ALASKA
PSYCHIATRIC
INSTITUTE

# MEDICAL STAFF
# RULES & REGULATIONS

EFFECTIVE JANUARY 2026

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For the purpose of this document, the term “Medical Staff” shall be defined as all members of the Medical Staff, inclusive of Psychiatrists, Non-Psychiatric Physicians, Advanced Nurse Practitioners, and Advanced Practice Professionals (Physician Assistants). The Medical Staff Rules and Regulations shall apply to all members of the Medical Staff. Further clarification for the types of Medical Staff is defined in the Bylaws.

I. Employment Rules and Regulations

A. Orientation

Upon hiring or contracting by the State of Alaska and appointment to the Medical Staff, each Medical Staff member shall be provided with an orientation according to facility policy and procedure (HR-040- 05.01).

Additional orientation specific to Medical Staff or department specific functions will be provided by the State computer-based learning system or by printed materials. All members of the Medical Staff are expected to become familiar with any and all materials provided for orientation as well as demonstrate competency with the topics within the first 30 days of employment or contract assignment.

Separate orientation and competency assessment is performed for utilization of the Electronic Health Record (EHR). This is part of, but performed separately from, other Medical Staff orientation proceedings.

B. Outside Employment

Pursuant to The Alaska Executive Branch Ethics Act:

No public employee may work for (paid or unpaid) a person or organization other than the employee’s own department, if that work is incompatible or in conflict with the proper discharge of official duties. A public employee must report outside employment or service to the designated ethics supervisor of the DHSS Commissioner’s (DHSS Commissioner’s Office) supervisor. Changes in outside employment or services should be reported as they occur

If a Medical Staff member wishes to practice or work outside of his or her state employment, he or she shall discuss the outside employment with the Medical Director. Such employment shall be noted annually on the “Ethics Disclosure Form (State form 03-202)” The Ethics Disclosure Form is to be resubmitted by July 1st of each year as applicable. Failure to disclose outside employment may result in disciplinary action.

At no time is a Medical Staff member allowed to be working offsite of Alaska Psychiatric Institute (API) for another employer (paid or unpaid) during assigned API work hours. Medical Staff members are not allowed to be "on the clock" or On-Call for an outside employer during API assigned duty hours. If there is a conflict of work hours, it is the responsibility of the Medical Staff member to notify the Medical Director of such and develop an Alternative Work Week (AWW) agreement. It is expected that the assigned work hours for API will take precedent over outside commitments. Failure to disclose additional employment or continuing to work offsite of API during expected work hours without an Alternative Work Week agreement may result in disciplinary action and possible termination of privileges at API.

***Note:*** *Pursuant to the Provider Agreement between the State of Alaska and the Locum Tenens agency, no locum tenens LP shall take additional compensated or uncompensated work during the period of work assignment without written permission of the API Medical Director.*

COMPENSATION BY PHARMACEUTICAL COMPANIES

API does not encourage the participation of employed or contracted Medical Staff as compensated speakers for the endorsement of a specific pharmaceutical product. At no time is a Medical Staff member (employed or contracted) allowed to participate as a voluntary or compensated speaker for pharmaceutical products during scheduled work hours. If anyone on the Medical Staff do participate as a voluntary or compensated speaker for a pharmaceutical product, the details of this relationship need to be communicated to the Medical Director and the ethics supervisor of the DFCS Commissioner's office, in writing

C. Hours of Duty

Duty hours for the facility's Medical Staff are from 0800 to 1600 hours, five (5) days per week.

An Alternative Work Week may be considered if the alternative hours meet the needs of the facility. The following are specific AWW developed for psychiatric medical staff LPs. An AWW for psychiatric Attending LPs consists of four (4) days per week, three days of 10.5 hours with 30 minutes for lunch, one day of 8 hours with 30 minutes for lunch, on the fifth workweek day the patients of the LP that is off are covered by LP's that are participating in the AWW that are working that day. On Saturday and Sunday and on holidays, API medical staff duties are covered by at least one on call psychiatric medical staff LPs and one medical staff

Medical Officer. A doctor of medicine or osteopathy is on duty or on call at all times.

Additional Alternative Work Weeks for non-exempt (bargaining unit) employees are contingent upon approval by the bargaining unit representatives and the API Medical Director.

Medical Staff positions are overtime ineligible, however hours beyond routine may be necessary to cover court hearings or other patient care duties. Medical Staff are expected to be available by API cell phone for the entirety of the work shift regardless of location.

