UCI MEDICAL CENTER  
MEDICAL STAFF  

RULES AND REGULATIONS  

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RULES AND REGULATIONS OF THE MEDICAL STAFF

A. ADMISSION AND DISCHARGE OF PATIENT

1. Patients will be accepted at the Medical Center for care and treatment, in accordance with the requirements of applicable laws, regulations and accreditation standards. Patients with a primary diagnosis of alcoholism or drug abuse are not candidates for admission except for provision of detoxification and appropriate consultations and referral.

2. The policy and procedures for the admission of patients to the Medical Center shall be those specified in pertinent Administrative Policies and Procedures.

3. Medical Staff Members shall be responsible for the medical care and treatment of patients in the Medical Center and for the supervision of all Housestaff who attend said patients. The patient shall be attended by the Medical Staff Member at least daily. Medical Staff Members shall be responsible for the prompt completion and accuracy of the medical records and for the supervision of all Housestaff in the prompt completion and accuracy of entries into the patient's medical record.

4. The attending Medical Staff Member or the Housestaff (under the supervision of the attending Medical Staff Member) shall be responsible for the appropriate handoff of patient information using a standardized approach such as SBAR (Situation, Background, Assessment, Recommendation), any necessary special instructions and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Medical Staff Member, a note covering the transfer of responsibility shall be entered in the medical record.

5. The admission order must identify the attending before the patient will be admitted. The resident shall inform the Admitting Department of the name of the attending. The Admitting Department shall call the resident of the admitting service for the attending physician's name when the patient is admitted through the Emergency Department. It is the attending physician's responsibility to document in the chart when he or she is going off service and who the new attending will be. An order must be written to change the attending physician. Once the order is written, Nursing Services personnel will change the name in the TDS computer.

6. No patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated by the admitting Medical Staff Member.

7. Every effort shall be made to admit all patients seen in the Emergency Room who require hospital care.
8. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart within twenty-four (24) hours of admission.

9. A patient admitted on an emergency basis will be assigned to the appropriate Department or service. A Medical Staff Member and appropriate Housestaff, to provide for necessary care under the supervision of the Medical Staff Member, will be assigned to the patient. A personal private patient of a Member of the Medical Staff shall be assigned either to that practitioner or his/her designee.

10. If a Member of the Medical Staff is unable to attend his or her patient in the Emergency Room, the physician on duty in the Emergency Room shall attend the patient until the Clinical Department Chief of the appropriate department designates a Member of the Medical Staff to attend the patient.

11. The admissions clerk will admit patients on the basis of the following order of priorities:

   a. Emergency Admissions

      Upon an emergency admission, the attending physician shall complete and sign the Medical Center's admission referral form with information to justify the emergency. Failure to furnish this documentation, or evidence of willful or continued misuse of this category of admission, will be brought to the attention of the Medical Executive Committee for appropriate action.

   b. Urgent Admissions

      This includes all patients including those scheduled for surgery. If it is not possible to handle all such admissions, the Clinical Department Chief may decide the urgency of any specific admission.


Transfer priorities shall be as follows:

   a. from Emergency Room to appropriate patient bed;

   b. from Obstetric patient care area to General Care area, when medically indicated;

   c. from an Intensive Care Unit to General Care area;

   d. from temporary placement in an inappropriate geographic or clinical service area to the appropriate area.
No patient will be transferred without such transfer being approved by the responsible Medical Staff Member.

13. The admitting Medical Staff Member shall be held responsible for giving the appropriate Staff such information as may be necessary to ensure the protection of the patient from self-harm and to ensure the protection of others whenever the patient might for any reason be a source of danger.

14. For the protection of patients, the Medical and nursing staff, and the Medical Center, certain principles are to be met in the care of the potentially suicidal patient:

a. Any patient known or suspected to be suicidal must have a consultation by a Medical Staff Member assigned to the Department of Psychiatry.

b. An admitted patient known to be suicidal shall receive psychiatric care and whatever other service the emergency situation requires. Specific appropriate physical provisions and nursing coverage must be made available for the patient's safety. If these cannot be ensured, the patient should be referred, if possible, to the UCI Neuropsychiatric Center or other facility that has appropriate accommodations.

15. Patients who have a psychiatric illness while in the hospital, or who suffer the results of alcoholism or drug abuse, and are diagnosed as such after admission, will be referred for psychiatric consultation and provided with an appropriate referral.

16. Admissions and Discharge: Special (Critical) Care Units. If any questions as to the validity of admission to or discharge from an intensive care unit should arise, that decision is to be made through consultation with the appropriate Special (Critical) Care Unit. Objective criteria will be developed by all Special Care Units.

17. The Medical Staff Member is required to document the need for continued hospitalization when further stay is questioned by a member of the Performance Improvement Committee (PI Committee) or its designee. This documentation must be in conformity with the Utilization Management policies and shall include:

a. an adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient;

b. plans for post-discharge care.

Any patient remaining in the Medical Center for longer than twelve (12) months will be periodically reviewed by the Utilization Management function through the Performance Improvement Committee for appropriateness of continued stay at the acute care level.
18. Patients shall be discharged only on a physician's order. Should a patient leave the Medical Center against the advice of the Medical Staff Member, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

19. In the event of a patient death in the Medical Center, the deceased shall be pronounced dead by a Medical Staff Member or designated resident (who must be a licensed physician) within two hours of the time of discovery of death. If the housestaff pronounces the patient, the housestaff must contact the attending physician to discuss the diagnosis and completion of the death certificate. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a Medical Staff Member or the designated member of the Housestaff. Policies with respect to release of bodies shall conform to state and local laws.

20. It shall be the duty of all Medical Staff Members to secure consent to meaningful autopsies whenever possible. An autopsy may be performed only after obtaining consent as defined by state law. Except in coroner cases, all autopsies shall be performed by a physician assigned the responsibility by the Department of Pathology. The Department of Pathology shall notify the attending physician when an autopsy is scheduled. Provisional anatomic findings shall be recorded in the medical record within forty-eight (48) hours and the complete protocol should be made a part of the record within 60 days. The Medical Staff shall use the following criteria to obtain autopsies. These criteria are not exclusive of a physician's right to request an autopsy on any death.
   a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
   b. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
   c. Deaths in which an autopsy may help to allay concerns of, and provide assurance to, the family and/or the public regarding the death.
   d. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.
   e. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
   f. Unexpected or unexplained deaths that are apparently natural and not subject to forensic medical jurisdiction.
   g. Natural deaths that are subject to, but waived by, a forensic medical jurisdiction, such as persons dead on arrival at the hospital, deaths within 24 hours after admission, and deaths in which the patient sustained an injury while hospitalized.
   h. Deaths resulting from high-risk, infectious and contagious diseases.
   i. All obstetric deaths.
   j. All neonatal and pediatric deaths.
   k. Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs.
1. Deaths known or suspected to have resulted from environmental or occupational hazards.

21. Coroner's Cases

The law requires death to be reported to the coroner in the following circumstances:

a. Violent, sudden, or unusual deaths.
b. Unattended deaths.
c. Deaths related to or following known or suspected self-induced or criminal abortions.
d. Known or suspected homicide, suicide, or accidental poisoning.
e. Deaths known or suspected as resulting in part from or related to an accident or injury, either old or recent.
f. Deaths due to drowning, fire, hanging, gunshot, stabbing, cutting, exposure, starvation, acute alcoholism, drug addiction, strangulation, or aspiration.
g. Where the suspected case of death is sudden infant death syndrome.
h. Death in whole or in part occasioned by criminal means or associated with a known or alleged sexual crime.
i. Deaths suspected to be due to contagious disease that has not been reported to the Department of Health Services.
j. Deaths due to occupational diseases or hazards.

The coroner also asks for reports of deaths due to drug addiction, pneumoconiosis and therapeutic misadventures as well as deaths during or within 24 hours after operations.

B. ELECTRONIC CLINICAL INFORMATION SYSTEM

All members of the Medical Staff of UC Irvine Medical Center are required to complete the Medical Center’s orientation and training session on the use of the Medical Center’s electronic clinical information system prior to performing any and all clinical activity. Individuals who are members of the Medical Staff prior to the implementation date of the electronic medical record will complete such training on or before the implementation date.

After implementation date, all new members of the Medical Staff shall complete training as part of the department orientation process and prior to performing any and all clinical activities. Immediately following such training, the system shall be utilized for all applicable patient care activities.

C. MEDICAL RECORDS

1. A Medical Staff member shall be responsible for the preparation of a complete and legible medical record for each patient. All signatures shall be legible or
accompanied by a printed name of the signator. Stamped signatures, in lieu of a written signature, are not acceptable on any medical record (CMS – CR 5971).

2. An admission history and physical examination ("H & P") shall be recorded within twenty-four (24) hours of admission by a physician or approved non-physician practitioner. This report should include all pertinent findings resulting from an assessment of all the systems of the body appropriate to age and diagnosis. The H & P shall be dictated within 24 hours after the patient's admission, unless the patient will be taken to surgery before that time, in which case the H & P report must be placed in the patient's chart before the patient is taken to surgery. In the event it is impossible to have a dictated H & P report prepared and placed in the chart prior to surgery (e.g., it is a life-threatening emergency), the physician shall include a handwritten report in the record. Any time a patient has surgery, there must be an interval medical history and physical examination performed and recorded on the chart within the previous 24 hours. The interval note for elective surgical procedures must include any changes in the history relevant to the procedure being performed, examination of the heart, lungs, neurological status, and target organs for the surgical procedure to be performed.

If a complete H & P was performed prior to the patient's admission to the Medical Center, a reasonably durable, legible copy of these reports may be used in the patient's Medical Center medical record in lieu of the admission history and report of physical examination, provided these reports were recorded by a Medical Staff Member within thirty (30) days of the admission. In such instances an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must be recorded within 24 hours.

If the patient is readmitted to the Medical Center within 30 days of a previous discharge for the same or a related condition, an interval admission note stating the reason for readmission and any changes in the history and physical examination report may be written in lieu of a complete history and physical examination report. A copy of the original history and physical examination shall be placed in the patient's medical record.

3. For history and physical examinations performed by appropriately credentialed Allied Health Professionals, the findings, conclusions, and assessment of risk shall be confirmed or endorsed by the Attending Physician prior to major diagnostic or therapeutic intervention or within 24 hours, whichever occurs first. Major diagnostic and therapeutic intervention is defined as any intervention requiring informed consent.

4. EXAMINATIONS

A. History and Physical: The following requirements apply to the scope of pre-procedure assessment required in the following patient category:
Category 1: Acute Hospital Admission: The patient’s history and physical examination, nursing assessment, and other screening assessments are completed within 24 hours after admission as defined in section 4B below. If a complete H&P was performed prior to the patient’s admission to the Medical Center, a copy of the report may be used in the patient’s medical record, in lieu of the admission history and report of physical examination, provided the report was recorded by a medical staff member within thirty (30) days of the admission. In such instances an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must be recorded within 24 hours.

Category 2: Surgical or other invasive diagnostic or therapeutic procedures performed under the care of an anesthesiologist (regional and/or general anesthesia) or monitored anesthesia care (MAC) or deep sedation performed under the care of a non-anesthesiologist require a history and physical (see 4B below) performed within 30 days prior to the procedure and present in the chart. If an H & P was performed prior to admission, an interval update must be done and recorded in the chart. An interval update records any changes since the last H & P was performed.

Category 3: Procedures performed under moderate sedation require a directed history and physical examination within the preceding 30 days, with an interval update if the H & P was performed prior to admission. This H & P includes, but is not limited to:
- Review of systems
- Patient history
- Identification of allergies
- Current prescriptions, over-the-counter medications, and herbal supplements
- Cardiovascular and Respiratory assessment
- Assessment of the system or body part undergoing intervention.

Category 4: Procedures where minimal sedation and/or local anesthetic are used require a directed history and physical examination within the preceding 30 days, with an interval update if the H & P was performed more than 24 hours prior to the procedure. This H & P includes, but is not limited to:
- Documentation of the plan for the procedure
- Identification of allergies
- Current prescriptions, over-the-counter medications, and herbal supplements
- Assessment of the system or body part undergoing intervention

B. The H & P may be performed by the surgeon, anesthesiologist, or appropriately credentialed Allied Health Professional working within a standard procedure (see 4E below). It should include:

1. History:
   - Chief Complaint
   - History of Present Illness
   - Review of Systems
   - Past, Family and Social History
Medications: Current prescriptions, over-the-counter medications, and herbal supplements
Allergies

2. Physical Examination:
   General appearance
   Vital Signs

3. Examination of at least 9 elements from the 7 body areas or 13 Organ Systems:
   BODY AREAS:
   Head, including face
   Neck
   Chest, including breasts and axillae
   Abdomen
   Genitalia, groin, buttock
   Back, including spine
   Each extremity
   ORGAN SYSTEMS:
   Ophthalmologic  Musculoskeletal  Allergic/Immunologic
   Otolaryngologic  Integumentary  Gastrointestinal
   Cardiovascular  Neurologic  Genitourinary
   Respiratory  Psychiatric  Hematologic/Lymphatic
   Endocrine

C. Surgeon’s note: If the H & P was not performed by the surgeon, the surgeon must write a preoperative note describing the surgical assessment and therapeutic plans and confirming the discussion of alternatives, risks and benefits of the proposed treatment with the patient.

D. Presedation or preanesthesia assessment: Any patient for whom moderate or deep sedation/analgesia or anesthesia is contemplated must receive a presedation or preanesthesia assessment immediately prior to sedation/analgesia or anesthesia induction.

E. History and Physical performed by Non Physicians: Individuals who are not licensed independent practitioners (non-LIP’s) may perform a history and physical under the responsibility and accountability of a physician and pursuant to the non-LIP’s scope of practice (e.g., Residency Competency, Standardized Procedures, or Scope of Service).

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Each entry will show the date and time of each note. Whenever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily and more often when warranted by the patient's condition.

6. All clinical entries in the patient's medical record shall be dated, timed and authenticated by a housestaff, Medical Staff Member, or authorized Allied Health
Professional. Medical Students and Allied Health Students may document clinical entries. All these entries must be co-signed by their appropriate supervising practitioner. There shall be an entry in the patient record by an attending physician each day. Title designation shall be included, e.g., R2, R.N., M.D., D.D.S.

7. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations is kept on file in the Health Information Management Department's record room.

8. A physician's routine orders, when applicable, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the licensed physician.

9. Consultation shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

10. The current obstetrical record shall include a complete prenatal record on all patients treated at the Medical Center. The prenatal record may be a legible copy of the attending physician's office record transferred to the Medical Center before admission, but an interval admission note must be written that includes pertinent additions to the history any subsequent changes in the physical findings.

11. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless a licensed physician has documented justification that such delay would be detrimental to the patient.

12. A preoperative diagnosis prior to surgery shall be noted by the responsible physician.

13. Operative reports or other high risk procedure reports dictated or written immediately after an operation or other high risk procedure shall include the following: record the name of the primary surgeon and assistants, procedure(s) performed and description of each procedure, findings, estimated blood loss, specimens removed, disposition of each specimen, complications, transfusions, and postoperative diagnosis.

14. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible Medical Staff Member at the time of discharge of all patients.

15. A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty eight (48) hours except for normal obstetrical deliveries, normal newborn infants and certain selected patients with problems of a minor nature. These latter exceptions shall be identified by the Medical Executive Committee and final summation-type progress notes shall be sufficient to justify the diagnosis and
warrant the treatment and end result. This progress note shall document the patient's condition at discharge, discharge instructions and follow-up care required. All summaries shall be dated and signed by the responsible Medical Staff member, or licensed housestaff, at the time of discharge of all patients.

16. The patient's medical record shall be complete at the time of discharge including a signed history and physical examination, consultation report (if applicable), operative report (if applicable), TNM Cancer Staging form (if applicable) and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in a stated place in the Health Information Management Department for fourteen (14) days after discharge. The patient's medical record shall be incomplete until any required TNM Staging form is completed, signed by the Attending Physician and inserted into the medical record.

17. If any medical record remains incomplete after fourteen (14) days following patient discharge, the responsible physician shall have Medical Staff privileges suspended according to UCIMC Administrative Policy and Procedure, Health Information Management: Medical Records Completion Requirements.

18. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information, unless permitted by law.

19. Records may be removed from the Medical Center campus and safekeeping only in accordance with a court order, subpoena, or statute. All records are the property of the Medical Center, which is owned and operated by The Regents of the University of California. In case of readmission of a patient, all previous records shall be available for use by the Medical Staff Member. Unauthorized removal of charts from the Medical Center is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee.

20. Free access to all medical records of all patients shall be afforded to Medical Staff Members for bona fide study and research consistent with preserving the confidentiality of information concerning the individual patients. Subject to the discretion of the Director, and only under compelling circumstances, former Medical Staff Members shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patient in the Medical Center.

21. Ambulatory Care Records:

a. An outpatient visit record will be initiated on every patient seen in an ambulatory care setting. The record will be annotated to reflect all pertinent information on each patient.
b. Prior pertinent medical record information will be available to the attending practitioner and other authorized individuals.

c. At the time of each visit, demographic and clinical information is updated, as necessary and pertinent new information shall be entered in the record.

d. The record of each patient receiving continuing primary ambulatory services shall include a problem summary list to facilitate continuity of care.

e. The list shall be initiated and maintained for each patient by the third visit, with updates on subsequent visits as described in accreditation standards.

f. The list shall be filed and maintained as the top report on the Outpatient side of the patient record.

g. When surgical services are provided on an outpatient basis, an accurate, complete description of the techniques and findings of the operative procedure is written or dictated immediately following surgery.

h. All clinical entries shall be dated, timed and authenticated by the housestaff, Medical Staff Member or authorized Allied Health Professional.

i. The Attending and Supervising Physician shall review and then countersign and date the following reports prepared by a medical student or resident:
   (a) Admission History and Physical Examination Report if an Admission History and Physical Examination was not performed and dictated by the Attending Physician.
   (b) Consultation Reports
   (c) Operative Reports

D. GENERAL CONDUCT OF CARE

1. Every patient, at time of admission to the Medical Center, will sign or have signed on behalf of the patient, a general consent form. It will be the duty of all admitting personnel to ensure that the consent form has been properly completed and authenticated. In addition to the general consent form, a specific informed consent will be obtained by the practitioner, if appropriate. This form shall document that the provider has explained the nature of the procedure, the risks, complications, and expected benefits or effects of the procedure and any alternatives to the procedure and their risks and benefits. As stated in the UC Irvine Medical Center Informed Consent Policy and Procedure, all operative and invasive procedures require the patient’s written informed consent. An operative/invasive procedure is defined as a diagnostic and/or therapeutic maneuver which involves incision of the skin or other tissues, puncture or insertion of an instrument into a body cavity or space, or any procedure involving a substantial risk of discomfort, pain or complication. The list of
procedures noted in the Informed Consent Policy and Procedure is exempt from obtaining written informed consent. All other procedures require written consent. (Refer to Patient Care Related, Informed Consent Policy).

2. All patient care orders shall be written clearly, legibly, and completely by either Housestaff, Medical Staff Member or Practitioner. Treatment orders shall be signed, dated, and timed by the initiating Housestaff, Medical Staff Member or authorized Allied Health Professional. Orders which are unclear, illegible or incomplete will not be carried out until rewritten or understood by the nurses. Signatures must be legible or accompanied by a printed version of the name.

3. Acceptance of physician orders given either verbally or by telephone is a process designed solely to facilitate patient care; physicians should personally record and sign orders in the medical record whenever possible. Verbal orders, that is orders given verbally by a physician physically present at the time, are to be accepted only when the urgency of the clinical situation precludes the physician from personally recording and signing those orders in the medical record. Similarly, use of telephone orders should be reserved for situations where delay involved in personally recording and signing the order would have a negative impact on patient care.

Telephone and verbal orders are accepted only by a registered nurse or licensed pharmacist. The staff member taking the order shall document the order, then read back the order and request confirmation of what was ordered/transcribed and verify the Practitioner pager number to properly identify the ordering physician. In addition, respiratory therapists may take verbal orders for respiratory therapy and Radiology Technologists may take verbal orders for imaging examinations following the above process. The individual taking the order will then promptly record it in the medical record, date, time and sign the order along with the notation that it was either a verbal or telephone order.

Nurses and pharmacists are authorized to decline acceptance of telephone or verbal orders that do not meet the criteria specified in this section. Furthermore, individuals issuing telephone or verbal orders that do not comply with the criteria outlined in this section may also be subject to appropriate disciplinary action as specified in the Bylaws of the UCI Medical Staff.

Orders other than for restraint or seclusion must be countersigned by the responsible physician within forty-eight (48) hours. Orders for restraint and seclusion must be signed within twenty-four (24) hours. The responsible physician shall be the physician who issued the order.

