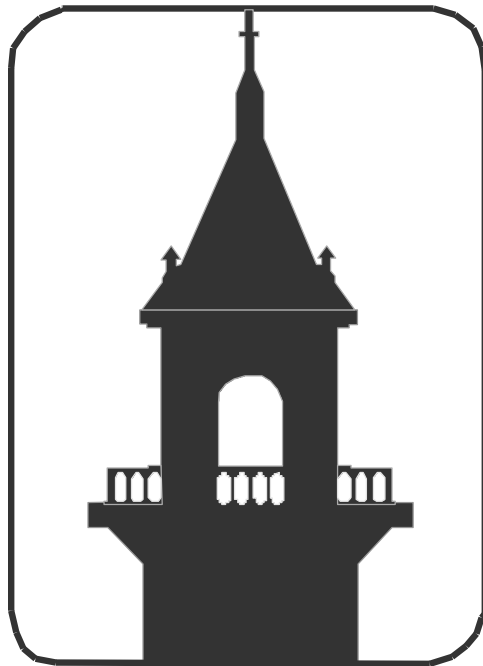


**DESERT REGIONAL
MEDICAL CENTER**

MEDICAL STAFF

**RULES AND
REGULATIONS**



ADOPTED: MAY 1993

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INTRODUCTION

Changes to the Rules and Regulations are covered in the Medical Staff Bylaws under Section 14.1.

A. ADMISSION AND TREATMENT OF PATIENTS

1. Patients shall be admitted upon the written or verbal order of a member of the Medical Staff. Patients may be admitted to this hospital and treated only by physicians who have filed a written application, submitted proper credentials, and have been duly appointed to membership on the Medical Staff and granted admitting privileges by the Governing Board. All practitioners shall be governed by the official admitting policy of Desert Regional Medical Center.

Patients may be admitted by a podiatrist or dentist member of the Medical Staff, who shall immediately upon admission designate a physician to perform a medical evaluation (history and physical) of the patient. An exception to this rule is the Oral Surgeon or Podiatrist who has applied for and been granted the privilege of performing his/her own history and physical on patients. The designated physician shall be responsible for the general medical condition of the patient throughout the hospital stay.

2. The hospital shall be primarily for the care of patients with acute conditions.
3. Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In the case of an emergency, the provisional diagnosis shall be stated as soon after admission as possible. Handwritten or dictated admission notes indicating admitting diagnosis and reason for admission shall be entered within twenty-four (24) hours of admission.
4. Medical Staff members admitting patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever or to assure protection of the patient from self harm.
5. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient admitted to the hospital, for the prompt completeness and accuracy of the medical report.

Each member of the Medical Staff shall provide assurance of immediacy of adequate professional care for his/her patient in the Hospital by being available or having available through his/her office eligible alternate practitioners with whom prior arrangements have been made. The member shall document in the patient's chart that care has been turned over to an alternate practitioner. The alternate practitioner must be a member of the Medical Staff. Failure of the attending practitioner to meet the above requirements may result in loss of medical staff privileges. In case of failure of the member or alternate to attend his/her patient, the President of the Medical Staff (or designee), the Chair of the Department (or designee) concerned, or, if necessary, any member of the Medical Executive Committee shall have authority to call an appropriate member of the Active Staff to provide such coverage.

6. COMMUNICABLE DISEASE

It is the responsibility of the attending physician to notify admitting/outpatient registration if a patient is coming to the hospital for treatment with a potential communicable disease. The physician must indicate precautions that should be taken. Admitting/outpatient registration is responsible for notifying the nurse epidemiologist or his/her designee.

7. SPECIAL CARE UNITS

Areas of restricted bed utilization and specialty care units shall be as follows: Pediatrics, Intensive Care Units, Rehabilitation, and Skilled Nursing Facility (SNF). In order to assure that the facilities of these special care and monitored bed units are available to those patients whose medical conditions require them, a means must be provided to resolve questions which may arise as to whether a given patient's admission to those units is necessary and appropriate. Therefore, while it remains Desert Regional

Medical Center's practice to give every due consideration to the opinion of the attending physician as to whether his/her patients should be admitted to or discharged from such a unit, superior authority in such decisions is given to the Physician Director, or his/her designee, of the special care unit to which the patient is to be admitted.

8. All patients in the Special Care units will be seen by an appropriate physician in accordance with the unit's policies and procedures. A progress note is to be written at least daily by the attending physician or his/her designee. A limited statement such as "stable" does not constitute an appropriate progress note.
9. TRANSFER PRIORITY
 - a. Patient transfer priorities are as follows (in order from highest to lowest):
 - b. From Emergency Department to appropriate patient bed;
 - c. From Intensive Care Unit to general care area;
 - d. From Cardiac Care Unit to general care area;
 - e. From temporary placement in a clinical service area to the area appropriate for the patient.

No patient shall be transferred without such transfer being approved by the responsible practitioner, in which case appropriate notification shall take place.

B. ALLIED HEALTH PRACTITIONERS

1. General. AHPs are health care providers who may work independently or dependently to provide health care services to patients. All AHPs working at this hospital must be under the supervision of a member of the medical staff. AHPs are not members of the medical staff but may hold designated clinical privileges.
 - a. AHPs are health care professionals who:
 - i. hold a current, valid and unrestricted license, certificate, or other legal credential as required by this state which authorizes the AHP to provide patient care services;
 - ii. are in a category of AHPs designated by the Governing Board to provide practice prerogatives under a defined degree of supervision and monitoring, and are individually designated by the Governing Board of this hospital to exercise specific practice prerogatives in this hospital; and
 - iii. meet the qualifications in these rules and regulations, in the referenced sections of the medical staff bylaws, in departmental rules and regulations, and applicable medical staff and hospital policies.
 - b. AHPs are not entitled to medical staff membership or prerogatives.
2. Categories of AHPs Eligible for Practice Prerogatives
 - a. Audiologist
 - b. Certified Registered Nurse Anesthetist (CRNA)
 - c. Clinical Psychologist
 - d. Marriage Family and Child Counselor
 - e. Nurse Practitioner
 - f. Nurse Midwife

- g. Physician Assistant
- h. Physician Nurse Liaison
- i. Surgical Technician

[NOTE: On an annual basis, the Governing Board needs to identify those categories of AHPs which the Governing Board will designate as able to apply for practice prerogatives at this hospital. Furthermore, AHPs need to be credentialed; the important issue is what patient services AHPs perform, NOT the source of their employment.]

