Rules and Regulations

ARTICLE 1: CLINICAL AND OTHER PRIVILEGES

1.1 Non-MD and non-DO providers

1.1.1 Privileges granted to non-MD and/or non-DO providers shall be based on their current licensure, relevant training or experience, current competence, ability to work with other practitioners, and Hospital personnel. All practitioners who are not MDs or DOs, unless granted specific independent admitting privileges, shall be required to have their inpatients co-admitted by a physician who is an MD or DO and is credentialed as a Licensed Independent Practitioner of the appropriate clinical specialty.

1.1.2 When surgical privileges are exercised by dentists and non-physician providers who don't have admitting privileges, the patient shall receive the same basic medical appraisal as patients admitted to other surgical services. A Medical Staff member with independent admitting privileges assigned to the Active Staff category shall be responsible to perform an admission medical evaluation and for the ongoing inpatient medical care, including care of any medical problem which may be present at the time of admission or which may arise during hospitalization.

1.2 Primary admitting responsibility

1.2.1 A Medical Staff member with admitting privileges must evaluate all new patients within 24 hours of admission. Inpatients must be rounded on at least daily, with a progress note made to document that visit. The Attending Physician or APCs ultimately responsible for the care of the patient. The Attending should see the patient within a period of time commensurate with the medical needs of the patient. If there is any significant change in the patient's condition, the Attending Physician or designee should be called immediately. The Attending Physician or designee will be available in a timely manner for emergent cases. Upon transfer to the Critical Care Unit, the Attending provider will be notified immediately.

1.2.2 A practitioner with admitting privileges will manage and coordinates care for any medical or psychiatric issues outside the scope of dentists, podiatrists, optometrists, chiropractors, or clinical psychologists. For hospitalized patients, practitioners who are not appropriately privileged to independently admit, must provide a written record relevant to their expertise, including patient history, examination, operative notes, diagnosis, and treatment plan. They are also responsible for daily progress notes and preparing the discharge summary.

1.2.3 The co-admitting practitioner (with independent admitting privileges) is responsible for the provision of a written history and physical examination relating to the general health status of the patient, as well as management of any conditions which are outside

the realm of the limited practitioner. The co-admitting practitioner will also enter a discharge summary.

1.2.4 When a patient under the care of a practitioner without admitting privileges requires emergency admission to the Hospital and no co-admitting physician can be readily identified, the emergency room physician is to be notified and the usual emergency room backup mechanisms will be used to assign a physician to the patient.

1.3 Rehabilitation unit

Patients on the Inpatient Rehabilitation Facility must be admitted by a rehabilitation specialist and seen at least three times per week.

1.4 Inpatient Hospice

Patients under the General Inpatient Hospice Benefit: Since Inpatient Hospice patients are seen and assessed daily by the Hospice Interdisciplinary Team, LIP rounds may occur less frequently than daily, although they must occur at least every other day.

1.5 Surgical admissions

1.5.1 A podiatrist, oral surgeon, or other surgical non-physician specialty may perform the admission history and physical on patients who fall within American Society of Anesthesiologists (ASA) Class 1 and 2 classifications, in accordance with the privileging criteria as determined by the Credentials Committee. This may include specialty specific education or training related to history and physicals as advised by appropriate specialty regulatory bodies, to be ultimately determined by the Credentials Committee.

1.5.2 Observation and monitoring of clinical activity will be in accordance with the Credentialing and Peer Review policies.

1.6 Hospital and Community Need, and Ability to Accommodate.

In considering new applications for appointment and clinical privileges, changes in privileges or staff appointment status, or principal division or section affiliation, the Board may also take into account any policies, plans, and objectives it has formulated. This includes considerations of current and projected hospital patient care needs, as well as the ability to provide the necessary physical, personnel, and financial resources required if the application is approved.

1.7 Care designation

The care of an active patient of any practitioner can be arranged by their Division Chief or Division Chief designee of the appropriate Medical Staff Division in such case that circumstances require it

Article 2: PHYSICIAN ORDERS

2.1 Requirements for Electronic Treatment Orders and Authentication

2.1.1 All orders for treatment shall be electronically entered and must be authenticated in accordance with Washington State law. Where documentation in the EHR is available, the Practitioner must document in the form of typing, dictation, voice recognition, templates, and similar methods to provide legible and searchable text. Authentication includes the practitioner's signature, date, time and physician number or electronic authentication. Exceptions to this rule must be approved by the Medical Executive Committee.