Infrequently, verbal orders may be signed (authenticated) by the Attending Physician or authorized provider on the patient care team. The circumstances under which this alternative to the requirement that the prescriber sign the verbal order should be exceptional. An example would be when the prescribing physician is off-service, on
vacation, or otherwise unavailable. It is still required that the verbal orders be signed (authenticated) within 48 hours.

All physician orders are to be recorded and signed using the electronic medical record provided by the UCI Medical Center hospital information management computer system whenever possible. The use of paper records is acceptable only when appropriate electronic means of record keeping are not available. In the case of a paper record, the signature must be clearly legible or accompanied by a legible printed record of the individual’s name.

The policies and procedures applicable to telephone and verbal orders given by physicians are also applicable to telephone and verbal orders given by allied health professionals to the extent that these individuals are permitted to give patient care orders within their authorized scope of practice.

4. All previous orders will be canceled upon departure of the patient to the operating room.

5. All drugs and medications administered to patients shall be those drugs listed in the latest edition of: United States Pharmacopeia, National Formulary, American Medical Center Formulary Services, of AMA Drug Evaluations or newly approved medications that are not listed but have been approved by the Pharmacy & Therapeutics Committee. Drugs for bona fide clinical investigations will be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Medical Centers", and all regulations of the Federal Drug Administration. Investigational drugs may be used only if the physician complies with the policy governing use of investigational drugs and secures Human Subjects Review Committee approval. All uses must be in compliance with the federal Protection of Human Subjects regulations. Investigational drugs must be dispensed by the Hospital pharmacy according to established procedure for handling investigational drugs.

6. The acquisition and disposition of controlled substances is defined in UCIMC Administrative Policy and Procedure: Medication Management - Controlled Substances.

7. No research shall be conducted on or involve any patient at the Medical Center until all requirements of the University, Medical Center, and Human Subjects Review Committee have been complied with and in accordance with UCIMC Administrative Policy and Procedure Informed Consent, Protocols and Human Research.

8. Consultations shall be used in accordance with the requirements established by individual Clinical Department Chiefs and the Medical Executive Committee. Each Department will be responsible for defining specific policies for those conditions that will require written consultations. The Medical Staff Member is primarily responsible for requesting consultations when indicated and for calling in qualified consultants. He or she will provide written authorization, except in an emergency, to
permit another Medical Staff Member or Allied Health Professional to attend or examine his or her patients.

9. Response to consultation requests shall be within twenty four (24) hours by the Department or practitioner receiving the request. The level of physician responding may be designated by the responding Department unless a specific request is made by the Medical Staff Member. Any Medical Staff Member or Allied Health Professionals with defined patient care abilities in the Medical Center is qualified to respond when called for consultation if within his or her specialty field.

10. Emergency Department Consultations: Considering the nature of the Emergency Department services, when a consultation is requested and it is specified as STAT, the consulting Department will respond by sending a Medical Staff Member, Chief Resident or Senior Resident to the area specified by the Emergency Department requester within fifteen (15) minutes. If the request for consultation is not specified as STAT, the consulting Department will respond as soon as possible within one (1) hour.

11. If a nurse (RN) has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the nurse's superior who in turn may discuss the matter with the Attending Physician and if the matter is not resolved, she may then refer the matter to the Chief Patient Care Services Officer. If warranted, the Chief Patient Care Services Officer may bring the matter to the attention of the Clinical Department Chief wherein the responsible practitioner has Clinical Privileges. Where circumstances are such as to justify such action, the Clinical Department Chief may request a consultation.

E. REGULATORY STANDARDS RELATED TO PATHOLOGY/CLINICAL LABORATORY

All patient specimens for diagnostic testing must be submitted to the Department of Pathology and Laboratory Medicine for evaluation in-house or for referral to an approved Clinical Laboratory.

The Medical Center’s Department of Pathology and Laboratory Medicine provides for prompt performance of adequate examination and in-vitro testing in anatomic pathology, hematology, chemical pathology, microbiology, transfusion medicine, molecular pathology, and tissue typing.

While the patient is under the Medical Center’s care, all laboratory services shall be performed in the Medical Center’s pathology and clinical laboratories under the auspices of the Department of Pathology and Laboratory Medicine or shall be sent to an approved reference laboratory.
When organized central pathology and clinical laboratory services are not offered, the Department of Pathology shall identify acceptable reference or contract laboratory services and make recommendations to the Medical Executive Committee for approval.

Reference and contract laboratory services shall meet applicable standards for clinical laboratories.

To ensure compliance with regulatory standards, the clinical laboratory has oversight for Point-of-Care tests (POCT) performed on patients under UCI Medical Center’s care.

F. **INSURANCE**

Non-faculty applicants and members of the Clinical Non-Teaching category, and other Medical Staff members when providing services outside of the scope of the member's faculty appointment, are required to maintain professional liability insurance in the amounts of $1,000,000 per occurrence and $3,000,000 in aggregate.

G. **EMERGENCY SERVICES**

1. There shall be Medical Staff medical coverage in the Emergency Department at all times and care will be rendered in accordance with established policies and procedures.

2. Policies and procedures of the Emergency Department, established by the Department involved, will define the procedures and the duties and responsibilities of all personnel assigned to that service. The Medical Staff shall designate appropriately qualified medical personnel for the purposes of providing Medical Screening Examinations in the Emergency Department.

3. An emergency room record will be initiated for every patient seen in the Emergency Department. The record will be annotated to reflect all pertinent information on each patient in accordance with these Rules and Regulations. All records will be dated, timed, and signed by the responsible Medical Staff Member.

4. There will be a disaster plan, which will define the actions of all personnel during an actual or practice disaster. The plan will establish procedures for the treatment and admission of mass casualties.

5. In compliance with state and federal laws, there will be an Emergency Department policy and procedure, which delineates the medical specialties and the obligations of on-call physicians to provide immediate response for emergency patient consultation.

H. **RESTRAINT POLICY**

Body restraints may be used upon the order of a physician in accordance with UCIMC Administrative Policy and Procedure - Restraint and Seclusion.
I. CLINICAL DEPARTMENTS
In addition to the functions of the Departments described elsewhere in the Bylaws and Rules and Regulations, the Clinical Department Chief of each Clinical Department, or his or her designee shall:

1. Publish a standard format of policies and procedures that pertain to the proper and efficient operation of their individual Department and to the treatment of patients on that service;

2. Develop programs for continuing medical education of its Staff Members, house officers, and students and cooperate with the Continuing Medical Education Committee of the College of Medicine. Such continuing medical educational programs shall be open to all Medical Staff Members. A weekly or a monthly program shall be made available to all Staff Members in the Department. Attendance by Medical Staff Members shall be documented;

3. Develop ambulatory care and inpatient services not only for the proper care of patients but also for undergraduate and graduate education and research programs;

4. Supervise, monitor, and determine the scope and required training for any health care services provided by non-physician professionals and cooperate with the Interdisciplinary Practice Committee described in Article XI of the Bylaws; and more particularly, in these Rules and Regulations in Section M., Subsection 7;

5. Review and approve/disapprove all clinical research programs in conjunction with the Academic Department Chairs and the Human Subjects Review Committee of the College of Medicine;

6. Hold regular meetings with Department Medical Staff Members and when appropriate non-physician practitioners, to review results of Performance Improvement/Quality Assessment Resource monitoring of the care provided in the Department.

J. GENERAL RULES REGARDING SURGICAL CARE OR OTHER HIGH RISK PROCEDURES AND THE USE OF MODERATE OR DEEP SEDATION/ANALGESIA OR ANESTHESIA

1. Except in cases of emergency, inpatients scheduled for surgery should be admitted the day of the procedure with testing and evaluation completed according to admission policies.

2. All major surgical or invasive procedures, other than emergency, involving general or regional anesthesia, shall not be performed until the history and physical examination and appropriate tests are completed. Any procedures requiring an anesthetic or moderate or deep sedation/analgesia shall require at a minimum a short-form history and physical examination.
3. Written and signed informed surgical consent shall be obtained prior to any operative procedure, except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances must be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

4. Except in severe emergencies, the history and physical examination, preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. In any emergency, the Medical Staff Member shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

5. The anesthetist or licensed practitioner monitoring an anesthetic or sedation/analgesia case shall maintain a complete time-based anesthesia or sedation record to include evidence of pre-anesthetic or pre-sedation/analgesia evaluation, medication administration, patient response, interventions, recovery and post anesthetic or appropriate post-sedation/analgesia follow-up of the patient's condition.

6. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately to provide pertinent information for anyone required to attend to the patient. All surgical operations shall be fully described and recorded immediately by the operating surgeon or designee. Operative reports shall be dictated or written immediately after surgery and made a part of the medical record within 72 hours following the operation. The operative report or other high risk procedure reports records the name of the primary surgeon and assistants, procedure(s) performed and description of each procedure, findings, complications, transfusions, estimated blood loss, specimens removed, disposition of each specimen and postoperative diagnosis.

7. All tissues removed during the operation shall be examined by a surgical pathologist who shall make such examination as the pathologist considers necessary to arrive at a tissue diagnosis except for the specimens listed below that by their nature or conditions do not permit meaningful examination and interpretation and that by not carrying out an examination will not compromise the quality of patient care.

Specimens excluded from the pathologist examination requirement:

a. Specimens that by nature or condition do not permit meaningful examination and interpretation: a cataract, orthopedic appliance, newborn foreskin, bone from degenerative joints, bunions, or a portion of a rib removed only to enhance operative exposure; menisci, articular cartilage and blood clots.
b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring requirements.

c. Foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.

d. Placentae that are grossly normal as determined by the obstetrician in attendance and are from pregnancies without significant fetal or maternal disease and have been removed in the course of operative and nonoperative obstetrics.

e. Teeth, provided the number, including fragments, are recorded in the medical record.

The pathologist's authenticated report shall be made a part of the patient's medical record within seventy-two (72) hours. The Department of Pathology and Laboratory Medicine shall serve as the custodian of the tissue specimens and will be responsible for storage and ultimate disposition in accordance with department policy.

8. A qualified assistant physician must be present and scrubbed in any major surgical procedure.

9. All patients admitted for dental care will be a dual responsibility of a physician and a dentist. The physician is responsible for the history and physical examination and the patient's general health while hospitalized. The dentist will be responsible for the part of their patients' history and physical examination that relates to dentistry and for the dental, physical, and history justification for admission, and the dental portion of the operation and findings, progress notes, and the discharge summary.

10. All patients admitted for podiatric care will be a dual responsibility of a physician and a podiatrist. The physician is responsible for the history and physical examination and the patient's general health while hospitalized. The podiatrist will be responsible for the part of their patients' history and physical examination that relates to podiatry and for the podiatric, physical, and history justification for admission, and the podiatric portion of the operation and findings, progress notes, and the discharge summary.

11. Details of required documentation for anesthetics are specified in Department of Anesthesiology and Perioperative Care Policies and Procedures and for Moderate and Deep Sedation/Analgesia are specified in the hospital policy entitled Guidelines for the Care of the Patient Receiving Moderate or Deep Sedation/Analgesia for Diagnostic, Therapeutic and Minor Surgical Procedures.

12. Personnel involved in sedation/analgesia are specified in the hospital policy entitled Guidelines for the Care of the Patient Receiving Moderate or Deep Sedation/Analgesia for Diagnostic, Therapeutic and Minor Surgical Procedures.
13. Privileging Requirements for Staff Physician and Staff Physician Designees for Moderate and Deep Sedation/Analgesia requires:

Initial Privileges for Administration and Management of Moderate Sedation/Analgesia Requires:

1. A letter of Recommendation from the respective Department Chair to the Credentials Committee.

2. Approval of Request for Privileges from the Medical Director for Sedation to the Credentials Committee.

3. Current Certification in the appropriate Advanced Life Support in order to demonstrate ability to Rescue from deeper than intended sedation/analgesia
   a. ACLS or ATLS for Adult Privileges
   b. PALS for Pediatric Privileges
   c. NRP for Neonatal Privileges

4. Successful completion of UCI Computer Based Training (CBT) Course and Test for Moderate Sedation/Analgesia. This shows proof of education in policy, procedure, formulary of approved sedation/analgesia drugs and chemical rescue drugs.
   a. Adult Module for Adult Privileges
   b. Pediatric Module for Pediatric Privileges
   c. Neonatal Module for Neonatal Privileges

5. Signed Attestation that the practitioner has read and understood the policy for “Guidelines for the Care of the Patient Receiving Moderate or Deep Sedation for Diagnostic, Therapeutic and Minor Surgical Procedures”.

Renewal of Privileges for Administration and Management of Moderate Sedation/Analgesia Requires:
Proof that the provider has performed 40 Moderate Sedation/Analgesia cases in the last two (2) years (20 if renewing within one (1) year) and repeat 3-5 of the above requirements every two years to maintain Moderate Sedation/Analgesia Privileges OR
Repeat the Initial Privileging Process listed above.

Initial Privileges for Administration and Management of Deep Sedation/Analgesia (includes privileges for Moderate Sedation/Analgesia)

1. Hold Privileges in one of the following specialties:
   a. Emergency Medicine (Adult and Pediatric Privileges)
b. Adult Critical Care Medicine (Adult Privileges)
c. Pediatric Critical Care Medicine (Pediatric Privileges)
d. Neonatology (Neonatal Privileges)
e. Oral Surgery (Adult Privileges)
f. Dentistry with appropriate evidence of permit from the State of California (Adult Privileges)
g. Podiatry (Adult Privileges)

2. A letter of Recommendation from the respective Department Chair to the Credentials Committee.

3. Approval of Request for Privileges from the Medical Director of Sedation to the Credentials Committee.

4. Hold current Endotracheal Intubation Privileges* in the category of the request (Adult, Pediatric or Neonatal) and current certification in the appropriate Advanced Life Support in order to demonstrate ability to Rescue from deeper than intended sedation/analgesia
   a. ACLS or ATLS for Adult Privileges
   b. PALS for Pediatric Privileges
   c. NRP for Neonatal Privileges

*If the provider applying for privileges does not have endotracheal intubation privileges, he/she must successfully complete an Anesthesiology approved advanced airway management course.

5. Successful completion of UCI Computer Based Training (CBT) Course and Test for Moderate and Deep Sedation/Analgesia.
   a. Adult Module for Adult Privileges
   b. Pediatric Module for Pediatric Privileges
   c. Neonatal Module for Neonatal Privileges

6. Signed Attestation that he/she has read and understood the policy for “Guidelines for the Care of the Patient Receiving Moderate or Deep Sedation for Diagnostic, Therapeutic and Minor Surgical Procedures”. (we have to write/rewrite this)

7. Three (3) proctored cases of deep sedation/analgesia under the Medical Director of Sedation or Designee.

Renewal of Privileges for Administration and Management of Deep Sedation/Analgesia Requires:
   1. Proof that the provider has performed 40 Deep Sedation/Analgesia cases in the last two (2) years (20 if renewing within one (1) year) and repeat 4-6 from above requirements every two years to maintain Deep Sedation/Analgesia Privileges

OR
2. Repeat the Initial Privileging Process listed above.

K. PSYCHIATRIC PATIENT RECORDS

A record shall be maintained for each patient admitted to the psychiatric unit, which includes the following elements:

a. Identification sheet

b. Psychiatric history and physical examination. The psychiatric history and physical examination shall be completed within 24 hours after the patient's admission or immediately before the admission. The psychiatric evaluation, including a medical history, shall contain a record of the patient's mental status, and note the onset of illness, the circumstances leading to the admission, attitudes, behavior, estimate of intellectual functioning, mental functioning, orientation, and an inventory of the patient's assets in descriptive, not interpretative fashion. A complete neurological examination shall be recorded at the time of the admission physical examination when indicated.

c. Legal authorization for the admission (i.e., whether the patient is voluntary or involuntary, and the legal status. See the CAHHS Consent Manual and the Psychiatry Department Rules.)

d. Consultation reports, including those concerning neurologic examinations, psychological evaluations, reports of electroencephalograms, dental records, and reports of special studies.

e. An order sheet, including medication, treatment, diet, and restraint orders. (See the "Drug and Medication Orders" Rules and the UCIMC Administrative Policy and Procedure pertaining to patient restraints.)

f. A treatment plan. This treatment plan must be based upon an inventory of the patient's strengths as well as his or her disabilities, and include a substantiated diagnosis in the terminology of the American Psychiatric Association's Diagnostic and Statistical Manual, short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides justification and documentation for the diagnoses and for the treatment and rehabilitation activities carried out.

g. Progress notes, including current or working diagnosis, the complaints of others regarding the patient, as well as the patient's comments. The psychiatric rehabilitative activities service therapists (e.g., occupational, music, art, dance and recreation therapists) must enter signed progress notes in the patient's record at least daily and write a summary note upon completion of the treatment program.
The treatment must be documented in such a manner and with such frequency as to assure that all active therapeutic efforts, such as individual and group therapy, drug therapy, milieu therapy, occupational therapy, recreational therapy, industrial or work therapy, nursing care and other therapeutic interventions are included.

The frequency with which progress notes must be entered should be determined by the condition of the patient, but must be recorded at least daily. The progress notes should contain recommendations for revisions in the treatment plan as indicated, as well as precise assessment of the patient's progress in accordance with the original or revised treatment plan.

h. Nursing notes, which include a concise and accurate record of nursing care; a record of pertinent observations of the patient, a record of the medications that are administered; and a record of the restraints used, if any. (See the Medical Center's Policy on the use of restraints, Administrative Policy- Restraint and Seclusion).

i. Social service records, including reports of interviews with patients, family members, and others that provide an assessment of home plans and family attitudes, and community resource contacts, as well as social history.

j. Reports of ancillary and support services and staff, including dietitian notes, a vital sign sheet, reports of all laboratory tests performed, and reports of all X-ray examinations performed.

k. Operative reports, if any operations are performed. Operative reports shall be dictated or written immediately after surgery.

l. Consent forms. (See the "Consent for Treatment” Rules.)

m. Documentation pertaining to the denial of any patient right. (See the Psychiatry Department Policy pertaining to Denial of Patients' Rights.)

n. A discharge summary, which shall briefly recapitulate the significant findings and events of the patient's hospitalization, his or her condition on discharge, and the recommendations and arrangements for future care.
L. **Allied Health Professionals**

Allied Health Professionals are the health care professionals who provide patient care within the scope of their training and licensure, and consistent with the California Administrative Code, but are not Medical Staff members. Specific clinical duties and responsibilities of Allied Health Professionals are defined by protocol approved by the applicable Departments, the Interdisciplinary Practice Committee, the Medical Executive Committee and the Governing Body. Allied Health Professionals shall be individually assigned to an appropriate clinical Department/service and shall carry out their activities subject to Department/service policies and procedures and/or standardized procedures in conformity with the applicable provisions of the Medical Staff Bylaws, Rules and Regulations. Allied Health Professionals will not be Members of the Medical Staff. Allied Health Professionals may not admit patients.

1. **OVERVIEW**

   a. The credentialing process for Allied Health Professionals (AHPs) is similar to that for credentialing of Medical Staff Members. However, the Interdisciplinary Practice Committee (IDP), rather than the Professional Practice Evaluation Committee, has primary responsibility for overseeing the credentialing of AHPs. The credentialing process for AHPs is summarized in Section 2, below.

   b. The types of AHPs currently eligible to apply for service authorization are:

   (1) Licensed Clinical Psychologists
   (2) Nurse Anesthetist
   (3) Nurse Midwife
   (4) Nurse Practitioner
   (5) Physician's Assistant
   (6) Registered Nurse First Assistant
   (7) Audiologist
   (8) Allied Health Professional Researcher
   (9) Clinical Nurse Specialist
   (10) Optometrist
   (11) Acupuncturist
   (12) Perfusionist
   (13) Speech Pathologist
   (14) Clinical Neurophysiologist
   (15) Ph.D. Medical Geneticist
   (16) Naturopathic Practitioner
   (17) Pathology Assistant

   c. When an AHP in a category that has not been approved as eligible to apply for service authorization under the terms of the Medical Staff Rules and Regulations, the IDP may begin to process an application at the same time the
request for recognition of the profession is processed; however, no right to practice in the Medical Center is thereby created or implied.

2. PROCESSING THE APPLICATION

a. Applications shall be submitted and processed in a manner parallel to that specified for Medical Staff applicants in the Medical Staff Bylaws, Article V (Appointment and Reappointment), except that the applications shall be submitted to the IDP rather than to the Professional Practice Evaluation Committee. Applicants shall be required to pay the established non-refundable application processing fee.

b. Once the application is determined to be complete, it will be forwarded to the Department Chief for review and recommendation. The application is forwarded to the Interdisciplinary Practice Committee (IDP) for consideration. The IDP may meet with the applicant and the sponsoring or supervising physician (if applicable). The IDP shall evaluate the AHP based upon the standards set forth in Section M, Subsection 7.

c. Whenever possible, the IDP shall include practitioners in the same AHP category when conducting an evaluation. The IDP forwards its recommendations to the Professional Practice Evaluation Committee.

d. Thereafter, the application shall be processed by the Medical Executive Committee and Governing Body.