The Governing Board shall, at least once each medical staff year, review and designate the categories of AHPs eligible to apply for practice prerogatives in this hospital. The Governing Board shall also identify the types of practice prerogatives and terms and conditions that may be granted to qualified AHPs in each category. The Medical Executive Committee shall make recommendations to the Governing Board as to the categories of AHPs that should be eligible for practice prerogatives, and to the types of practice prerogatives, and the terms and conditions that apply to each AHP category for purposes of supervision and reporting. The degree of supervision required, whether direct or remote, should be clearly established for each AHP. For each category of AHP, it shall be determined whether or not they may make entries in the medical record and whether countersignatures are required and by whom.

The hospital shall make available to the medical staff and any interested applicant, a list of the AHP categories that are eligible for practice prerogatives at this hospital. Any AHP in a category not identified by the Governing Board as eligible for practice prerogatives may submit a request in writing to the Chief Executive Officer asking for consideration by the Governing Board. The Governing Board shall consider such request at its annual review of the AHP categories.

2. **Qualifications:** To be eligible for, and to maintain practice prerogatives a AHP must at a minimum, meet each of the following requirements in addition to any requirements recommended by the Medical Executive Committee and required by the Governing Board:
 - a. hold a current, unrestricted license/certificate/appropriate legal credential in a category of AHPs that the Governing Board has identified as eligible for practice prerogatives;
 - b. document his/her background, relevant training, education, experience, demonstrated current competency, judgment, character, and physical and mental health status (subject to reasonable accommodation if and to the extent required by law), with sufficient adequacy to demonstrate that patient care services will be provided by the AHP at the professional level of quality and efficiency established by the medical staff and Governing Board;
 - c. submit an application for practice prerogatives on the form prescribed by the medical staff and Governing Board, providing requested information and documentation;
 - d. provide written confirmation of the existence and extent of required supervision by a physician member of the medical staff as required by the Governing Board;
 - e. document his/her strict adherence to the ethics of the medical staff and of the AHP's respective profession; his/her ability and agreement to work cooperatively with others in the hospital setting; and his/her willingness to commit to and regularly assist the hospital in fulfilling its obligations related to patient care within the areas of the AHP's professional competence and credentials; and
 - f. maintain professional liability insurance in amounts, of a type, and with a carrier, as required by the Governing Board.
3. **Procedure for Granting Practice Prerogatives.**

- a. Each AHP must apply and qualify for practice prerogatives by submitting an application on the approved form to the IDPC. The applicable medical staff department chair shall determine the qualifications and competence of AHP who are not licensed independent practitioners providing patient care services. The IDPC will submit a recommendation to the MEC with recommendation for approval to the Governing Board. Applicant must provide all necessary information, and agree to be bound by the applicable medical staff bylaws, rules and regulations, departmental rules and regulations, and medical staff and hospital policies. Applications for initial practice prerogatives, annual supervisory evaluation and bi-annual reappraisal, thereof, shall be submitted and processed in accordance with the procedures stated in the medical staff bylaws and the applicable provisions of the medical staff and department rules and regulations. There must be verification that each AHP's required licensure/certification/registration are current and unrestricted, and documentation that each AHP has the required type and amount of professional liability insurance in full force.
- b. Each AHP who is granted practice prerogatives shall be assigned to the clinical department appropriate to the AHP's practice prerogatives and shall be assigned a supervising physician on the medical staff, if appropriate, for purposes of supervision and reporting. The degree of supervision required, whether direct or remote, shall be clearly established for each AHP.
- c. For each category of AHP it shall be determined whether or not they may make entries in the medical record and whether countersignatures are required and by whom. The signature of the supervising physician alone is sufficient for reports dictated by AHPs at the discretion of the supervising physician.
- d. Unless otherwise specified in the bylaws or departmental rules and regulations, AHPs shall be subject to terms and conditions paralleling those in the bylaws as they apply to the more limited practice of AHP's.
- e. A system for objectively evaluating the performance of each AHP on an annual basis shall be established. The findings of these evaluations shall be considered in any decision to renew "practice prerogatives."
- f. All rules and qualifications shall be applied uniformly to all AHPs in a given category.
- g. No AHP shall be entitled to exercise any practice prerogative at this facility without prior approval of the Governing Board, because the individual previously was permitted to exercise that prerogative at this or any other institution or because the individual is permitted to perform that prerogative under state law. This hospital is not required to grant all or any prerogatives permitted by law or requested by an individual.
- h. Temporary privileges may be granted under the following conditions:

Temporary clinical privileges may be granted only when the information available

- i. reasonably supports a favorable determination regarding the requesting applicant's qualifications, judgment, and ability to exercise the clinical privileges requested, and only if the Practitioner is licensed to practice in the State of California, and provides evidence of professional liability insurance with the amount, type acceptable to the Medical Executive Committee.
- ii. In exercising temporary privileges, the Practitioner shall act under the supervision of his/her supervising physician-

4. Responsibilities.

As a condition of applying for, or being granted a practice prerogative, each AHP agrees to:

- a. fulfill those responsibilities required by the medical staff bylaws, rules and regulations, departmental rules and regulations, and applicable medical staff and hospital policies;
 - b. retain appropriate responsibility within the AHP's area of professional competence and within the scope of practice prerogatives granted, for the care of hospital patients;
 - c. participate, as appropriate, in quality/performance review including but not limited to Partnership for Change evaluations, and monitoring activities required of AHPs, in supervising initial appointees of the AHP's same profession, and in discharging such other functions as may be required from time to time;
 - d. serve on medical staff, departmental and hospital committees to which the AHP is assigned;
 - e. attend the meetings of the department to which the AHP is assigned, as permitted by departmental rules and regulations;
 - f. attend educational programs in the AHP's field of practice as may be required by the hospital, by licensure, certification, registration, or the supervising practitioner;
 - g. comply with the terms and conditions of the granting of practice prerogatives and all policies, procedures and protocols that may be implemented from time to time by the department, medical staff or hospital; and
 - h. Maintain the confidentiality of all peer review related matters and waive any right under state law to voluntarily disclose such matters.
5. Termination of Practice Prerogatives.