2.1.2 Orders may be entered and pended into the electronic medical record by Registered Nurses, Medical Assistants, and others authorized by CMS and Washington State Law, within the scope of their licensure, for signature by the appropriate Medical Staff member

2.2 Verbal and Telephone Orders

2.2.1 Verbal orders shall only be used in emergency or unusual circumstances and are not acceptable when the practitioner is present and able to write the order. Verbal or telephone orders shall not be given for chemotherapy.

2.2.2 Verbal and telephone orders shall be documented within the medical record and shall include the name of the licensed practitioner and shall be signed, dated and timed within 48 hours by a practitioner responsible for the care of the patient

2.2.3 All verbal and telephone orders require the person accepting the order to document the order and then read it back to the ordering practitioner. Where documentation in the EHR is available, the person accepting the order must document in the form of typing, dictation, voice-recognition, templates, and similar methods to provide legible and searchable text.

2.3 Protocols for Specific Categories of Orders

2.3.1 One time or recurrent procedure orders will expire 30-days after order is written/entered. All other orders will expire one-year after written/entered.

2.3.2 Only practitioners holding a currently valid DEA Controlled Substances Registration Certificate may write orders for narcotics or drugs classified in the DEA Controlled Substances Category. If available, Medical Residents may utilize an institutional DEA license when prescribing within the hospital.

2.3.3 The Pharmacy and Therapeutics Committee may enact time limitations for specific open-ended medication orders. The dispensing pharmacist will immediately rewrite the medication order with the time limitation to provide written notification to the prescribing practitioner.

2.3.4 Abbreviations and chemical symbols used in order writing must appear on a list approved by the Executive Committee of the Medical Staff. Any abbreviations, acronyms, and symbols noted on the "prohibited list" shall not be used in order writing. Both a record of approved and prohibited symbols and abbreviations shall be kept on file in the Medical Records department.

2.3.5 Drug names shall not be abbreviated in order writing. Orders shall not be written with a zero after the decimal point of whole numbers (such as 1.0). Orders shall always be written with a zero before decimal doses (such as 0.5).

2.3.6 In order for patients to receive or self-administer medication not issued by the hospital pharmacy, its identity must first be verified by the pharmacy, its container labeled with the name and strength of the drug and an order for same (including name, strength, route, and frequency of administration) must be written by a practitioner. A patient's medications not issued by the hospital pharmacy shall be returned to him at the time of discharge, unless otherwise directed by the practitioner.

2.3.7 All Nurse Initiated orders require approval by appropriate hospital and Medical Staff committees prior to use.

2.3.8 Use of any non-Federal Drug Administration (FDA) approved drug or medical device or the collection of any patient information for the purposes of investigative studies requires approval by an Institutional Review Board listed on PRMCE's Federal Wide Assurance (FWA) and approved by PRMCE's internal oversight prior to use or collection of data. The investigator will comply with all policies issued by the Institutional Review Board. The investigator will surrender all medications and devices to the Pharmacy and Biomedical Departments for proper control and certification prior to use.

2.3.9 Orders for restraints shall be per hospital policy.

ARTICLE 3: MEDICAL RECORDS

3.1 Operative Report.

3.1.1 Operative reports shall be entered into the EHR as soon as possible and no later than 24 hours after Category I procedure, by the primary surgeon or practitioner performing the procedure. Specific Category I procedures are listed in the Medical Staff Bylaws

3.1.2 Uncomplicated vaginal deliveries and Category II procedures require an operative report entered into the EHR in the form of typing, dictation, voice-recognition, templates, and similar methods to provide legible and searchable text.

3.1.1 All Category I and Category II procedures require a procedure note immediately after the procedure and accessible in the EHR before the patient is transferred to the next level of care.

3.1.4 At a minimum, all operative notes shall include the name of the primary surgeon and assistants, findings, procedures performed with description of each, estimated blood loss as indicated, description of the findings, specimens removed (if applicable) and postoperative diagnosis (JC Standard RC.02.01.03, 2009)

3.2 Consultation Reports

3.2.1 A consultation report may be submitted by the practitioner who is privileged in the field in which the opinion is sought. The consultation report shall show evidence of review of the patient's existing record, pertinent findings on examination of the patient, and the consultant's opinion and recommendations.

