MEDICAL STAFF

RULES & REGULATIONS

EL CAMINO HEALTH
MEDICAL STAFF
RULES AND REGULATIONS

A. ADMISSIONS/DISCHARGES

1. Patients shall be admitted only under the care of a qualified member of the Medical Staff. The attending physician must be available to the admitted patient at all times or must arrange such coverage.

Allied health practitioners may initiate arrangements for admission and complete charts and forms pertinent to the admission and the medical record if privileged to do so within their scope of practice and under the supervision of the attending physician (if applicable).

2. Except in an emergency, patients shall not be admitted to the Hospital until a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon as possible after admission.

3. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary or appropriate to assure the protection of other patients from those who are a source of danger from any cause whatsoever.

4. According to policy of Medical Staff (see Operating Room Committee policy), pre-operative lab work shall be ordered at the discretion of the admitting surgeon. If pre-op lab work is ordered, the attending surgeon will be responsible for either including a copy of the lab work in the chart or in the dictated H&P or the admission note in the progress notes.

5. Potassium levels shall be obtained within 72 hours of surgery for all patients on potassium depleting diuretics.

6. All laboratory procedures, for patients being investigated or treated within the Hospital, shall be done in the Hospital except in those circumstances where the Hospital refers laboratory work outside the Hospital.

7. Decisions concerning the use of reference laboratories for studies not performed in the Hospital shall be delegated to the director of the medical laboratory services.

8. Each patient on admission shall be provided with a wristband unless the patient's condition will not permit such identification. Minimum information shall include the name of the patient and the Hospital admission number.

9. Patients shall not be routinely admitted to a distinct part of the Hospital unless it is appropriate for the level of care required by those patients.

10. Patients with critical burns shall be treated in a Burn Center unless transfer of the patient to the center is contraindicated in the judgment of the attending physician.

11. Any outpatient psychotherapist arranging for inpatient psychiatric care of his/her patient at El Camino Hospital will share with the ECH treatment team all information

relevant to the patient's treatment. When the outpatient therapist is not the admitting psychiatrist, a special effort should be made to inform the admitting psychiatrist of all relevant treatment issues. This communication is for purposes of ensuring optimal short-term patient care. Information must be held in strict confidence within the treatment setting, but the availability of relevant information to the treatment team is essential to provide adequate and appropriate therapy.

12. A mentally competent adult shall not be detained in the Hospital against his will. An unemancipated minor shall not be detained against the will of his parent or legal guardian. In those cases where the law permits an unemancipated minor to contract for medical care without the consent of his/her parent or guardian, he/she shall not be detained in the Hospital against his/her will. This provision shall not be construed to preclude or prohibit attempts to persuade a patient to remain in the Hospital in his own interest nor the detention of a mentally disordered patient for the protection of himself or others under the applicable provisions of the Welfare and Institutions Code, Section 5000, et seq., until transfer to an appropriate facility can be arranged.

13. Patients shall not be transferred or discharged for purposes of effecting a transfer from the Hospital to another health facility unless arrangements have been made in advance for admission to such health facility and the person legally responsible for the patient has been notified or after reasonable attempts have been made to notify the responsible person. A transfer or discharge shall not be carried out if, in the opinion of the patient's physician, such transfer or discharge would create a medical hazard.

14. A minor shall be discharged only to the custody of his or her parent or to his legal guardian or custodian, unless such parent or guardian shall otherwise direct. This provision shall not be construed to preclude a minor legally contracting for medical care from assuming responsibility for himself upon discharge.

15. Patients may only be discharged upon the order of a Medical Staff member.

16. In the event that a hospitalized patient refuses treatment by a physician, the affected physician will:
a. Communicate with the patient with regard to what he/she needs (tests, follow-up care, etc).
b. Ask a physician in his/her call group or specialty to take over care of the patient ***or,***
c. Ask the chief of department or chief of staff for assistance in assigning another physician to care for the patient.

If the affected physician is acting as a consultant, the primary physician will find another consultant, absent an emergency situation. The primary physician is always responsible for the patient's care in the immediate emergency situation absent the patient's direct wishes to not be cared for in the interim.

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a. Prior to initiation of definitive therapy at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, it is strongly recommended that review and report of the findings must be documented by an ECH pathologist.

b. Prior to initiation of definitive therapy for breast cancer at El Camino Hospital which is based on interpretation of a biopsy or cytology done at an outside lab, review and report of the findings must be documented by an ECH pathologist.

B. RECORDS

The responsible staff member shall be accountable for the preparation of a complete medical record for each patient. Unless otherwise provided in standing orders, protocols, or guidelines, a record shall include (a) identification data; (b) chief complaint; (c) details of present illness; (d) relevant past, social, and family histories; (e) inventory of body systems; (f) complete physical examination; (g) provisional diagnosis; (h) consultation reports; (i) reports from laboratory, i.e., pathology, radiology, etc.; (j) progress notes detailing medical surgical treatment that reflect any change in condition and results of treatment; (k) reports of procedures (also see below), e.g., nuclear medicine, radiology, anesthesia; (l) principal & secondary diagnosis(es); (m) discharge summary, discharge instructions; (n) follow-up plans; and (o) appropriate consents; and (p) autopsy results, if applicable. All entries shall be dated, timed, and authenticated by the appropriate practitioner. Any entries made for the practitioner (fellow, resident, physician assistant, etc.) must be dated, timed, and counter-signed by the practitioner, except emergency department (ED) reports. ED assessments may be dictated and signed by the responsible nurse practitioner or physician's assistant, and must include the name of the supervising ED physician. The ED physician must document in the ED record that he/she has reviewed the assessment and care provided.

Medical Records may be authenticated by a computer key code, in lieu of a physician's signature, only when that physician has placed a signed statement in the hospital administrative offices to the effect that he/she is the only person who has possession of the key code and the only person who will use the key code. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice.

History & Physical (H&P)

1. H&P must be completed by a practitioner privileged to perform H&Ps – these are defined as:
   a. MD/DO
   b. DDS/DMD
   c. DPM
   d. Nurse Practitioner – must be countersigned by supervising practitioner within 14 days of the patient's discharge.
   e. Certified Nurse Midwife
   f. Physician Assistant – must be countersigned by supervising practitioner within 14 days of the patient's discharge.

2. H&P must be completed and documented for each patient no more than 30 days before or 24 hours ***after*** admission, but prior to surgery or procedure requiring anesthesia services.

   At a minimum, the following systems must be included in the H&P:
   a. Heart and lungs
   b. Abdomen
   c. General appearance and orientation
   d. Vital signs (including blood pressure, heart rate, respiratory rate, and temperature – afebrile is acceptable) or reference to vital signs obtained elsewhere in the admission

process
e. Major integumentary
f. Musculoskeletal or sensory systems when problems such as blindness, deafness, missing limbs, or open sores and wounds exist
g. Rectal/pelvic examinations are recommended when pertinent to the admission diagnosis
h. Salient features of the case
i. Drug tolerances
j. Pertinent positive and negative findings that relate to the reason for admission.

