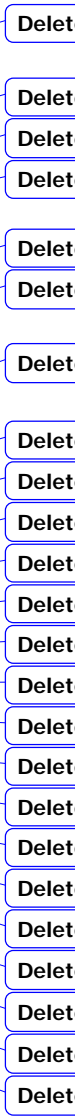




General Rules and Regulations

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I. GENERAL RULES REGARDING PATIENT CARE

1.1 Admissions and Discharges

Patients admitted through the emergency service who have no attending physician shall be assigned to a physician member of an on call panel from the appropriate department.

A medical screening examination to determine the presence or absence of an emergency medical condition may be performed by the following practitioners: MD, DO, Registered nurse under approved standardized procedures (OB, ER and Psych nurses) and Physician Assistants under approved protocols or guidelines. A mental status assessment may be performed by the above noted group of practitioners and to include the following: Clinical Psychologist, Marriage, Family, Therapist and Licensed Clinical Social Worker.

1.2 General Policy

Only physicians, dentists, podiatrists and psychologists who are members of the Medical Staff may admit patients to the hospital. All patients admitted by dentists, podiatrists and psychologists shall have a history and physical examination by a M.D./D.O., staff physician, in addition to the dental, podiatric or psychologic history and physical examination.

In accordance with the Bylaws of the Medical Staff, the practice of division of fees under any guise whatsoever is prohibited and is cause for automatic termination from staff membership.

The Medical Staff shall maintain a Manual of Medical Staff Policies, which are approved by the Medical Executive Committee and Board of Directors and are reviewed and revised as necessary.

1.3 Dentists

Dentists shall be assigned to and be under the direct jurisdiction of the Department of Surgery. Privileges granted to a dentist shall be based on their training, experience, and demonstrated competence and judgment. 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. All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the dental care of the patient, including the dental history and physical exam and all appropriate elements of the patient's chart.

1.4 Podiatrists

Podiatrists shall be assigned to and be under the direct jurisdiction of the Department of Surgery. The scope and extent of surgical procedures that each podiatrist may perform must be specifically defined and recommended in the same manner as for all other surgical

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privileges. All podiatric patients shall receive the same basic medical appraisal by an MD/DO as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or may arise during hospitalization. The podiatrist is responsible for the podiatric care of the patient, including the podiatric history and physical examination and all appropriate elements of the patient's chart.

1.5 Psychologists

Psychologists shall be assigned to and be under the jurisdiction of the Department of Medicine/Family Practice. Privileges granted to psychologists shall be based on their training, experience and demonstrated competence and judgment. Psychologists may admit, diagnose and treat mental disorders, establish treatment plans, discharge patients and write orders consistent with their licensure. All patients admitted by a psychologist shall receive the same basic medical appraisal as patients admitted by other practitioners. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

In addition to a history and physical examination by a physician (MD/DO) within 24 hours of admission, patients admitted by a psychologist must also have a full psychologist evaluation and a full psychiatric evaluation by a psychiatrist (MD/DO) within 24 hours of admission.

A psychiatrist will be responsible for monitoring any organic treatment in the absence of another licensed medical practitioner (MD/DO) on the case. On such cases, the psychiatrist or other licensed medical practitioner shall provide appropriate input into the patient's treatment plan. In addition, prior to writing a discharge order on a patient receiving medication or organic treatment, psychologist will consult with psychiatrist or other licensed practitioner on appropriateness of discharge and discharge orders. Psychologist is responsible for providing psychological discharge summary.

1.6 Membership

The attending physician shall be defined as the Licensed Independent Practitioner responsible for the overall care of the patient. The covering physician shall be defined as the Licensed Independent Practitioner who acts as the attending physician in the absence of the attending physician.

Members of the Allied Health Professional Staff (AHP Staff) shall not be eligible for membership on the Medical Staff. The following disciplines have been approved by the Medical Staff:

CRNA (Certified Registered Nurse Anesthetist)	PA (Physician Assistant)
RNP (Registered Nurse Practitioner)	LCSW (Licensed Clinical Social Worker)
MFT (Marriage, Family, Therapist)	RNFA (Registered Nurse First Assist)
C (Chiropractor)	LPT (Licensed Psychiatric Technician)

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RN (Registered Nurse – 5150 Holds only)
Surgical Technician – (non-employees)

RN/CST (Registered Nurse/Certified

1.7 Confidentiality

All members of the Medical shall comply with the Evidence Code 1157 as it pertains to the confidentiality of records to include reviews pertaining to or conducted during Medical Staff meetings as defined in the hospital's Performance Improvement Plan.