3. CREDENTIALING CRITERIA

a. BASIC REQUIREMENTS
The applicant must belong to an AHP category approved for practice in the Medical Center by the Governing Body.

b. If required by law, the applicant must hold a current, unrestricted state license or certificate.

c. In addition, those AHPs providing services under a contractual arrangement shall meet all the conditions of their contract with the Medical Center.

d. The applicant must document his or her experience, education, background, training, demonstrated ability, judgment, and physical and mental health status with sufficient adequacy to demonstrate that any patient he or she treats will receive care of the generally recognized professional level of quality and efficiency in the community and as established by the Medical Center, and that he or she is qualified to exercise the authorized services within the Medical Center.
4. **PROVISIONAL STATUS**

All AHPs initially shall be appointed to a Provisional Status for at least 12 months. Advancement from the Provisional Status will be based upon whether the professional's performance is satisfactory, as determined by the department in which the AHP is assigned, IDP (when its review is necessary for the authorized services), the Medical Executive Committee and the Governing Body.

5. **DURATION OF APPOINTMENT AND REAPPOINTMENT**

a. AHPs shall be granted service authorization for no more than 24 months. Reappointment to the AHP staff shall be processed every other year, in a parallel manner to that specified in Article V, Appointment and Reappointment, in the Medical Staff Bylaws for Medical Staff Members.

b. Applications for renewal of the AHP's service authorization must be completed by the AHP and Supervising Practitioner and submitted for processing in a parallel manner to the reappointment procedures set forth in Article V in the Medical Staff Bylaws. Applications are required to be accompanied by the established processing fee for AHP’s.

6. **EXCEPTION TO CREDENTIALING PROCESS - CONTRACT ALLIED HEALTH PROFESSIONALS**

a. On occasion, the Medical Center may determine that the interests of patient care are best served by entering into a contract with an entity, which provides AHPs to work within the Medical Center. These AHPs are neither employees nor independent contractors of the Medical Center, nor are they independent professionals working in their own private practice. Rather, they are...
employees of independent contractors of an entity that has agreed to provide certain health services to the Medical Center's patients. For purposes of these Rules, these persons shall be referred to as "Contract AHPs" and the entity employed or contracting with them shall be referred to as the "Contracting Entity."

b. Ordinarily, contract AHPs must complete the full AHP credentialing process prior to being permitted to render patient care within the Medical Center. Formal credentialing as described in these Rules may be waived for contract AHPs whom the contracting entity warrants to be adequately qualified to perform the patient care activities described in the contract.

c. Whether the contracting entity is responsible for credentialing the contact AHPs will be determined by Medical Center administration and shall be made a part of the written contract between the Medical Center and the contracting entity. If the contracting entity will credential the Contract AHPs, the following shall apply:

1. The contracting entity shall provide a written description of the activities to be performed by the Contract AHPs. This description may be contained in the contract itself or in a separate job description.

2. The Medical Center Director may ask the appropriate Medical Staff Department and the IDP to review the job descriptions or contract provisions describing the activities of the Contract AHPs for completeness, accuracy and appropriateness.

3. The contracting entity shall review each AHP using standards comparable for each AHP category at the time the contact AHP is first associated with the contracting entity and then periodically (at least every 2 years) therefore, based on actual performance. For each Contract AHP assigned to the Medical Center, the contracting entity shall certify, in writing, that this condition has been met for that individual. Upon receipt of this certification, individual contract AHPs will not be required to submit applications for AHP service authorization.

4. Contract AHPs shall be limited in their scope of practice to those activities described in the contract or in the job description provided by the contracting entity.

5. Contract AHPs shall be subject to such observation requirements as may be recommended by the appropriate department to which the AHP will be assigned, the IDP, and
the Medical Executive Committee and approved by the Governing Body.

6. Quality improvement evaluations of the performance of AHPs shall be conducted by the appropriate Medical Center Department Director or Medical Center Director or his or her designee. A report will be made to the Performance Improvement Committee on an annual basis unless that Committee requests a report more frequently.

7. Contract AHPs are expected to be competent and cooperative in the Medical Center setting. The Contracting entity shall immediately remove or reassign out of the Medical Center any Contract AHP reasonably determined by the Medical Center Administration not to meet these conditions.

8. As a condition for the exception to the credentialing process provided in this Rule, all Contract AHPs shall agree in writing to waive all procedural rights afforded by the Rules and the Medical Staff Bylaws and to release the Medical Center, its employees, agents and Medical Staff Members from any and all liability for any decisions affecting the AHPs practice at the Medical Center.

9. Upon expiration or termination of the contract between the Medical Center and the contracting entity, the Contract AHP's right to provide patient care services to Medical Center patients will automatically terminate as well. No procedural rights will be afforded to Contract AHPs in the event the contract is terminated.

10. Where the contract does not provide for the contracting entity to perform the evaluation, each Contract AHP shall be subject to all of the credentialing procedures of these Rules. The applicant must be determined, on the basis of documented references, to adhere strictly to the lawful ethics of his or her profession, to work cooperatively with others in the hospital setting so as not to adversely affect patient care, to be willing to participate in and properly discharge responsibilities as determined by the Medical Staff.

7. SPECIFIC REQUIREMENTS

In addition to meeting the general requirements outlined above, applicants must meet any specific requirements established for his or her category of AHP.
8. **OBSERVATION**

   a. All new AHPs shall be subject to proctoring for at least three (3) cases. The number may be increased in the Department rules.

   b. Each department shall be responsible to establish observation programs appropriate to each category of AHP granted service authorization within that department. The department shall determine the appropriate frequency and methods of proctoring and/or initial evaluation, which may include concurrent or retrospective chart review or consultations. AHPs exercising surgery or anesthesia practice services shall be observed during surgery.

   c. The proctor or evaluator should be a member in good standing of the Medical Staff who exercises appropriate clinical privileges; however, in appropriate circumstances, the Department Chief may assign an appropriately credentialed AHP to serve as the proctor/evaluator. Whenever possible, the proctor/evaluator should not be the Sponsoring or Supervising Physician of the AHP being observed.

   d. The Governing Body may approve alternative observation procedures for employee or Contract AHPs.

9. **GENERAL DUTIES**

   Upon appointment, each AHP shall be expected to:

   a. Consistent with the service authorization granted to him or her, exercise independent judgment within his or her areas of competence and, if applicable, within the limits of an approved standardized procedure, provided that a Medical Staff member who has appropriate privileges shall retain the ultimate responsibility for each patient's care.

   b. Participate directly in the management of patients to the extent authorized by his or her license, certificate, other legal credentials, any applicable standardized procedures, and by the service authorization granted by the Governing Body.

   c. Write orders to the extent established by any applicable Medical Staff or Department policies, rules or standardized procedures and consistent with the service authorization granted to him or her.

   d. Record reports and progress notes on patient charts to the extent determined by the appropriate department, and in accordance with any applicable standardized procedures.

   e. Assure that records are countersigned as follows:
The Supervising Practitioner, if any, shall countersign all entries except routine progress notes; (2) unless otherwise specified in the Rules or specific supervision protocols, all chart entries that require countersignatures must be countersigned within 14 days after the entry is made.

f. Consistent with the service authorization granted to him or her, perform consultations as requested by a Medical Staff Member.

g. Comply with all Medical Staff Bylaws, Rules and Regulations and Medical Center policies.

10. PREROGATIVES AND STATUS

AHPs are not members of the Medical Staff, and hence shall not be entitled to vote on Medical Staff or department matters. AHPs shall not be required to pay dues. They are expected to attend and actively participate in the clinical meetings of their respective departments, to the extent consistent with department rules.

11. CORRECTIVE ACTION

Whenever the activities, professional conduct, or professional practice of any AHP are considered to be lower than the acceptable standards, or to be disruptive to the operations of the Medical Center, corrective action against such AHP may be taken by the President of Staff, the Professional Practice Evaluation Committee, the Interdisciplinary Practice Committee, Medical Executive Committee, of the Governing Body, or their designees.

A. Corrective action may consist of summary suspension of all patient care services performed by the AHP. The Interdisciplinary Practice Committee or the Professional Practice Evaluation Committee, as appropriate, shall review the circumstances warranting the corrective action and shall then recommend whatever corrective action it deems appropriate, including written reprimand, probation, suspension, curtailment or termination of service authorization, or restoration of practice prerogatives to the Medical Executive Committee. The Medical Executive Committee will then review the Committee’s findings and recommendations, and shall submit their recommendations to the Governing Body for final determination.

B. AHPs, with the exception of Clinical Psychologists shall not be entitled to those Rights afforded in Article VIII of the Medical Staff Bylaws. AHPs, other than Clinical Psychologists and contract AHPs, shall have the right to challenge any action that would constitute grounds for corrective action by filing a written grievance with the President of Staff. Within fifteen (15) days of receipt of such a grievance, the President of Staff or designee shall initiate an interview before the Interdisciplinary Practice Committee or the
Professional Practice Evaluation Committee, as appropriate. The interview shall include, if possible, the participation of an individual of the same licensure or occupation as the individual being interviewed. The affected individual shall be informed of the circumstances giving rise to the proposed action and may present information relevant thereto. The Committee shall submit record of the findings of such interview to the Medical Executive Committee, which shall act thereon. The action of the Medical Executive Committee shall be final, subject to approval by the Governing Body.

12. **STANDARDIZED PROCEDURES**

   a. **DEFINITION**

   "**Standardized Procedures**" means the written policies and protocols for the performance of Standardized Procedure functions, and which have been developed in accordance with the requirements of State law.

   b. **FUNCTIONS REQUIRING STANDARDIZED PROCEDURES**

   Standarized procedures are required whenever any registered nurse (including, but not by way of limitation, Nurse Anesthetists, Nurse Practitioners, and Nurse Midwives) practices beyond the scope of practice taught in the basic curriculum for registered nurses as contemplated by the California Nurse Practice Act (i.e., whenever special training and/or experience are necessary in order for the nurse to perform the procedure or practice in question).

12. **DEVELOPMENT OF STANDARDIZED PROCEDURES**

   a. Standardized procedures may be initiated by the appropriate Department, the affected AHPs, or sponsoring or Supervising Practitioners.

   b. Representatives of the category of AHPs that will be practicing pursuant to the Standardized Procedure shall be involved in developing the standardized procedures. Standardized procedures shall be reviewed by the department, and then must be approved by IDP, the Medical Executive Committee, and the Governing Body.

   c. The IDP is responsible for assuring that standardized procedures are a collaborative effort among administration and health professions, including physicians and nurses. Each Standardized Procedure shall:

      1. Be in writing and show the date or dates of approval by the IDP.

      2. Specify which standardized procedure functions registered nurses may perform and under what circumstances.
3. State any specific requirements which are to be followed by registered nurses in performing particular standardized procedure functions.

4. Specify any experience, training, and/or education requirements for performance of standardized procedure functions.

5. Establish a method for initial and continuing evaluation of the competence of those registered nurses authorized to perform standardized procedure functions.

6. Establish a method of maintaining a written record of those persons authorized to perform standardized procedure functions.

7. Specify the nature and scope of review and/or supervision required for performance of standardized procedure functions; for example, whether the functions must be performed under the immediate supervision of a physician.

8. Set forth any specialized circumstances under which the registered nurse is to immediately communicate with a patient's physician concerning the patient's condition.

9. State the limitations on settings or departments, if any, in which standardized procedure functions may be performed.

10. Specify patient record keeping requirements.


14. CATEGORIES OF ALLIED HEALTH PROFESSIONALS THAT HAVE BEEN APPROVED FOR GRANTING OF SERVICE AUTHORIZATION FOR PROVISION OF SERVICES AT THE MEDICAL CENTER WITH THE REQUIREMENTS APPLICABLE TO EACH CATEGORY OF AHP.

a. Licensed Clinical Psychologists

An applicant for clinical psychologist allied health professional appointment must hold a clinical psychologist degree, have not less than two years clinical experience in a multidisciplinary facility licensed and operated by this or another state or by the United States to provide health care or be listed in the latest edition of the National Register of Health Service Providers in Psychology, and hold a valid and unsuspended certificate to practice clinical psychology issued by the California Board of Psychology.
b. **Scope of Practice**

A Licensed Clinical Psychologist may receive service authorization to perform the following professional services at the Medical Center pursuant to a Medical Staff Member's order:

1. Conduct psychological testing and diagnostic procedures;
2. Render a psychological diagnosis;
3. Provide appropriate psychotherapy;
4. Write orders regarding patient activity within the Medical Center and nursing management of a patient's behavior problems;
5. Document, in patient's medical record, information detailing the patient's response to psychological treatment; and
7. Perform hypnosis, if the Licensed Clinical Psychologist:
   (i) Can demonstrate experience in the clinical use of hypnosis; and
   (ii) Has had course work in hypnosis from qualified instructors and has experience in a clinical setting using hypnosis under supervision.

c. A Licensed Clinical Psychologist shall not:

1. Prescribe drugs, perform surgery, administer electroconvulsive therapy, or otherwise practice medicine.
2. Use biofeedback instruments that pierce or cut the skin.
3. Knowingly undertake any therapy or other professional activity in which the characteristics of his or her own personality may likely interfere with the professional services rendered or which may result in harm to the patient or client; or
4. Perform services that are outside his or her education, training, and experience.

d. Every patient being treated by a Clinical Psychologist at the Medical Center shall at all times be under the general care of a physician on the Medical Staff, who shall have responsibility for the patient's overall medical condition. Such physician shall perform the admitting history and physical on any patient treated by the Clinical Psychologist at the Medical Center.

e. A Clinical Psychologist shall at all times identify himself or herself as a psychologist when engaged in any therapy or other professional activity.

f. Nothing in this Section shall be deemed to create any vested rights in Licensed Clinical Psychologists to receive or maintain any privileges in the
Medical Center. Provisions as defined in Article VIII of the Medical Staff Bylaws shall apply to Clinical Psychologists.

b. Nurse Anesthetist

A Nurse Anesthetist shall be currently licensed as a registered nurse in California and currently certified as a Nurse Anesthetist by the California Board of Registered Nursing and the American Association of Nurse Anesthetists.

1. A Nurse Anesthetist may administer anesthesia only upon the direct order of a qualified physician who:

   (1) Is a current member in good standing of the Medical Staff of the Medical Center;
   (2) Is acting within the scope of his or her licensure and privileges; and,
   (3) Has personally evaluated the patient in question.

2. A Nurse Anesthetist may receive authorization to perform the following professional services at the Medical Center;

   (1) Induce Anesthesia;
   (2) Maintain anesthesia at the required levels;
   (3) Support life functions by induction or intubation procedures if necessary during the period in which anesthesia is administered;
   (4) Recognize and take appropriate corrective action for abnormal patient responses to the anesthesia or any adjunctive medication, or to other forms of related therapy; and
   (5) Observe and provide appropriate resuscitative care until the patient has regained control of his or her vital functions.
   (6) Perform other functions according to standardized procedures adopted by the Medical Center.

3. A Nurse Anesthetist shall consult with the physician responsible for the anesthesia, the Chief of the Department of Anesthesiology, or other qualified physician when necessary or appropriate.

c. Nurse Midwife

A Nurse Midwife shall be currently licensed as a registered nurse in California and currently certified as a Nurse Midwife by the California Board of Registered Nursing.

1. A Nurse Midwife may receive authorization to perform the following professional services at the Medical Center, under the supervision of a physician who is a member of the Medical Staff:
(i) Provide routine gynecological and family planning care, including fitting vaginal diaphragms, insertion of intrauterine devices, and selection of contraceptive agents from an approved formulary;

(ii) Provide care to women during pregnancy, as long as the medical situation meets criteria accepted as normal, and refer any complications to a physician immediately;

(iii) Manage labor and deliveries on his or her own responsibility, including the following specific procedures, as long as the medical situation meets criteria accepted as normal:

(iv) Administering intravenous fluids, analgesics, and postpartum oxytocics and Rhogam;

(v) Performing amniotomies during labor;

(vi) Applying external or internal monitoring devices;

(vii) Administering local anesthesia (paracervical blocks, pudendal blocks, and local infiltration);

(viii) Performing episiotomies; and

(ix) Repairing episiotomies and lacerations.

(x) Refer any complications during delivery to a physician immediately;

(xi) Care for the mother and infant immediately after delivery, as long as the medical situation meets criteria accepted as normal, and refer any complications to a physician immediately;

(xii) Provide emergency care for complications, including resuscitation of the newborn, until the assistance of a physician can be obtained; and

(xiii) Furnish drugs or devices (other than controlled substances) to patients under the following conditions:

(a) The drug or device is furnished incidentally to the provision of family planning services or of routine health care or perinatal care rendered to essentially healthy persons within the Medical Center;

(b) The drug or device is furnished pursuant to a standardized procedure, which is promulgated by the Medical Center in accordance with legal requirements;
(c) The drug or device is furnished under the supervision of the attending physician, who (1) collaborated in the development of the standardized procedure, (2) approved by the standardized procedure, (3) is available by telephone at the time of patient examination by the Nurse Midwife, and (4) supervises no more than four (4) Nurse Midwives at one time;

(d) The drug or device is furnished pursuant to certification from the Board of Registered Nursing that the Nurse Midwife has completed (1) at least 6 months physician-supervised experience in the furnishing of drugs or devices, and (2) a course in pharmacology covering the drugs and devices to be furnished; and

(e) The drug or device is furnished under a number issued by the Board of Registered Nursing to the Nurse Midwife, to be included on all transmittals of orders for drugs or devices.

(ixv) Perform and repair episiotomies, and repair first-degree and second-degree lacerations of the perineum, but only if the following additional conditions are met:

(a) The Supervising Physician holds privileges to perform these procedures;

(b) The procedures are performed pursuant to protocols developed and approved by the Supervising Physician, the Nurse Midwife, the director of the department or service in which the Supervising Physician holds his or her episiotomy privileges, the Interdisciplinary Practice Committee, and the Medical Center Director (or his or her designee).

(c) These protocols shall require that all complications are referred to a physician immediately, shall provide for immediate care of patients who are in need of care beyond the scope of practice of the nurse midwife, or emergency care when the Supervising Physician is not on the premises, and shall establish the number of Nurse Midwives that a Supervising Physician may supervise.

(d) "Criteria accepted as normal" include situations where by the patient's history reveals no condition that would adversely affect, or be adversely affected by, pregnancy; where there is no indication of current pathology present in the mother or fetus; and where there are no obstetric findings indicating the likelihood of an operative delivery.
(e) Provide other services set forth in standardized procedures which are promulgated by the Medical Center in accordance with the Interdisciplinary Practice Committee, Medical Executive Committee and the Governing Body.

(f) A Nurse Midwife shall not:

1. Assist in childbirth by any artificial, forcible, or mechanical means, such as forceps, vacuum extractors, or cesarean section; or

2. Perform any turning of the fetus.

3. Practice medicine or surgery.

2. The supervising physician need not be physically present when the Nurse Midwife performs services at the Medical Center.

d. Nurse Practitioner

A Nurse Practitioner shall be currently licensed as a registered nurse in California and currently certified as a Nurse Practitioner by the California Board of Registered Nursing.

A Nurse Practitioner may receive authorization to perform the following professional services at the Medical Center:

1. Perform tasks or functions which fall within the customary scope of nursing practice; and

2. Furnish drugs or devices (other than controlled substances) to patients under the following conditions:

   (i) The drug or device is furnished incidentally to the provision of family planning services, routine health care, or prenatal care, or when rendered for primary health care (primary health care includes presence or absence of disease) within the Medical Center;

   (ii) The drug or device is furnished pursuant to a standardized procedure or protocol, which is promulgated by the Medical Center in accordance with legal requirements;

   (iii) The drug or device is furnished under the supervision of the attending physician, who: (1) collaborated in the development of the standardized procedure, (2) approved the standardized procedure, (3) is available by telephone at the time of patient examination by the
Nurse Practitioner, and (4) supervises no more than four (4) Nurse Practitioners at one time;

(iv) The drug or device may include Schedule II through Schedule V controlled substances, and shall be further limited to those drugs agreed upon by the Nurse Practitioner and the Supervising Physician. The Nurse Practitioner must have a current furnishing number, DEA registration, and have completed a BRN approved course on Schedule II controlled substances. When Schedule II controlled substances are furnished by a Nurse Practitioner, they shall be furnished in accordance with a patient-specific protocol approved by the treating or Supervising Physician.

(v) The drug or device is furnished pursuant to certification from the Board of Registered Nursing that the Nurse Practitioner has completed (1) at least 6 months' physician-supervised experience in the furnishing of drugs or devices, and (2) a course in pharmacology covering the drugs and devices to be furnished; and

(vi) The drug or device is furnished under a number issued by the Board of Registered Nursing to the Nurse Practitioner, to be included on all transmittals of orders for drugs or devices.