An AHP's practice prerogatives shall terminate automatically at the sole discretion of the Chief Executive Officer, Chief of Staff or chairman of the department upon the occurrence of any of the following:

- a. suspension, restriction, termination, voluntary relinquishment, or the imposition of terms of probation (whether voluntary or involuntary) on the medical staff membership or privileges of any supervising practitioner;
 - b. termination of the supervisory/sponsoring relationship between the AHP and the supervising practitioner;
 - c. suspension, revocation, expiration, voluntary or involuntary relinquishment or restriction, termination, or imposition of terms of probation by the applicable licensing or certifying agency of the AHP's license, certificate or other legal credential which authorizes the AHP to provide health care services;
 - d. failure of the AHP to perform properly assigned duties including but not limited to medical record completion;
 - e. conduct by the AHP which interferes with or is detrimental to the provision of quality patient care;
 - f. failure of the AHP to maintain professional liability insurance as required;
 - g. failure of the supervising physician to maintain professional liability insurance as required;
 - h. failure of any supervising practitioner to maintain active staff membership and clinical privileges in good standing;
6. SCOPE OF SERVICES

Only those patient care services specifically requested in the application may be granted. Clinical activities in any field other than those specifically authorized are expressly prohibited.

8. ADULT CRITICAL CARE UNITS

An Allied Health Practitioner can not do the initial assessment of the patient – history and physical or consultation. The attending physician needs to write a separate, independent progress note on the patient every day. AHPs may write progress notes in the chart to document their participation in the patient's care. The AHP can not write orders in the adult critical care units. They may take and write a verbal order from the attending physician. They may perform procedures in the Adult Critical Care Units in accordance with their Standardized Procedures.

9. MEDICAL SUPERVISION

Dependent practitioners must be under the direction of a member of the Medical Staff of Desert Regional Medical Center who possesses clinical privileges in the area in which the dependent practitioner will practice. The Medical Staff member shall have the ultimate responsibility for the patient. Any patient care services granted under this, and like policies, are contingent upon the continued Medical Staff membership of the sponsoring physician. Furthermore, it is the responsibility of both the dependent practitioner and the sponsoring physician to notify the Hospital, in writing, of any changes in physician sponsorship which may occur at any time during the dependent practitioner's tenure at Desert Regional Medical Center. All dependent practitioners providing patient care services at Desert Regional Medical Center shall, at all times, wear a distinctive name badge identifying the individuals as an Allied Health Practitioner. Desert Regional medical Center will supply said name badge to the dependent practitioner. Failure to notify Medical Staff Services of changes in sponsorship will constitute grounds for termination of the AHP's access to Desert Regional Medical Center.

Dependent practitioner delineated privileges shall be limited to the standards, procedures, and freedom to act authorized by the Desert Regional Medical Center delineated privileges for similar licensed or certified classifications. All dependent practitioner notations regarding the care rendered or observations made in the patient's chart will be made in the progress notes, and countersigned by the supervising physician daily (except where otherwise required by California Medical Board). All telephone orders must be received by Hospital employees only. Dependent practitioners are not authorized to give telephone orders.

10. MONITORING/REAPPRAISAL

Independent practitioners with clinical privileges will be monitored on the full scope of privileges granted. Policies and procedures shall identify the time frame and number of cases required to complete proctoring.

Re-appraisal will be conducted every two years. The reappraisal must include peer recommendations. Evaluations will be conducted by the supervising physician on an annual basis.

11. APPEAL PROCESS

- a. Except for those practitioners reportable to their professional board pursuant to Business and Professions Code 805, allied health professionals are not entitled to the procedural rights set forth in the Medical Staff Bylaws. However, an AHP shall have the following rights to a review and appeal of any actions that would constitute grounds for a hearing or fair review under the Medical Staff Bylaws if such action were to be taken against a member of the Medical Staff.
- b. The AHP shall be notified in writing of the adverse action and the reasons for the action. The AHP shall have fifteen days (15) following receipt of the notification to file a written request for review of the action. Upon receipt of the written request, the Medical Executive Committee or a committee duly appointed by either the Medical Executive Committee or President as the designee of the Medical Executive Committee shall review the basis for the adverse action. As part of the committee's review, the AHP shall be invited to attend a meeting with the committee. At the interview, the committee and AHP shall review the adverse action and present information and documents. The AHP shall respond to questions. The review process, including the

interview, shall be conducted as a peer review meeting in accordance with such procedures as the committee deems appropriate. The interview shall not constitute a "hearing" or "fair review" as defined in the Bylaws. Minutes shall be prepared to record the discussion and the evidence presented during the interview.

- c. Following the review, based upon the interview and all other information available to it, the Medical Executive Committee shall determine whether the adverse action should be upheld, terminated or modified. The AHP shall be notified in writing of the outcome by the President or designee.
- d. If the AHP is dissatisfied with the outcome of the review, the AHP may request that the Governing Board review the decision by submitting a request for review within thirty days (30) of receipt of notice of the outcome. The request shall specify the basis for the appeal, including any and all information and evidence in support of the allied health practitioner's appeal. Following review of the written request, the Governing Board will have the discretion to either (i) decline further review and to make a decision based upon the information provided in the written request and other information available to Governing Board, or (ii) to further review the Medical Executive Committee's recommendation in accordance with such procedures as the Governing Board deems appropriate. The Governing Board shall notify the AHP in writing of the Governing Board's decision.

C. CONSENT FOR MEDICAL AND SURGICAL PROCEDURES

1. GENERAL CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the hospital must be obtained as the patient is admitted. The Admitting Department should notify the attending physician whenever such consent has not been obtained.

2. INFORMED CONSENT

See Administrative Policy and Procedure: Informed Consent P-029

3. EMERGENCY SITUATIONS

In the case of an emergency where delay would result in immediate danger to the life and health of the patient, and where it is impossible to obtain the consent of the patient or his/her legal representative, two physicians (whenever possible) may certify in the medical record that such an emergency exists and procedures to correct, treat, or diagnosis the emergency condition only may be performed without said consent.

D. CONSULTATIONS

1. RESPONSIBILITY FOR CONSULTATION

The good conduct of medical practice includes the proper and timely use of consultations. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment rests with the physician responsible for the care of the patient. On the other hand, it is the duty of the organized Medical Staff, through its Department Chairs and the Medical Executive Committee to see that those with clinical privileges do not fail in the matter of calling consults as needed.