Outpatients receiving local anesthesia or conscious sedation require, as a minimum, a current statement of present illness, a statement of absence of infection or intercurrent disease, a description of cardiorespiratory status, known allergies, current medications, and a preoperative diagnosis.

Obstetrical records should include all pertinent and significant prenatal information. A durable, legible original or reproduction of the office or clinical prenatal record is acceptable. The report of the physical examination shall reflect a comprehensive current physical assessment

ECT Patients - For patients receiving a series of ECT treatments, the history and physical must be within thirty (30) days prior to the initial treatment. For subsequent treatments within the same series, an update to the H&P will be required (the update must include auscultation of the lungs and heart and any significant change in condition or absence of any significant change). This may be documented on the anesthesiologist pre-anesthesia assessment form.

3. **Updates**: When the H&P is conducted within 30 days of admission (inpatient or outpatient), an updated examination, including any changes in the patient's condition, must be completed and documented by a qualified practitioner (see #1 in this section) within 24 hours of admission (inpatient or outpatient), but prior to surgery or a procedure requiring anesthesia services when the H&P was completed within the previous 30 days.

    a. The update must include review of the H&P, updated examination including auscultation of the lungs and heart, and any significant change in condition or absence of any significant change from the previous report. If the patient is an inpatient, the update may be documented in the progress note or on the 'Procedure Notes' form.

4. If the reviewing practitioner finds the H&P incomplete, inaccurate, or otherwise unacceptable, he/she may disregard the H&P and perform a new H&P within 24 hours or prior to surgery/procedure as noted above.

Other Medical Record Documentation:

1. Pre-Anesthetic and Post-Anesthetic Notes
   There shall be pre-anesthetic and post-anesthetic notes documented in the medical record which include the anesthesiologist's pre-anesthetic evaluation, the patient's condition upon admission to the Post Anesthesia Care Unit, a description of the post-operative course, a description of any anesthesia complications, and a description of the patient's condition upon discharge from the Post Anesthesia Care Unit.

2. Operative Reports

The immediate procedure note must be entered in the medical record immediately after the procedure and before the patient is transferred to the next level of care for inpatients. This documentation includes the name(s) of the primary surgeon(s), co-surgeon(s) and assistant(s), and name of procedures performed, findings, estimated blood loss, specimens removed, and complications, if any; and postoperative diagnosis. This documentation must be documented in the electronic medical record on the 'post procedure note'. Downtime paper forms may be used when the EMR is not functional.

The comprehensive operative summary describing techniques, findings, and tissues removed or altered must be entered into the medical record or dictated immediately after the procedure and is considered delinquent if not completed within 24 hours of surgery and signed by the surgeon. The following are to be included in the operative summary:

- Date and times of the surgery;
- Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
- Pre-operative and post-operative diagnosis;
- Name of the specific surgical procedure(s) performed;
- Type of anesthesia administered;
- Complications, if any;
- A description of techniques, findings, and tissues removed or altered;
- Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and
- Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.
- All discrepancies in surgical counts and efforts taken to reconcile such discrepancies shall be documented in the operative summary.

3. Progress notes shall be written/dated/timed/signed on each day of the hospital stay and within 24 hours of discharge by the attending physician, his/her associate, or his/her designated PA or NP with El Camino Hospital privileges.

4. Orders for treatment and tests must be entered into the computer system by the Medical Staff member or authorized person at the direction of the staff member. When ordering diagnostic CT, MRI, PET, or nuclear medicine imaging exams, the practitioner should consider the patient's age and recent imaging exams. Drug and treatment orders must be appropriately signed within forty-eight (48) hours. All other orders must be signed within seventy-two (72) hours or prior to the discharge or transfer of the patient. Telephone orders shall immediately be recorded and then read back to the staff member for confirmation, shall be signed by the person to whom dictated with the name of the Medical Staff member per his own name, and shall be signed by the Medical Staff member within the prescribed time limits.

Persons authorized to accept orders defined: Persons to accept and transcribe orders at the direction of Staff Member shall include the nursing staff, pharmacists, and those

persons designated by department guidelines or service protocols in conformity with applicable statutory provisions.

Orders and patient referrals for outpatient services shall be accepted from any member of the El Camino Hospital Medical Staff or Allied Health Professional Staff who holds a current, unrestricted California license and is privileged to do so.

Practitioners (physicians, podiatrists, dentists, and other allied health professionals) who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order outpatient services and refer patients for outpatient services in accordance with the provisions and condition set forth below.

a. If the ordering practitioner is not a member of the El Camino Hospital Medical Staff or Allied Health Professional Staff, verification that the practitioner is licensed and acting within his/her scope of practice in the State in which he/she sees the patient shall be obtained by the outpatient department(s) prior to performing or providing the test, study, or outpatient service. The license shall be verified via the appropriate website or by obtaining verbal verification from the appropriate licensing board by the department providing the service. In addition, a telephone number for the ordering practitioner will be verified by the outpatient department(s) prior to performing or providing the test, study, or outpatient service.
b. Orders for outpatient services must include the name of the patient, the date of the order, the test or treatment to be performed, and the reason for the test or treatment to be performed (symptoms or diagnosis). Orders for outpatient diagnostic tests (i.e., laboratory, radiology exams, EKG, etc.) may be submitted on a requisition form, a prescription/order form from the practitioner's office, or may be telephoned to the appropriate department by the practitioner's office staff with follow-up written orders.
c. Results shall be directly sent to the ordering practitioner unless otherwise requested by the ordering practitioner. As required in California Health and Safety Code 123148(f)(1)-(4), the health care professional is required to discuss the results with the patient prior to electronic medical record auto releasing. Results will be released to the patient seven (7) days after results are finalized. The electronic medical record will release routinely processed tissues including but not limited to skin biopsies, pap smear tests, products of conception, and bone marrow aspirations for morphological evaluation, even if they reveal a malignancy.
d. Practitioners who are not members of the El Camino Hospital Medical Staff or Allied Health Professional Staff may order or refer patients for all outpatient services provided by El Camino Hospital except for chemotherapy orders.

Verbal or telephone orders must be signed/authenticated, dated and timed by the author within 48 hours. Faxed or electronic signatures may be used to authenticate a verbal or telephone order. Signature/authentication by a practitioner other than the author is permitted only when the author is unavailable, but not for convenience or as common practice. Verbal or telephone orders should be limited to those situations in which it is impossible for the prescriber to enter it into a computer.

In the case of an incorrect order, the practitioner must document in the medical information system or on the Unsigned Orders Summary, that the order was entered incorrectly.

5. A Record of Newborn must be completed for each normal newborn. The Admission Examination must be completed within twenty-four (24) hours of birth by the attending physician.