(vii) The term "furnish" shall include ordering a drug or device in accordance (i) with standardized procedure, and (ii) transmitting an order of a Supervising Physician.

3. Perform tasks or functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in standardized procedures, promulgated by the Medical Center in accordance with the Interdisciplinary Practice Committee, Medical Executive Committee and the Governing Body.

e. **Physician's Assistants**

1. A Physician's Assistant shall be currently licensed by the Physician's Assistants Examining Committee of the Medical Board of California.

2. A Physician's Assistant shall have a Supervising Physician who:

   (i) Is a physician currently licensed by the State of California;

   (ii) Has not been prohibited by the Medical Board of California to supervise a Physician's Assistant (effective July 1, 2001);
(iii) Is a current member in good standing of the Medical Staff at the Medical Center and practices actively at the Medical Center; and

(iv) Meets the requirements set forth in Section detailing Supervision below.

3. Scope of Practice - A Physician's Assistant may receive service authorization to perform the following professional services at the Medical Center:

(i) Take a history, perform a physical examination, assess the patient, and record the pertinent data in a manner meaningful to the Supervising Physician;

(ii) Order, transmit and order for, perform or assist in performing laboratory and screening procedures delegated by the Supervising Physician, provided that the procedures are consistent with the Supervising Physician's practice and with the patient's condition;

(iii) Perform or assist in performing therapeutic procedures delegated by the Supervising Physician, provided that the procedures are consistent with the Supervising Physician's practice and with the patient's condition;

(iv) Order or transmit an order for x-ray, other studies, therapeutic diets, physical therapy, occupational therapy, respiratory therapy, and nursing services;

(v) Recognize and evaluate situations which call for the immediate attention of the Supervising Physician and institute, when necessary, treatment procedures essential for the life of the patient;

(vi) Administer or provide medication to a patient or transmit a prescription from the Supervising Physician to a person who may lawfully furnish the medication to the patient, subject to the following conditions;

(a) Any prescription transmitted by the Physician Assistant shall be based on either a patient-specific order by the Supervising Physician or on written protocol which specifies all criteria for the use of a specific drug or device and any contraindications for the selection;

(b) The Supervising Physician must countersign and date within 7 days the medical record of any patient cared for by the Physician Assistant for whom the Supervising Physician's Schedule II prescriptions has been transmitted or carried out;
(c) A Physician Assistant may not administer, provide, or transmit a prescription for controlled substances listed in Schedules II through V inclusive without a patient-specific order by the Supervising Physician.

(vii) Transmit orally, or in writing on the patient's medical record, a prescription from the Supervising Physician to a person who lawfully may furnish the medication.

(viii) Instruct and counsel patients regarding matters pertaining to their physical and mental health, such as diets, social habits, family planning, normal growth and development, aging, and understanding and managing their diseases;

(ix) Assist the Supervising Physician by arranging admissions, making appropriate entries in the patient's medical record, reviewing treatment and therapy plans, ordering, transmitting orders for, routine diagnostic laboratory tests and radiology services, ordering therapeutic diets, ordering physical therapy treatment, ordering occupational therapy treatment, ordering respiratory care services, acting as first or second assistant in surgery under the direct supervision of the Supervising Physician, and providing continuing care to patients following discharge;

(x) Facilitate the Supervising Physician's referral of patients to the appropriate health facilities, agencies, and resources of the community; and

(xi) Perform, outside the personal presence of the Supervising Physician, surgical procedures, which are customarily performed under local anesthesia, which the Supervising Physician has determined the Physician Assistant has training to perform. All other surgical procedures requiring other forms of anesthesia may be performed by a physician assistant only in the personal presence of an approved supervising physician.

4. A Physician's Assistant shall not:

(a) Perform any task or function that requires the peculiar skill, training, or expertise of a physician, dentist, or dental hygienist;

(b) Determine eye refractions or fit glasses or contact lenses; or

(d) Prescribe or use any optical device for eye exercises, visual training, or orthoptics (this does not however, preclude administering routine visual screening tests).
5. Supervision

The Physician's Assistant applicant's Supervising Physician shall submit a signed, written request which describes those tasks and functions that the Physician's Assistant would perform in the Medical Center.

The Supervising Physician shall establish the following, in writing, together with any necessary documentation:

(a) Those specific duties and acts, including histories and physical examinations, that the Physician's Assistant would be permitted to perform outside of the Supervising Physician's immediate supervision and control;

(b) That the Supervising Physician has a valid unrestricted California Medical License from the Medical Board of California which permits supervision of the Physician's Assistant in the particular type and scope of practice applied for.

(c) The Supervising Physician shall notify the Medical Center and the Medical Staff immediately in the event that his or her medical license is revoked, suspended, or otherwise modified by the Medical Board of California; and

(d) He or she shall comply with all Medical Board of California regulations regarding supervision of the Physician Assistant.

The Physician's Assistant shall practice only under the direction and supervision of a Supervising Physician. No Supervising Physician, other than an emergency care physician as provided below, shall supervise more than two Physicians' Assistants at any one time. Notwithstanding the foregoing, an emergency care Physician may have a supervisor relationship with more than 2 emergency Physician Assistants at any one time, provided that the emergency physician does not oversee the work of more than 2 such Physician Assistants while on duty at any one time.

The supervision of the Physician's Assistant by the Supervising Physician shall include at least the following:

(1) Review, either in person or by telephone, of the findings of the patient's history and physical examination and of the performance by the Physician's Assistant of any of the services set forth in the Scope of Practice above. Such review may be performed either before or after treatment, depending upon the significance of the findings and
the status of the patient, but in any event shall be on a continuous and timely basis;

(2) Except in emergencies, on-site supervision by the Supervising Physician of any surgery requiring other than local anesthesia; and

(3) Responsibility on the part of the Supervising Physician to follow the progress of the patient and to make certain that the Physician's Assistant does not function autonomously.

(4) Availability of the Supervising Physician in person or by electronic communication when the Physician Assistant is caring for patients.

(5) Observation or review of the Physician Assistant's performance of all tasks and procedures that the Supervising Physician will delegate to the Physician Assistant until the Supervising Physician is assured of competency;

(6) Establishment of written transport and back-up procedures for the immediate care of patients who are in need of emergency care beyond the Physician Assistant's scope of practice for such times when the Supervising Physician is not on the premises;

(7) Establishment of written guidelines for the adequate supervision of the Physician Assistant, which shall include one or more of the following:

(i) Examination of the patient by the Supervising Physician the same day as care is given by the Physician Assistant.

(ii) Countersignature and dating of all medical records written by the Physician Assistant within thirty (30) days of when the care was given by the Physician Assistant;

(iii) Adoption of protocols by the Supervising Physician to govern the performance of a Physician Assistant for some or all tasks. The minimum content for any such protocol governing absence of symptoms, signs, and other data necessary to establish a diagnosis or assessment, any appropriate test or studies to order, drugs to recommend to the patient, and education to be given the patient. For protocols governing procedures, the protocol shall state the information to be given the patient, the nature of the consent to be obtained from the patient, the preparation and technique of the procedure, and the follow-up care. Protocols shall be developed by the Supervising Physician, adopted from, or referred to, texts or other sources. Protocols shall be signed and dated by the Supervising Physician and the Physician Assistant. The Supervising Physician shall review, countersign, and date a
minimum sample of 10% of medical records of patients treated by the Physician Assistant functioning under these protocols within thirty (30) days. The Supervising Physician shall select or review those cases which by diagnosis, problem, treatment, or procedure, represent, in his or her judgment, the most significant risk to the patient;

(8) On-site supervision by the Supervising Physician of any surgery requiring other than local anesthesia; and

(9) Responsibility on the part of the Supervising Physician to follow the progress of the patient and to make certain that the Physician Assistant does not function autonomously.

f. Registered Nurse First Assistant

An applicant for Registered Nurse First Assistant service authorization shall:

1) Be currently licensed as a registered nurse in California; and

2) Either:

   (a) Be currently certified as a "registered nurse first assistant" by the National Certification Board: Perioperative Nursing; or

   (b) Be a graduate of Registered Nurse First Assistant Program accredited by the National Certification Board: Perioperative Nursing, who is obtaining the necessary clinical experience before taking the certification examination of the National Certification Board: Perioperative Nursing to become a "registered nurse first assistant."; or

   (c) Demonstrate sufficient training and experience to ensure the ability to act as a Registered Nurse First Assistant at a level that will ensure that patients receive care of the proper quality.

3. Scope of Practice

(a) A Registered Nurse First Assistant may receive service authorization to perform the following professional services at the Medical Center under the direct supervision of a physician on the Medical Staff:

   (1) Perform the following preoperative services:

      (i) Conduct patient interviews;
      (ii) Perform patient assessments;
      (iii) Perform patient teaching;
(iv) Perform physical examinations.

(2) Perform the following intraoperative services:

(i) Assist with positioning, preparing, and draping the patient.
(ii) Provide retraction for adequate exposure;
(iii) Use surgical instruments;
(iv) Perform dissection;
(v) Apply pressure;
(vi) Suction the wound area;
(vii) Pack sponges or laparotomy pads into body cavities to hold tissues or organs out of the operating field;
(viii) Grasp of fixate tissue with screws, staples or other devices;
(ix) Suture tissues;
(x) Perform knot tying;
(xi) Provide hemostasis by clamping vessels, suturing or tying clamped vessels, or cauterizing vessels;
(xii) Cauterize tissues;
(xiii) Apply Bovie power to instrumentation held by the surgeon when the surgeon is unable to do so;
(xiv) Inject medications;
(xv) Provide closure of the surgical wound by suturing fascia, subcuticular tissue, and skin; and
(xvi) Affix and stabilize drains, clean the wound and apply the dressing, and assist in applying casts.

(3) Perform the following postoperative services:

(i) Remove dressings, sutures, skin staples, drains, chest tubes, and casts;
(ii) Perform postoperative assessments;
(iii) Perform postoperative teaching; and
(iv) Conduct discharge planning.

(4) Perform other functions according to standardized procedures adopted by the Medical Center.

(b) A Registered Nurse First Assistant shall not function concurrently as a scrub or a circulating nurse.

g. **Audiologist**

An applicant for Audiologist service authorization shall be:
(1) Licensed Audiologist
Currently licensed by the Speech-Language Pathology and Audiology Examining Committee of the Medical Board of California as an Audiologist.

(2) Scope of Practice
Eligible to service authorization to perform the following professional services at the Medical Center:

a. Measure and test auditory, vestibular, and related functions.
b. Appraise and predict auditory dysfunction.
c. Consult, counsel, and instruct patients regarding auditory dysfunction and modification of communicative disorders involving speech, language, auditory behavior, or other aberrant behavior resulting from auditory dysfunction; and
d. Plan, direct, conduct, supervise or participate in programs of identification of auditory disorders, hearing conservation, aural habilitation, and rehabilitation including hearing aid recommendation (e.g., specifying amplification requirements) and evaluation procedures.
e. Perform such other functions as detailed in the Audiologist’s Job Description that is within the scope of the license of the audiologist and as approved by the practitioner’s supervising physician and as approved by the Interdisciplinary Practice Committee, Medical Executive Committee and the Governing Body.

h. Allied Health Professional Researcher

An applicant for Allied Health Professional Researcher service authorization shall be:

(1) Currently licensed or credentialed, as required by California law, or is exempted by California from licensing requirements for the purpose of conducting research as a limited license health care professional, other than a physician, dentist or podiatrist.

(2) An employee of The Regents of the University of California and perform research pursuant to an IRB approved protocol. Contact with patients will be defined by the IRB approved protocol and be stated in the employee’s job description. The job description shall be approved by the Interdisciplinary Practice Committee, the Medical Executive Committee and the Governing Body.
i. **Clinical Nurse Specialist**

A Clinical Nurse Specialist shall be currently licensed as a Registered Nurse in California and currently certified as a Clinical Nurse Specialist by the California Board of Nursing.

A Clinical Nurse Specialist may receive authorization to perform the following professional services at the Medical Center:

1. Perform tasks or functions which fall within the customary scope of nursing practice; and

2. Perform tasks or functions within the expanded scope of nursing practice as developed in collaboration with physicians and defined in standardized procedures, promulgated by the Medical Center in accordance with the Interdisciplinary Practice Committee, Medical Executive Committee and the Governing Body.

3. Provide expert clinical practice, education, research, consultation and clinical leadership to a select patient population.

j. **Optometrist.**

An applicant for Optometrist service authorization shall be required to have a supervising physician in the Department of Ophthalmology who is a member of the UCI Medical Center Medical Staff. The applicant shall be:

1. Licensed Optometrist
   - Currently licensed by the State of California Board of Optometry of the Department of Consumer Affairs and must meet the requirements of the Board for licensure.

2. Scope of Practice
   - Eligible for service authorization to perform the following professional services at the Medical Center:
     
     a. General optometric services.
     
     b. Pre- and postoperative eye care;
     
     c. Emergency eye care services;
     
     d. The use of pharmaceuticals in the diagnosis and treatment of eye disease; and
     
     e. Optometric specialty areas, such as fitting contact lenses, treating low vision, and providing vision therapy services.
     
     f. Perform such other functions as detailed in the Optometrist’s job description that is within the scope of practice of the license of the optometrist and as approved by the supervising
k. **Acupuncturist**

An applicant for Acupuncturist service authorization shall be:

1. **Licensed Acupuncturists**
   - Currently licensed by the Acupuncture Board of the State of California as an Acupuncturist.

2. **Scope of Practice**
   - Acupuncturists may receive service authorization to perform the following professional services to outpatients at all UCI Ambulatory sites under the indirect supervision of the Acupuncture Program Director and/or supervising physician:
     
     1) Insert needles into the skin to stimulate certain points on the body in order to prevent or modify the perception of pain or in order to control pain for the purposes of assisting in the treatment of diseases or dysfunctions;
     2) Administer electroacupuncture, cupping and moxibustion to stimulate a certain point or points on or near the surface of the body in order to prevent or modify the perception of pain or in order to control pain for purposes of assisting in the treatment of disease or dysfunctions; and
     3) As an adjunct to the treatment described above in 1) and 2) prescribe or provide oriental massage, acupressure, breathing techniques, exercise or nutritional information.

   a. **Acupuncturists shall not perform** any procedure in the UCI Ambulatory sites beyond the scope of acupuncture licensure, including:
      1) Making incisions in the skin and manipulating nerve tissue with forceps;
      2) Inserting sutures in order to stimulate a certain point or points on or near the surface of the body;
      3) Using ultrasound or diathermy in order to generate deep heat within body tissues;
      4) Using lasers or magnets in order to stimulate a certain point or points on or near the surface of the body; or
      5) Using heat therapy or hydrotherapy in order to stimulate a certain point or points on or near the surface of the body. (However, an acupuncturist may use heat therapy and hydrotherapy in order to prepare the patient for acupuncture treatment.)

   b. **Acupuncturists shall not**
1) Sever or penetrate tissues in order to excise a needle that has broken subcutaneously; or
2) Treat complications, such as pneumothorax, hematoma or peritonitis, arising from acupuncture.
c. Acupuncturists shall refer the complications as set forth in b(1) or b(2) to the attending physician.
d. Acupuncturists shall be responsible to know and adhere to all applicable infection control requirements of the Medical Center and of the Acupuncture Board.

1. **Perfusionist**

An applicant for Perfusionist service authorization shall be required to have a supervising physician who is a member of the Medical Staff of UCI Medical Center.

(1) Clinical Perfusionists shall be currently certified by the American Board of Cardiovascular Perfusion or its successor thereof as determined by the Medical Board of California, Division of Licensure. These requirements will be deemed to have been met if the Perfusionist is currently certified by the American Board of Cardiovascular Perfusion or the person has practiced as a Perfusionist and has annually performed a minimum of 40 cases of cardiopulmonary bypass during cardiac surgery in a licensed health facility in the United States and has done so for at least five years between January 1, 1987, and January 1, 1993.

(2) Scope of Practice

a. Clinical Perfusionists may receive service authorization to provide the safe and successful conduct of extracorporeal cardiopulmonary bypass under the immediate direction of the operating cardiac surgeon.
b. Perform such other functions as detailed in the Perfusionist’s Job Description that is within the scope of California Business and Professions Code Section 2590-2596, and as approved by the practitioner’s supervising physician and as approved by the Interdisciplinary Practice Committee, Medical Executive Committee and the Governing Body.

m. **Speech Pathologist**

An applicant for Speech Pathologist service authorization shall be:

(1) Licensed Speech Pathologist
Currently licensed by the Speech-Language Pathology and Audiology Examining Committee of the Medical Board of California.

(2) Scope of Practice
Eligible for service authorization to perform the following professional services at the medical center for the purposes of identifying, preventing, managing, rehabilitating, ameliorating or modifying disorders of speech, voice or language:

1) Measure and test as follows:
   i) With respect to speech related to articulation, fluency, mastication or swallowing, measure and test the development of patients’ articulation, fluency, mastication or swallowing;
   ii) With respect to voice involving vocal quality and vocal production, measurement and test the development of patients’ voice quality and voice production;
   iii) With respect to language involving auditory processing, auditory memory, verbal language, written language, visual processing, visual memory, cognition and communication, and nonverbal/aural language, measure and test the development of patients’ auditory processing, auditory memory, verbal language, visual processing, visual memory, cognition and communication and nonverbal/aural language.

2) Predict disorders
3) Counsel patients
4) Conduct binary pure tone screening for the purpose of determining if the screened individuals are in need of further medical or audiological evaluation and
5) Plan, direct, conduct, and supervise programs for identification, evaluation, habilitation, and rehabilitation of the disorders of speech voice or language described in subparagraph 2.a., above.

a. Speech Pathologists shall not:
   1) Perform invasive procedures;
   2) Conduct physical examinations; or
   3) Prescribe medications.

n. Ph.D. MEDICAL GENETICIST

An applicant for Ph.D. Medical Geneticist shall:
1) Be Certified by the American Board of Medical Genetics (ABMG) as Ph.D. Medical Geneticist and/or Clinical Molecular and/or Clinical Biochemical Geneticist.
2) Meet disclosure requirements outlined in the Business and Professions Code, Section 2053.6.

Scope of Practice

Ph.D. Medical Geneticists may receive service authorization to perform the following professional services at the Medical Center:

1) Provide Clinical Consultation to Appropriate Health Care Professionals:
   a. Participate with physicians and appropriate health care professionals in clinical evaluations and patient review conferences.
   b. Assemble and review clinical and laboratory data and provide advise as to possible diagnoses, additional investigations, and possible therapeutic approaches.

2) Provide Clinical Consultation to Patients and their Families:
   a. Provide evaluation, diagnosis and genetic counseling to patients and their families with genetic (Mendelian, mitochondrial, other) and/or metabolic disorders.
   b. Evaluate clinical information and family data for evidence of hereditary disorders.
   c. Recommend commonly accepted therapeutic approaches for the treatment of genetic disorders.
   d. Evaluate the efficacy of commonly accepted therapeutic interventions for genetic disorders.
   e. Recommend medication regimes for complex genetic disorders.

o. Naturopathic Practitioner

An applicant for Naturopathic Practitioner privileges shall:

1) Hold a degree in Naturopathic Medicine from an approved Naturopathic Medical School AND
2) Hold a current license as a Naturopathic doctor in the State of California

Scope of Practice

As defined by S.B. 907, and Approved Regulations (08/16/05) for the state of California, clinical responsibilities of a Naturopathic Practitioner will include:
a. Performing physical and laboratory examination for diagnostic purposes.
b. Order diagnostic imaging studies.
c. Dispense, administer, order and prescribe or perform food, neutraceuticals, vitamins, minerals, amino acids, enzymes, botanicals and their extracts, (including natural hormones), homeopathic medicines, dietary supplements and non-prescription medicines as defined by the federal Food, Drug and Cosmetic Act.
d. Hydrotherapy, naturopathic physical medicine, massage and therapeutic exercise.
e. Health education and counseling.
f. Practitioner will be responsible for interviewing, examining, and assessing patients at Gottschalk Medical Plaza and satellite clinics/Susan Samueli Center for Integrative Medicine. If at any time consultation on difficult case is necessary, direct physician supervision may be required.
g. Indirect physician supervision is appropriate to ensure that clinic policies and procedures are followed, such as adhering to efficient time management skills, filling out chart notes completely, and managing patient care wisely.
h. Practitioner will be responsible for documenting each patient visit thoroughly, including subjective, objective, assessment, and treatment plan.
i. Practitioner will regularly review patient cases, i.e. patient history, physical examination findings, and treatment plan with supervising physician when requested.
j. The practitioner also will collaborate with other clinicians at the Samueli Center on patient cases.
k. During patient visits, practitioner will educate patients on the effects, benefits, and techniques of naturopathy.
l. The practitioner will be available for observation when UCI medical students or residents perform clinical rotations at the Samueli Center Integrative Medicine Clinic.

p. Clinical Neurophysiologist

An applicant for Clinical Neurophysiologist shall:

1) Be employed by a physician in good standing at UCI Medical Center or under contract with UCI Medical Center to perform such services.
2) Specialize in established clinical electrophysiological procedures for the objective analysis and intra-operative monitoring of the peripheral and central nervous systems as demonstrated by advanced degrees in neurophysiology or audiology (MA; Ph.D.)
Scope of Practice

1) A Clinical Neurophysiologist is devoted to the scientific field of recording and studying the electrical activity of the brain. The Clinical Neurophysiologist possesses the knowledge, attributes and skills to obtain interpretable recordings of the patient’s nervous system function.