3.2.2 The consultation report will be made a part of the patient record and may be utilized as a history and physical provided the report contains all the required elements.

3.3 Discharge Documentation

3.3.1 Discharge summaries shall be entered into the EHR by the attending/discharging practitioner at discharge for all inpatients, including all transfers, expirations, and AMA's. The discharge practitioner or their designee is ultimately responsible for entry of the discharge summary. Where documentation in the EHR is available, the practitioner must document in the form of typing, dictation, voice-recognition, templates, and similar methods to provide legible and searchable text.

3.3.2 Discharge summaries shall include the reason for hospitalization; significant findings/hospital course; principal diagnosis and all relevant diagnoses established during the course of care; procedures performed and treatment rendered; patient's condition at discharge; and instructions to the patient and caregiver, if any.

3.3.3 A discharge summary is not required for the patients undergoing Category 1 outpatient invasive procedures and outpatients hospitalized for less than 24 hours with only minor problems, provided the medical record documents the patient's condition at discharge, discharge instructions, and required follow-up care, if applicable.

3.3.4 For transfers of patients from acute to sub-acute level of care (rehab or hospice for example) within PRMCE and the caregivers change, a transfer summary indicating the patient's condition at the time of transfer and the reason for the transfer is required. When the caregivers remain the same, a progress note may suffice.

3.4 Progress notes and other note types

3.4.1 Progress notes shall be entered by practitioners, including members of the Medical Staff, participating in the care and treatment of the patient. Progress notes shall give a pertinent daily chronological report of the patient's course in the hospital and should reflect any change in condition and the results of treatment.

3.4.2 Emergency Department records must include the following: pertinent history of illness or injury and physical findings, including the patient's vital signs; summary of emergency care given to the patient prior to arrival; diagnostic and therapeutic orders; clinical observations, including the results of treatment; reports of procedures, tests and results; diagnostic impression; conclusion at the termination of evaluation/treatment; final disposition; the patient's condition on discharge or transfer; and instructions to the patient/caregiver for follow-up care.

3.4.3 In the event of transfer to another facility, the following information will be documented in the medical record: the name of the receiving facility; the stability of the patient; the risks, benefits and alternatives of the transfer; the name of the person responsible for the patient during the transfer; name of the receiving practitioner; consent to the transfer; and pertinent medical information which will accompany the patient.

3.4.4 Rounding and progress note entry for patients who are medically stable and on custodial care, as designated by hospital policy, while awaiting placement for non-acute services will be seen at least every 7 days. Rounding may be more frequent if medical issues arise.

3.4.5 Preliminary report of gross autopsy findings must be provided within (2) working days from the date of the autopsy. Final autopsy reports should be available no later than (60) days after the death. Allowance may be needed if portions of a case are referred for external consultation, and completion of the case is dependent upon information from those consultants.

3.4.6 Each practitioner involved in the management of a cardiac or respiratory arrest Code Blue shall dictate or write a note within 24 hours of the event, documenting his/her actions, including medications or procedures ordered or performed. The Code Blue record may be used to verify dictation.

3.5 Anesthesia Record

3.5.1 A pre-anesthesia evaluation must be completed and documented for each patient who receives general, regional, or monitored anesthesia. A pre-anesthesia evaluation is not required for moderate sedation because it is not considered to be anesthesia.

3.5.1.1 The evaluation must be performed by an individual with the privilege to administer anesthesia within PRMCE, and may not be delegated to an individual without such privileges.

3.5.1.2 The pre-anesthesia evaluation must be completed and documented within 48 hours immediately prior to the first dose of medication(s) for the purpose of inducing

anesthesia associated with any procedure requiring anesthesia. The pre-anesthesia evaluation of the patient includes, at a minimum:

3.5.1.2.1 Review the medical history, including anesthesia, drug and allergy history

3.5.1.2.2 A heart and lung assessment is required to be documented in the medical record prior to moderate or deep sedation by a member of the medical staff with appropriate privileges.

3.5.1.2.3 Interview and examination of the patient

3.5.1.2.4 The following elements of the pre-anesthesia evaluation must be reviewed and updated as necessary within 48 hours, which may also have been performed within 30 days prior to the 48-hour time period:

3.5.1.2.5 Notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk).

3.5.1.2.6 Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

3.5.1.2.7 Additional pre-anesthesia data or information, if applicable and as required in accordance with standard practice prior to administering anesthesia (e.g., stress tests, additional specialist consultation);

3.5.1.2.8 Development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the patient (or patients representative) of the risks and benefits of the delivery of anesthesia.