6. Medical Screening Exams (as defined under the Emergency Medical Treatment and Labor Act) shall be performed and documented in the Emergency Department and Labor and Delivery. Medical Screening Exams shall be performed by a credentialed MD, DO, certified nurse midwife, Emergency Department physician assistants under appropriate supervision and within scope of practice, or, in the case of a patient presenting with pregnancy and/or signs and symptoms of labor, RNs who have demonstrated current competence (per hospital policy) in assessing the laboring patient.

7. A discharge summary is required on all stays over forty-eight (48) hours, except for uncomplicated obstetrical cases and normal newborns. Discharge summaries are also required for patients who are transferred to another acute care facility or who die within forty-eight (48) hours, and shall be written or dictated at the time of discharge, transfer or death.

   A discharge summary should briefly recapitulate the reason for hospitalization, the significant findings, the procedures performed, and treatment rendered, the condition of the patient on discharge, medications, and any specific instructions given to the patient and/or family regarding follow-up care.

   For stays less than forty-eight (48) hours, a final progress note may be completed in lieu of a discharge summary unless the patient is transferred or dies. If a discharge summary is not required, the following information must be included in the final progress note: diagnosis, condition of the patient, diet, activity, medications, and follow-up instructions (if not covered with a pre-printed form).

8. Discharge instructions are required on all hospital stays, including short-stay and cancelled surgeries. Discharge instructions must include the following elements: 1) Discharge medication reconciliation; 2) discharge diet; 3) follow-up appointments; 4) activity level; 5) signs/symptoms to watch for.

9. In the event of a death, a discharge summary should be added to the record which the physician must authenticate. The final summary should indicate the reason for admission, the findings, course in the hospital including significant conditions (present on admission and comfort care), and immediate cause of death.

10. When a necropsy is performed, the provisional anatomic diagnosis should be recorded on the medical record within seventy-two (72) hours and a final completed report shall become a part of the record.

11. The records of discharged patients will be completed within 14 days following discharge.

12. All forms designed to become a part of the medical record must be approved by the Medical Records Committee and by the Medical Staff Executive Committee.

13. Procedures for making changes or amendments to record entries:

    a. Any individual who discovers an error or omission of his or her own shall immediately upon discovery correct it and do so in accordance with the procedures in this section.
    b. Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated), initialed and dated/timed.
    c. Errors or omissions discovered at a later time shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined out (not obliterated).

14. Physician Review of Medical Records
    A physician may request to review a chart only when he/she is actively involved in that patient's care or if reviewing the case for official peer review or quality assessment purposes. Any abuse of this privilege may result in disciplinary action.

15. Health Insurance Portability and Accountability Act of 1996 (HIPAA)
    This Act, as implemented by the HIPAA Privacy Regulation (42 CFR Parts 160 and 164) requires that El Camino Hospital implement policies and procedures to protect the privacy and security of "protected health information" and to afford patients certain rights with regard to their information. "Protected health information" includes any health-related information that identifies or could be used to identify an individual, including patient medical and billing records. HIPAA applies both to the Hospital and to the members of the Medical Staff
    a. El Camino Hospital has adopted privacy practices for the use and disclosure of patient information within the Hospital. These privacy practices are summarized in the Hospital's Notice of Privacy Practices, which is furnished to patients and posted at the Hospital's facilities.
    b. The Notice of Privacy Practices applies to all patient health information created or received in the course of providing health care or conducting business operations at any hospital operated location. The Notice is given jointly on behalf of the Hospital and the members of the Medical Staff. It does not, however, apply to patient health information at other locations, such as a Medical Staff member's private office.
    c. Each member of the Medical Staff shall abide by the terms of the Notice of Privacy Practices and with the Hospital's policies and procedures for health information privacy and security, as amended from time to time. Medical Staff members must adopt their own notice of privacy practices at their private offices as necessary to comply with the Privacy Regulations.

C. REMOVAL OF ORIGINAL RECORDS FROM THE HOSPITAL

Original records may be removed from the Hospital's custody only pursuant to court order, subpoena or statute, with exception of x-rays and other images, tracings, recordings and clinical and anatomical pathological materials which are sought for purposes of continuing care of the patient.

D. AUTOPSIES

Every member of the Medical Staff shall try to secure permission for autopsy when appropriate. No autopsy shall be performed without the written consent of the appropriate party. All autopsies shall be performed by the hospital pathologist(s) or by a physician to whom he may delegate the duty. In all cases where any doubt exists regarding the legal status of death, the coroner shall be notified and request for an autopsy made. (Indications for autopsy are found in the Pathology Department Policy "Autopsies for QA – Indications for Autopsy".)

E. CONSULTATIONS

Consultation(s) shall be obtained by all Medical Staff members whenever the patient appears to be developing unexpected complications or untoward results which threaten life or serious harm, either from the failure of the patient to appropriately respond to the therapy being given and/or substantial medical uncertainty in diagnosis and management.

The Consultant shall document the fact the fact that all available, pertinent past medical records were examined.

F. MANDATORY CONSULTATIONS

Mandatory consultation(s); in specific, urgent or critical clinical conditions; may be imposed at the discretion of a Medical Staff officer, department or division chief or their designees with concurrence of a Medical Staff officer. Mandatory consultations may be imposed on any staff member in a specific urgent clinical management problem and/or as an overall continuing requirement in all similar types of clinical management cases.

Mandatory consultations may be imposed by departments or division guidelines for all staff members or classes of members in specific clinical conditions, subject to approval of the Medical Staff Executive Committee.

The consultant in a specific urgent or critical situation may or may not be a staff member, but must be a practitioner with acknowledged expertise. Temporary privileges, if necessary, may be granted at the discretion of an appropriate Department Chief, Chief of Staff, and Hospital Administration and are subject to Sections 6.5-l and 14.2 of the Bylaws.

The imposition of mandatory consultation requirements on a member in a specific, urgent or critical clinical condition, or such imposition on all members or a class of members, does not constitute a reduction in privileges. Mandatory consultation requirements constitute a reduction in privileges of a member when the requirement is imposed on the individual member and as a continuing requirement in all similar cases.

Patients who have attempted suicide prior to or during their hospitalization, or who have suicidal ideation identified following hospitalization, must be evaluated for suicidal risk prior to discharge. Such evaluation is to be done by a psychiatrist or by a member of the Behavioral Health Services staff who must then review the case with a psychiatrist prior to discharge.

If an inpatient is on an involuntary psychiatric hold (i.e. 5150 or 5152); then a psychiatrist must evaluate the patient directly prior to such a hold being released.

G. PATIENT COVERAGE

Each staff member is responsible to respond to an emergency involving a member's patient or have a substitute staff member respond. In case of failure to respond, the Medical Staff officers or department executive officers of the appropriate department or service shall have the authority to request emergency services from any staff member. When a staff member finds a substitute for coverage of his practice that substitute physician must be a member in good standing of the El Camino Hospital Medical Staff with similar scope of privileges and will assume all duties of the primary physician.