2) The Clinical Neurophysiologist is a skilled practitioner and may receive privileges to perform the following professional services at the Medical Center under the direct supervision of a physician on the Medical Staff:

**General skills:**
- Communicating with patients, family and other health care providers
- Taking and abstracting histories
- Applying adequate recording electrodes and using EEG and EP techniques
- Documenting the clinical condition of patients
- Understanding and employing the optimal utilization of EED and EP equipment

**Electro-neurodiagnostic:**
- Auditory Brainstem Response (ABR)
- Auditory Cortical
- Auditory Cognitive
- Pattern Visual Evoked Potential Monitoring
- Visual Evoked Response (VER)
- LED Visual VEP
- Somatosensory Evoked Potential Monitoring (SEP or SSEP)
- Sterotactic Computer Engineer and Imaging Systems Operator
- Sterotactic Neurophysiology of Equilibrium and Balance Disorders
- Electroencephalography (EEG)
- Electromyography (EMG)
- Nerve Conduction Studies
- Intraoperative microelectrode recording (MER)

Pathology Assistant

An applicant for Pathology Assistant shall meet the following requirements:

1. Bachelor’s degree and two years of technical experience in Pathology
2. Completion of a 2-year Pathology Assistant program
3. Pathology Assistant certified or eligible

Scope of Practice:

Responsible for the gross examination and dissection of anatomic pathology specimens and the performance of postmortem examinations. Prepare tissue for
numerous pathological tests including frozen section diagnosis, flow cytometry, and immunohistochemical staining. Photographs gross and microscopic specimens.

M. CONTINUING MEDICAL EDUCATION

The Medical Staff is committed to continuing medical education as a required component of the credentials of each Medical Staff Member. The Medical Center has particular strengths in this area by virtue of being a major university hospital with each of the medical services headed by the Academic Department Chair of the respective department in the College of Medicine. All faculty members are reviewed regularly for professional competence, teaching expertise, evidence of increasing stature in continuing medical education, and research. Promotion in academic rank is dependent upon these activities. In addition, all full-time members of the Medical Staff, being related to one of the College of Medicine departments, attend numerous ward rounds, seminars, patient care review analyses, autopsy reviews, and grand rounds given by distinguished visiting physicians.

The College of Medicine is approved for awarding Category I credit in its educational programs and the specific departmental activities are so recognized. All Medical Staff Members other than Clinical Non-Teaching, Honorary and Retired staff categories are required to participate in at least seventy-five (75) hours per year in teaching and/or supervision in training programs.

The responsibility of continuing medical education shall be delegated to the respective Academic Department Chairs of the departments of the College of Medicine (who, in most instances, are the Clinical Department Chiefs of their respective departments in the Medical Staff structure). Since, in California, each physician, dentist and podiatrist is required by the Medical Board of California to take a minimum number of units of Category I credit of continuing medical education to retain their license, the Medical Staff Office shall require each Medical Staff Member to send in a copy of the material authenticating his or her CME activities, relating in part to the Member's scope of practice, when necessary to maintain his or her appointment.

All physicians with patient care responsibilities are expected to maintain appropriate CPR proficiency, but documentation of certification status is not a requirement for membership.

N. COMMITTEES AND FUNCTIONS

Please refer to Article XI, Section 1, INTRODUCTION and Section 2. GENERAL PROVISIONS and Article XIII for general information regarding committees. The following Standing Committees are detailed in the following Subsections:

1. Bylaws, Rules and Regulations Committee
2. Cancer Committee
3. Code Blue Committee
4. Critical Care Committee
5. Department Committees
Subsection 1. **BYPALWS, RULES AND REGULATIONS COMMITTEE**

This Committee shall at least include, but not be limited to representatives from four of the Clinical Services and the Secretary. The Administrative Director of the Medical Staff shall serve as an ex officio member without vote. The Committee shall be responsible for reviewing the Bylaws, Rules and Regulations and for preparing amendments for review by the Medical Staff. The Committee shall meet annually or more often as necessary and report its meetings in writing to the Medical Executive Committee. The Committee shall recommend to the Medical Executive Committee and the Governing Body any changes deemed necessary or desirable in the Bylaws, Rules and Regulations, and cause departments to develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws, Rules and Regulations and with Medical Staff and Governing Body policies. The quorum shall consist of not less than three (3) Medical Staff members.

The Committee shall recommend to the Medical Executive Committee and the Governing Body any changes deemed necessary or desirable in the Bylaws, Rules and Regulations and cause Departments to develop and implement rules and regulations to establish standards of patient care and ascertain that these rules and regulations are consistent with Medical Staff Bylaws, Rules and Regulations and with Medical Staff and Governing Body policies. The Committee shall review at least annually the Medical Staff Bylaws, Rules and Regulations for any needed change.

Subsection 2. **CANCER COMMITTEE**

The Cancer Committee shall meet at least quarterly and shall be comprised of members of the Medical Staff with at least one board certified physician
representative from surgery, medical oncology, radiation oncology, diagnostic radiology, gynecology, pathology, thoracic surgery, urology, pain management and palliative care. The required physician composition shall also include the Cancer Liaison Physician appointed by the American College of Surgeons, Commission on Cancer (CoC). Required non-physician members appointed to the Committee shall include representatives from the Cancer Center Administration, Cancer Registry, Clinical Research, In-patient and Ambulatory Oncology Nursing Services, Performance Improvement, Pharmacy, Health Information Management, Rehabilitation and Social Services. Other physician and nonphysician members may be appointed to the committee based on the needs of the institution. Each required member or his/her designee shall attend at least 75% of the cancer committee meetings held during any given year.

The primary purpose of the cancer committee is to lead the Cancer Program through setting goals, monitoring program activity, and evaluating patient outcomes and improving care. The Committee is responsible for monitoring, assessing, and identifying changes that are needed to maintain the CoC Cancer Program accreditation.

The Committee's responsibilities shall include the following: develops and evaluates the annual goals and objectives for the clinical, educational, and programmatic activities related to cancer; promotes a coordinated, multidisciplinary approach to patient management; ensures that educational and consultative cancer conferences cover all major sites and related issues; ensures that an active supportive care system is in place for patients, families and staff; promotes clinical research; monitors the quality of patient care through completion of quality management studies that focus on access to care, and outcomes utilizing nationally accepted quality improvement measures and evidence-based treatment guidelines; and ensures an accurate, complete and timely cancer registry database for reporting and monitoring care.

The Committee shall maintain liaison on matters concerning cancer, with other staff and committees of the Medical Staff, the local and state branches of the American Cancer Society, State Medical Society, local and state health agencies, the Department of Professional Services, the Commission on Cancer of the American College of Surgeons, and the National Cancer Institute. The Committee shall maintain minutes of its meetings which shall be forwarded to the Medical Executive Committee.

Subsection 3. ACUTE RESPONSE COMMITTEE

The Committee shall meet at least biannually, and more often as needed. The Committee shall be a multidisciplinary committee whose members shall include Medical Staff representatives who are specialists in the areas of
Anesthesiology, Critical Care, Emergency Medicine, Pulmonary Medicine, Cardiology, and Surgery. The committee membership shall also include Critical Care Nursing, Nursing Education, Pharmacy, Performance Improvement, Respiratory Care, and a representative from Administration. The Committee shall have overall responsibility for monitoring the Cardiopulmonary Resuscitation process by reviewing and revising the Committee's policies and procedures and by monitoring the appropriateness of patient care provided by multidisciplinary Code Blue Team members.

Patients with cardiac, pulmonary, or cardiopulmonary arrest often require cardiopulmonary resuscitation. Therefore, the hospital has an organized mechanism for providing resuscitation services. This mechanism includes:

a. Appropriate policies, procedures, processes, or protocols governing the provision of resuscitation services;
b. Appropriate equipment placed strategically throughout the hospital close to areas where patients are likely to require resuscitation services;
c. Appropriate staff trained and competent to recognize the need for and use of designated equipment in resuscitation efforts;
d. Appropriate data collection related to the processes and outcomes of resuscitation; and
e. Ongoing review of outcomes related to resuscitation in the aggregate to identify opportunities for improvement of resuscitation efforts.

Minutes of meetings shall be prepared and submitted to the Medical Executive Committee.

Subsection 4. CRITICAL CARE COMMITTEE

The Committee shall meet at least quarterly, and shall be a multidisciplinary committee whose members shall include the directors of each critical care unit as voting members. The Director of Nursing, Critical Care Units shall be a voting member of this Committee and the Director of Nursing, Director of Women's and Children's shall serve as an ex officio member. The Committee shall be responsible for developing general policies necessary to guide the activities of Medical Center special care units. It shall review and evaluate the quality, safety, and appropriateness of patient care in the special care units, within the framework of the Medical Staff Performance Improvement Plan. Such review shall include an annual evaluation of morbidity and mortality rates for each unit, the annual review and approval of policies and procedures for each unit, and continuing review of specific or general problems identified by ICU staff, and special charges, as assigned by the President of the Staff or Chair, Performance Improvement Committee. Minutes of meetings shall be prepared and submitted to the Medical Executive Committee.
Subsection 5. **DEPARTMENT COMMITTEES**

Each department shall have a committee consisting of at least 3 Active Staff Members. The Department Committee shall meet as often as necessary, but at least quarterly. The Department Committees shall assist the Department Chief to carry out the responsibilities assigned to the Department Chief, including the duties to review applicants for appointment, reappointment, and clinical privileges and to fulfill the responsibility for peer review. The Department Committee shall also fulfill the quality improvement functions assigned to them by the Performance Improvement Committee, including review of department Members' cases for the purposes of fulfilling the quality improvement, surgical case review, blood usage, medical records, medication and drug usage and tissue and death review functions otherwise assigned to the Performance Improvement Committee.

Subsection 6. **EPIDEMIOLOGY AND INFECTION PREVENTION COMMITTEE**

This committee shall be composed of at least one Medical Staff Member from each of the following Departments: Medicine, Surgery, Pediatrics/Neonatology, Pathology (when their area is involved) and Obstetrics/Gynecology. Ex-officio members shall include a representative from administration, with vote, the Infection Control Practitioner, with vote, and representatives from the nursing department/service, and the microbiology section of the laboratory. When available, a physician infectious disease specialist and a liaison member from the state or local health department should participate in the meetings. Other individuals, representing the Operating Room, Pharmacy, Environmental Health & Safety, Central Services, Nutrition Services, Respiratory Care Services, etc., shall participate as consultants on an as-needed basis when their area is involved.

The Committee shall establish a system for the surveillance of nosocomial infections; approve the systems used to collect and analyze data; monitor the interventions employed to prevent and control infections, including an Employee Health Program; approve policies and procedures describing the role and scope of each department/service in infection prevention and control activities (every two years). The committee also approves the type and scope of surveillance activities related to microbiological reports, definitions and criteria used to identify nosocomial infection; looks for unusual epidemics, clusters of infections, unusual pathogens, and occurrences of nosocomial infection which exceed the usual baseline levels. The Epidemiology and Infection Prevention Committee shares joint responsibility for antibiotic review with the Pharmacy and Therapeutics Committee. The Epidemiology and Infection Prevention Committee shall assure that written policies and procedures are made known to personnel through orientation, on-the-job and in-service training, and documented continuing education. The Committee reviews environmental and employee performance monitors of patient care.
support departments/services such as Central Services, and Environmental Services. The Epidemiology and Infection Prevention Committee through its Chair or designee shall have authority to institute any appropriate control measures or investigations when there is reasonable concern that there is a danger to any patient or personnel from an infection hazard. The Committee Chair or designee shall serve as a member of the Performance Improvement Committee as provided in the Performance Improvement Plan. The overall Department/individual practitioner findings will be sent to each Department and, after any required peer review, the information will be placed in the appropriate individual practitioners' files.

The Epidemiology and Infection Prevention Committee shall meet as often as necessary to accomplish its functions, but at least quarterly. The meeting minutes will be sent to the Medical Executive Committee.

Subsection 7. INTERDISCIPLINARY PRACTICE COMMITTEE

A. The Interdisciplinary Practice Committee shall be composed of five (5) physician members of the Active Medical Staff or Non-Teaching Clinical Staff appointed by the President, five (5) Registered Nurse members appointed by the Director of Nursing, the Director or designee, and the Director of Nursing. Additional ex officio members may be appointed for one-year terms by the Chair. The term of appointment shall be annual or until a successor is appointed. A quorum shall consist of a majority of physicians and a majority of registered nurses eligible to vote. The Chair of the Committee is appointed by the Governing Body, after consultation with the President of Staff and the Director, alternating between a physician and a registered nurse each year. The committee shall meet as often as required but at least quarterly. The meeting minutes shall be sent to the Medical Executive Committee.

The Committee shall evaluate and make recommendations regarding the need for and appropriateness of the performance of medical center services by Allied Health Professionals (AHPs) and the standards and requirements of AHP's for proposed procedures. The Committee shall evaluate and monitor the services provided by AHPs to ensure the quality of medical care consistent with the responsibilities of members of the Medical Staff.

All actions of the committee must be approved by a majority of the voting physician members and by a majority of the voting licensed professional members, and by the applicable Clinical Department Chief. Prior to approval of standardized procedures, consultation shall be obtained from staff in the medical and nursing specialties under review. All actions will be subject to the final approval of the Governing Body.
Nothing in this Section shall entitle registered nurses or other AHP’s to eligibility for membership on the Medical Staff. Further, nothing stated in this Section shall be deemed to create any vested rights for registered nurses or other AHP’s to receive or maintain any prerogatives in this Medical Center. The hearing and appeal rights under these Bylaws shall not apply to registered nurses or other AHP’s unless otherwise required by law.

B. The Interdisciplinary Practice Committee shall be responsible for:

1. Recommending policies, protocols and standardized procedures to the Medical Executive Committee for granting expanded roles to registered nurses and Allied Health Professionals to provide for the assessment, planning and direction of the diagnostic and therapeutic care of patients;

2. Reviewing the credentials of registered nurses who practice according to standardized procedures and Allied Health Professionals and making recommendations to the Medical Executive Committee for granting and/or rescinding expanded role prerogatives;

3. Yearly reviewing of approved interdisciplinary practice programs, protocols and policies;

4. Identifying functions and/or procedures that require the formation and adoption of standardized procedures in conformance with applicable law in order for them to be performed by registered nurses, and initiating the preparation of such standardized procedures;

5. Reviewing and recommending approval to the Medical Executive Committee of all such standardized procedures covering practice by registered nurses and Allied Health Professionals;

6. Recommending policies for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. The administration of policies may be administered by the Interdisciplinary Practice Committee or by delegation to the director of nursing;

7. Maintaining a permanent record of the committee’s proceedings and activities, which shall be filed in the Medical Staff Administration Office. The names of registered nurses and Allied Health Professionals who have been approved to perform procedures pursuant to a standardized procedure shall be on file in the office of the director of nursing;

8. Obtaining recommendations from members of the medical staff specialty or clinical field of practice under review, and from persons
in the appropriate nonmedical category who practice in the clinical field or specialty under review;

9. Establishing clear lines of responsibility of the nursing service for nursing care of patients and of the Medical Staff for medical services in the facility;

10. Establishing written policies for the conduct of its business.

C. Each standardized procedure shall:

1. Be in writing and show dates of approval, including approval by the Interdisciplinary Practice Committee;

2. Specify the standardized procedure functions that licensed professionals are authorized to perform and under what circumstances;

3. State any specific requirements that are to be followed by licensed professionals in performing all or part of the functions covered by the particular standardized procedure;

4. Specify any experience, training or special education requirements for performance of the functions;

5. Establish a method for initial and continuing evaluation of the competence of those personnel authorized to perform the functions;

6. Provide for a method of maintaining a written record of those persons authorized to perform the functions;

7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedure functions; for example, if the function is to be performed only under the immediate supervision of a physician, that limitation must be clearly stated. If physician supervision is not required, that fact should be clearly stated;

8. Set forth any specialized circumstances under which the licensed professional is to communicate immediately with a patient's physician concerning the patient's condition;

9. State any limitations on settings or departments within the facility in which the standard procedure for functions may be performed;
10. Specify any special requirements for procedures relating to patient record keeping;

11. Provide for periodic review of the standardized procedure.

Subsection 8. **MEDICAL ETHICS COMMITTEE**

The Medical Ethics Committee shall meet quarterly, and as needed on an ad hoc basis. The Committee shall be comprised of at least five members of the Active Medical Staff including one second or third year resident member. Whenever possible, Medical Staff representation should include but not be limited to physicians from the following specialties: Pediatrics, Surgery, Medicine, Ob/Gyn, Psychiatry, Physical Medicine and Rehabilitation, Pathology and/or Radiology. Additional representation shall be multidisciplinary and include the Chaplain, representatives from social services and nursing. Non health care professionals should comprise no more than one-third of the total committee membership and may include community representatives such as a lawyer and clergyman. When consultation is requested, the committee shall be responsible for facilitating communication and treatment decisions in cases with unresolved ethical issues, with reference to current Medical Staff and social policy and widely held ethical standards. Any member of the Medical Center community, including patients and families of patients may request consultation. Additional responsibilities of the Committee include participating in the development and review of policies and procedures with ethical implications, serving the functions of an Infant Care Review Committee, facilitating and sponsoring educational forums of the Medical Center community, and community at large. The Committee should be proactive in trying to avoid conflicts and utilize mediation to achieve positive results. The Committee shall submit minutes of its meetings to the Medical Executive Committee.

Subsection 9. **MEDICAL RISK MANAGEMENT COMMITTEE**

The committee shall consist of five (5) Members of the Active Staff, and one or more ex officio representative(s) of the Director, and shall provide liaison with the Governing Body Advisory Council through the Performance Improvement Committee. The Committee shall meet as often as required, but at least quarterly and submit minutes of the meeting to the Medical Executive Committee.

The committee shall review event reports, filed, pending and potential malpractice suits, and medically related claims against the Medical Center, its agents, or employees, and evaluate such claims and advise Risk Management about merit and shall recommend to the Medical Executive Committee policies, directives, or guidelines which may prevent future malpractice claims. The Chair of the Risk Management Committee shall be appointed by
the President of Staff on a biennial basis. The Committee may appoint ad hoc or standing subcommittees, subject to the approval of the Medical Executive Committee, to review and coordinate its functions. Minutes of meetings shall be prepared and submitted to the Medical Risk Management Committee.

Subsection 10. PROFESSIONAL PRACTICE EVALUATION COMMITTEE

A. Representatives appointed by the respective Clinical Department Chiefs of the following Departments will be members of this Committee: Surgery, Medicine, Pediatrics, Radiology, Obstetrics and Gynecology, and Psychiatry. In addition, four members will be selected from the following Departments on a rotational basis, for a two year appointment: Ophthalmology, Family Medicine, Physical Medicine and Rehabilitation, Dermatology, Neurology, Neurosurgery, Anesthesiology, Pathology, Radiation Oncology and Orthopedic Surgery. The Chief Executive Officer or his/her designee, and the Director of Medical Staff Administration shall serve as ex officio members. Each appointee shall serve as long as appointed by the Clinical Department Chief, appointment to be confirmed biennially. The Committee shall meet monthly, or a minimum of ten times per year. The Secretary of the Medical Staff shall serve as Chair. The Vice President of the Medical Staff shall serve as the Vice Chair. The committee shall submit minutes of its meetings to the Medical Executive Committee.

B. The responsibilities, duties and authority of this Committee shall include:

1. to receive and review Departmental Chiefs' recommendations;

2. to standardize departmental and cross-departmental credentialing procedures by reviewing and approving privilege lists and systems from Departments;

3. to review and make recommendations on all physicians, dentists and podiatrists requesting Medical Staff membership and Clinical Privileges, reappointment, or modification of appointment;

4. to update appropriate forms;

5. to develop and recommend policies to the Medical Executive Committee;

6. to receive and review recommendations of the Interdisciplinary Practice Committee regarding the qualifications of Allied Health Professionals to provide specific patient care services in the Medical Center;
7. to provide oversight of Ongoing Professional Practice Evaluation activities and on its own behalf or in concert with other Medical Staff Departments or Committees, provide oversight of Focused Professional Practice Evaluations to assess members’ general competencies. The Vice President of the Medical Staff will provide oversight of the OPPE process and serve as a liaison reporting any issues of concern to the respective Department Chairs.