3.5.2 An Intraoperative anesthesia record or report for each patient who receives general, regional, or monitored anesthesia, including deep sedation, shall include, at a minimum,

3.5.2.1 Name and hospital identification number of the patient;

3.5.2.2 Name(s) of practitioner(s) who administered anesthesia, and as applicable, the name and profession of the supervising anesthesiologist or operating practitioner

3.5.2.3Name, dosage, route and time of administration of drugs and anesthesia agents; Technique(s) used and patient position(s), including the insertion/use of any intravascular or airway devices;

3.5.2.4 Name and amounts of IV fluids, including blood or blood products if applicable; Timed-based documentation of vital signs as well as oxygenation and ventilation parameters; and

3.5.2.5 Any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment.

3.5.3 The post anesthesia evaluation must be performed by an individual with the privilege to administer anesthesia within PRMCE, and may not be delegated to an individual without such privileges.

3.5.3.1 The post-anesthesia evaluation must be completed within 48 hours following the completion of the surgery or procedure that required anesthesia services.

3.5.3.2 The calculation of the 48-hour time frame begins at the point the patient is moved into the designated recovery area.

3.5.3.3 The evaluation may occur in the PACU, Critical Care, or other designated recovery location. However, the evaluation should not begin until the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation. The evaluation may occur in the PACU, Critical Care, or other designated recovery location.

3.5.3.4 The evaluation should be clearly documented and conform to current standards of anesthesia care, including at a minimum:

- Respiratory function, including respiratory rate, airway patency, and oxygen saturation.
- Cardiovascular function, including pulse rate and blood pressure.
- Mental status.
- Temperature.
- Pain.
- Nausea and vomiting; and
- Postoperative hydration.

3.5.3.5 A practitioner who has appropriate clinical privileges and who is familiar with the patient, is responsible for the decision to discharge a patient from a post-anesthesia recovery unit, based on direct assessment or criteria established and approved by the Medical Staff.

3.6 Timeliness Requirements and Incomplete Medical Record Process.

3.6.1 A chart lacking the following items, as applicable, shall be considered incomplete: history and physical; consultation reports; operative report(s); discharge summary/documentation.

3.6.2 All entries in the written medical record must be timed, dated, include the practitioner's ID number and authenticated by the responsible practitioner by signature or initials at the time of entry.

3.6.3 A stamped physician or practitioner signature is not acceptable

3.6.4 Electronic signature authentication shall be acceptable for electronic records.

3.6.5 Practitioners will be expected to review the patient's orders that are entered within the previous 48 hours.

3.6.6 Results of the medical screening examination are expected to documented in the medical record within 48 hours of the conclusion of an Emergency Department visit.

3.6.7 The discharge summary is expected to be completed within 72 hours of a patient's discharge

3.6.8 It is expected that a practitioner responsible for the care of the patient will have the knowledge of the patient's hospital course, medical plan of care, condition and current status; therefore, it is expected that the covering practitioner will cosign any unsigned order unless the order is clearly inappropriate.

3.6.9 A record lacking the required documentation will be marked incomplete by the Medical Records Department and the practitioner will be notified. An initial Notification of Incomplete Medical Records will be sent to the practitioner no sooner than 14 days after the deficiency occurs. Seven (7) days after the date of the initial notification, a second notice will be sent to the practitioner warning that they will be placed on probation if the chart(s) is not completed within one additional week, or seven (7) days.

3.6.10 If the record remains incomplete for a total of 30 days (16 days after the date of initial notification), it will be considered overdue and the practitioner will be notified by special notice that they are being placed on probationary status for one year.

3.6.10.1 If two or more instances of 30 day delinquency occur during the probationary period, the provider will automatically relinquish privileges until such time that the delinquencies are corrected.

3.6.10.2 The UM/UR committee will have latitude to forgo the probationary period based on extenuating circumstances communicated by the provider. The committee may also determine that the deficiencies are trivial in nature and decline to enact probation. Providers in question, however, will be monitored and if the pattern persists, probation can be re-considered.