***Note:*** *Pursuant to the Provider Agreement between the State of Alaska and the locum tenens Agencies, locum tenens assigned physicians are not eligible for alternative work week hours.*

FLEXIBLE WORK HOURS AND HOLIDAY DUTY HOURS

Flexible work hours may be negotiated with the Medical Director to meet the needs of a unit. Weekends and Holidays are assigned to Medical Staff within the on-call pool on a volunteer basis, if there is inadequate coverage, weekend and holiday call will be assigned to contracted/locum tenens providers, if inadequate coverage still persists, weekend and holiday coverage will be assigned by the Medical Director in a systematic and fair manner utilizing a revolving list of providers based on last time provider took call.

D. Cell Phones and Social Media

API issues cell phones for on call and unit coverage duties to all members of API medical staff. Cell phones issued by the State of Alaska are not to be used for personal, non-work-related communications. Texting patient identifiable information is prohibited. API medical staff members have the option of using their personal cell phone for work communications but must authorize and comply with state regulations regarding the use of personal cell phones for state work.

API Medical Staff are responsible for the upkeep of issued cell phones and should immediately report any problems to the Medical Staff Coordinator. API staff are expected to maintain vigilance for missed calls or diversions to voicemail when on duty or on call.

API Medical Staff should not advertise nor utilize their employed position for self-gain through social media. Medical staff members are expected to practice professional judgment and decorum when using social media for non-work-related communications. Employed medical staff members are ambassadors of the State of Alaska and may be held accountable for negative social commentary. The use of social media in a disruptive or negative manner towards an individual (patient, co-worker, supervisor, etc.), group (API leadership,.), or setting (DFCS, API, etc.) manner may result in disciplinary action as per State of Alaska Personnel Regulation.

E. Personal Leave

For details regarding personal leave, the Medical Staff member is referred to personnel policies for the State of Alaska. Elective personal (annual) leave must be integrated with the needs of the facility and other Medical Staff members and should be planned at least 4 weeks in advance. This future planning allows coverage to be scheduled and on-call duties to be covered (via locum tenens physicians or other staff coverage arrangements).

Members of the Medical Staff who intend to utilize personal leave with less than 4-weeks' notice shall be responsible for ensuring that their patients are covered during their absence. Likewise, if elective personal leave is scheduled less than 4 weeks in advance the Medical Staff member is responsible for finding coverage for their assigned on-call days.

Regardless of the period of notice of request for elective personal leave, the Medical Director and Medical Staff Coordinator will work with the provider intending to take leave, in an effort to find coverage solutions to enable the provider to take the leave they are requesting.

For brief absences (sick leave, unplanned/emergent leave), the Medical Staff member shall arrange coverage to the extent possible and notify the Medical Director and the Nursing Shift Supervisor (NSS) office, Communications Center and his or her treatment team. If the Medical Staff member is not able to arrange for coverage of their duties, they will inform the Medical Staff Office personnel as soon as possible.

***Note:*** *Contracted and locum tenens providers are not compensated for leave as per the contract with the Provider Company/Agency and the State of Alaska. Contracted and locum tenens providers must follow the leave process outlined for*

*all Medical Staff with a mandatory notification of 4 weeks in advance for planned leave.*

F. Continuing Medical Education and Administrative Leave
API supports ongoing professional development for all employed staff. It is the responsibility of the licensed medical staff member to obtain adequate training hours to maintain licensure and API staff appointment. Continuing Medical Education (CME) funds are not to be used for reimbursement of personal purchases funds can only be accessed through API procurement. All use of CME funds requires a signed and approved training agreement. It is the responsibility of the medical staff member who is pursuing CME to obtain permission for training prior to scheduling travel or leave.

All medical staff members are strongly encouraged to find training resources and opportunities within the state of Alaska. Out-of-state travel and subsequent out-of-state training require approval from the API CEO. Medical Staff members anticipating the need to travel out of state for CME training should provide a letter of justification including the benefits of the training and relation to API work duties. An employee may pursue out of state training without approval only if they are using their own personal funds for training and travel.

API Medical Staff members are eligible for up to 7 days of paid administrative leave per fiscal year to complete CME training. The medical staff member is responsible for providing documentation of completion of CME on days administrative leave was given prior to the due date for the timesheet of that pay period. Failure to provide documentation will result in personal leave being utilized. Use of administrative leave for CME activities requires approval by the Medical Director and follows the same guidelines as utilization of personal leave. More than one staff member on leave (personal or administrative) over the same time period requires the permission of the Medical Director. Administrative leave does not utilize hours from the staff member's personal leave bank. Administrative leave is provided as a courtesy to medical staff members and is not required by personnel regulations for training activities.