8. to monitor activities implemented for evaluation of the performance of patient care, such as for practitioners in provisional status or who have been granted temporary privileges pending Medical Staff appointment;

9. to initiate, investigate, review, and report on corrective action matters and on any other matters involving the clinical, ethical, or professional conduct of any practitioners assigned or referred by the President of Staff; and

10. to assure that a separate credentials file is maintained for each Staff Member, each practitioner with clinical privileges, and all Allied Health Professionals, including reports from quality/performance assessment and improvement activities and of corrective actions of any degree.

Subsection 11. MEDICAL STAFF WELL-BEING COMMITTEE

The committee shall consist of at least five (5) physician members of the Medical Staff appointed by the President of Staff. Each member shall serve a 3 year term with the membership terms so staggered as to maintain reasonable continuity of the committee's function. The committee itself, may appoint on an ad-hoc basis as it deems necessary, no more than three physician members to serve on an ad-hoc basis for the follow-up and handling of specific counseling cases. The Committee shall educate members of the Medical Staff about physician health, well-being and impairment; about appropriate responses to different levels and kinds of distress and impairment; and about appropriate resources for prevention, treatment, and rehabilitation. The Committee shall serve as a resource where information and concerns about the health of a physician can be referred for confidential consideration. The Committee shall provide advice, recommendations, and assistance to individual physicians and to groups or committees who request assistance or recommendations. The committee shall meet as often as necessary but not less than quarterly. It shall maintain only such records of its proceedings it deems advisable, but shall report its activities on a confidential basis to the Medical Executive Committee.
A. **PURPOSE**

This Rule addresses referral of Medical Staff Members who possibly suffer chemical dependence, or mental or physical impairment, for evaluation and initiation of treatment for the purposes of assisting the Member and protecting patients.

B. **PHILOSOPHY**

Chemical dependence (including dependence on mood-altering drugs, such as alcohol, cocaine, opiates, and depressants) is seen as a medical condition that requires treatment. Untreated or relapsing chemical dependence, mental impairment, or physical impairment is incompatible with safe clinical performance in any medical specialty.

C. **ASSISTING IMPAIRED MEDICAL STAFF MEMBERS**

1. All Medical Staff Members should share their concerns about chemical dependence, or mental or physical impairment, in themselves or other Members, in confidence, with the Medical Staff Well-Being Committee.

2. The Medical Staff Well-Being Committee is dedicated to helping the Members identify chemical abuse, and mental and physical impairments, and helping the Members to obtain treatment to alleviate the problem. Even though the Committee's mission is to assist Medical Staff Members, patient safety must be primary. Thus, if the Medical Staff Well-Being Committee finds a risk of harm or danger to patients and the Practitioner does not willingly withdraw from clinical practice, the Committee will ask the President of Staff to initiate corrective action.

D. **CONFIDENTIALITY**

1. The Medical Staff Well-Being Committee shall maintain strict confidentiality. It will release information only with the express agreement of the Member, as needed to carry out Medical Staff duties, or as required by law. Releases to carry out Medical Staff duties shall be limited, insofar as possible, to protecting patients and carrying out Medical Staff Well-Being Committee activities.

2. The Medical Staff Well-Being Committee shall periodically report on its activities to the Medical Executive Committee, without identifying individuals.

3. The Medical Staff Well-Being Committee shall report directly to the President of Staff on the status of particular cases.
E. REPORTING AND INVESTIGATING PROCEDURE

1. The Medical Staff Well-Being Committee will investigate all reports of impairment to determine whether a problem exists. This protocol applies to Members who have impairments, as well as applicants who have a history of impairment.

   a. The investigation may include evaluation of written reports; interviews of associates, relatives, and others at the Hospital, office or home (when authorized by the doctor); and chart review of records at this or other hospitals for the purpose of identifying impairment rather than assessing quality of care.

   b. If a problem may exist, the Practitioner in question will be invited to meet with the Committee or a minimum of two (2) Committee members, to discuss the problem and the findings from the investigation. The interview will be informal.

   c. The Committee may ask the Practitioner to be evaluated by a Practitioner, including a psychiatrist, other psychotherapist, or substance abuse counselor. The Committee will ask the Practitioner to sign a form authorizing disclosure of the results of the evaluation to the Committee. The Practitioner should be given a list of professionals acceptable to the Medical Staff Well-Being Committee. The report should address the diagnoses, prognosis, and treatment program recommendation.

   d. Practitioners who have chemical dependency abuse will be referred to a treatment program approved by the Medical Staff Well-Being Committee. Practitioners who have other types of impairment will be referred for treatment approved by the Medical Staff Well-Being Committee.

   e. The Medical Staff Well-Being Committee will draw up a contract between it and the Practitioner, delineating the Committee's expectations for treatment and monitoring. The contract, as a minimum, will require the Member to agree to the following conditions, depending upon the nature of the impairment:

      (1) To provide documentation from an evaluating or treating professional that initial treatment has been provided and that the Member may safely practice.

      (2) To abstain from using any drugs or alcohol, except as approved by the treatment program and the Medical Staff Well-Being Committee.
(3) To participate in an ongoing treatment program. Any specific terms, such as continuing psychiatric counseling, securing medical treatment or Attending Practitioner recovery groups two nights a week and Alcoholics Anonymous or Narcotics Anonymous a minimum of two nights a week, or as prescribed by the Treatment Program and/or the Medical Staff Well-Being Committee, should be stated.

(4) To agree to any indicated random testing of bodily fluids, by the treatment program or as directed by the Medical Staff Well-Being Committee.

(5) To meet regularly, and at least quarterly, with a monitor appointed by the Medical Staff Well-Being Committee.

(6) To allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the re-entry agreement, and the Medical Staff Well-Being Committee.

(7) To request a medical leave of absence in the event the Medical Staff Well-Being Committee finds that the impairment or failure to comply with the re-entry agreement presents a risk to patients.

(8) To sign whatever forms are needed to authorize release of information from the treatment programs to the Medical Staff Well-Being Committee, and request that reports shall be made regularly, at defined time intervals, such as quarterly.

(9) To acknowledge that any failure to comply with the conditions will result in immediate referral to the President of Staff, for corrective action.

(10) To provide for post treatment monitoring of a sufficient duration (usually three to five years).

(11) To participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.

f. When the treating program or the Medical Staff Well-Being Committee concludes that the Member cannot practice safely, the Member shall request a leave of absence. Discontinuance of the leave shall be contingent upon the Member satisfying the Medical Staff Well-Being Committee he or she can return safely to practice (if the Member still chooses to comply voluntarily with the Medical Staff Well-Being Program).

g. Also when indicated based upon the severity and duration of the chemical dependence, or mental or physical impairment, the Member may be required
to (1) pass an oral or written test administered by an appointed panel of Department Members and/or (2) be proctored on at least 20 cases and for at least 3 months, and have reports of satisfactory performance on the cases.

2. The investigation may be closed at any time it appears there is no problem.

3. If the Practitioner refuses to cooperate at any stage, the matter will be referred to the President of Staff, together with a statement that the Practitioner is not participating in a Medical Staff Well-Being Program, and the Committee has reason to suspect that the Member may be impaired as a result of chemical abuse, mental illness or physical injury or condition. The Medical Staff should initiate its own corrective action investigation, and not ask the Medical Staff Well-Being Committee to share the confidential information that was gathered during an investigation or while a Member was fulfilling his or her Agreement with the Committee. The Medical Staff Well-Being Committee should be asked only to indicate what action may be necessary to protect patients. Other evidence should be developed independently in order to preserve the integrity of the Medical Staff Well-Being Committee's promises of confidentiality.

4. After successful completion of the treatment program for a minimum period, such as 3 years, the Medical Staff Well-Being Committee shall close the active case. It will open a monitoring case for a defined period of time, such as 2 years, and review the Practitioner's status every 6 months.

Subsection 12. NUTRITION SUPPORT COMMITTEE

The Nutrition Support Committee is a subcommittee of the Pharmacy and Therapeutics Committee. It meets at least annually and more often as needed. The Committee shall be a multidisciplinary committee whose members including the following:

**Members:**
- Physician from Department of Surgery, Chair
- Physician from Department of Surgery, member
- Physician from Department of Medicine, member
- Physician from Pediatric Neonatal, member
- Senior Director Ancillary Services, member
- Clinical Nutrition Manager, member
- Lead Dietitian, member
- Clinical Dietitian, member
- Clinical Dietitian, member
- Clinical Nurse Specialist, member
- Outpatient Nurse Supervisor, member
- Pharmacist, member
The Committee’s responsibilities shall include the following:

- To develop, implement, and promote quality nutrition care based on best practice while supporting the Medical Center Mission and Values
- Evaluate nutrition related policies, processes or protocols governing the provision of clinical nutrition services
- Promotes a coordinated and multidisciplinary approach to patient’s nutrition management
- Evaluate any new tube feeding and oral nutrition supplement products
- Review nutrition PI data and provide guidance to achieve its goal

Subsection 13. OPERATING ROOM/PROCEDURAL SERVICES COMMITTEE

The Committee is primarily a user's committee and members shall be drawn from among the major clinical departments using the operating rooms and other procedural services areas of the medical center. There shall also be one resident representative of the Housestaff selected from one of the major clinical departments utilizing the operating room or other procedural services area who shall be an ex officio member to the committee. The Committee will consider any and all problems relating to the operation of the Operating Rooms and other Procedural Services areas. The Committee will be responsible for reviewing subject and making recommendations in the following areas: professional services, staffing, rules, educational facilities, equipment and others as deemed necessary by the Chair and/or President of Staff. This Committee should meet as required, but not less than quarterly. The Committee shall submit minutes of its meetings to the Medical Executive Committee.

Subsection 14. PHARMACY AND THERAPEUTICS COMMITTEE

A. Membership on this committee shall consist of at least five (5) Medical Staff Members, and as ex officio members, one pharmacist, a dietitian, the director of nursing service or his/her representative and the Director or his/her representative. The Medical Center pharmacist shall be a voting member. The Committee shall meet monthly, with a minimum of ten (10) meetings per year, and shall establish a drug formulary and guidelines for the control and distribution of all drugs including investigational drugs, perform drug usage evaluation, and consider general problems of drug therapeutics. The Committee shall maintain general oversight of Medical Center and Dietary and Food Service activities, and nutritional therapeutics and establish standards for the management and monitoring of devices for the provision of enteral and parenteral nutrition.

The Committee shall submit minutes of its meeting to the Medical Executive Committee.
B. The responsibilities, duties, and authority of the Pharmacy and Therapeutics Committee are to take all reasonable steps to:

1. Cause an objective evaluation of the clinical use of all drugs (by individual drug or category of drug) in the Medical Center, establishing priorities for specific drug or drug category reviews, and using measurable criteria/indicators in the review process. After any required peer review, the summarized findings will be entered into the appropriate practitioner performance profiles;

2. Cause a well-controlled or closed formulary to be established and implemented to help control drug use in the Medical Center. The committee will evaluate and make recommendations to the Medical Executive Committee as to which drugs should be added to and deleted from the formulary. Requests for formulary changes from individual Medical Staff Members must be submitted to the committee in writing, to include the rationale for the change. The committee's action shall be transmitted to the requesting practitioner by the committee chairman;

3. Define and evaluate all significant untoward reactions to drugs. In addition, the committee shall strive to assure the adequate reporting of actual or suspected untoward drug reactions, including the recommendation of periodic in-service training for nursing service personnel and other appropriate Medical Center personnel;

4. Define and evaluate all significant medication errors;

5. Assist in the formulation of and approve all professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs in the Medical Center;

6. Help assure the centralized function and adequacy of intravenous admixtures, total parenteral nutrition, and admixture of chemotherapeutic agents;

7. Make recommendations to the Medical Executive Committee on protocols proposed for the use of investigational or experimental drugs in the Medical Center; and

8. Assist in development of approved drug policies in use in the Medical Center.

Subsection 15. QUALITY AND SAFETY OVERSIGHT COMMITTEE

The Quality and Safety Oversight Committee (“Committee”) shall meet at least monthly, no less than ten (10) times per year, and shall provide for the oversight and integration of Medical Staff and administrative activities related to quality assessment, performance improvement and patient safety. The Committee shall have broad responsibilities to plan, design, measure, assess, and improve systems and processes within the Medical Center under the direction of the Medical Executive Committee. The Committee may establish
subcommittees at its discretion to accomplish assigned duties. However, committee and subcommittee structures and functions shall be described in an annual plan, which shall be approved by the Medical Executive Committee and Governing Body. The Committee shall provide regular reports to the Medical Executive Committee covering performance improvement, patient safety, medication error reduction and other topics specified in the approved plan.

Subsection 16. RADIATION/ISOPOE SAFETY COMMITTEE

The Radiation/Isotope Safety Committee is a Medical Staff Committee appointed by the Director, UCI Medical Center, and is delegated authority to formulate policy in radiation safety; to review the operations and procedures of the Radiation Safety Office; and to establish standards and regulations for radiation protection. The Committee shall meet at least quarterly, and shall oversee the use of ionizing radiation and radioisotopes for programs involving patients, human subjects, and non-human use at the Medical Center and its satellite facilities as required by federal and state regulations and University policy including the review and approval of Authorized Users, User Permits (Radiation Use Authorizations), and License Amendments as specified by conditions of the Medical Center's radioactive materials license. The Radiation Safety Committee shall consist of not more than twelve nor less than six members, including five members of the Medical Staff, the Medical Center Radiation Safety Officer, and a representative from Medical Center Administration who has the authority to delegate resources for the radiation safety program. At least one Medical Staff member shall be recognized as a specialist in each of the following areas: Nuclear Medicine, Diagnostic Radiology, and Therapeutic Radiology. Where not otherwise represented by members of the Medical Staff, the Committee shall include the following ex officio members who shall be appointed as "Ex officio with vote"; the UCI Medical Center Radiation Safety Officer; the UCI Campus Radiation Safety Officer; a medical physicist; and at least two users of radioisotopes who are knowledgeable and experienced in the pertinent kinds of radioactive material use and in radiation safety. The Committee shall submit minutes of its meetings to the Medical Executive Committee.

Subsection 17. SEDATION/ANALGESIA COMMITTEE

This subcommittee of the Performance Improvement Committee, reporting to the Medical Executive Committee, is a Medical Staff Committee appointed by the Chief Medical Officer of UCI Medical Center. The Chair of the Committee shall be the Medical Director of Sedation, recommended by the Chair of the Department of Anesthesiology and Perioperative Care and appointed by the Chief Medical Officer.
The Committee shall be responsible for overseeing and coordinating the development of policies and practice guidelines and for overseeing compliance with policies and practice guidelines regarding the practice of sedation/analgesia by non-anesthesia providers for diagnostic, therapeutic and minor surgical procedures within the University of California, Irvine Medical Center. The Committee shall advise the Medical Executive Committee, the Performance Improvement Committee and the Chair of Anesthesiology and Perioperative Care regarding policy matters concerning the practice of sedation/analgesia by non-anesthesia providers.

The Committee shall monitor the functions of any designate sedation/analgesia practices and advise the Medical Executive Committee, Performance Improvement Committee and the Chair of Anesthesiology and Perioperative Care regarding the findings.

The Committee shall monitor and review sedation/analgesia education materials and programs (including credentialing) designed for staff and patients.

In addition, the Committee will evaluate periodically sedation/analgesia practices by non-anesthesia providers at University of California, Irvine Medical Center and advise the Medical Executive Committee, Performance Improvement Committee and the Chair of Anesthesiology and Perioperative Care regarding recommended changes to policy and practice as indicated, following CMS, JCAHO and ASA guidelines. Evaluation will include adverse event reviews, location audits, and/or other applicable and necessary quality improvement methods, including, as indicated, patient satisfaction surveys.

Members from the Committee or the hospital staff at large involved in sedation will be selected to form ad hoc committees to review clinical issues as needed.

The voting membership of the Committee shall include:
Medical Director of Sedation, Director of the Acute Pain Service or designee, Representative of Pharmacy, Staff Physician from NICU, Staff Physician from an Adult ICU, Staff Physician from CDDC, Staff Physician from Emergency Department and one Member at Large from another department where moderate sedation/analgesia is provided, to include but not be limited to:
Interventional Radiology, Cardiology, Pulmonary Medicine, ENT, Plastic Surgery, Pediatric Radiology

The ex-Officio membership of the Committee shall include, but not be limited to:
Sedation/Analgesia Nurse Coordinator, Neonatal RN, Critical Care RN, RN from CDDC, RN from Emergency Department, Representative of the Chief
Executive Officer and Representative from Performance Improvement Committee.

Any Staff Physician or Practitioner with Moderate or Deep Sedation/Analgesia Privileges, any Sedation Nurse Professional or any other person with concerns regarding Sedation/Analgesia may attend Committee meetings.

The Committee will meet when called by the Chair but at least ten (10) times per year. A quorum shall be no less than three (3) voting members of the committee.

Minutes of meetings shall be prepared and submitted to the Medical Executive Committee, Performance Improvement Committee and the Chair of Anesthesiology and Perioperative Care. An annual report shall be submitted to the Medical Executive Committee, Performance Improvement Committee and the Chair of Anesthesiology and Perioperative Care.

Subsection 18. TRAUMA COMMITTEE

This subcommittee of the Medical Executive Committee is formed in accordance with designation of the Medical Center as Level 1 Trauma Center by the County of Orange. The Trauma Committee will be interdepartmental in its function and will be composed of Medical Staff Members from four to five appropriate medical services, the Director of Emergency Service, and the Trauma Coordinator. Supervising Nurses of the Emergency Room, ICU, O.R. and the Surgical Intensive Care Unit Nurse Coordinator will serve as ex officio members. The Chair of the Trauma Committee will be the Director of the Trauma Service. The Director of the Medical Center Trauma Service shall be considered an ex officio member of the Medical Executive Committee with vote. This is an interdisciplinary Performance Improvement Committee charged with the responsibility for overseeing of trauma patient care. This shall include evaluating the management of and service rendered to trauma patients, and recommending policies, protocols and standards for the management of trauma patients. This Committee shall meet quarterly, or more frequently as needed, and provide copies of its minutes to the Medical Executive Committee.

Subsection 19. TRAUMA SYSTEMS COMMITTEE

This subcommittee of the Hospital Performance Improvement Committee is formed in accordance with designation of the Medical Center as a Level 1 trauma center by the County of Orange. The Trauma Systems Committee will be interdepartmental in its function and will be composed of the following Medical Staff Members: Trauma Director, SICU Medical Director, Emergency Medicine Liaison, Neurosurgery Liaison, Orthopedic Liaison, and Blood Bank Director. The following departmental representatives will also be members; Chief Nursing Officer, Trauma Program Manager, Trauma
Floor nursing administrator, Base Hospital Coordinator, Operating Room nursing administrator, Trauma and SICU Case Managers, Rehabilitation Services administrator, Respiratory Therapy administrator, Step Down Unit nursing administrator, Epidemiology and Infection Prevention administrator, Trauma Clinic nursing administrator, Acute Rehabilitation Unit nursing administrator, Emergency Department nursing administrator, Radiology administrator, Trauma Service midlevel practitioner, Trauma Clinical Social Worker and Injury Prevention Coordinator. The Chair of the Trauma Systems Committee will be the Director of the Trauma Service. This is an interdisciplinary Performance Improvement Committee charged with the responsibility of addressing, assessing, and correcting global trauma program and system issues. The Committee works to correct overall program deficiencies to continue to optimize patient care. This Committee shall meet quarterly, or more frequently as needed, and provide copies of its minutes to the Hospital Performance Improvement Committee.

Subsection 20. TRAUMA (PEDIATRIC) COMMITTEE
This subcommittee of the Hospital Performance Improvement Committee is formed in accordance with designation of the Medical Center as a Level 1 trauma/burn center caring for pediatric patients by the County of Orange. The Pediatric Committee will be interdepartmental in its function and will be composed of the following Medical Staff Members: Trauma Director, Pediatric Intensivist, Director of Pediatric and Neonatal Anesthesiology, Burn Unit Medical Director, SICU Medical Director, Pediatric Radiologist and Child Abuse Pediatrician. The following departmental representatives will also be members; Pediatric Nurse Manager, Pediatric Nurse Educators, Director of Women and Childrens Services, Trauma Program Manager, SICU and Burn Unit Case Manager, Burn Program Manager, Burn Unit Nurse Manager, Child Life Specialist, Pediatric Pharmacist, Pediatric Dietician, Pediatric Physical Therapist, and the Pediatric and Burn Unit Clinical Social Workers. The Chair of the Pediatric Committee will be the Director of the Trauma Service with the Pediatric Intensivist as the Co-Chair. This is an interdisciplinary Performance Improvement Committee charged with the responsibility of addressing, assessing, and correcting global pediatric trauma and burn program and system issues. The Committee works to correct overall program deficiencies to continue to optimize patient care. This Committee shall meet quarterly, or more frequently as needed, and provide copies of its minutes to the Hospital Performance Improvement Committee.
APPENDIX A

STATEMENT OF APPLICANT

I acknowledge that a single joint application may be used for the University of California, Irvine Medical Center, Medical Staff, the UCI Health Systems Medical Group, and University of California Irvine College of Medicine. Each of these entities will separately and independently privilege, credential and/or appoint an applicant. An applicant may be granted an appointment or privileges with one entity and may not be granted the same by another of these entities.