The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant. Except in an emergency, he will provide written or verbal authorization to permit another practitioner to attend or examine his/her patient. If consultation is requested in less than 24 hour, then it is the responsibility of the requesting practitioner to contact the consulting practitioner personally.

2. QUALIFICATIONS OF CONSULTANT

Any practitioner with clinical privileges in this hospital may be called for consultation within his/her area of expertise.

3. CONSULTATION TIME FRAMES

Consultation shall be done within twenty four (24) hours of notification. If consultation cannot be done in that time frame and it is required, another consultant should be requested. The requesting practitioner shall document a written order for the consultation on the order sheet in the patient record. When requesting a consultation, it is the responsibility of the requesting physician to document the request for consultation and supply the consultant with pertinent information concerning the patient and the reason for the consultation.

4. REPORT OF CONSULTANT

Consultations shall show evidence of a review of the patient's record and pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made part of the patient's record and should be written or dictated within 24 hours following the consultation. A limited statement such as, "I concur" does not constitute an acceptable report of consultation. Except in an extreme emergency, preoperative consultation shall be recorded prior to the operation.

5. CONSULTATION REQUIREMENTS

Consultation is required in the following situations:

- a. In situations where specific skills of other practitioners may be needed;
- b. When the Chair of the clinical department or the President of the Medical Staff (or designee) determines the patient will benefit from consultation.
- c. SUICIDE ATTEMPT - All patients with a suicide attempt, or an injury resulting from an intentional self-destructive act, shall have a psychiatric consultation (if there is a psychiatrist available) or mental health evaluation by social services before discharge or other disposition.
- d. OBSTETRICAL PATIENTS - To ensure the optimum care of an Obstetrical patient of twenty (20) weeks gestation or greater who is not admitted to the Perinatal Department, a consult with a primary Obstetrical physician is required.
- e. Other medical conditions as determined in writing by a clinical department and approved by the Medical Executive Committee.

6. INABILITY TO OBTAIN CONSULTATION

If a practitioner is unable to obtain consultation for a patient in a clinical setting that the practitioner believes requires consultation, the practitioner shall contact the Chair of the Clinical department (or designee) in which the consultation is being sought. It shall be the responsibility of the Chair of the affected Department to insure that the appropriate care is rendered to the patient. This responsibility may be met by:

- a. Arranging suitable consultation;
- b. Recommending transfer of the service of the practitioner who is able to arrange the appropriate consultation; or
- c. Recommending transfer of the patient to another institution able to provide the needed services.

7. PATIENT REQUEST FOR CONSULTATION

In recognition of the rights of the patient, any request for consultation made by the patient shall be given due consideration.

E. CRITICAL CARE PATIENT MANAGEMENT

1. The Critical care Providers will be staffed by physicians who possess the following qualifications:
 - a. Trained and Board Certified in primary specialty. Successfully completed an accredited program (by ACGME) in Critical Care Medicine OR have all of the following equivalent qualifications.
 - b. Appropriate current experience in the practice of Critical Care Medicine with an accredited training in Pulmonary Medicine, Cardiology, Anesthesia, or General Surgery.c. Current ACLS or ATLS certification.
 - d. Current privileges to perform the following procedures: airway management with endotracheal intubation, mechanical ventilation, central venous catheters, pulmonary arterial catheters, arterial catheters, temporary transvenous pacing wire, manage and place tracheostomy tubes and perform bronchoscopies.
 - e. Current experience and ability to manage common critical care conditions including but not limited to: Hemodynamic instability, respiratory failure, acute neurological insults, acute renal failure, acute life threatening endocrine or metabolic derangements, drug overdoses, serious infections, and nutritional failure requiring nutritional support.
 - f. Occasionally, other qualified consultants may be called to help manage those conditions.

F. DEATHS

1. PRONOUNCEMENTS

In the event of a hospital death, the deceased shall, within one hour be pronounced dead by the attending practitioner or his/her designee. A registered nurse is authorized to pronounce death of designated "Do Not Resuscitate" (DNR) patients, upon written order of the attending practitioner, except if the patient is a designated major organ donor. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a practitioner member of the Medical Staff or his/her designee. A death summary shall be written or dictated for all patients who expire.

2. AUTOPSIES

No autopsy shall be performed without proper written consent in accordance with State law. Most autopsies, except coroner cases, shall be performed by outside contract agency. The medical staff and specifically the attending practitioner shall be notified when an autopsy is being performed. Autopsies should be considered but need not be limited to the following circumstances:

- Deaths within 48 hours of a surgical, invasive, or high risk treatment or procedure, including radiology procedures;
- Death associated with an adverse patient occurrence while under treatment;
- All deaths when the diagnosis would not be expected to result in death;
- Death occurring while patient is being treated under an experimental regimen;
- Death related to pregnancy, or within 7 days following delivery;
- Death in infants and children with congenital malformations;

Limited autopsies in appropriate circumstances (for example, thorax only in cases of suspected myocardial infarction or lung tumor.)

The autopsy report shall be distributed to the attending physician and become a part of the patient's record. The autopsy findings of clinically relevant cases shall be analyzed and evaluated for possible educational opportunities by the Quality Council Committee and Peer Review Committee.

3. NOTIFICATION OF NEXT OF KIN

The physician will inform the family unless special circumstances exist and the physician requests the nurse to do so. The nursing unit will inform the Admitting Department, the Nursing Office, and the mortuary selected by family.

G. DISASTER ASSIGNMENTS

1. There shall be a plan for the care of mass casualties at the time of major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. The plan shall be developed by a disaster planning committee which includes members of the Medical Staff and the Chief Executive Officer or his/her designee.
2. All physicians without a specific assignment will report to the emergency Operations Center located in the Doctor's Dining Room. The President of the Medical Staff or designee and Chief Executive Officer or designee of the hospital will work as a team to coordinate activities and directions. In cases of evacuation from hospital premises, the President of the Medical Staff or his/her designee will, during the disaster, authorize the movement of patients.
3. The disaster plan shall be rehearsed at the hospital as part of a coordinated drill in which other community emergency service agencies must participate. The drills, which should be realistic, involves the Medical Staff, as well as administrative, nursing, and other hospital personnel.

H. DISCHARGE OF PATIENTS

Patients shall be discharged only on written order of the attending practitioner or verbal order which is later countersigned. The attending practitioner shall see that the record is complete, state the final diagnosis, and sign the record.