***Note:*** *Pursuant to the Provider Agreement between the State of Alaska and the locum tenens Agencies, locum tenens on assignment at API will not be granted leave of duty to attend CME activities.*

G. Quality Improvement and Professional Competency Programs

All Medical Staff members (active and associate categories) are expected to have familiarity with the Quality Improvement and Professional Competency programs.

Participation in Quality Assurance and Performance Improvement (QAPI) and Professional Competency program activities is required of all categories of Medical Staff members. For details of Quality Improvement programs, the Medical Staff member is referred the following facility policies and procedures:

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| QI-010-06.01 | Quality Improvement/Performance Improvement Program |
| QI-020-01 | FMECA |
| LD-020-06.01 | Sentinel Events |

Participation in Professional Competency programs is required of all active and associate category Medical Staff members. For details of Professional Competency programs, such as Ongoing Professional Performance Evaluations (OPPE) and Focused Professional Performance Evaluations (FPPE), the Medical Staff member is referred to the following facility policies and procedures:

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| MS-040 | Medical Staff Peer Review |
| MS-010-06.04 | Utilization Review Program |

H. Disaster Plan Participation
Members of Medical Staff will participate in the Disaster Plan as well as disaster exercise activities in which the facility may participate as an entity. All Medical Staff members are expected to complete basic Incident Command Systems (ICS-100) training as developed by the Alaska Division of Homeland Security & Emergency Management within the first 6 months of employment/contract at API.

I. Standards of Conduct/Disruptive Behaviors
Members of the Medical Staff (including contracted/locum tenens work) shall be familiar with the Standards of Conduct for all API and State of Alaska employees as described in HR-040-06.

In addition, API has a zero-tolerance policy for disruptive behavior and/or impaired Medical Staff members. API promotes a safe and fair workplace environment. It is the duty of all members of the API Medical Staff to report any suspicious or disruptive behavior on the part of another provider at API.

***Note:*** *Although this section specifically applies to physicians and other LPs, the principles are applicable to unsafe or disruptive behaviors of other API employees as well.*

Suspicion of an impaired Medical Staff member is required to be reported to the Medical Director, CEO or their designees immediately. Investigations into allegations of impaired Medical Staff will follow as per facility P&P MS-047 "Practitioner Health".

Disruptive behaviors are those which cause an inhospitable work environment (i.e. hostile workplace). API has a zero-tolerance policy for disruptive behaviors. It is solely to the discretion of API Administration to determine what behaviors/actions are considered disruptive.

Disruptive behaviors include but are not limited to:

- Bullying
- Verbal Aggression/Verbal Abuse
- Racial or Ethnic Slurs/Harassment
- Sexual Harassment
- Sexual Misconduct (social/professional boundary issues)
- Physical Aggression
- Theft/Pilfering of Facility or State Property
- Breach of Patient Confidentiality
- Gossip or Rumor Promulgation of Malicious Intent

Upon receipt of a verbal complaint of disruptive behavior(s), to the extent the source will allow being interviewed, the Medical Director/CEO (or designee) will obtain details of the alleged actions. In the event an investigation cannot be conducted because the complainant will not discuss, or a complainant cannot be identified (i.e. anonymous), the Medical Director/CEO (or designee) will address the issue with the Medical Staff member directly and identify behavior(s) of concern. This collegial intervention is not a formal investigative process.

Upon receipt of a written complaint of disruptive behavior(s)s, similar investigatory efforts will be made, however as the complaint is in writing it will become part of a Medical Staff members confidential personnel file.

The complaint will be investigated to determine if the complaint is founded or unfounded. For purposes of this section (Standards of Conduct/ Disruptive Behaviors), "founded" means that sufficient evidence exists to conclude that the

complaint should be substantiated. “Unfounded” means that there is insufficient evidence to substantiate the complaint. If upon further investigation it is determined that the complaint of disruptive behavior(s) is founded [are present], the Medical Staff member will immediately be placed on a Focused Professional Performance Evaluation (FPPE) status and monitored for concerning behavior(s). The length of FPPE is at the discretion of the Medical Director. If upon further investigation or FPPE it is determined that the disruptive behaviors are a level of seriousness that is creating a harmful or hostile work environment, the Medical Staff member will immediately be placed on Administrative Leave until the issue can be resolved further.