II. GENERAL CONDUCT AND CARE

2.1 Surgery Requirements

- 1 All pre-admission paperwork will be kept in Admitting.
- 2 All physicians, upon admission of a patient, shall submit a provisional diagnosis and other pertinent details to assure the proper placement and care of the patient.
- 3 A durable, legible copy of an office history and physical may be substituted if it has been obtained within seven (7) days of admission and any subsequent changes recorded at time of admission.
- 4 An informed consent policy shall be included in the Administrative Policy and Procedure Manual. The physician shall be responsible for the informed consent on patients receiving care at this hospital, according to the policy. The original consent form shall be made a part of the patient's medical record.
- 5 Physicians shall not be the attending physician or the operating surgeon for first-degree relatives (parents, children, siblings or spouses) who are patients in the hospital. This will not preclude the physician from being the first assistant at a surgical procedure, or writing an order in the chart if the attending physician approves that order.
6. Any physician who orders a surgical procedure implies there will be an order for anesthesia.

2.2 Proctoring

- A. Proctoring will be required of all new staff members as well as those requesting a modification of their current privileges as outlined in each individual department rules.
- B. With regard to any physician transferring from one department to another, requirements for proctoring will be left up to the new department.

2.3 Care in the ICU

All patients admitted to the Intensive Care Unit will be managed by the Intensivist unless, specified in the medical record by the attending physician and only if the patient's condition is limited to a single diagnose, which relates to the attending's subspecialty and/or board certified or equivalent in Internal Medicine.

In the event there is a disagreement or the Internist is unavailable the Intensivist has the ultimate authority of the case.

III. CONSULTATION

Consultation with a qualified consultant is required in all critically ill patients unless the attending physician has been granted appropriate privileges as documented on the delineation of privileges.

Except in an emergency, consultation is required in the following situations:

- a) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
- b) Where there is serious doubt as to the choice of therapeutic measures to utilized;
- c) When the patient's clinical course requires care beyond the expertise of the attending physician.

Requests for consultation and participation in management shall be recorded on the physician's order sheet. If any controversy arises, the Chair of the respective Department of the Medical Staff, or his/her designee, shall have ultimate authority to determine if further consultation is required.

3.1 Procedures for Consultation

The Attending Physician

It is the responsibility of the attending physician to write on the order sheet a request when consultation is desired.

Consultation Only

This applies when the attending physician desires only a consultant's opinion and his recommendations as to diagnosis and treatment. There is no obligation on the part of the consultant beyond reviewing the chart, examining the patient and dictating the consultation including diagnosis and recommendations.

If, the attending physician and the consultant agree that the consultation shall take over the full responsibility of care that the attending physician shall be relieved of any further

responsibility, such an agreement shall appear in the patient's medical record, signed by both physicians. In this event, the record shall also show that the patient was notified and has agreed to this change.

Consult continuing with treatment

This applies when the attending physician desires the consultant not only to give a diagnosis, but also to continue with the management of the case for that particular problem for which he/she has been called as a consultant. This does not relieve the attending physician from a continuing responsibility of the general patient management. Under these circumstances there may be one or more consultants handling particular problems while the attending physician coordinates the entire management program.

Documenting the consultation

Consultation reports shall record the date and time of consultation and show evidence of having examined the patient, reviewed the medical record, recorded the findings, diagnosis or impression, and outlined recommendations for treatment. These recommendations should be entered on the chart immediately upon completion of the consultation.

Notification of the Family

- a. It is the attending physician's responsibility to notify the patient and/or a responsible member of the family that consultation is being requested and it is also the attending physician's responsibility that an order is written on the chart for request of consultation.
- b. The attending physician may request, orally or in writing, that the consultant not disclose their findings and recommendations to the patient or his family. However, the consultant is not bound by this request if he/she feels the patient's protection requires his/her own disclosure.

IV. ORDERS

RN's, LVN's, Licensed psychiatric technicians, pharmacists, physicians, physical therapists, (for certain topical drugs only), and respiratory therapists when the orders relate specifically to respiratory therapy, may accept verbal drug orders for drugs they are licensed to administer within their scope of practice.

4.1 Drugs and Devices

Drugs and devices used shall be those approved by the Federal Drug Administration with the exception of drugs for bona fide clinical investigation, which shall be approved by an Institutional Review Board.

4.2 Generic Drug substitutions

Generic drug substitutions may be made without notice to the attending physician unless he/she clearly specifies to the contrary in writing on the standard order sheet.