H. HOSPITAL SERVICES

Outpatient diagnostic or therapeutic services may be performed only on request of a Medical Staff member with clinical privileges or practitioners who by training, practice, and California licensure would otherwise qualify for Medical Staff membership or if approved by the Medical Staff Executive Committee.

I. PROCEDURE FOR CREATION OF NEW MEDICAL STAFF DEPARTMENTS

Existing services or divisions of the Medical Staff may be considered for provisional department status if:

1. This is mandated by Joint Commission or Hospital Board of Directors, and
2. A majority of the members of the considered service or division approve, and
3. The considered service or division has at least 15 Medical Staff members.

Procedure for obtaining provisional department status:
Following approval by a majority of its members, a written request shall be forwarded to the Medical Staff Executive Committee. If the Medical Staff Executive Committee grants provisional departmental status, it shall be bound to review the performance of this provisional department after one year. At this review, the Executive Committee may grant full department status or mandate an additional six-month provisional period. If an additional six-month provisional period is mandated, the Medical Staff Executive Committee will again review the performance of this provisional department at the end of this time and will either grant full department status or will return it to its prior division or service level.

Responsibilities of a provisional Medical Staff department shall include:

1. The establishment of regular meetings at the frequency of not less than quarterly, which must be attended by not less than 50% of its members
2. The maintenance of minutes that reflect concurrent review of appropriateness of care provided by its members consistent with the Quality Assessment program of the Medical Staff
3. The review and recertification of its members' privileges in accord with established guidelines
4. The development of departmental guidelines which are to be submitted to the Medical Staff Executive Committee within three months
5. The development of member privileging criteria which are also to be submitted for approval to the Medical Staff Executive Committee within three months

The Chief and Vice-Chief may sit on the Medical Staff Executive Committee during the provisional period, but may not vote until the department has been granted full status.

J. FEES

An applicant to the Medical Staff shall be required to pay $300 as a processing fee.

K. RESIDENTS

1. Nature of Affiliation: Residents engaged in patient care at El Camino Hospital must be post-doctoral trainees (residents or fellows) in training programs of approved teaching institutions which have a contract with El Camino Hospital. Residents must be licensed by the Medical Board of California. They may be authorized to perform clinical duties consistent with their training program, and as outlined in the contract between El Camino Hospital and the residency program and the Medical Staff Guidelines for Supervision of Residents (Medical Staff Policy/Procedure, Section 9). The contracting teaching institution must provide professional liability insurance for residents to cover the performance of all clinical duties at El Camino Hospital. The Medical Staff Executive Committee and Board of Directors shall approve the residency contract. Authorization to perform clinical duties will cease at the completion of an individual physician's rotation or under the terms of the contract. Residents are required to comply in all respects with the Medical Staff Bylaws and

   Rules and Regulations, departmental or service rules and regulations as well as applicable policies and procedures.

   Residents do not enjoy the due process rights afforded Medical Staff members. Moreover, the Medical Staff retains the right to require the immediate suspension or withdrawal of any resident if such action is deemed warranted in order to protect patients or other individuals.

2. Supervision: All clinical care provided by residents shall be under the supervision of a member of the Medical Staff. Guidelines for supervision can be found in the ECH Medical Staff Policies and Procedures, Section 9. All policies related to supervision of residents shall be approved by the Medical Staff Executive Committee.

   1. Authorized Activities: A resident may make entries in the patient's medical record as delineated in the Medical Staff Guidelines (Medical Staff Policy/Procedure, Section 9). The extent to which the resident may otherwise participate in patient care services and make entries in the medical record shall be determined by the Supervising Physician and Training Program and shall be consistent with the applicable Guidelines.

L. ALLIED HEALTH PROFESSIONALS

Allied Health Professionals ("AHPs") are covered in the Medical Staff policy regarding these practitioners.

M. DEA Certification Waiver

Exemption may be granted upon written attestation of the physician that the physician will not prescribe controlled substances in the hospital. The Department Chief and Medical Staff Executive Committee need to concur that a DEA is not required based on the physician's attestation.

Appendix I

A. BREAST STEERING LEADERSHIP COMMITTEE

1. COMPOSITION

Composition of the Breast Steering Leadership Committee are approved members of the Commission on Cancer (CoC) Committee who have current specialty board certification in their area of specialty who treat breast patients, have current medical licensure and active medical staff appointments.

Non physician committee members hold appropriate breast program relationships and accountability as outlined in the applicable National Accreditation Program for Breast Cancer (NAPBC) standards. Physician members are medical staff in Medical and Radiation Oncology, Pathology, Breast Imaging Radiology, and Palliative Care.

Non physician members may include research staff, physical therapy, tumor registry, social work, nursing, hospital administration, nurse practitioners, physician assistants, and patient survivors.

2. DUTIES

The committee is the governing body of the breast center and is chaired by Breast Program Leader or Medical Director. This multidisciplinary committee contributes to:

(a) The policies and procedures of the breast center
(b) Dissemination of information
(c) Active assessment of treatment
(d) Goal setting
(e) Planning, initiating, and determining quality standards and projects and research goals, all following national guidelines of NAPBC and CoC under the direction of the American College of Surgeons.

3. MEETINGS

Meetings will follow national guidelines as established by NAPBC and CoC and will meet quarterly following established CoC quarterly meetings.

B. CANCER CARE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Committee shall consist of at least one Board certified physician representative, from Surgery, Gyn Oncology, Medical Oncology, Radiation Oncology, Radiology and Pathology, and all other representatives as required by the current American College of Surgeons/Commission on Cancer Standards.

2. DUTIES

The Committee shall:

(a) Develop and evaluate annual goals and objectives for clinical, educational and programmatic activities related to cancer;
(b) Promote a coordinated, multi-disciplinary approach to patient management;
(c) Coordinate educational and consultative cancer conferences to cover all major sites and related issues;
(d) Monitor quality management and improvement through completion of quality management studies that focus on quality, access to care and outcomes;

(e) Promote clinical research;
(f) Supervise the Cancer Registry and ensure accurate and timely abstracting, staging and follow-up reporting;
(g) Perform quality control of registry data;
(h) Encourage data usage and regular reporting;
(i) Uphold medical ethical standards; and
(j) Annually provide a summary quality management report to the Medical Staff Executive Committee.