At any time during the investigative process (and prior to conclusion of such investigation), if the Medical Staff member chooses to relinquish their privileges voluntarily such will be accepted, and the matter considered closed although this must be reported to the National Practitioners Data Bank.

If following investigation/FPPE it is determined that the complaint of disruptive behavior(s) is founded and factual, the Medical Staff member will be placed on Administrative Leave (if not already on such status. The medical staff member and the medical director with or without the API CEO will meet with Human Resources to develop an immediate plan of correction. If the Medical Staff member refuses to participate in a Plan of Correction or if the Plan of Correction is not completed in an acceptable time frame, the Medical Staff member will have their privileges Automatically Relinquished and the Medical Staff member will lose the right to a fair hearing. The Medical Staff member will be given the opportunity to resign voluntarily. If the Medical Staff member chooses not to resign, the Medical Director and/or CEO will request the Governing Body to revoke the privileges of the individual.

If the period of Administrative Leave/restriction of privileges is greater than 30 consecutive days, the Medical Staff member must be reported to the National Practitioner Data Bank.

***Note:*** *If the Medical Staff member is contracted (e.g., Locum Tenens) and a complaint of disruptive behavior(s) is founded and factual, the assignment will be canceled, and the contracted Medical Staff member will be asked to leave immediately. In the event of a Locum Tenens LP on assignment is asked to leave, the company providing the LP will be contacted for an immediate replacement.*

***Note:*** *If at any time during the investigative phase the contracted Medical Staff member requests to leave the assignment, the request will be honored. Information gathered regarding the contracted Medical Staff member will be held in a confidential personnel file for the same duration as employed Medical Staff members.*

J. Nepotism
Members of the Medical Staff shall be familiar with and abide by the State of Alaska Administrative Manual, AAM.100.050 concerning nepotism.

K. Resident/Fellow and Student Supervision
Medical Staff may participate in the supervision of Resident/Fellow Physicians or medical students pursuant to the Medical Staff P&P MS-049 and MS-050. Supervision of Resident/Fellow Physicians and/or medical students is on a voluntary basis. Supervision of medical students and Resident/Fellow Physicians implies responsibility and oversight for the actions of the student/Resident/Fellow by the supervising Medical Staff member. Medical Staff choosing to supervise in an educational role must comply with the expectations and training obligations of the home academic institution. This includes the proper and timely completion of all review/evaluations of the Resident/Fellow Physician or medical student. Failure to comply with the expectations as a supervisor will result in the loss of the privilege to supervise.

API supports graduate medical education and academic integrity. As such, all members of the Active category of Medical Staff are encouraged to participate in the education of medical students and Resident/Fellow physicians. Participation may be limited to didactic sessions, academic literature contributions or participation on the Academic Integrity Committee.

II. Rules and Regulations Concerning Committee Participation

A. Medical Staff Meetings
The Medical Staff meetings shall be held every week, unless pressing issues or a holiday prevents this. Medical Staff meetings are scheduled for every Tuesday at noon on the second floor at API. The Medical Executive Committee (MEC) meeting occurs on the third Tuesday of each month.

Attendance is mandatory and quantified for Medical Staff meetings for all Active category Medical Staff members. Pre-arranged (excused) absences are not included in the percentage of meetings attended.

Medical Staff meetings are a mechanism for clearinghouse information regarding facility policies and procedures, a mechanism of collegial support, as well as an opportunity for education, quality improvement and risk management.

For Active category Medical Staff, attendance at less than 50% of Medical Staff meetings will result in a trigger for FPPE.

Locum tenens and contracted medical staff are encouraged to attend all meetings, however, attendance is not mandatory.

B. Attendance and Participation in Committees
Medical Staff Members appointed by the Medical Director to other Facility Standing Committees shall attend at least 50% of the committees to which the Medical Staff Member has been appointed to qualify for reappointment to the committee.

All Active category Medical Staff members are expected to participate in committees within the Medical Staff as well as other facility committees. Failure to comply with assigned committee attendance may result in loss of reappointment to the Active category for Medical Staff.