1. INSTRUCTIONS ON DISCHARGE

Appropriate instructions for care are given to the patient and/or the family using current hospital format, and a copy is retained in the medical record.

a. SKILLED NURSING FACILITY (SNF) - DISCHARGE/TRANSFER

Discharge summary for all SNF - patients must include:

- i. Diagnosis
- ii. Resident rehab potential
- iii. Recapitulation of resident stay and prior treatment
- iv. Physician orders for immediate care of resident
- v. Post discharge plan of care developed with participation of resident and/or family which will assist the resident to adjust to his/her new living environment.

This must be completed at time of discharge or as soon as possible thereafter so it will be available for release to authorized person/agency with consent of resident/legal representative.

2. DISCHARGE/FINAL DIAGNOSIS

The discharge or final diagnoses, procedures, and complications must be recorded in the progress notes immediately upon discharge. All relevant diagnoses established at the time of discharge, as well as all procedures performed are recorded using acceptable disease and operation terminology that includes topography and etiology as appropriate. If the patient is discharged with a telephone order, the nurse may document the discharge diagnosis on the order sheet.

3. DISCHARGE AGAINST MEDICAL ADVICE (AMA)

Patients, who leave the hospital against the medical advice of the attending practitioner, or without proper discharge, shall sign a release of responsibility provided by the hospital. This release shall become part of the patient's hospital record. If the patient refuses to sign, the unsigned form shall be made a part of the medical record with a notation as to the patient's refusal to sign.

4. PATIENTS WITH ACTIVE TUBERCULOSIS

Any person known or suspected to have active tuberculosis shall not be discharged or transferred until a treatment plan is submitted to and approved by the local health officer. [AB 803]

I. DUES AND APPLICATION FEES

1. APPLICATION FEES

All Medical Staff applications and applications for AHP will be charged a processing fee. This fee shall be determined by the Medical Executive Committee on an annual basis. These fees are not refundable.

2. STAFF DUES

Covered under Medical Staff Bylaws Section 14.2.

J. EMERGENCY DEPARTMENT

1. DESCRIPTION

The hospital operates a 24-hour Emergency/Trauma facility. It is staffed continuously by emergency physicians.

2. PHYSICIAN CALL ROTATION

An Emergency Department call panel has been established for the purpose of assuring specialty coverage for emergency and trauma patients and referring emergency patients who have no private physician to members of the Medical Staff for treatment beyond that which can be provided by the emergency physician. On call lists shall be established and maintained at the direction of the Medical Executive Committee. The Chair of each Department shall be responsible for the development of an equitable call schedule for each specialty area in accordance with the guidelines established by the department and as noted in the Medical Staff Bylaws.

All active and provisional members who have completed proctoring may serve on the Emergency Department Call Roster. Courtesy members may serve when a need has been demonstrated.

3. GUIDELINES

Each department shall establish written guidelines for each specialty call schedule which shall outline the category of membership from which the schedule is developed, criteria for the rotation to be used (e.g. daily/weekly/monthly), how members are to be listed (alphabetically or otherwise), whether or not exceptions are acceptable and how they are to be determined, and to whom the responsibility of developing and distributing each call schedule is designated. When scheduled on call, each practitioner

shall accept the care of all patients who are appropriately referred without discrimination on the basis of the patient's race, creed, sex, age, national origin, ethnicity, citizenship, religion pre-existing medical condition (except to the extent it is pertinent to medical care), physical or mental handicap, insurance status, economic status, or ability to pay. Each practitioner shall accept requests for consultations for inpatients or Emergency Department patients when scheduled on call for Emergency Department.

4. EXCHANGE OF COVERAGE

A practitioner who is unable to provide panel coverage during his/her scheduled time (including when he or she is detained due to another medical commitment) is responsible for arranging coverage by a practitioner of the same specialty and meets the criteria for serving on the call roster. Any exchanges of coverage date with other practitioners shall be communicated in writing to the Medical Staff Services Department. They will record the changes on the call list and notify the Emergency Department of the same. Any difficulty with practitioners not taking coverage assigned will be communicated to the appropriate Department Chair, who in turn refers initially to the practitioner's Alternate Coverage List for a substitute practitioner. If practitioners on the Alternate Coverage list cannot take the call, the Department Chair will assign another practitioner.

5. RESPONSE TO REQUESTS FROM EMERGENCY PHYSICIANS

On call practitioners shall respond to all requests from the emergency physician and shall be available to appear within 45 minutes from the initial page or telephone call, unless otherwise agreed to with the requesting emergency physician. Any such agreement regarding alternative arrival time of the on call practitioner shall be appropriately documented by the emergency physician in the subject patient's medical record. Each practitioner must let the Emergency Department know how to reach him or her immediately and remain close enough to the Hospital to be able to arrive within the required time frame.

6. UNASSIGNED PATIENT

If an unassigned patient returns to the Emergency Department within 30 days of a hospital discharge and requires admission or inpatient follow-up, for complications secondary to a non-diagnostic, interventional procedure within the purview of the physician who previously managed the patient, then that physician shall manage the patient. Patients not described above shall be assigned to the on-call physician. for a medical reason within the purview of the physician who previously managed the patient, then that physician shall manage the patient. After 30 days, the on-call-covering physician shall manage the patient.

K. GENERAL CONDUCT

1. COVERAGE

a. Medical Coverage

In the case of an emergency, when the physician in charge is not available, the Chief of Staff, the Chair of the appropriate Department, or their designee shall assign a qualified member of the Medical Staff to assume care of the patient until the patient's physician is available.

b. Administrative Coverage

Problems involving the Medical Staff should be referred to the appropriate Department Chair (or designee). If that physician is not available or not responsive, the matter is to be referred to the Chief of Staff. If the Chief of Staff is not available, other members of the Medical Executive Committee are to be contacted in the following order:

Chief of Staff-Elect-/Treasurer of the Medical Staff

Immediate Past- Chief of Staff

Other members

All members of the Medical Executive Committee are authorized to take action as appropriate.