3.6.11 Practitioners on vacation, ill, or attending a professional seminar shall notify the Medical Records Department of the specific time period they will be absent. The practitioner will be required to complete their overdue medical records upon return to practice to avoid probationary action.

3.6.12 Incomplete medical records will be considered delinquent and will be included in the Chart Delinquency Rate as calculated for The Joint Commission, if not completed within thirty (30) days of discharge.

3.6.13 Medical staff is expected to respond to coding queries in a timely manner. Consistent or repeat failure to respond to reasonable requests for coding clarification may result in referral to Peer Review.

3.7 General Medical Record Practices

3.7.1 Access to a patient's medical record is limited to practitioners who are involved in the care of the patient and/or review of care provided, hospital employees involved in the current care of the patient, and appropriate Allied Health personnel. Unobstructed access to medical records shall be given to members of the Medical Staff and hospital staff for bona fide research and study consistent with preserving confidentiality, and subject to the conditions imposed by the Hospital policy(s) regarding clinical research.

3.7.2 The Medical Staff shall not include derogatory or inflammatory comments directed towards patients, hospital staff, medical staff, policies, or care provided by others in the medical record.

ARTICLE 4: CONSULTATION

4.1 Any practitioner with privileges in the Hospital may be called upon for consultation within their area of privileges as sanctioned by the respective Division and the Credentials Committee.

4.2 Consultants are required to provide consultation when requested without exception, or to arrange an alternative consultant.

4.3 Consultants will respond in timely fashion to requesting practitioners commensurate with the medical needs of the patient as determined by the treating physician. If an expected response time is discussed at the time of initial request, it should be honored by the responding physician.

4.4 Consultation requests can be initiated by any member of the Medical Staff with primary patient care responsibilities.

4.5 In unusual circumstances, where there is dispute about a practitioners decision not to call a consult, the question can be escalated in a manner consistent with the Chain of Command policy. Any person along the published chain of command will have authority to request consultation for the patient in question.

4.6 Consults ordered through HUC's (Health Care Unit Coordinators), or nursing staff will not be recognized, except if the situation is emergent, or a routine procedure is requested.

4.7 Physicians with ICU admitting privileges that are not critical care board certified will be able to admit patients to the ICU but will require a mandatory critical care consult. This patient population includes surgical patients as well as medical subspecialty patients.

ICU patients will remain under the primary care of their admitting physicians while Intensivists actively co-manage their care.

4.7.1 Patients admitted to the ICU require a consult by an intensivist. The intensivist will co-manage the care of the patient with the attending physician.

4.7.2 The intensivist providing the consultation is defined as:

4.7.2.1 Board certified physicians who are additionally certified in the subspecialty of critical care medicine, or...

4.7.2.2 Physicians board certified in emergency medicine that have completed a critical care fellowship in an ACEP accredited program, or...

4.7.2.3 Neuro-intensivists are an approved alternative to intensivists in providing care in neuro-ICU's.

4.7.4 Board certified cardiologists and cardiothoracic surgeons who admit patients to the ICU and who are caring for patients with specific cardiac diagnosis or procedures do not require an intensivist consult.

ARTICLE 5: PROFESSIONAL SERVICES

5.1 Laboratory/Pathology

5.1.1 No laboratory tests are done routinely on admission unless dictated otherwise by specific nursing unit policies or standing orders.

5.1.2 Blood may be administered only by the written order of a qualified medical staff member or non-member LIP. The anesthesia graphic record, with evidence of blood administration and signed by the responsible anesthesiologist, will suffice for patients transfused in the operating room.

5.1.3 Tissues and foreign bodies removed in the OR shall ordinarily be sent to the department of Pathology for examination. A report by a medical staff pathologist will be made a part of the patient's medical record.

5.1.4 Exemptions from the requirement that specimens removed are to be examined by a pathologist may be made, but only when the quality of care is not compromised by the exemption, when another suitable means of verification of the removal has been routinely used, and when a procedure note documents the removal. Categories of specimens that may be exempted are included in the Medical Staff Policies.

5.1.5 Authority for the performance of autopsies will be in accordance with the laws of the State of Washington. All autopsies shall be performed by a medical staff pathologist or by a physician he/she designates. The completed autopsy report is to be included in the patient record within sixty (60) days unless exceptions for special studies are established by the Medical Staff.