4.3 Discontinuation of drugs

All drug orders for patients undergoing surgery will automatically be discontinued at the time of surgery. Orders for antibiotics, narcotics, hypnotics, and anticoagulants will stop automatically after seventy-two (72) hours and must be rewritten by the physician unless the original order specified a duration of therapy. Orders for oncology chemotherapy agents must specify the number of doses to be administered. All orders for patients transferring into or out of ICU or DOU will be automatically discontinued at the time of transfer.

V. MEDICAL RECORDS

5.1 Contents of the Medical Records

- A. All acute patients must be seen on a daily basis with daily progress notes being written, or signed-off, by the attending physician.
- B. Physicians who are not available are required to provide coverage and the covering physician must be on the staff of Pacific Hospital of Long Beach and assume total patient care responsibility. In the event of inappropriate orders, when the physician involved (either the attending or the physician covering) is unwilling to correct the order, the Chair or Vice-Chair of their respective department is to be contacted; if both the Chair and Vice-Chair are unavailable, the Chief of Staff shall be called.
- C. When certain parts of the medical record are either so confidential or are required by law to have extraordinary means taken to preserve their privacy, such as in some psychiatric illnesses or with retro virus test results, these portions may be stored separately from the unit record. The medical record shall indicate a portion has been filed elsewhere.
- D. The medical record shall document an offer for psychiatric consultation in all known suicide attempts and intentional drug overdose patients.

5.2 History and Physicals

- A. History and physical examination reports shall be written or dictated within twenty-four (24) hours after or seven (7) days prior to admission to inpatient services, by a physician or, when applicable, a qualified oral surgeon. Exception: A patient admitted to the Skilled Nursing Unit must have a written history and physical within 5 days prior to admission to unit or completed within 72 hours of admission.

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B. History and physicals for any inpatient procedure shall be dictated and placed on the chart prior to surgery. If the report is dictated but not on the chart prior to surgery, there must be a complete, comprehensive, and detailed admission note or complete, comprehensive and detailed history and physical written in the chart. The note must contain pertinent findings or sufficient patient information within 24 hours of admission so that clinicians can manage the patient and guide the plan of care.

C. The "History and Physical Form" will only be used for outpatient surgery and non-surgical inpatient admissions.

D. The content of a complete history and physical will include the following items as indicated:

Past Medical History	Physical Examination
Past Surgeries and Hospitalizations	Vital signs
Psychosocial/Personal History	
Family History	Skin
Allergies	Head
Current Medications	Eyes
Chief Complaint	Ears
Present Illness	Nose and sinuses
Current Lab & Imaging Data	Mouth
Review of Systems	Throat
General	Neck
Respiratory	Thorax, anterior and posterior
Cardiovascular	Breasts
Gastrointestinal	Heart
Renal	Blood Vessels
Urinary	Lymphatics
Genito-Reproductive	Lungs
Musculoskeletal	Abdomen
Neurological	Genitourinary
Hematologic	Vaginal
Endocrine	Rectal (reason for deferral must be stated)
Psychological	Neurological
Musculoskeletal	Extremities
Diagnosis; Statement of Impressions or conclusions drawn	Statement of the course of action planned for the patient

5.3 Progress notes

All physicians/surgeons are required to submit either a copy of their outpatient notes or place a pre-procedure note in the chart prior to surgery for the following items: indications for surgery, necessary imaging and lab results and informed consent.

5.4 Operative Reports

Operative reports shall be dictated immediately after surgery.

5.5 Authentication of Entries

- A. All orders for studies and treatment of patients shall be in legible writing by the physician. Verbal orders shall be documented on the medical record with the name of the physician giving the order and the individual's name and title receiving the order. Verbal drug orders shall be accepted from a physician only. The attending or covering physician shall countersign, date and time such orders within forty-eight (48) hours.
- B. Those sections of the medical record that are the responsibility of the medical practitioner are to be authenticated by that practitioner.

5.6 Final Diagnosis

A final note in the progress notes may be substituted for the discharge summary in the care of patients with problems of a minor nature that require less than a forty-eight (48) hour period of hospitalization and in cases of normal newborn infants and uncomplicated obstetrical deliveries. This note shall include discharge instructions given to the patient and/or family.

5.7 Discharge Summary

- A. Patients shall be discharged only on an order of the attending physician, dentist, podiatrist, psychologist, or their designee.
- B. The records of discharged patients shall be completed within fourteen (14) days following discharge. A notification will be sent to the physician reminding him/her of the incomplete record(s). Any physician who fails to respond to a request to complete record(s) prior to two weeks (14 days) of discharge will be subject to suspension of Medical Staff privileges. Any physician who does respond to a request to complete record(s), yet fails to complete record(s) present for completion, may be subject to suspension of Medical Staff privileges.
- C. The medical record shall contain a discharge summary which shall briefly recapitulate the significant findings and events of the patient's hospitalization, the reason for hospitalization, procedures performed and treatment rendered, the

patient's condition on discharge and the recommendation, arrangements for future care and instructions to the patient and family, if any.