In making this application, I acknowledge that I have received and read the Bylaws, Rules and Regulations of the Medical Staff of the Medical Center, and that I am familiar with the principles, standards, and laws pertaining to the practice of medicine, podiatry or dentistry, and I agree to be bound by the terms thereof while I am an applicant and if I am granted Medical Staff membership or clinical privileges in all matters relating to my application to and membership on the Medical Staff. If accepted as a Member of the Medical Staff, I agree to abide by all the present and future rules and regulations of the Medical Staff, College of Medicine, Medical Center, and The Regents of the University of California regarding teaching, research, public and professional service, and conduct, as applicable to my practice. I agree to refrain from fee splitting.

I hereby signify my willingness to appear for the interview in regard to my application, authorize the University of California Irvine College of Medicine, the Medical Center, its Medical Staff and Health Systems and their representatives to consult with Administrators and members of medical staffs of other hospitals or institutions with which I have been associated and with others, including past and present malpractice carriers, who may have information bearing on my professional competence, character, health status, ability to work with others, and ethical qualifications. I hereby further consent to inspection by the University of California Irvine College of Medicine, the Medical Center, its Medical Staff and the Health Systems and their representatives of all records, information and documents relating to my credentials and qualifications ("peer review information") by and between UCI Medical Staff and other health care organizations (e.g. hospital medical staff, medical group, independent practice association [IPAs], health plans, health maintenance organization [HMOs], preferred provider organizations [PPOs], other health delivery systems or entities, medical societies, professional associations, medical school faculty positions, training programs, professional liability insurance companies [with respect to certification of coverage and claim history], licensing authorities, and businesses and individuals acting as their agents - collectively "health care organizations") for the purpose of evaluating this application and any recredentialing application regarding my professional training, experience, character, conduct and judgment, ethics, and ability to work with others. In this regard, the utmost care shall be taken to safeguard the privacy of patients and the confidentiality of patient records, and to protect peer review information from being further disclosed.

I hereby release from liability all representatives of the University of California Irvine College of Medicine, the Medical Center, its Medical Staff, Health Systems and The Regents of the University of California for their acts performed in good faith and without malice in connection with evaluating my application and my credentials and qualifications, and I hereby release from any liability any
and all individuals and organizations who provide information to the University of California Irvine, College of Medicine, the Medical Center, its Medical Staff or Health Systems in good faith and without malice concerning my professional competence, ethics, character and other qualifications for staff appointment and clinical privileges, and I hereby consent to the release of such information.

I hereby further authorize and consent to the release of information at any time by the University of California Irvine, College of Medicine, the Medical Center, its Medical Staff, Health Systems, or The Regents of the University of California to other hospitals, their medical staffs and medical associations on request regarding any information the University of California Irvine College of Medicine, the Medical Center and the Medical Staff may have concerning me as long as such release of information is done in good faith and without malice, and I hereby release from liability the University of California Irvine College of Medicine, the Medical Center, its Medical Staff, Health Systems, and The Regents of the University of California for so doing.

I understand and agree that I, as applicant for Health Systems, faculty and/or Medical Staff appointment or privileges, have the burden of producing adequate information for proper evaluation of my professional, ethical and other qualifications for membership and clinical privileges and for resolving any doubts about such qualifications. I further understand that any misstatements in or omissions from this application constitute cause for denial of appointment or cause for summary dismissal from the faculty of the University of California, Irvine College of Medicine or Health System Medical Group(if applicable) and UCI Medical Center Medical Staff, as applicable. All information submitted by me in this application is true to the best of my knowledge and belief. By signing this application I certify that my physical and mental health is sufficient, with reasonable accommodation, to render quality care to all patients and that I will obtain a physical examination upon request.

I understand that membership on the Active, Courtesy and Provisional (other than Clinical Non-Teaching) Medical Staff of the Medical Center requires continuing membership on the faculty. If my faculty membership is terminated, my Medical Staff status will be automatically terminated, however, I may apply for reassignment to the Clinical Non-Teaching Staff category at my option if the termination is for non-disciplinary reasons as defined in reporting requirements of Business & Professions Code 805.

I also agree to notify UCI Medical Staff in writing via the President of Staff, within five (5) days of receiving any written or oral notice of any adverse action, including without limitation, any filed and served malpractice suit or arbitration action; any adverse action by the Medical Board of California taken or pending including but not limited to, any accusation filed, temporary restraining order or interim suspension order sought or obtained, public letter or reprimand, public reproof, and any formal restriction, probation, suspension or revocation of licensure; any adverse action taken by any Health care Organization, which has resulted in the filing of a Section 805 report with the Medical Board of California or a report with the National Practitioner Data Bank; any revocation of DEA, license; a criminal conviction of, or a plea of guilty or nolo contendere for any felony or for any misdemeanor related to the practice of a health care profession, fraud or abuse relating to any government health program, third party reimbursement or controlled substance, whether or not an appeal has been filed or is pending; any change in participation status in any government health program including any exclusion or other sanction imposed or recommended by
any such government health program or any cancellation, non-renewal or material reduction in medical liability insurance policy coverage.

I hereby affirm that the information submitted in this application and any addenda thereto is true to the best of my knowledge and belief and is furnished in good faith. I understand that omissions or misrepresentations may result in denial of my application or termination of my privileges, employment or physician participation agreement.

A photocopy of this document shall be as effective as the original.

Print Name Here______________________________

Signature_______________________Date___________

This statement will appear as part of the initial application and application for reappointment and will be signed and dated by all applicants.
APPENDIX B
APPLICATION FOR APPOINTMENT TO THE MEDICAL STAFF

All applications for appointment to the Medical Staff must be on the prescribed form and must be signed by the applicant. Such applications shall include, but not be limited to the following:

1. Detailed information printed on the application form documenting the applicant's professional training, clinical expertise, and teaching ability (if applicable);

2. Names and addresses of three (3) professional references who can attest to the applicant’s teaching ability (if applicable), professional experience and status;

3. Information concerning whether the applicant's professional license to practice in any state, other professional registration/license, DEA registration, if applicable, (DEA Certificate must include schedules 2, 2N, 3, 3N, 4 and 5), certification as Medicare or Medi-Cal provider, academic appointment, membership in any medical, podiatric or dental society, fellowship or Board certification, membership or clinical privileges or prerogatives at any hospital staff or any affiliation or status at any other health care entity, hospital privileges, or professional liability insurance are or have ever been or are currently in the process of being denied, revoked, suspended, reduced, limited, placed on probation, not renewed, investigated or voluntarily or involuntarily terminated or whether the applicant has been charged with any felony or convicted or any crime and a full explanation if any of the above is answered affirmatively;

4. If an applicant or member of the Medical Staff does not require a DEA certificate for the performance of his or her duties, this will be documented by a memorandum by the Department Chief. Telemedicine providers are exempt from this requirement.

5. Medical Staff privileges may be approved for a provider whose DEA is pending; however, a UCIMC physician with a valid DEA certificate must write all prescriptions requiring a DEA number until the practitioner has a valid DEA certificate. The physician writing the prescription must be familiar with the patient’s case and must document the circumstances in the patient chart.

6. Names of all other hospitals and other health care entities on which the applicant is a Medical Staff member or has applied for staff membership or with which the applicant is or has been otherwise affiliated;

7. Information regarding any past or pending malpractice claims, suits, settlements or arbitration proceedings involving the applicant’s professional practice;

8. The name and address of the malpractice insurance carrier and the limits of liability, other than the University self-insurance program, or a statement attesting to the reason why the physician does not have malpractice insurance.
9. Information regarding whether the applicant is able to perform all services, with or without reasonable accommodation, according to accepted standards of professional performance and without posing a direct threat to the safety of patients;

10. The Department in which the appointment is sought. An applicant may apply for appointment in two separate departments. Dual appointments will require signature approval by both Department Chairs and privilege delineation forms for each department. One department shall be designated by the President of the Medical as the primary departmental affiliation.

11. A statement of board certification or if applicant is actively pursuing board certification.

The following attachments must accompany the application for Medical Staff membership:

1. Request for specific privileges as delineated by the clinical departments.
2. A copy of the applicant's current California professional (medical, dental or podiatric) license, and any other state professional licenses, drug enforcement agency certification including schedules 2 through 5 inclusive, if applicable, and any other certificates/permits (such as Radiology, Fluoroscopy or Radiography Supervisor and Operator Permit issued by the State of California Department of Health Services, Radiographic Branch).
3. Documentation of the applicant’s continuing medical education credits for the previous two years.
4. Copy of military discharge (if applicable).
5. Current curriculum vitae.
6. Copy of certification of professional liability insurance, and documentation of any liability cases.
7. Copies of all reports from licensing agencies, and the National Practitioner Data Bank.
8. If international graduate, copies of college/medical school diplomas, a certificate of internship and residency, and copy of ECFMG certificate.
10. Signed pharmaceutical services signature form.
11. Confidential report on communicable disease screening.
13. Medical Staff Member Responsibilities in Fire and Disaster
14. HIPAA Acknowledgment for Healthcare Providers
15. In order to verify that the practitioner requesting approval is the same practitioner identified in the credentialing documents a copy of any of the following will be required:
   
   - A current picture hospital ID card
   - A valid picture ID issued by a state or federal, agency (e.g. driver’s license or passport)
APPENDIX C
ADVANCEMENT AND PROCTORING PROCEDURES

All provisional Medical Staff members must be proctored in accordance with the Proctoring Program. New applicants shall be proctored for three months or longer, as determined by the Chief of the practitioner’s clinical department, if the applicant has not admitted a suitable number of cases during that period. In addition to the proctoring requirements imposed during the provisional period, proctoring is also required when additional privileges requested have special training and competency requirements designated by the clinical department. The number of proctored cases required for a particular procedure may be based on departmental criteria. A minimum of the first three elective cases shall be required. An emergent case can be proctored in lieu of one of the first three elective cases where appropriate. The Chief of the practitioner’s clinical department or the President of the Medical Staff may require that a practitioner be proctored for more than three cases. Proctoring shall be extended for 3 additional cases at a time, for a maximum number of 24 cases.

All new members of the Medical Staff on Provisional status, including those with temporary appointments, will be proctored by a Class I practitioner of the same department or other practitioner designated by the Chief of the practitioner’s clinical department or the President of the Medical Staff. New members are defined as those practitioners who have been approved by the Governing Body for provisional status on the Medical Staff. Emergency (one-time only) temporary appointments are exempt from proctoring requirements. Appointment to Provisional status is for a period of one year, which commences on the date of approval of the Provisional appointment by the Governing Body. (See Article III, Section 2, Subsection 2).

A Class I practitioner is defined as one who has satisfactorily met the proctoring requirements and has been advanced from Provisional Staff status and granted Class I privileges. Supervision will include concurrent chart review, direct observation in the case of invasive procedures, and monitoring of diagnostic and treatment techniques.

Proctoring reports shall be completed fully and in a timely manner. The proctor shall complete the proctoring form for each case proctored and submit it to the Department through the Medical Staff Office. At the conclusion of the Provisional period, the completed proctoring forms are considered in making the advancement decision. Failure to be advanced from Provisional status may result in automatic termination of the Medical Staff Member from the Medical Staff, in accordance with Article III. All advancements are subject to approval through the Medical Staff Professional Practice Evaluation Committee, Medical Executive Committee, and Governing Body.

Evidence of proctoring from a nearby institution is acceptable provided:

1. The proctor is a member of the UCIMC and the other hospital;

2. The proctor is a practitioner who would have been eligible to serve as a proctor at UCIMC; and

3. The applicant must have requested the same range and level of privileges at both hospitals.

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Copies of the proctoring report are to be kept in a confidential file at both hospitals.

More than one person should be involved in proctoring whenever possible. It is not always necessary for a proctor to have the same specialty qualifications as the person being observed. For example, surgical techniques in a number of specialties can often be adequately observed by a surgeon from a different specialty. A proctor shall not receive a fee for the time of proctoring services.
APPENDIX D
PROTOCOL FOR GRANTING TEMPORARY EMERGENCY/DISASTER PRIVILEGES
IN EVENT OF DISASTER

PROTOCOL FOR CREDENTIALING LICENSED INDEPENDENT PRACTITIONERS
“LIPS”) AND
ALLIED HEALTH PROFESSIONALS (“AHPs”) IN THE EVENT OF DISASTER

Background

During recent disaster conditions, physicians, dentists, podiatrists and allied health professionals
(AHPs) volunteered to help at hospitals where they did not have Medical Staff privileges or practice
privileges and were not employed. The following emergency credentialing protocol is provided for
the Medical Center, physicians, dentists, podiatrists and AHPs in an effort to protect patient safety
and take advantage of available resources during a disaster.

Policy

Licensed independent practitioners (LIPs) and AHPs who do not possess staff privileges or practice
privileges at and are not employed by the Medical Center may be granted temporary
emergency/disaster privileges to work in the Medical Center during a disaster, as defined as any
occurrence or officially declared emergency or disaster that inflicts destruction, harm or distress,
and that creates healthcare demands that exceed the capabilities of the Medical Center and/or the
Medical Staff. Whether it is local, state, or national, the Director of the Medical Center, President
of Staff, or his/her designee(s) may grant temporary emergency/disaster privileges and such
decision(s) to grant temporary emergency/disaster privileges shall be made on a case-by-case basis
to work in the Medical Center during an “emergency.” The LIP or AHP must present a professional
license to practice, a photo identification, and any other information requested by the Emergency
Privilege Coordinator or as described below or as described in the Medical Staff Bylaws.

Definition

"Allied Health Professional" is defined as a currently licensed clinical psychologist, physician
assistant, nurse midwife, nurse practitioner, or nurse anesthetist.

“Emergency” is defined as any officially declared emergency, whether it is local, state or national.

“Licensed Independent Practitioner” is defined as a physician (M.D. or D.O.), dentist or podiatrist.

Process

During an emergency, a LIP or AHP may present her/himself to the Medical Center. All staff
should be alerted to direct the LIP or AHP to the person(s) designated in the Medical Staff Bylaws
or Medical Center disaster policies to grant temporary emergency privileges. The LIP or AHP
would then be asked to present at a minimum a valid government-issued photo identification issued
by a state or federal agency (e.g. driver’s license or passport) and at least one of the following:
• A current license to practice,
• A current hospital picture identification card that clearly identifies professional designation,
• Primary source verification of the license
• Picture identification which indicates that the individual is a member of a Disaster Medical Assistance Team (DMAT) or picture identification which indicates the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state or municipal entity.
• Identification by current hospital or medical staff member(s) who possesses personal knowledge regarding volunteer’s ability to act as a licensed independent practitioner during a disaster,

Name and telephone number(s) of hospital(s) where the person has recently practiced or has current affiliation (if applicable). After viewing the license and photo identification, the Medical Center representative must record the date and the time the request for emergency/disaster privileges was made, license number, expiration date and type of photo identification, identification number and expiration date and type of photo identification, including an identification number and expiration date if possible. If possible, copies should be made of the license and the photo identification. The Medical Center representative should immediately try to contact the facility where the person has recently practiced to verify that the person is in good standing. The Medical Center representative should also try to call the licensing board to verify that the person is in good standing. If these calls cannot be completed right away, temporary emergency/disaster privileges may still be issued pending verification of the person's good standing. Primary source verification of licensure, and hospital affiliation(s) will begin as soon as the immediate situation is under control, and is completed within 72 hours from the time the volunteer practitioner presents to the Medical Center. In the extraordinary circumstance that primary source verification cannot be completed in 72 hours, verification will be done as soon as possible. Documentation of why primary source verification could not be performed in the required time frame as well as evidence of the practitioner’s demonstrated ability to continue to provide adequate care, treatment, and services and an attempt to rectify the situation as soon as possible will occur. A written record of this information and verification(s) shall be retained in Medical Staff Administration utilizing the established temporary privileges form. The National Practitioner Data Bank (NPDB) and Office of the Inspector General (OIG) will be queried as soon as feasible utilizing the above process. In the event the verification process reveals any adverse information or suggests the practitioner is not capable of rendering services in an emergency, the emergency/disaster privileges shall be immediately terminated. It is recommended that the LIP be paired with a currently credentialed Medical Staff member. The AHP should be paired with a similarly licensed AHP or physician. Whenever possible, the LIP or AHP granted temporary emergency/disaster privileges should act only under the direct supervision of a Medical Staff member or hospital employee. It is also recommended that the name of the LIP or AHP to whom he or she is assigned be recorded along with the licensing information.

Physician assistants may be granted temporary emergency/disaster privileges to provide services at the request of responsible officials or pursuant to a mutual aid operation plan established and approved under the California Emergency Services Act. A licensed physician will supervise their practice during the emergency. The supervising physician does not have to be available personally or electronically if that availability is not possible or practical due to the emergency. If the
supervising physician is not available to supervise the physician assistant, the physician assistant may be supervised during the emergency by a local licensed physician health officer and/or a licensed physician designated by a local health officer that does not have the Medical Board of California approval that is usually required for supervising physician assistants. During an emergency, there is no limit on the number of physician assistants a supervising physician may simultaneously supervise.

A LIP's and an AHP's temporary privileges will be rescinded as determined by the President of the Medical Staff in the event any information is received that suggests the person is not capable of rendering services in an emergency. The practitioner granted emergency/disaster privileges shall, by signed statement, be bound by all Medical Center policies and procedures, rules and regulations and the Medical Staff Bylaws, any directives from the President of Staff, Department or Service Chief, supervising physician or any other Medical Center or Medical Staff leader. There will be no rights to any hearing or review in the event a LIP’s or AHP's temporary privileges are terminated or expire regardless of the reason. Emergency/disaster privileges shall be valid only for the duration of the emergency or disaster and shall automatically terminate at the end of the needed services.

References:
JCAHO Standards MS.01.01.01 EP 17
Business & Professions Code 900
APPENDIX E
FITNESS FOR DUTY
POLICY AND PROCEDURES

POLICY

It is the policy of UCI Medical Center, University of California Irvine ("UCI") not to allow an impaired (physically or emotionally) practitioner to practice medicine at UCI Medical Center or any of its ambulatory sites. An impaired practitioner is defined as one who is in a mental or physical state that would preclude the practitioner from practicing safely. This includes, but is not limited to, practitioner under emotional distress, and those under the influence of alcohol or other mood altering medication. Practitioners may be referred for the following: substance use disorders, psychiatric disorders including major depression, bipolar disorders and personality disorders, other addictive disorders, obsessive compulsive disorders, cognitive disorders, disruptive behaviors or organic brain disorders.

The hospital and related health care environments involve the interaction of numerous employees, members of the public, patients and practitioners in endeavors related to the maintenance of health. Therefore, condoning alcohol or drug abuse by our practitioners is contrary to the hospital's purpose. Moreover, a practitioner impaired by alcohol or drugs poses serious risk to patient care, general safety, and general work place efficiency. Thus, this policy has been adopted.

It is the intent of UCI to offer assistance to those practitioners who will benefit from rehabilitation and/or hospitalization.

OBJECTIVES

To enhance the safety and security of UCI patients, practitioners and employees.

A. Making assessment for impairment is a Medical Staff decision.
B. Facilitating safe removal of the impaired practitioner from the Medical Center.
C. Referring the impaired practitioner as indicated.

DRUG/ALCOHOL SCREENING PROCEDURE

If it is reasonably noted that a practitioner is impaired, the President of the Staff and/or his designee shall have authority to request a "Fitness for Duty Evaluation". An informed Consent for Drug/Alcohol Screen and an Authorization for Use or Disclosure of Medical Information must be signed by the practitioner, following which an observed urine sample and/or blood sample will be collected for drug and/or alcohol. If deemed impaired, the practitioner will be relieved of duties.

D. Observer:
1. Document suspected impairment based upon observable, work-related behavior or condition by completing "Report of Observed Behavior" within appropriate time.

2. Notify one of the following:
   a. A member of the Medical Staff Well-Being Committee
   b. President of Staff
   c. In the event 2-a or 2-b is not available, contact the Administrator on Call.
   d. Chief Medical Officer

3. Observer or designee shall witness signature by practitioner of:
   a. Informed Consent – Drug/Alcohol Screening
   b. Authorization for Use or Disclosure of Medical Information to the Medical Staff Well-Being Committee.

4. Remain with the practitioner until one or more of the representatives listed in item number D-2, a-b is available to interview the practitioner.