2. HARASSMENT

It is the Policy of Desert Regional Medical Center to provide a work place and working environment free of all types of harassment by any individual, therefore any type of harassment is not permitted. Harassment by a medical staff member against any individual (e.g., against another medical staff member, house staff, hospital employee, visitor, or patient) on the basis of race, religion, color, national origin, ancestry, physical disability, mental disability, medical disability, marital status, sex or sexual orientation shall not be tolerated. "Sexual harassment" is unwelcome verbal or physical conduct of a sexual nature which may include verbal harassment (such as epithets, derogatory comments or slurs), physical harassment (such as unwelcome touching, assault, or interference with movement or work), and visual harassment (such as the display of derogatory cartoons, drawings, pictures or posters, or the inappropriate touching of oneself or other in another's presence). Sexual harassment includes unwelcome advances, requests for sexual favors, and any other verbal, visual, or physical conduct of a sexual nature when (1) submission to or rejection of his/her conduct by an individual is used as a factor in decisions affecting hiring, evaluation, retention, promotion, or other aspects of employment; or (2) his/her conduct substantially interferes with the individual's employment or creates an intimidating, hostile, or offensive work environment. Sexual harassment also includes conduct which indicates or implies that employment and/or employment benefits are conditioned upon acquiescence in sexual activities. All allegations of harassment shall be immediately investigated by the appropriate Medical Staff organization and, if confirmed, will result in appropriate corrective action, from reprimands up to and including termination of medical staff privileges or membership, if warranted by the facts.

3. MEDICAL STAFF MEETINGS - SUBMISSION OF AGENDA ITEMS

a. Submissions by Hospital Personnel

In order to ensure continuity and proper use of department/committee time, agenda items to be reviewed/approved by medical Staff departments/committees, shall first be submitted to the Medical Staff Services Department. Once approved by the Chair of the appropriate department or committee, the proposed materials shall be forwarded to the medical Staff Assistant at least seven (7) working days prior to the next regular meeting for inclusion in the agenda.

b. Submission by physicians

Physicians wishing to submit agenda items shall present them to the Medical Staff Services Department for inclusion in the agenda of the particular committee seven (7) working days prior to the committee meeting in question. Items should be approved for inclusion in the agenda by the department/committee Chair.

c. Submission for General Medical Staff meetings

Agenda items for General Staff meetings shall be submitted to the President of the Medical Staff at least fourteen (14) days prior to the scheduled meeting.

d. The department or committee chair will make the final decision regarding additions or deletions to the agenda.

L. MEDICATION ORDERS

1. AUTHORITY

The Pharmacy and Therapeutics Committee has the primary responsibility for the functions, policies and activities of the Pharmacy Department in the Hospital as related to the Medical Staff. The Committee reviews, at least annually, all of the policies in their fully detailed form and is responsible to the Medical

Executive Committee. Other Medical Staff committees may approve specific items within their area of responsibility or specialty with the Pharmacy and Therapeutics Committee completing the final review.

2. EXPERIMENTAL/INVESTIGATIONAL DRUGS

Experimental/Investigational Drugs must be approved in advance by the Institutional Review Board Committee and be in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and all regulations of the Federal Drug Administration and any agency responsible for the investigation, such as the National Cancer Institute and the Drug Enforcement Administration.

3. FORMULARY STANDARDS

The hospital formulary systems is a method whereby the Pharmacy Department and the Hospital Medical Staff, working through the Pharmacy and Therapeutics Committee evaluates, selects, and approves from the available medicinal agents and dosage forms, those that are considered the most therapeutically appropriate, effective, and safe (with cost containment one of the considered factors).

4. GENERIC SUBSTITUTIONS

- a. The Pharmacy and Therapeutics Committee will establish a list of non-proprietary substitutions of medications ordered by the proprietary name. The addition of any drug to the list must be approved by this Committee. The pharmacy will review the manufacturer, availability, cost, and bioavailability, where available.
- b. Any drug which is approved for addition to the list may be substituted for a drug which has been ordered by trade (proprietary) name, provided that:
 - i. It is chemically equivalent to the trade name drug;
 - ii. It does not differ significantly in clinical effect from the trade name drug (both in efficacy and bioavailability);
 - iii. The physician issuing the original drug may or may not choose to use a generic drug.
- c. Substitution, according to the approved list, will be at the discretion of the Pharmacy Department which will be obligated to inform the nursing staff of any substitutions made in order to maintain clear communications and prevent medication errors.

5. .AUTOMATIC STOP ORDERS

- a. All medication orders are discontinued when the patient goes to surgery and must be reordered post-operatively;

Medication orders are discontinued when the patient has a change in the level of care;

Transfers into or out of ICU, or patients undergoing surgery;
- b. All Schedule II medications will be discontinued after seven (7) days if not specifically reordered;

6. ADVERSE DRUG REACTIONS/MEDICATION ERRORS

Medication errors and adverse drug reactions shall be reported immediately to the attending practitioner and/or prescribing practitioner. An entry of the medication administered, the time, and the dosage is to be documented on the appropriate medication record. A standard protocol will be followed by the Pharmacy Department. Adverse drug reactions are tracked on an on-going basis and reviewed as part of the Medical Staff Quality Improvement Program.

7. MEDICATION BROUGHT IN BY PATIENT

Patients are not allowed to take their own medication while a patient at Desert Regional Medical Center unless: (1) The Pharmacy does not normally stock the item and the time to obtain it would cause a therapeutic delay, or the item is expensive and the patient recently acquired the medication. Refer to Administrative Policy & Procedure: Patient's Own Medication.

8. ROUTE OF ADMINISTRATION

The route of administration must be clearly specified or it cannot be processed and dispensed by pharmacy

9. MEDICAL SCREENING EXAMINATIONS

Practitioners who have received special training may perform Medical Screening Examinations as described in federal/state transfer legislation, including the Emergency Medical Treatment and Active Labor Act ("EMTALA"). The Department Chair or designee will monitor the competency and performance of those practitioners who have been delegated this function.

M. ORDERS

1. ORDER WRITING

All practitioners' orders shall be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until re-written or understood by the nurse. The sole use of "renew", "continue order", and similar terms are not acceptable.

- a. SKILLED NURSING FACILITY (SNF) - Documentation in medical record of physician signed certification for continued stay every seven (7) days and upon discharge from acute care.

2. TELEPHONE ORDERS

A verbal order will be considered to be in writing if dictated to a registered nurse, pharmacist, respiratory therapist, medical technologist, physical therapist, registered dietitian, physician's assistant or a licensed vocational nurse functioning within his/her sphere of competence. All telephone orders must be received by Hospital employees only. All orders dictated over the telephone shall be signed, timed, and dated by the appropriately authorized person to whom dictated, with the name of the physician per his/her own name. The responsible practitioner shall sign, time and date all verbal orders within 48 hours. Verbal or telephone orders given in the Skilled Nursing Facility need to be signed within five (5) days.

