its Chairperson.

19.3-21 Tissue Committee

The tissue committee shall be composed of members of the medical staff from surgery, gastroenterology, obstetrics and gynecology, and pathology.

The duties of the Tissue Committee shall be to:

a. review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. In the latter case, however, a screening mechanism based upon pre-established criteria may be established.

b. review all removed tissue when the tissue is found to be normal or not consistent with the clinical diagnosis, and develop and implement measures to correct any problems discovered.

c. review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis.

d. Following the recommendation of the surgical departments, the medical executive committee may describe a system by which the function of the tissue committee shall be coordinated with departmental surgical case review.

e. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Quality and Safety Council.

The Tissue Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-22 Transfusion Committee

The Transfusion Committee shall be composed of physicians including representation from pathology, medicine, surgery, anesthesiology, nursing, administration and other assigned members as may be necessary and appropriate.

The duties of the Transfusion Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for Blood Bank and transfusion review;

b. monitor standards for transfusion practice, distribution, handling, use and administration to promote appropriate use of blood and blood products;

c. monitor and evaluate the appropriateness of transfusions for blood and blood products, transfusion reactions and physician ordering practices; and

d. maintain a permanent record of its proceedings and submit quarterly reports of its

activities and recommendations to the Medical Executive Committee.

The Transfusion Review Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-23 Tumor Board

The Tumor Board shall be composed of physicians, nurses, administration and other assigned members as may be necessary and appropriate to fulfill the requirements for cancer designation by the American College of Surgeons and the Cancer Commission of the California Medical Association.

The duties of the Tumor Board shall be to:

a. conduct multidisciplinary, patient-oriented treatment planning cancer conferences to improve the care of patients with cancer. Conferences shall focus on:
    1) pretreatment evaluation
    2) staging
    3) treatment strategy
    4) rehabilitation
    5) problem cases

b. provide relevant educational programs related to cancer care to the Medical Staff.

The Tumor Board shall meet as often as required according to the Standards on the Commission of Cancer but at least biannually.

19.3-24 Utilization Review Committee

The Utilization Review Committee shall be composed of physicians, nurses and administration including representation from the Utilization Review Department, Medical Social Services and other assigned members as may be necessary and appropriate.

The duties of the Utilization Review Committee shall be to:

a. develop, implement and assess appropriate quality control and performance improvement measures for the Utilization Review Program;

b. to maintain utilization review and quality control measurements and to conduct utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors that may contribute to the effective and efficient utilization of resources and services;

c. to obtain, review and evaluate information and data generated by the hospital's case management service;

d. act on recommendations related to utilization review received from the President of the Medical Staff, the Medical Executive Committee, the Departments and other committees;

e. maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The Utilization Review Committee shall meet quarterly or as often as necessary at the call of its Chairperson.

19.3-25 San Leandro Leadership Committee

The San Leandro Leadership Committee shall be composed of physicians on the Active medical staff. The initial Chair and Vice Chair of this committee shall be the San Leandro Chief of Staff can Vice Chief of Staff immediately prior to the merger of its license with AHS, with the Chair to designate seven (7) additional members. The initial Chair, Vice Chair and members shall serve for the balance of what would have been the remainder of the former Chief of Staff's term of office. Thereafter, the Chief of Staff shall designate the Chair, Vice Chair and committee members, provided the membership will include at least seven (7) physicians who are Site Directors from the Medical Staff Departments.

The duties of the San Leandro Leadership Committee shall be to:

a. Provide a mechanism to assure the Medical Staff is informed of the needs and concerns at the San Leandro facility, patients and Medical Staff members, including but not limited to San Leandro facility-specific quality and safety initiatives, patient satisfaction issues, infection control issues, drug and formulary issues, and other quality measures.
b. Recommend policies and procedures, protocols, and standing orders specific to the San Leandro facility to address local concerns and needs.
c. Make recommendations to help assure the San Leandro facility's unique circumstances and significant differences in patient populations and services are addressed.
d. Appoint a member of this committee to serve as the ex-officio non-voting member of the MEC, which is in addition to the four (4) voting positions on the MEC that are held by the committee chair, committee vice chair and two at-large positions from the San Leandro facility.
e. Maintain a permanent record of its proceedings and submit quarterly reports of its activities and recommendations to the Medical Executive Committee.

The San Leandro Leadership Committee shall meet at least quarterly and as often as necessary at the call of the Chair.

ARTICLE 20 DISTRIBUTION OF THE RULES AND REGULATIONS

20.1 Each Medical Staff member and APP shall be given a copy of these Medical Staff Rules and

Regulations, which contain a general outline of policies and procedures related to the Medical Staff. Medical Staff members and APPs agree, by being granted Medical Staff membership or AHP status in any capacity, to abide by these Rules and Regulations.

Approved	**Date**
Medical Executive Committee	5/2019
Board of Trustees	5/2019