XIV. Rules and Regulations Concerning the Care and Treatment of Patients
At least one qualified Licensed Practitioner (LP), as represented by a Physician, Physician's Assistant, or Psychiatric Advanced Nurse Practitioner with privileges, shall be available (on-call) at all times as the Officer of the Day (OD). The Medical Director or his/her designee shall be responsible for formulating the on-call duty roster which shall be posted. An Attending LP shall be assigned by team to every patient, assuming responsibility for the care and condition of each patient.

A. Admitting LP
For newly admitted patients, the Admitting LP (usually the Officer of the Day/OD) serves as the Attending LP until a treatment team is assigned and the responsibility is passed to the assigned team Attending LP.

The Admitting LP is responsible for the initial set of admission orders for the patient during after-hours (after 1600 (4:00) PM, Monday through Friday). If during routine work hours, the assigned team Attending LP will be responsible for admission orders.

On weekends (Saturday, Sunday) the roles of Attending LP and Admitting LP are delegated to the two LPs on call. For those participating in the Alternative Work Week, those LPs arrange amongst themselves who covers the duties of whichever LP has their regular day off that day, excluding holidays, when these duties are delegated to the two LPs on call.

On Holidays, the roles of the Attending LP and Admitting LP are delegated to the two LPs on call.

B. Attending LP

An Attending LP will promote the health and well-being of his/her patients which shall include on-going therapeutic investigation, diagnosis, maintenance of a complete and accurate clinical record in both paper and electronic format, the supervision and care of the patient, and documentation of the patient's status and condition shall be unambiguous and complete. Orders shall be sufficiently accurate to direct care for the patient. The Attending LP is the primary provider responsible for a patient's care during their admission at API and ultimately decides on readiness for and date of discharge.

The Attending LP shall evaluate the patient and document an Admission Psychiatric Evaluation (APE) on the day of admission as per the documentation time frames if the patient is admitted prior to 1400 (2PM) on regular workdays.

All admissions after 1400 (2PM) need not be evaluated until the following day's work hours but no later than 24 hours after the time of admission.

Example: admitted at 1600 on Thursday, may not be evaluated later than 1559 Friday.

Failure to complete and initiate documentation of the APE within 24 hours of admission is a measure for Ongoing Professional Performance Evaluation (OPPE) for the delegated/assigned Attending LP.

On weekends (Saturday, Sunday) the role of Attending LP(s) for the hospital (all units) is delegated to the weekend on call LPs.

On Holidays, the role of the Attending LP for the hospital (all units) is delegated to the on-call LPs.

The delegated/assigned Attending LP is responsible for the Admission Psychiatric Evaluation (APE) as well as Medication Reconciliation in the first 24 hours of a patient's admission. The Attending LP is expected to comply with documentation standards as outlined in API P&P IM-050-05.04 "Documentation Standards" and as outlined in Patient Care Documentation within this document.

C. Officer of the Day (OD)

At least one psychiatric Medical Staff LP shall be on call at all times and serve as Officer of the Day (OD). The Medical Director or his/her designee shall be responsible for formulating the duty roster which shall be posted for Medical Staff members' access on the Common Drive (G:) in the medical file.

i. Coverage

The Medical Staff member designated as Officer of the Day (OD) shall provide coverage from 0800 hours on the day of assignment to 0800 hours the following day during the scheduled work week. During after-hours (1600-0800 the following day), he/she shall be responsible for triage questions from the Admissions Screening Officer (ASO) during the 24-hours of call. The OD is also responsible for admission orders and any other unit staff questions regarding patient care during after-hours.

The delegated weekend on call LP(s) will assume OD duties all day Saturday and Sunday as well as each covering Saturday or Sunday after-hours.

ii. Duties

The OD shall be available by phone (as provided by API) for consultation regarding all patients presented or being considered for admission during on-call hours. The OD is not available as an
on-call consultant to outside facilities or agents. The consultation role is to the ASO and/or Nursing Shift Supervisor (NSS) for API only

The OD will determine the necessity for admission, if applicable, and proper placement within the Facility setting, as well as complete or consult with the ASO for any emergency screening necessary for patients who may have an emergent medical condition warranting further medical workup.

The OD shall function as the Admitting LP to provide admission orders (after-hours) and examination of patients according to P&P ASSESS-01-02-03 "Registration and Admission Assessment Procedure", unless this duty is otherwise delegated to the Attending LP working at the time.

The OD shall be available by phone (as provided by API) for evaluation or consultation regarding all patients currently admitted to API.

The OD shall see any patient as reasonably requested by the Nursing Staff.