5.2 Medical Imaging

5.2.1 Orders for medical imaging examinations must include the reason the study is being performed.

5.2.2 Use of radiation-producing devices and materials will be monitored by the Radiation Safety Committee.

5.2.3 Invasive medical imaging studies must be ordered by a member of the medical staff or non-member LIP. Outpatient medical imaging studies requested by nonmembers of the medical staff will be dealt with through Hospital policy.

5.2.4 Invasive imaging studies requiring the injection of contrast material into the arteries of the head or heart must have prior consultation by the appropriate specialty before the exam is performed.

ARTICLE 6: TRAUMA SERVICES

6.1 As part of their duty to provide backup to the Hospital Emergency Department, members of the medical staff will be responsible for the care of trauma patients. The schedule of specialists/sub-specialists for unassigned patients will be used for assignment of trauma patients who present to the Emergency Department.

6.2 Physicians covering the Trauma and Acute Care Surgery Team need to respond in a timely fashion upon notification of a FULL Trauma Activation. Other physicians whose services are determined necessary are also expected to come to the Hospital in a timely fashion upon notification of a call requesting their services, within criteria set by certification and accrediting bodies.

ARTICLE 7: ANESTHESIA SERVICES

7.1 The Department of Anesthesiology shall include members of the medical staff who have successfully completed a training program recognized by the American Board of Anesthesiology or the American Association of Nurse Anesthetists (AANA). Each anesthesiologist or nurse anesthetist who provides anesthesia services may do so only after requesting and being permitted privileges as outlined in the Medical Staff Bylaws. Anesthesiologists and Nurse Anesthetists are licensed independent practitioners who have been granted independent practice privileges within the Hospital and are organized under one department with a clearly defined leadership structure led by the section medical Directors(s). Active Staff members shall be assigned by the Section Medical Directors(s) or designee on a daily basis to share in the care of all surgical and obstetrical patients, and provide consultations when requested. The exact duties of each clinician shall be determined by the Section Medical Director(s) or their designee within the guidelines established by the Credentials Committee.

7.2 CMS Conditions of Participation require that Anesthesia Services throughout the hospital are organized into one anesthesia service, under the direction of the Director(s)

of Anesthesia Services. The Director(s) must be a qualified doctor of medicine (MD) or doctor of osteopathy (DO) who is a board certified Anesthesiologist. Such anesthesia services are divided into two categories; anesthesia and Analgesia/Sedation. The definitions of these categories are included in the CMS Clarification of the Interpretive Guidelines for the Anesthesia Services Condition of Participation (§482.52).

7.3 "Anesthesia", specifically includes:

7.3.1 General anesthesia.

7.3.2 Regional anesthesia.

7.3.3 Monitored anesthesia care (MAC).

7.3.4 Deep sedation/analgesia is included in MAC. An example of deep sedation would be a screening colonoscopy when there is a decision to use Propofol.

7.4 General anesthesia, regional anesthesia and monitored anesthesia, including deep sedation/analgesia, may only be administered by:

7.4.1 A qualified and privileged anesthesiologist

7.4.2 A qualified and privileged MD or DO (other than an anesthesiologist);

7.4.3 A dentist, oral surgeon or podiatrist who is qualified and privileged to administer anesthesia under State law

7.4.4 A qualified and privileged CRNA

7.5 Clinical privileges in anesthesiology are granted to physicians and other providers qualified to administer anesthesia who are qualified by training to render patients insensible to pain and to minimize stress during surgical, obstetrical, and certain medical procedures.

7.6 Anesthesia Administration by a Physician (as defined by CMS)
The Hospital's anesthesia services policies address the circumstances under which an MD or DO who is not an anesthesiologist, a dentist, oral surgeon or podiatrist is permitted to administer anesthesia. In the case of a dentist, oral surgeon or podiatrist, administration of anesthesia must be permissible under State law and comply with all State requirements concerning qualifications. Generally accepted standards of anesthesia care govern the Hospital's policies regarding administration of anesthesia by these types of practitioners as well as MDs or DOs who are not anesthesiologists.