3. MEETINGS
The committee shall meet at least quarterly and will submit an annual report to the **Quality Council**.

C. CREDENTIALS COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The committee shall be multi-disciplinary consisting of voting and non-voting members. Voting members will be 9-13 active members of the Medical Staff with representation from the departments of Medicine, Surgery and Maternal Child Health and includes the Chair of the Committee and the Chair of IDPC. Non-voting members will include the Chief Medical Officer and Medical Staff Office representative. The voting members will be appointed by the Enterprise Chief of Staff on the recommendations of the Credential Committee Chair and the Department Chairs and to be approved by the Medical Executive Committee. The Chair of the Committee will be appointed by the Enterprise Chief of Staff and approved by the MEC for a 1 year term with unlimited extensions as long as the Chair is eligible and extension is approved by the MEC. Chair will be ex-officio and without voting rights at the Medical Executive Committee. The voting members cannot be department Chairs or Vice-Chairs or members of the Medical Executive Committee.

2. DUTIES (including but not limited to the following:)
(a) Review of initial applications for membership to the Medical Staff or Allied Health status
(b) Review of reapplications for membership to the Medical Staff or Allied Health status
(c) Review of request for privileges at time of initial application and reapplication or at the request of the Medical Staff member.

3. MEETINGS
Monthly or at the discretion of the Chair of the Committee.

D. CRITICAL CARE COMMITTEE – *MV Campus*

1. COMPOSITION
The Committee will consist of physician and non-physician members. Physician members include representatives from the Medical Staff as well as pulmonologists, intensivists and anesthesia critical care. Non-physician members include Nursing Director of ICU/ED, Director of Infection Prevention, Director of Respiratory Services and Nursing representatives from the ICU. The Chair of the Committee will be the Medical Director of the ICU, appointed by the Chief Medical Officer in consultation with the Enterprise Chief of Staff and approved by the Medical Executive Committee for a period of 1 year with unlimited extensions as long as the Chair is eligible and approved by the MEC.

2. DUTIES

(a) Establish guidelines for care of patients on the critical care units.
(b) Perform ongoing review of patient care on the critical care units.
(c) Participate in evaluation and selection of equipment purchases.
(d) Review cases referred from other medical/staff committees as requested.

3. MEETINGS

Monthly or at the discretion of the Chair.

E. HEART AND VASCULAR INSTITUTE (HVI) COMMITTEE - *Enterprise*

1. COMPOSITION

Committee members will include physicians involved in the diagnosis and treatment of cardiovascular and peripheral vascular disease including cardiologists, interventional cardiologists, vascular surgeons, cardiothoracic surgeons, interventional radiologists, interventional neuroradiologists, and interventional nephrologists. Nonvoting members may include support staff from the Cardiac Catheterization Laboratory, Angiography and Interventional Radiology Services, Non-invasive Imaging and Surgery. Physician or patient care related issues of the HVI Committee will be addressed by the Physician Excellence Committee and/or Leadership Council with MEC oversight. The Chair will be an active member of the Medical Staff in good standing appointed by the Chief Medical Officer for a term of 1 year with unlimited extensions as long as the Chair is eligible and approved by the MEC.

2. DUTIES

(a) Conduct multidisciplinary review of coronary and peripheral vascular intervention procedures performed at El Camino Hospital.
(b) Develop recommendations and/or criteria for clinical privileges for percutaneous endovascular procedures.

(c) Develop protocols for a registry of cases performed at El Camino to include indications and outcomes statistics to ensure consistent quality of care

(d) Promote teaching and education amongst the healthcare professionals involved in the evaluation, combined percutaneous-surgical diagnostic and therapeutic endovascular procedures.

(e) Review selected cases identified via medical staff approved criteria and refer cases for secondary peer review to the appropriate department executive committee.

3. MEETINGS

The committee shall meet as often as necessary, but at least quarterly and will submit an annual report to the Quality Council.

F. CONTINUING MEDICAL EDUCATION/LIBRARY COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The continuing medical education/library committee shall be composed of physician members and other health professionals of the Medical Staff whose number shall be appropriate to the size of the hospital and amount of program activities produced annually. The Chair and the members will be appointed per Article 11.1-2 of the Bylaws.

2. DUTIES

The continuing medical education/library committee shall perform the following duties:

(a) Plan, implement, coordinate and promote educational activities that relate, at least in part, to the type and nature of care, treatment, and services offered by the hospital for the Medical Staff. This includes:

1. Identifying the educational needs of the Medical Staff;
2. Formulating clear statements of objectives for each program;
3. Assessing the effectiveness of each program;
4. Choosing appropriate teaching methods and knowledgeable faculty for each program; and
5. Documenting staff attendance at each program.

(b) Assist in developing processes to assure optimal patient care and contribute to the continuing education of each practitioner.

(c) Establish liaison with the quality assessment and improvement program of the hospital in order to be apprised of problem areas in patient care, which may be addressed by a specific continuing medical education activity.

(d) Maintain close liaison with other hospital Medical Staff and department committees concerned with patient care.

(e) Make recommendations to the Medical Staff Executive committee regarding library needs of the Medical Staff.

(f) Advise administration of the financial needs of the continuing medical education program.

3. MEETINGS

At least quarterly. It shall maintain minutes of the program planning discussions and report to the Leadership Council and Medical Executive Committee.

G. INFECTION CONTROL COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Infection Control Committee shall be a multi-disciplinary committee of physician and non-physician members. The physician members including Chair will be appointed per Article 11.1-2 of the Bylaws with representation from the departments of Medicine, Surgery and Maternal Child Health. Non-physician members will include Director of Infection Prevention, and representation but not limited to nursing, microbiology and pathology divisions, pharmacy, facility and environmental services, sterile processing, central services, operating room and Employee Health.

2. DUTIES

The Infection Control Committee shall:

(a) Develop a hospital-wide infection program and maintain surveillance over the program.

(b) Develop a system for reporting, identifying and analyzing the incidence and cause of all nosocomial infections, including assignment of responsibility for the ongoing collection and analytic review of such data, as well as for required follow-up action.

(c) Develop and implement a preventive and corrective program designed to minimize infection hazards, including establishing, reviewing, and evaluating aseptic, isolation, and sanitation techniques. Such techniques shall be defined in written policies and procedures.

(d) Develop written policies defining special indications for isolation requirements in relation to the medical condition involved and for monitoring the implementation of the policies and quality of care administered.

(e) Act upon recommendations related to infection control received from the Chief of Staff, the Medical Staff Executive Committee, the departments, and other Medical Staff and Hospital committees.

3. MEETINGS

The Committee and subcommittees (if any) shall meet at least quarterly. It shall maintain a record of its proceedings and shall submit quarterly reports to the Quality Council and Critical Care Committee.

H. INTERDISCIPLINARY PRACTICE COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The Committee shall be multi-disciplinary consisting of active members of the Medical Staff, Chief Nursing Officer, Chief Medical Officer or designee, registered nurses and allied health practitioners. The Chair of the Committee and he physician members will be appointed per Article 11.1-2 of the Bylaws. Physician members to include department or division chairs or their designees that employ Allied Health professionals. The Chair of the IDPC will be a member of the Credentials Committee.