- D. A Short Stay Discharge Summary for Newborns with uncomplicated deliveries, uncomplicated scheduled Cesarean sections, uncomplicated vaginal deliveries, skilled nursing, or for patients hospitalized for less than 48 hours may be substituted for the dictated discharge summary. The Short Stay Discharge Summary, which may be handwritten, documents the patient's outcome, condition at discharge, discharge instructions, and required follow-up care.
- E. A Dictated Death Summary will be completed on all patients regardless of length of stay, recapping the events that lead to death, including diagnosis and causes of death.

5.8 Incomplete Records

Incomplete records shall be filed incomplete only on the approval of the Medical Executive Committee. No Medical Staff member shall complete a medical record on an unfamiliar patient in order to retire a record for another staff member who is deceased or unavailable for other reasons.

5.9 Signature Stamp

When signature stamps or computer keys are authorized (for use in the medical record), the individual whose signature the stamp represents places it in the administrative offices of the hospital, a signed statement to the effect that the individual is the only one who has the stamp or key and is the only one who will use it. There is no delegation of the use of such a stamp or key to another individual.

5.10 Suspension

The Health Information Management department shall maintain the Suspension List. Members of the Medical Staff will be placed on the Suspension List (unless they have informed the Health Information Management department that they are on vacation or unavailable due to heal reasons) due to non-compliance with Medical Staff rules, Regulations or Policies regarding the timely dictation of operative reports, completion of history and physical, completion of discharge summary, as described elsewhere in these Rules and Regulations. Copies of the Suspension List does not preclude listed Medical Staff members from caring for bona fide emergencies, nor from completing the care of patients who were hospitalized at the time the Medical Staff members was placed on the list. A Medical Staff member shall remain on the Suspension List until such time as they have complied with the Rules. Privileges suspended by placement on the Suspension List include admitting patients, performing or assisting at surgery and seeing patients under the name of a medical group or assisting at surgery and seeing patients under the name of a medical group or associate, or as a consultant.

VI. PATHOLOGY

- A. Every member of the Medical Staff is expected to be actively interested in securing autopsies. No autopsy shall be performed without the written consent of the relative or legally authorized agent as prescribed by law. All autopsies shall be performed by the hospital pathologist or by a physician specifically delegated this responsibility by the Medical Executive committee.
- B. Autopsy reports shall be documented in the medical record with a provisional anatomic diagnosis within three (3) days and a complete report within ninety (90) days.
- C. A three (3) day stop order shall be placed on all daily laboratory orders unless otherwise specified by the physician.

VII. HOUSE STAFF

A mechanism by which the house staff is supervised by members of the Medical Staff in carrying out their patient care responsibilities shall be described in the Medical Staff Policy and Procedure Manual.

RESIDENT SUPERVISION

Resident supervisors must meet the following specifications:

- a) Be licensed independent practitioners (LIPs)
- b) Hold clinical privileges that reflect the patient care responsibilities given to the residents (e.g., a resident allowed to take a history and physical must be supervised by an LIP with H&P privileges).

VIII. NOTICE OF PRIVACY PRACTICES

All physicians agree to abide by the terms of the hospital's Notice as part of their participation of the Medical Staff of Pacific Hospital of Long Beach. The physician and hospital's joint Notice describes, with reasonable specificity, the Hospital and physicians to which the Notice applies. The Notice states that the Hospital and physicians will share information to carry out treatment, payment, or health care operations.

IX. RESEARCH/INVESTIGATIONAL REVIEWS

A physician (recipient) must obtain Hospital approval prior to any research. The recipient must prior to Hospital approval provide the Hospital with an approved IRB and state and federal required consents and documentation. The patient's signed authorization to release information to the recipient until "end of study," is also required. Prior to Hospital approval the physician is to also provide the Hospital with the cost involved to the Hospital, such as extra laboratory, radiologic or other ancillary services or monitoring. The Hospital approves

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and disapproves research activities and may discontinue an approved research activity at any time, without notice. Research information without the patient's authorization may be obtained with hospital approval so long as there has been a Data Use Agreement established and recipient pays reasonable agreed upon preparatory fees for a Limited Data Set.

Revised by Board of Directors:

03/20/02

12/18/02

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