5. Provide assistance by Security Department if safe transportation to home is required.

E. Medical Evaluation:

1. Practitioner shall be interviewed by one or more of those representatives listed in D-2 a-b to determine fitness for duty, a "Report of Observed Behavior" shall be completed.
   a. Fit-allow practitioner to return to work and notify the President of Staff of findings.
   b. Unfit-send physician home and notify President of Staff of action taken.

F. Security Department:

The Security Department will be notified that the impaired practitioner will be leaving premises.

1. Assist practitioner in making arrangements for safe transportation.

2. Security personnel will arrange transportation or call taxicab, if needed.

G. Emergency Department:

1. Assure signing of appropriate consents by practitioner.
2. Obtain observed (forensic) urine specimen and/or blood sample from practitioner.

3. Send completed Fitness for Duty record to Medical Staff Office.

H. Laboratory:

1. Responsible for obtaining forensic urine specimen and/or blood sample from Emergency Department personnel and maintaining chain of custody of specimen(s).

2. Number-only specimen identification shall be maintained for purposes of confidentiality of test results.

3. Test results will be sent only to the President of Staff or his/her designee.

I. President of Medical Staff or Designee:

1. Receives results of laboratory tests (as per special number-only identification system established with Laboratory to maintain physician confidentiality). The President of the Medical Staff also receives:
   a. Informed Consent for Drug/Alcohol Screening.
   b. Authorization for Use or Disclosure of Medical Information to Chief of Staff, designee and/or Medical Staff Well-Being Committee.
   c. Behavior Observation Reports
   d. Directed history, physical and mental status exam by Emergency Room physician, if any.

2. Discusses results of tests with physician. If positive, refers practitioner to Medical Staff Well-Being Committee.

3. Maintains confidentiality of reports, consents, and test results.

J. Billing:

Costs are the responsibility of the practitioner.
REPORT OF OBSERVED BEHAVIOR

The circumstances under which said practitioner’s condition was called to my attention are as follows (third person):

Please state with sufficient detail information to warrant the belief that the person for whom evaluation and treatment is sought is in fact impaired (first person):

NAME: ________________________________________________________________

DEPARTMENT: __________________________________________________________

DATE: __________________________________________________________________

PRESIDENT OF STAFF SIGNATURE __________________________________________
CONTRACT FOR IMPAIRED AND/OR DISRUPTIVE PRACTITIONER

The Medical Staff Well-Being Committee is available to assist the practitioner with initiation and maintenance of a recovery program. Practitioners may be referred for the following: Substance use disorders, psychiatric disorders including major depression, bipolar disorder and personality disorders, other addictive disorders, obsessive compulsive disorders, cognitive disorders, disruptive behaviors or organic brain disorders. The Medical Staff Well-Being Committee responsibilities include:

1. Acting in an advocacy role for you.

2. Offering you an on-going support system.

3. Working together with you to develop and coordinate a comprehensive recovery program.

4. Entering into a contract with the Practitioner, delineating the Committee’s expectations for treatment and monitoring. The contract, as a minimum, will require the Member to agree to the following conditions, depending upon the nature of the impairment.

Practitioner Responsibilities (Maintaining Fitness for Duty):

1. Maintaining active involvement with the Medical Staff Well-Being Committee, as specified in this contract to provide for post treatment monitoring or a sufficient duration (usually three to five years). Monitoring duration:

2. Entering an appropriate treatment program as agreed upon by the Medical Staff Well-Being Committee to assure that the problem is being addressed effectively and participating until discharged by the program. This may include participation in a professional support and monitoring program provided by a private agency approved by the Medical Staff Well Being Committee. Entered into such treatment program on _______________. Type of Program: ____________________________.

3. Providing documentation from an evaluating or treating professional that initial treatment has been provided and that I may safely practice.

4. Remaining in the outpatient program until my discharge is approved by the professional support and monitoring program (if appropriate) and the Medical Staff Well-Being Committee. If dissatisfied with
the monitoring program, I will negotiate a change with the Medical Staff Well-Being Committee.

5. Agreeing to undergo a comprehensive history and physical including psychological testing (if appropriate) and a drug screen.

6. Agreeing to Release of Information. The Medical Staff Well-Being Committee is requiring that I authorize the treating physician(s) and/or therapist(s) to communicate information to the Medical Staff Well-Being Committee. The release includes authorization for the committee to provide sufficient information to the treating physician(s) or therapist(s) to have an understanding of the problem that is being evaluated/assessed/treated. Agreeing to allow free and open communication between the treating professionals, the recovery support network, those persons responsible for verifying compliance with the pre-entry agreement, and the Medical Staff Well-Being Committee. To sign whatever forms are needed to authorize release of information from the treatment programs to the Medical Staff Well-Being Committee, and request that reports shall be made regularly, at defined time intervals, such as quarterly.

7. When the treating program or the Medical Staff Well-Being Committee concludes that I cannot practice safely due to impairment or failure to comply with the re-entry agreement and it presents a risk to patients, I shall request a leave of absence. Discontinuance of the leave shall be contingent upon my satisfying the Medical Staff Well-Being Committee that I can return safely to practice (if I shall choose to comply voluntarily with the Medical Staff Well-Being Program).

8. Recovery Plan. I will be required to participate in a specific ongoing recovery plan sufficient for the situation and to my recovery. The monitoring plan is designed to accumulate the information, which will, over time, document my participating in the plan of treatment agreed upon. When the problem is chemical dependency, regular participation in a self-help group of persons recovering from chemical dependence are required where appropriate, a group of recovering physicians or health professionals may be required such as (A.A., N.A., P.A., C.A.). I will be required to meet regularly, and at least quarterly, with a work site monitor appointed by the Medical Staff Well-Being Committee. If there is a change in the work site monitor, I must submit this change to the Well Being Committee for approval.

9. If the problem is substance abuse, abstaining completely from any mood-altering chemical except by prescriptions from my primary
physician (excluding myself). In some instances I may be asked to take prophylactic medication, Antabuse and Naltrexone which should show up positive in the urine specimen. In the event that the Antabuse and/or Naltrexone do(es) not show up in the urine, this may be grounds for initiating action with a referral to the Medical Executive Committee for corrective disciplinary action.

10. Offering and obtaining supervised urine/blood samples for drug screens at the discretion of my primary physician, therapist, treatment program or the Medical Staff Well-Being Committee.

11. Realizing that this contract is subject to periodic review by the Medical Staff Well-Being Committee, I agree to participate in a regular review of the agreement, and to modify it as necessary to achieve the goals of continued recovery.

12. Also when indicated based upon the severity and duration of the chemical dependence, or mental or physical impairment, I may be required to (1) pass an oral or written test administered by an appointed panel of Department members and/or (2) be proctored on at least 20 cases and for at least 3 months, and have reports of satisfactory performance on the cases.

13. Agreeing to abide in notifying the Medical Staff Well-Being Committee of any healthcare facility(ies) in which medical care is being rendered to patients. I further agree to allow the Medical Staff Well-Being Committee to communicate with the corresponding Medical Staff Well-Being Committee of that facility (ies) and agree to release and exchange of confidential information as deemed appropriate.

14. Agreeing to abide by the Medical Staff Well-Being Committee recommendations in the event of a relapse. If a relapse is manifested in observable work-related deficiencies (rendering him/her unfit for duty) later proved to be substance induced, I may be terminated from the Medical Staff.

15. I have selected Dr._______________________________as my primary physician.

16. I have selected Dr. ___________________________ as my Work Site Monitor who will be requested to provide updates as needed but at least monthly to the Medical Staff Well Being Committee for the first six months. After six months an evaluation of my progress will be conducted to determine the frequency of the updates by my Work Site Monitor.
I understand that if I do not adhere to the conditions of this contract:

1. The Medical Staff Well-Being Committee may elect to remove themselves from any advocacy role.

2. The Medical Staff Well-Being Committee may determine that I am not able to perform my duties safely and the President of the Medical Staff will be informed.

3. I understand that given the current situation with the Medical Board Diversion Program, the Medical Staff Well Being Committee has the right to change the monitoring organization, should a state-wide or UC affiliated program be established.

Expenses for diagnosis and treatment of psychological, physical, or alcoholism and/or other drug dependencies, emotional, or mental impairments are the responsibility of the practitioner.

Expenses incurred as a result of participating with a private professional support and monitoring group are the responsibility of the practitioner.

SIGNED:_______________________________________________________________

Impaired Practitioner

SIGNED:_______________________________________________________________

Medical Staff Well-Being Committee, Chair

WITNESS:____________________________________________________________

DATE:_________________________________________________________________

Approved:  MEC 1/96; JCC 3/96
Revised:  MEC 06/2003, GBAC 06/2003, MEC 11/03, GBAC 11/03, 5/08
APPENDIX F
RESPONSIBILITY OF ATTENDING/HOUSESTAFF

1. In the care of each patient a resident is accountable to the attending Medical Staff member responsible for that patient. On educational and administrative matters a resident is accountable to the training Program Director and Department Chair. On matters not resolvable at these levels, a resident shall have reasonable access to the Dean, College of Medicine, or Senior Associate Dean, Educational Affairs.

2. Each resident is expected to fulfill the clinical and educational requirements of the graduate medical education and graduate clinical training programs. Such clinical and educational requirements include the teaching of medical students, residents, and fellows.

3. Each resident is expected to comply with the public Principles of Medical Ethics of the American Medical Association. When assigned to rotations at affiliate hospitals, each resident shall become familiar with and comply with that institution’s regulations.

4. Each resident is required to obtain the appropriate State of California licensure as soon as he/she is eligible and to register for participation in the educational or clinical programs hereunder. The resident shall immediately notify the University, in writing, if any such licensure or registration is revoked, denied or otherwise restricted.

5. Each resident is required to maintain accurate and complete patient medical records in a timely manner as required by the Medical Staff in accordance with UCIMC Administrative Policy/Procedure for Health Information Management: Medical Record Completion Requirements.

6. Each resident is expected to apply cost containment measures in the provision of proper patient care.

7. Resident must wear at all times when on duty an identification badge or name-plate supplied or approved by the hospital to which assigned.

8. Each resident is expected not to engage in activity or employment that would interfere with his/her obligation to the University, or adversely affect the individual's full participation in the education and training program. Residents will obtain approval of their Department Chair prior to engaging in employment outside the training program, otherwise residents may utilize their off-duty hours, as they deem appropriate.
APPENDIX G

POLICY ON PATIENT-PROTECTIVE SUPERVISION OF RESIDENTS IN TRAINING (HOUSESTAFF)

The director of the relevant education program is responsible for the overall performance of house officers in training. Within that context:

1. Each patient’s attending physician shall coordinate in supervising evaluations, treatment, and procedures provided or performed by house officers in training. The purposes of this communication and coordination are dependable, compassionate care for the patient and a meaningful learning experience for the house officer in training.

2. The Medical Staff supervisor shall assess:

   a. the skill level of the housestaff by direct staff observation.
   b. authorize independent action by the housestaff.
   c. define the course of progressive independence from performing functions together with decreasing frequency of review. This process starts with close supervision, progressing towards independence as skills are observed.
   d. perform written evaluation and feedback to be considered in the progression levels. At all times, and at any level, the housestaff has access to advice and direction from the supervisor.
   e. maintain the core competences and ensure they are current as posted on the Medical Center intranet site.

3. Clinical Non-Teaching members of the Medical Staff do not participate in the teaching programs. Residents will not participate in the care of these patients in any way, except in the event of life-threatening emergency.

4. No Medical Staff member shall leave patients in the charge of residents in training as primary coverage.

5. In the case of clinical consultation, no Medical Staff member called to consult shall leave sole responsibility for the consultation up to a house officer in training.

6. The extent of participation of house officers in training in the care of a patient (if any) shall be disclosed and clarified to the patient and/or family members.
7. Medical Staff members responsible for supervising participation in patient care by house officers in training shall be members in good standing, with relevant clinical privileges at this hospital.

8. In compiling performance evaluation/quality improvement information from patient encounters where house officers in training have participated in care, information, conclusions, and activities to improve care related to the performance of the housestaff are communicated to the Medical Staff member responsible for supervising the house officer in that particular case.

9. These rules apply when a house officer is participating in patient care as a training exercise. If a house officer assumes another role (such as moonlighting coverage), then different rules, reflecting the degree of responsibility assumed and a relationship to Medical Staff membership and/or delineation of specific clinical privileges, requirement for liability insurance coverage shall apply.
Appendix H.

UC Irvine, College of Medicine (ACGME) Resident/Fellow Job Description

The UC Irvine College of Medicine is dedicated to advancing the knowledge and practice of medicine for the benefit of society and is committed to provide educational programs of the highest quality to medical students, residents, fellows, allied health students and graduate students. Our programs emphasize the most current knowledge in the health sciences and research and reflect the changing practice of medicine. The College of Medicine’s postgraduate medical education programs are designed to stimulate self-learning and critical inquiry and to exemplify those human values necessary to fulfill the professional commitments of a career in the health sciences. All trainees in ACGME accredited training programs are committed to achieving the following during the scope of their training at the UC Irvine College of Medicine, UCI Medical Center and all affiliated training sites:

1.) Develop and participate in a personal program of self-study and professional growth with guidance from the medical school’s faculty and teaching staff;

2.) Under the supervision of the medical school’s faculty and teaching staff, participate in safe, effective, and compassionate patient care, consistent with the trainees level of education and experience;

3.) Participate fully in the educational activities of the residency/fellowship training program and assume progressive responsibility in the teaching of junior residents, medical students and other allied health care providers as required;

4.) Participate in institutional programs and activities involving medical staff and adhere to established practices, procedures and policies of the institution and its affiliated training sites;

5.) Participate in the standing committees of the Medical Staff, and other institutional committees as assigned by the program director or through a peer selection process; especially those directly related to patient care review activities;

6.) Develop an understanding of ethical, socioeconomic and medical/legal issues that affect graduate medical education and the practice of medicine. Learn cost containment measures in the provision of patient care;

7.) Perform all duties in accordance with the established practices, procedures and policies of the institution, its programs, clinical departments, and other institutions to which the resident/fellow is assigned

8.) Adhere to the call schedule and rotation schedule of assignment in a timely fashion

9.) Document patient care in the medical record in a timely fashion as per institutional policy

10.) Adhere to the ACGME Institutional Requirements and the ACGME-RRC Program Requirements for the respective medical specialty;

11.) Participate in the evaluation of the training program and its faculty;

12.) Comply with the licensing requirements of the Medical Board of California, the laws of the State of California and Federal Government;

13.) Adhere to the “Policies for Residents Appointed and Paid Through the University of California, Irvine, College of Medicine”; and

UCI Medical Staff Rules & Regulations January 2012
14.) Adhere to the “University of California Irvine Graduate Medical Education Academic Due Process and Leave Guidelines”.

Approved by the Graduate Medical Education Committee December 17, 2003
Approved by Medical Executive Committee January 26, 2004
APPENDIX I

PROCTORING

General

All Medical Staff Members initially granted privileges shall complete a period of proctoring, in accordance with the requirements set forth in the Medical Staff Bylaws. All Practitioners granted temporary privileges during the pendency of their applications, on a probationary basis, or as locum tenens shall be proctored. Practitioners granted privileges to care for a specific patient (one time only) shall not be proctored, but shall comply with any special supervision required by the Department Chief or Director.

A privilege delineation shall be completed for each Practitioner who is granted clinical privileges. A copy of the delineation indicating the approved privileges shall be sent to the Practitioner, Department Chief, and the Operating Room. The privilege delineation form is available electronically via the Medical Center intranet system. A copy of the delineation shall also be maintained in the Practitioner's credential file. The privilege delineation shall indicate whether the Practitioner is required to be proctored.

Assignment of Proctor

1. The proctor must have unrestricted privileges to perform the procedures that he or she will proctor. If no Medical Staff Members who have the necessary expertise are available to proctor, special arrangements may be made for proctoring by non-Medical Staff Members (at sites other than the Hospital) and/or by Staff Members who have related privileges. Special arrangements must be approved by the Medical Executive Committee. All Active and Provisional Staff Members who have completed proctoring must assist in proctoring and a failure to fulfill this responsibility shall be grounds for corrective action, as specified in the Medical Staff Bylaws.

2. The Department Chief shall provide the Medical Staff Member with the names of 2 or more proctors.

Function and Responsibility of the Proctor

1. The proctor shall be responsible for evaluating the proctored Practitioner's performance from the time of the patient's admission until discharge and shall evaluate the indications for admission, discharge, diagnostic work-up and therapy management.

2. If surgery or an invasive procedure is performed, the proctor shall evaluate the indication for the procedure, the technique for the procedure, how it is performed, and the pre-operative, operative, and post-operative care of the patient. He or she shall utilize the patient's chart, discussions with the Practitioner, and actual observation as the basis for the review. If medical care is provided, the proctor shall review the care of the patient, utilizing the patient's chart, discussions with the Practitioner, and actual observation, as
necessary, as the basis for the review. Invasive medical procedures will be proctored by observation unless the case is an emergency or as otherwise specified in the Department rules.

For each case that is proctored, the proctor shall complete the Proctoring Form, and submit it to the Medical Staff Administration Office. After consultation with the Department Chief, Medical Staff Administration forwards the Proctoring Form to the Medical Staff Professional Practice Evaluation Committee.

Proctoring reports shall be completed fully and in a timely manner after the patient's discharge. They shall be submitted no later than 1 week after the patient is discharged.

The proctor's primary responsibility is to evaluate the proctored Practitioner's performance. However, if the proctor believes that intervention is warranted in order to avert harm to a patient, he or she may take any action he or she finds reasonably necessary to protect the patient.

If the proctor and the proctored Practitioner disagree on the appropriate treatment of a patient, the dispute shall be referred to the Department Chief or President of Staff for resolution.

A proctor may or may nor act as the assistant in a surgical procedure. Except when the proctor acts as a surgical assistant, no fee shall be charged by the proctor.

**Responsibility of the Proctored Practitioner**

1. The proctored practitioner shall be responsible for notifying one of the assigned proctors of each patient whose care is to be evaluated. For surgical or invasive medical procedures that will be observed, the proctored Practitioner shall be responsible for arranging the time of the procedure with the proctor.

2. The proctored Practitioner shall provide the information that is requested by the assigned proctor regarding the patient and the planned course of treatment.

**Proctoring Duration**

Each Practitioner granted clinical privileges must be proctored on at least the first 3 elective cases, or such higher minimum number of cases as may be identified in the Department Rules. An emergent case may be proctored in lieu of one of the first three elective cases, where appropriate.

**Extension of Proctoring**

If at the time of completion of the minimum number of cases required for general or special privileges, the Department Committee concludes that the Practitioner should be proctored on additional cases, the Department Chief shall notify the proctored Practitioner. Proctoring shall be extended for 3 additional cases at a time, for a maximum number of 24
cases. Failure to satisfactorily complete proctoring shall have the consequences set forth in the Medical Staff Bylaws. This provision does not, however, preclude the initiation of corrective action at an earlier time.

**Reciprocal Proctoring**

1. Reciprocal proctoring may be accepted to supplement actual observation on the premises.

2. Reciprocal proctoring is acceptable only if all of the following conditions are met:

   (a) The proctor is a Member of the Medical Staff at both hospitals, and is eligible to serve as a proctor in both hospitals or the proctor is a Medical Staff Member at one of the hospitals and eligible to proctor there.

   (b) The Practitioner has requested the same range and level of privileges at both institutions.

   (c) Copies of the actual proctoring reports are provided to both hospitals and maintained in confidential files at both hospitals or that the proctoring report is available for review upon request.

**Proctoring Review**

When the Department is considering whether to terminate proctoring requirements, and grant a Practitioner unrestricted privileges, it shall have the Medical Staff Administration Office first verify that the Practitioner remains in good standing at other hospitals where he or she is actively practicing if applicable. The information secured as a result of this review shall be taken into consideration by the Department in making its final recommendations.
APPENDIX J

PATIENT PRIVACY POLICIES AND PROCEDURES

Section 1. Commitment to Privacy Rule Compliance.

The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time (the “Privacy Rule” or “HIPAA”). Medical Staff members shall protect the privacy of patients’ health information as required by applicable federal law including the Privacy Rule and applicable state law. Further, the Medical Staff is committed to complying with the Privacy Rule in a manner that reasonably minimizes disruption to quality patient care.

Section 2. The Privacy Rule permits the UC Irvine Medical Center to permit its healthcare providers to use and disclose health information for purposes of treatment, payment and health care operations. Activities include peer review, credentialing, training, quality assurance and utilization review. All members of the Medical Staff or Allied Health Practitioner Staff shall, as a condition to the initial or further exercise of clinical or practice privileges, be required to complete the University of California’s HIPAA computer based education training module or other University of California’s HIPAA education training module.

Section 3. Discipline.

Whenever a Medical Staff member or Allied Health Practitioner uses or discloses health information in a manner inconsistent with the University of California Irvine Medical Center Policies and Procedures, the individual may be disciplined in accordance with Article VII of the Medical Staff Bylaws or Section K., Item 11 of the Medical Staff Rules and Regulations.