(a) The committee shall be responsible for appointment and reappointment of all allied health practitioners in approved categories.

(b) The committee shall review quality assessment issues pertaining to allied health practitioners at the time of reappointment as needed.

2. DUTIES

(a) The Committee shall establish written policies and procedures for the conduct of its business. Policies and procedures shall include but not be limited to:

1. Provision for securing recommendations from Medical Staff members in the medical specialty or clinical field of practice under review, and from persons in the appropriate non-medical category who practice in the clinical field or specialty under review.
2. Methodology for the approval of standardized procedures in accordance with Section 2725 of the Business and Professions Code, which requires affirmative approval of the procedures by the Administrator/ Chief Executive Officer or his/her designee, a majority of the physician members, and a majority of the registered nurse members after consultation has been obtained from medical and nursing staff members practicing in the medical and nursing specialties under review.
3. Provision for maintaining clear lines of responsibility of the nursing service for nursing care of patients and of the Medical Staff for medical services in the Hospital.
4. Provision for securing approval for each recommendation of the Committee from the Medical Staff Executive Committee and, if so approved, the Board of Directors.

(b) Registered Nurses: The Committee shall be responsible for recommending policies and procedures for the granting of expanded role privileges to registered nurses, whether or not employed by the facility, to provide for the assessment, planning, and direction of the diagnostic and therapeutic care of a patient in the Hospital. These policies and procedures will be administered by the Committee, which shall be responsible for reviewing credentials and making recommendations for the granting and/or rescinding of such privileges.

(c) Standardized Procedures for Registered Nurses: The Committee shall be responsible for:

1. Identifying the functions and/or procedures which required the formulation and adoption of standardized procedures under Section 2725 of the Business and Professions Code in order for them to be performed by registered nurses in the Hospital, and initiating the preparations of such standardized procedures in accordance with this Section.
2. The review and approval of such standardized procedures covering practice by registered nurses in the Hospital.
3. Recommending policies and procedures for the authorization of employed staff registered nurses to perform the identified functions and/or procedures. These policies and procedures may be administered by the Committee or by delegation to the Director of Patient Care Services.

(d) Each standardized procedure approved by the Committee shall:

1. Be in writing and set forth the date it was approved by the Committee.
2. Specify the standardized procedures which registered nurses are authorized to perform and under what circumstances.
3. State any specific requirements which are to be followed by registered nurses 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 standardized procedures.
5. Establish a method of initial and continuing evaluation of the competence of those registered nurses authorized to perform the standardized procedures.
6. Provide for a method of maintaining a written record of those persons authorized to perform the standardized procedures.
7. Specify the nature and scope of review and/or supervision required for the performance of the standardized procedures; for example, if the standardized procedure 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 registered nurse is to communicate immediately with a patient's physician concerning the patient's condition.
9. State any limitation on settings or departments within the Hospital where the standardized procedure may be performed.
10. Specify any special requirements for procedures relating to patient record keeping.
11. Provide for periodic review of the standardized procedure.

3. MEETINGS

As necessary. The Committee will report to the Credentials Committee with oversight by Leadership Council and Medical Executive Committee.

I. INSTITUTIONAL REVIEW BOARD – *Enterprise Committee*

1. COMPOSITION

The Institutional Review Board ("IRB") shall be composed in a manner which meets the requirement of the federal Health and Human Services ("HHS") and Food and Drug Administration ("FDA") regulations for the protection of human subjects. The IRB shall have at least five (5) members, with varying backgrounds to promote complete and adequate review of research activities commonly conducted in the institution. The IRB shall be sufficiently qualified through the experience and expertise of its members, and the diversity of the members' backgrounds, including consideration of the racial and cultural backgrounds of members and sensitivity to such issues as community attitudes, to promote respect for its advice and counsel in safeguarding the rights and welfare of human subjects. In addition to processing the professional competence necessary to review specific research activities, the IRB shall be able to ascertain the accessibility of proposed research in terms of institutional commitments and regulations, applicable law, and standards of professional conduct and practice. The IRB shall, therefore, include persons knowledgeable in these areas. If an IRB regularly reviews research that involves a vulnerable category of subjects, including but not limited to subjects covered by specific regulations, the IRB shall include one or more individuals who are primarily concerned with the welfare of these subjects.

The IRB may not consist entirely of men or entirely of women, or entirely of members of one profession. It shall include at least one (1) member whose primary concerns are in nonscientific areas (for example: lawyers, ethicists, members of the clergy), and at least one (1) member who is not otherwise affiliated with the institution or part of the immediate family of a person who is affiliated with the institution. No member may participate in the IRB's

initial or continuing review of any project in which the member has a conflicting interest, except to provide information requested by the IRB. The IRB may, in its discretion, invite individuals with competence in special areas to assist in the review of complex issues which require expertise beyond or in addition to that available on the IRB. These individuals may not vote with the IRB. The Chair will be a member of the Medical Staff appointed by the Chief Medical Officer (CMO) for a term of 1 year with unlimited extensions as long as the Chair is eligible and approved by the Medical Executive Committee. Administrative and financial responsibilities of the IRB will be the responsibility of the CMO or designee.

2. DUTIES

(a) The IRB must adopt and follow written procedures for carrying out the duties imposed by the HHS and FDA regulations, including procedures for:

1. Conducting its initial and continuing review of research and for reporting its findings and actions to the investigator and to the institution.
2. Determining which projects require review more often than annually, which projects need verification from sources other than the investigators, and that no material changes have occurred since previous IRB review.
3. Assuring prompt reporting to the IRB of proposed changes in a research activity, and for assuring that changes in approved research, during the period for which IRB approval has already been given, may not be initiated without IRB review and approval, except where necessary to eliminate apparent immediate hazards to the subject.
4. Assuring prompt reporting to the IRB of unanticipated problems involving risks to subject or others.
5. For research subject to HHS or FDA regulations, assuring prompt reporting of unanticipated problems involving risks to subjects or others by filing reports with the appropriate federal agency.
6. Assuring timely reporting to the appropriate institutional officials of any serious or continuing noncompliance by investigators with the requirements and determinations of the IRB. For research subject to the HHS and FDA regulations, these reports must also be made to HHS, or to the FDA, as appropriate.

(b) Except when an expedited review procedure is used, the IRB shall review proposed research at convened meetings at which a majority of the members of the IRB are present, including at least one (1) member whose primary concern is in nonscientific areas. This review must be conducted in accordance with the provisions set forth Paragraph (c) below. In order for the research to be approved it must meet the criteria set forth in California law and federal regulations and it must receive the approval of a majority of those members present at the meeting. Research which is approved by the IRB may be subject to further appropriate review and approval or disapproval by officials of the institution, but such review is not required. However, those officials may not approve any research subject to the California law and/or federal regulations referenced herein if it has not been approved by an IRB.