3. OTHER VERBAL ORDERS

Direct verbal orders may be given in situations where timeliness is important or where the health care providers are physically unable to write orders. Example: A physician performing CPR (cardiopulmonary resuscitation) would meet both criteria. A physician supervising CPR would meet the first criteria. A nurse midwife or an obstetrician who is scrubbed for delivery would meet the second criteria.

N. PRIVILEGING

1. TERMINATION OR GRANTING OF MEDICAL STAFF PRIVILEGES

- a. Termination or granting of Medical Staff privileges, based solely on economic criteria unrelated to clinical qualifications or quality of care is inappropriate, with the exception of statutory, regulatory, or judicial requirements, such as professional liability insurance or other exceptions which are defined in the Medical Staff Bylaws.
- b. Medical Staff privileges should not be tied to patient payor mix or diagnosis nor should Medical Staff members disadvantage the Hospital through selective or discriminatory practices.

- c. A practitioner's character, competence, training, experience, and judgment shall be considered prior to any action being taken by the Medical Staff regarding the continuing membership or privileges of that practitioner.

O. PROCTORING

Letters of reference, evidence of training, and Board Certifications are no substitute for first-hand observation. Therefore, it is the policy of Desert Regional Medical Center that all applicants for clinical privileges shall undergo a period of proctoring. Each individual department will be responsible for developing proctoring guidelines for that specific department.

1. WRITTEN POLICIES

Proctoring shall apply to ALL Provisional medical Staff members and those members requesting additional privileges, regardless of specialty or category of membership, so long as direct patient care is involved. If practitioner has been on staff previously, Department Chair may waive proctoring.

METHODS OF PROCTORING

Proctoring includes, but is not limited to, chart review, direct observation whenever possible in the case of invasive procedures, and monitoring of diagnostic and treatment techniques.

2. QUALIFICATIONS OF PROCTOR

- a. A proctor shall have sufficient expertise to judge the quality of work being performed.
- b. It is not necessary for a proctor to have the same specialty qualifications as the individual being proctored. For example, surgical technique in a number of specialties can be adequately observed by a surgeon of another specialty.
- c. Whenever possible, a proctor shall be a member of the appropriate department.
- d. In a situation where no member of the Medical Staff is deemed qualified to proctor the work of an applicant, the Medical Staff should consult its local medical society, the most closely related society to the applicant's profession, or California Medical Association for assistance.
- e. All proctors shall be approved to proctor by the appropriate department chair.

3. RECIPROCAL OBSERVING ARRANGEMENTS

- a. The hospital may accept evidence of proctoring from a nearby Medicare approved facility to supplement actual observation on the premises.
- b. This arrangement is acceptable only if the following conditions are present:
 - i. The proctor must be a member of the Medical Staff of both Medicare approved facilities; and
 - ii. The proctor must be someone who would have been eligible to serve as a proctor at Desert Regional Medical Center; and
 - iii. The same range and level of privileges must have been requested by the applicant in both Medicare approved facilities.

P. PROFESSIONAL LIABILITY INSURANCE

1. All members of the Medical Staff shall, at all times, maintain malpractice insurance as outlined in the Medical Staff Bylaws.

2. Cancellation, lapse, reduction, or other change in the amount or scope of the practitioner's malpractice insurance may result in automatic suspension of all or part of his/her clinical privileges as outlined in the Medical Staff Bylaws.

Q. REAPPOINTMENT ASSESSMENT AND ASSIGNMENT TO STAFF CATEGORY

1. Once an application has been verified and determined to be complete, it shall be presented to the appropriate Department Chair and Section Chief if applicable. Each applicant's qualifications and experience will be evaluated by the Department Chair and Section Chief if applicable and the Credentials Chair/Committee.
2. Profiles of physicians shall be developed for each practitioner based on their clinical activity at Desert Regional Medical Center.

STAFF CATEGORIES

- i. Active Staff - requires at least 50 patient contacts every 2 years
- ii. Courtesy Staff - less than 50 patient contacts every 2 years

Patient contacts include admissions, consultations and procedures.

3. Medical Record Suspensions – any practitioner with 100 or more days of medical record suspensions in a 24-month time frame or 50 days in a 12 month time frame shall be granted a one year reappointment. Three consecutive one-year appointments will result in a reappointment fee of \$1,000.00.
4. Physicians who do not submit 50 continuing medical education (CME) hours at time of reappointment may be given an extension of 60 days at the discretion of the Credentials Committee and subsequent approval of the Medical Executive Committee. The lack of completion of required CME hours (50 CME 2 year reappointment and 25 CME 1 year reappointment) within 60 days will be considered a voluntary resignation from staff. If an extension is not approved, the physician will be considered a voluntary resignation from the Medical Staff.

R. RESTRAINT AND SECLUSION

See the Administrative Policy and Procedure: Restrain Guidelines P-088.

S. SURGERY

1. GENERAL REQUIREMENTS

- a. A copy of the clinical privileges of practitioners with surgical privileges shall be kept in the Operating Suite. The original privileges are maintained by the Medical Staff Services Department and an additional copy is maintained by the Nursing Office. Privileges can also be viewed on line at eDRPrivileging.
- b. Operative Procedures that require an assistant surgeon are outlined in the Department of Surgery Rules and regulations and are on file in the Operating Suite.
- c. Prior to commencing surgery, the person responsible for administering anesthesia, or the surgeon, if a general anesthesia is not administered, shall verify the patient's identity and ascertain that the history and physical, appropriate screening tests, and informed consent appear in the patient's medical record.
- d. Mark the operative site – mark at or near the incision site, the mark is to be the word "yes" and it must be positioned to be visible after the patient is prepped and draped. The method of marking should be consistent throughout the organization. The person performing the procedure is to mark the site marking. The marking must take place with the patient or significant other involved, awake and aware, if possible.

- e. Conduct a time out immediately before starting the procedure. Conduct in the location where the procedure will be done, just before starting the procedure. The entire operative team must be involved and include the correct patient ID, correct side and site, agreement on the procedure, correct patient position, and availability of correct implants, special equipment, etc. ,

2. HOSPITAL WIDE GUIDELINES FOR ANESTHESIA USE

General Anesthesia is administered only in areas of the hospital meeting the approved standards of the Section of Anesthesia. Local anesthetic agents may be administered throughout the hospital. Epidural anesthetic agents may be administered in areas of the hospital where the nursing staff has been instructed in the use, monitoring and intervention of complications associated with this mode of anesthesia. Sedating agents, paralyzing agents, or anesthetic agents that alter the patient's level of consciousness may be administered in areas of the hospital where patients can be monitored.