7.7 "Sedation/analgesia", specifically includes:

7.7.1 Topical or local anesthesia

7.7.2 Minimal sedation

7.7.3 Moderate sedation/analgesia ("Conscious Sedation")

7.8 Who May Administer Topical/local anesthetics, Minimal sedation, and Moderate sedation:

The requirements above concerning who may administer anesthesia do not apply to the administration of topical or local anesthetics, minimal sedation, or moderate sedation. However, they must be given by appropriately trained medical professionals within their scope of practice. The Hospital has policies and procedures, consistent with State scope of practice law, governing the provision of these types of anesthesia services. Hospital must assure that all anesthesia services are provided in a safe, well-organized manner by qualified personnel.

7.9 Clinical privileges are also granted to practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of moderate or minimal sedation.

7.10 Rescue Capacity

Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, hospitals must ensure that procedures are in place to rescue patients whose level of sedation becomes deeper than initially intended, for example, patients who inadvertently enter a state of Deep Sedation/Analgesia when moderate sedation was intended. "Rescue" from a deeper level of sedation than intended requires an intervention by a practitioner with expertise in airway management and advanced life support. The qualified practitioner corrects adverse physiologic consequences of the deeper than intended level of sedation and returns the patient to the originally intended level of sedation. Individuals administering Moderate Sedation/Analgesia should be able to rescue patients who enter a state of Deep Sedation/Analgesia, while those administering Deep Sedation/Analgesia should be able to rescue patients who enter a state of General Anesthesia.

7.11 Anesthesia Quality Assessment & Performance Improvement

Anesthesia Services involves multiple hospital departments and services to focus on indicators related to improve health outcomes and the prevention and reduction of medical errors, track quality indicators, including adverse patient events, use[s] the data collected to monitor the effectiveness and safety of the services and quality of care and take[s] actions aimed at performance improvement.

ARTICLE 8: STUDENTS, RESIDENTS, FELLOWS

8.1 The Graduate Medical Education Committee, a hospital committee, shall have the responsibility for monitoring all aspects of residency education, maintain records as required by accreditation bodies or applicable laws, and report to and advise the Medical Executive Committee and the Board on all issues covering graduate medical education at the hospital. It will oversee and support compliance with Institutional Requirements of the Accreditation Council for Graduate Medical Education (ACGME). The committee shall provide to the medical staff written descriptions of the roles,

responsibilities and patient care activities of the participants of all graduate medical education programs. These descriptions will include identification of mechanisms by which the supervisor (s) and graduate education program director make decisions about each participant's progressive involvement and independence in specific patient care activities

8.2 All students/residents/fellows shall be registered in the Medical Staff Office by the Medical Staff member with whom they are working. The Medical Staff Office will be informed of the expected duration of their preceptorship/observation in the Hospital. The practitioners with whom they are training must have a license commensurate with that trainee's anticipated degree or specialty of practice.

8.3 Students/residents/fellow may be precepted in procedures by any member of the medical staff who has privileges commensurate with the procedure being performed. Both learners and staff will abide by the Medical Staff's Consent for Treatment Policy.

8.4 Students/residents/fellows who are part of an approved, formalized preceptor program recognized by the Medical Staff and approved by the Board may be permitted to perform procedures, assist in surgery, and render other aspects of patient care in the Hospital under the direct supervision of the preceptor and to an extent consistent with the privileges of the preceptor and within the limits of the student/resident/fellow's abilities as identified by the sponsoring institution and by the ACGME.

8.5 Residents/fellows may write and dictate history and physical examination reports, operative reports, and discharge summaries, which must be reviewed and attested by the preceptor. Medical students may write progress notes which can serve as accepted progress notes if attested by the preceptor.

8.6 Appropriately precepted student healthcare practitioners may write orders in the presence of a duly licensed and privileged practitioner, but the orders may not be implemented until they are cosigned by the practitioner.

8.7 For a formal preceptorship outside of locally sponsored residencies, the sponsoring institution will provide the Hospital with the objectives of the program, as well as evidence of liability coverage. In addition, they will indicate the general level of a student/resident/fellow's clinical abilities and the time frame of the preceptorship.

8.8 The Medical Staff Credentials Committee shall be informed of those residents and fellows that are fulfilling preceptorship in the Hospital. The preceptor must be an Active member of the medical staff.

ARTICLE 9: CHAIN OF COMMUNICATION

9.1 Medical Staff members will take appropriate actions to intervene in a patient's medical plan of care if there are concerns regarding the appropriateness of care by a practitioner or issues regarding practitioner behavior.

9.2 If the issue cannot be resolved, communication will follow the hospital Chain of Communication Policy