(c) The Institutional Review Board shall:

1. Review and have authority to approve, require modifications in (to secure approval), or disapprove all research activities covered by HHS, FDA, or California law and regulations.

   Require that information given to subjects as part of the informed consent process complies with the provisions of the applicable law or regulations. The

   IRB may require that information, in addition to that specifically mentioned

in the law or regulations, be given to the subjects when, in the IRB's judgment, the information would meaningfully add to the protection of the rights and welfare of subjects.

2. Require documentation of informed consent or waive documentation in accordance with the provisions of applicable law or regulations.
3. Notify the investigator in writing of its decision to approve or disapprove a proposed research activity, or of modifications required to secure IRB approval of the research activity. If the IRB decides to disapprove a research activity, it shall include in its written notification a statement of the reasons for its decision and give the investigator an opportunity to respond in person or in writing.
4. Conduct continuing review of research covered by these regulations at intervals appropriate to the degree of risk, but not less than once per year, and shall have authority to observe or have a third party observe the consent process and the research.
5. Have authority to suspend or terminate approval of research that is not being conducted in accordance with the IRB's requirements or that has been associated with unexpected serious harm to subjects. Any suspension or termination of approval shall include a statement of all reasons for the IRB's action and shall be reported promptly to the investigator, appropriate institutional officials, and appropriate regulatory authorities.

3. MEETINGS
At least quarterly or as deemed necessary by the Chair.

J. JOINT CONFERENCE COMMITTEE – *Enterprise Committee*

1. COMPOSITION
Chief Executive Officer or designee, Chiefs of Staff, Vice Chiefs of Staff, Immediate Past Chiefs of Staff, Board of Directors' representative, Medical Director of Quality Assessment/Utilization Management, Chief Nursing Officer, Senior Director of Quality and Patient Safety.

2. DUTIES
The Joint Conference Committee shall constitute a forum for the discussion of matters of hospital and Medical Staff policy, practice and planning, conflict resolution, and the Medical Staff Executive Committee or the Board of Directors may refer a forum for interaction between the Board of Directors and the Medical Staff on such matters as. The Joint Conference Committee shall exercise any other responsibilities set forth in these bylaws.

3. MEETINGS:
As needed.

K. MEDICAL ETHICS COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Committee will be multi-disciplinary with representation from the Medical Staff, community, nursing, clergy and administration. The Chair of the Committee and the members will be appointed as per Article 11.1-2 of the Bylaws. Members of the administration including

but not limited to hospital legal counsel, Risk management and CMO or designee will be ex-

officio without voting rights. Members on this committee having voting rights should not be professionally involved in the care of the patient whose case is being reviewed. No member will serve on this Committee if there can be a potential conflict of interest that may affect the quality of care of the patient while discharging their duties as a member of the Committee. Members of Medical Executive Committee, Credentials, Physician Excellence are excluded from serving on this Committee. They may serve as ex-officio members without voting rights when called upon to serve as reviewers. The Chair will report directly to the Leadership Council and to Medical Executive Committee.

2. DUTIES

(a) Provide counsel to physicians, hospital staff, and administration in the understanding, delineations and clarification of medical ethical dilemmas.
(b) Provide regular educational activities on medical ethical dilemmas to the institution.
(c) Assist in the development of ethical guidelines where appropriate.
(d) Submit recommendations to the department executive committee or Medical Staff Executive Committee as appropriate.

3. MEETINGS

As needed and no less than annually.

L. MEDICAL STANDARDS FOR INFORMATION TECHNOLOGY (MSIT) COMMITTEE – *Enterprise Committee*

1. COMPOSITION

The MSIT Committee shall be chaired by an appointee of the Chief Medical Officer. Physician members will be appointed per Article 11.1-2 of the Bylaws and representative**s** from nursing, the Health Information Management Department, Administration, and Information Systems.

2. DUTIES

The duties of the MSIT shall include:

(a) Review and evaluation of the electronic medical record, or a representative sample, to determine whether they: 1) properly describe the condition and diagnosis, the progress of the patient during hospitalization and at the time of discharge, the treatment and tests provided, the results thereof, and adequate identification of individuals responsible for orders given and treatment rendered; and 2) are sufficiently complete at all times to facilitate continuity of care and communications between individuals providing patient care services in the hospital;
(b) Review and make recommendations for Medical Staff and hospital policies, rules and regulations relating to the electronic medical record, including completion, forms and formats, filing, indexing, storage, destruction, availability, and methods of enforcement;
(c) Provide liaison with hospital administration and Health Information personnel in the employ of the hospital on matters relating to practices involving the electronic medical record;
(d) Incorporate Medical Staff input into information systems planning and decisions, such as internet, intranet, email, software applications, and Medical Information Systems (MIS) development, maintenance and upgrade, and other clinical data systems;
(e) Review the hospital-wide Information Management Plan on an annual basis and recommend additions or revisions as may be warranted based upon clinical needs assessment;
(f) Review the Medical Staff clinical data collections applications and recommend changes or upgrades as may be warranted.

3. MEETINGS
Will meet at the discretion of the chair and report annually to the Medical Staff Executive Committee.

M. PERFORMANCE IMPROVEMENT (PI)/SAFETY COMMITTEE – *Enterprise Committee)*

1. COMPOSITION
The Performance Improvement/Safety Committee shall be composed of the Chief Nursing Officer, Chief Medical Officer, Chief Quality Officer or designee, and representation from Patient Safety, Physician members of the Medical Staff, Nurse Managers, Infection Control Practitioner, Manager of QI/PI, Safety Management Specialist, and the Risk Manager.

2. CHAIRS
The committee will be co-chaired by the Chief Nursing Officer and one of the physician members (to be determined by the Chief of Staff).

3. DUTIES
(a) Oversee PI/Safety Teams
(b) Assess goals and monitor performance of the PI/Safety Teams
(c) Ensure PI/Safety Teams have adequate resources
(d) Identify gaps in hospital safety and performance – set targets for improvement

4. MEETINGS
The committee shall meet quarterly, or at the discretion of the chairs.

N. PERINATAL COMMITTEE – *Enterprise Committee*

1. COMPOSITION
This committee will be multi-disciplinary and at least composed of representatives from Pediatrics, OB/GYN, Neonatology, Anesthesia, Care Coordinator and Chief Nursing Officer. The Chair and the members will be appointed per Article 11.1-2 of the Bylaws.

2. DUTIES
(a) Review the ongoing care of patients in Labor and Delivery, NICU, Maternity, and the Nursery.
(b) Establish guidelines for the care of patients in Labor and Delivery, NICU, Maternity, and Nursery.
(c) Submit recommendations/concerns to Maternal-Child Health Department Executive Committee as appropriate.

3. MEETINGS
Monthly, or at the discretion of the Chair. The peer review activities will be monitored by the Physician Excellence Committee.