The Quality Management Committee of the Anesthesia Section shall be responsible for review and evaluation of the quality and appropriateness of hospital wide anesthesia care.

3. SPECIMENS

- a. All tissue removed shall be submitted to the Department of Pathology for the appropriate examination deemed necessary by the operating surgeon and/or pathologist.
- b. Each surgically removed specimen should be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnosis.
- c. Every specimen that is sent to pathology is examined by the hospital pathologist who shall make such examination, as he may consider necessary to arrive at a tissue diagnosis. The pathologist's authenticated report shall be part of the patient's medical record.
- d. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include:
 - i. Therapeutic radioactive sources, the removal of which is guided by radiation safety monitoring requirements;
 - ii. Foreign bodies (e.g. bullets) that, for legal reason, are given directly into the chain of custody to law enforcement representatives;
 - iii. The foreskin from the circumcision of a newborn infant;
 - iv. Placentas that are grossly normal and have been removed in the course of non-operative obstetrics;
 - v. Human lens fragments.

T. TRANSFER

1. All transfers shall be carried out in accordance with the Hospital policy on transfers.
 - a. The emergency physician or appropriate on-call physician must personally examine the patient prior to transfer, and find that the patient is stable. Patients who are not stable may be transferred only if the practitioner finds, within reasonable medical certainty, that expected medical benefits of the transfer outweigh the risks posed by the transfer. If the patient or his/her surrogate decision-maker insists upon transfer after the practitioner has explained the medical risks the benefits of transfer, then the patient must be signed out against medical advisement.

- b. In addition: (1) the receiving facility must consent to transfer, (2) staff and equipment necessary for a safe transfer must be arranged, (3) copies of pertinent medical records must be provided. And (4) the "Transfer Summary form" must be completed, and a copy sent with the patient.
2. Indigent or non-insured patients will be transferred to a more suitable facility whenever possible, provided the patient is medically fit for transfer. Practitioners will be required to see such patients only if the patient is not medically fit for transfer or cannot be transferred for other reasons.

U. UTILIZATION REVIEW PLAN, QUALITY ASSESSMENT AND IMPROVEMENT PLAN AND INFECTION CONTROL PROGRAM

The Utilization Review Plan, Performance Improvement Plan, and the Infection Control Program are all hospital wide plans that have been approved by the Medical Staff of Desert Regional Medical Center and are on file in the Medical Staff Services Department.

V. HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE COMPLIANCE

1. **Commitment to Privacy Rule Compliance.** The use and disclosure of health information is governed, in part, by the Standards for Privacy of Individually Identifiable Health Information adopted by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1966, as it may be amended from time to time (the "Privacy Rule"). Medical Staff members and allied health providers authorized to provide services at the hospital shall protect the privacy of patients' health information as required by the Privacy Rule, other applicable law and the hospital's privacy policies and procedures. Further, the Medical Staff and allied health providers are committed to protecting the privacy of patient health information in a manner that reasonably minimizes disruption to quality patient care.
2. **Organized Health Care Arrangement.** The Privacy Rule permits multiple health care providers that are Covered Entities (as defined in the Privacy Rule) and provide health care in a clinically integrated care setting, such as the hospital setting, to declare themselves an "organized health care arrangement." Organized health care arrangement status generally permits its health care provider participants to use and disclose health information for purposes of treatment, payment and health care operations activities of the arrangement to facilitate the appropriate sharing of health information in the hospital between and among the hospital, its workforce members and business associates. Medical Staff members and allied health providers authorized to provide services at the hospital (the "Hospital OHCA").
3. **Agreement to Participate in OHCA.** By applying for and exercising clinical privileges at the hospital, each Medical Staff member and allied health provider with service authorization agrees to participate in the hospital OHCA.
4. **Joint Notice of Privacy Practice**
 - a. **Agreement to Comply with Terms of Joint Notice.** The Privacy Rule requires a direct treatment provider that is a Covered Entity to deliver a notice of privacy practices to a patient no later than the provider's first date of service to the patient. Health care providers that participate in an organized health care arrangement may comply with this requirement by a joint notice. The implementation of a joint notice streamlines compliance with the Privacy Rule.
 - b. Accordingly, with respect to Protected Health Information (as defined in the Privacy Rule) created or received by a Medical Staff member or an allied health provider in connection with his or her provision of services in the Hospital, the Medical Staff member or allied health provider agrees to abide by the terms of the joint Notice of Privacy Practices of the Hospital OHCA then in effect unless the Medical Staff member or allied health provider has delivered a written notice to the Hospital specifying that he/she has opted out of the joint Notice of Privacy Practice. If a Medical Staff member or allied health provider opts out, he/she shall reference the Hospital OHCA in their individual Notice or Privacy Practices.

- c. Revisions to Joint Notice. The Hospital may revise the Hospital OHCA's joint Notice of Privacy Practices. In its reasonable discretion, upon thirty days notice of a revision (with a copy of the revised joint notice) to the Executive Committee. (unless the compliance date of a law necessitates a shorter notice period). If the Executive Committee does not object to the revised joint Notice of Privacy Practices before the expiration of the notice period, it shall become effective and binding upon Medical Staff members and allied health providers with service authorization upon expiration of the notice period.
5. Corrective Action. Whenever a Medical Staff member or allied health provider with service authorization uses or discloses health information in a manner inconsistent with the Privacy Rule, other applicable law, the Hospital's privacy policies and procedures or the Hospital OHCA's joint Notice of Privacy Practices, such use or disclosure will be deemed disruptive to the operations of the Hospital and contrary to these (Rules & Regulations) and Hospital policies. If the Executive Committee determines that such an inconsistent use or disclosure has occurred, it may undertake such corrective action as it deems appropriate in accordance with these (Rules & Regulations).

ADOPTED by the Medical Staff of Desert Regional Medical Center

Date: September 5, 2011

/s/ Narasimha Rao, M.D.
Chief of Staff

APPROVED by the Governing Board on

Date: September 15, 2011

/s/Frank R. Ercoli, M.D.
Chair, Governing Board