O. PHARMACY AND THERAPEUTICS COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Pharmacy and Therapeutics Committee is a multi-disciplinary committee consisting of members of the Medical Staff, Nursing, Pharmacy and Administration. The Chair of the Committee and the physician members will be appointed as per Article 11.1-2 of the Bylaws

in Consultation with the Chief Medical Officer.

2. DUTIES

The Pharmacy and Therapeutics Committee shall:

(a) Assist in the formulation of broad professional policies regarding the procurement, evaluation, selection, storage, distribution, dispensing, use, safety procedures, administration and all other matters relating to drugs and diagnostic testing materials in the Hospital.

(b) Advise the Medical Staff and the Hospital's Pharmaceutical Department on matters pertaining to the choice of available drugs and review all significant untoward drug reactions.

(c) Make recommendations concerning drugs to be stocked on the nursing unit floors and by other services.

(d) Develop and review periodically a formulary or drug list for use in the Hospital.

(e) Evaluate clinical data concerning new drugs or preparations requested for use in the Hospital.

(f) Establish standards concerning the use and control of investigational drugs and of research in the use of recognized drugs.

(g) Perform an annual review of all Standing Orders.

(h) Perform such other duties as assigned by the Chief of Staff or the Medical Staff Executive Committee.

3. MEETINGS

At least quarterly and at the discretion of the Chair.

P. QUALITY COUNCIL – *Enterprise Committee*

1. COMPOSITION

The Quality Council is a committee of the Medical Staff and hospital that provides oversight of quality improvement activities across the Enterprise. The Medical Staff representation includes the Chairs of the Enterprise Medical Staff Departments (Medicine, Surgery, Maternal Child Health), Medical Service Line Directors as deemed appropriate by the Enterprise Chief of Staff, and Directors of Anesthesiology, Radiology and Emergency Medicine or their designee. Hospital representation will include the Associate Chief Medical Officer, Chief Quality Officer or designee, Chief Nursing Officer or designee, Nursing Director (Critical Care/ED, Maternal Child Health, Medical/Surgical/Oncology Services), and Director of Medical Staff Information Technology.

2. CHAIRS

The Committee will be co-chaired by Chief Medical Officer and an active member of the Medical Staff appointed by the Enterprise Chief of Staff per Article 11.1-2 of the Bylaws. Chair will be ex-officio and without voting rights at the Medical Executive Committee.

3. DUTIES

(a) Set overall direction for QI activities at El Camino Hospital

(b) Align medical staff and hospital QI activities

(c) Align service line development and hospital growth initiatives with medical staff and hospital QI activities

(d) Continually review committees and reporting structures to ensure collaboration and teamwork with regard to QI activities.

4. MEETINGS
The committee shall meet quarterly, or at the discretion of the Chairs. The Chair will report to Medical Executive Committee.

Q. RADIATION SAFETY COMMITTEE - *Enterprise Committee*

1. COMPOSITION

The Committee will be Chaired by the Radiation Safety Officer (RSO) from the Division of Radiology and appointed by the Chief Medical Officer in consultation with the Enterprise Chief of Staff with approval by the Medical Executive Committee. Members from the Department of Medicine, Surgery and Maternal Child Health will be represented. Non- physician will include representatives from the administration, nuclear medicine and nursing.

2. DUTIES
(a) Establish radiation safety guidelines for staff and patients at El Camino Hospital.
(b) Review ongoing activities relative to radiation safety.
(c) Review proposals for diagnostic and therapeutic uses of unsealed radio nuclides.
(d) Review regulations for the use, transport, storage and disposal of radioactive materials used in Nuclear medicine
(e) Recommend remedial action when there is a failure to observe protection recommendations, rules and regulations.

3. MEETINGS
Meets every 3 months and as deemed necessary by the Chair.

R. TRANSFUSION AND TISSUE REVIEW COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The Transfusion and Tissue Review Committee is a multidisciplinary committee The Committee is Co-Chaired by the Medical Director of the Transfusion Service (from the Department of Pathology) and an active member of the Medical Staff appointed by the Enterprise Chief of Staff for a period of 1 year with unlimited extensions and approved by the MEC. The other members will include representation from the Department of Medicine, Surgery and Maternal Child Health, Chief Quality Officer or designee, Director if Accreditation/Public Reporting, Director of Laboratory and Pathology Services, Lab Manager from Los Gatos, Blood Bank Manager and Transfusion Safety Officer and other members as deemed necessary by the Chairs.

2. DUTIES
The duties of the transfusion committee shall include:
(a) Monitor the safety and utilization of transfusion of blood and blood products
(b) Provide data on blood utilization to Medical Staff members and hospital leadership
(c) Provide education on the safe and efficacious use of blood products
(d) The committee will also perform tissue review function through the Department of Pathology which includes review of surgical cases in which a specimen (tissue or non-tissue) is removed, as well as from those cases in which no specimen is removed. The

review shall include the indications for surgery and all cases in which there is a major discrepancy between the pre-operative and post-operative (including pathologic) diagnosis. The Medical Staff Executive Committee may describe a system by which the tissue review function shall be coordinated with departmental surgical case review.

3. MEETINGS
At least quarterly and at the discretion of the Chair.

S. UTILIZATION REVIEW COMMITTEE – *Enterprise Committee*

1. COMPOSITION
The utilization review committee shall consist of a sufficient number of members to afford fair representation. The committee will include at least 2 members of the Medical Staff. Members on this committee should have no financial interest in the hospital and should not be professionally involved in the care of the patient whose case is being reviewed. No member will serve on this committee if there can be a potential conflict of interest that may affect the quality of care of the patient while discharging their duties as a member of the committee. The Chair of the committee and its members will be selected by the Chief Medical Officer or designee in consultation with the Enterprise Chief of Staff for a 1-year term with unlimited extensions and to be approved by the MEC on a yearly basis. Subcommittees may be appointed by the committee for departments or divisions as the committee may deem appropriate.

2. DUTIES
The duties of the utilization review committee shall include:

(a) Conducting utilization review studies designed to evaluate the appropriateness of admissions to the hospital, lengths of stay, discharge practices, use of medical and hospital services and related factors which may contribute to the effective utilization of services. The committee shall communicate the results of its studies and other pertinent data to the Medical Staff Executive committee and shall make recommendations for the utilization of resources and facilities commensurate with quality patient care and safety; all peer to peer for "level of care denials" will be done by the Utilization Management medical director or designee. Attending physician can do peer to peer if requested by the Utilization Management medical director. This applies to all payors.

(b) Establishing a utilization review plan which shall be approved by the Medical Staff Executive Committee; and

(c) Obtaining, reviewing, and evaluating information and raw statistical data obtained or generated by the hospital's case management system.

3. MEETINGS
The utilization review committee shall meet as often as necessary at the call of its chair, but at least quarterly. It shall maintain a record of its findings, proceedings and actions, and shall make a quarterly report of its activities and recommendations to the Medical Executive Committee.

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