The OD shall notify the Medical Director or his/her designee of significant and unusual occurrences according to P&P LD-020-06, “Unusual Occurrences Reporting”.

iii. On Unit Duties After OD Shift
The OD is expected to perform duties as usual the following day (if OD shift during workweek). In the event the OD shift was especially time consuming overnight, the LP may contact the Medical Director, or designee, to request permission to leave early the day following the overnight OD shift. The LP may leave early dependent on completion of routine unit duties and no further obligations to patient care for the day. If permission is denied and LP leaves, or if LP is leaving early without seeking permission, the LP will trigger a period of FPPE for attendance to work duties.

iv. Shared Responsibilities and Hand-off Communication Expectations
In addition to the Admitting LP and Attending LP, other Physicians/Psychiatric Advanced Nurse Practitioners or Physician Assistants may share responsibility for a patient’s care. These may include physicians/ANPs/PAs from outside the treatment team covering the Attending LP’s patient; the Officer of the Day; an LP intervening in an emergent problem; or a Consulting LP. All interactions or interventions with a patient, regardless of assigned responsibility, will be documented by the LP providing care according to Documentation Guidelines.

Hand-off communications are an essential and expected duty of all Medical Staff members actively engaging in patient care. If a member of the Medical Staff is aware of a particular problem, issue, or situation in regard to one of his/her patients which might arise during off-duty hours, weekends or holidays, the Medical Staff member shall discuss this with the scheduled-on call LP and provide whatever information is necessary to assist the on-call LP in managing the problem, issue, and/or situation. Likewise, the reverse handoff is expected from the on-call LP to the weekday Attending LP staff or Medical Officer. Medical Staff members are expected to function as a team, thus necessitating the need for hand-off communications from the on-call LP to the Attending LP and vice versa.

D. Patient Care Documentation

All Medical Staff members shall complete required chart documentation in the patient's clinical record, in a timely manner if not specified otherwise. Additional documentation may be required dependent on circumstances or clarity of existing records. Facility documentation standards are detailed in the P&P IM-050-05.04, "Documentation Standards."

A summary of basic documentation by Medical Staff with time frames is as follows:

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| Initial Medication Reconciliation (Attending LP) | • Within 24 hours of admission. |
| Admission Psychiatric Evaluation (Attending LP) | • Completed in EHR within 24 hours of admission |
| History and Physical Examination (Medical Officer Staff) | • Completed in EHR within 24 hours of admission |
| Discharge Summary (Attending LP) | • Completed in EHR on day of discharge, prior to actual departure from hospital. May be completed ahead of actual discharge date, not to exceed 72 hours prior to discharge. |
| Day of Discharge Assessment (Covering LP) | • In the event the patient is discharged after hours, weekends, holidays and the discharge summary is complete, the covering LP will perform a day of discharge assessment to document the mental status exam and discharge education provided |
| Treatment Plan (Attending LP) | • Initial Practitioner Treatment Plan (ITPT) elements documented within 24 hours of admission (as noted in APE). Review with team and signing of Master Treatment Plan within 72 hours of admission; weekly review with team and updates, signing of Treatment Plan. |
| Progress Notes (Any Medical Staff member providing patient care services) | • Documented in the EHR within 72 hours of admission, then twice weekly for the first 8 weeks of admission by the Attending LP, followed by a minimum of at least one note a week thereafter. There is no prohibition of documenting more frequently. |

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| | • Updates towards the progress of objectives in the Master Treatment Plan (MTP) should be noted at least once a week by the Attending LP.<br>• Anytime medical care is provided, or further evaluation needed, it is expected that a progress note will be documented outlining the information obtained from the patient, staff or by exam.<br>• Medical Decision making as to initiation of medications/work-up/consultations is expected to be documented. |
| 30 Day Medication Review Progress Notes (Attending LP) | • A 30-Day Medication Review will be documented with a Medication Review progress Note every 30 days of admission. The Attending LP will review all the currently prescribed medications (psychiatric, PRN, medical, etc) and review for continued use and possible adverse drug interactions. Medications no longer needed (especially PRNs) should be discontinued. |
| Healthcare Professional Student/Resident/Fellow Physician Co-signatures | • Review and Co-signature within the EHR within 24 working hours of the completion of the note/document by the student/Resident/Fellow |
| Special Progress Notes (Any Medical Staff member providing patient care services) | • May be warranted on an as-needed basis at the time of an event.<br>• Examples: Seclusion and/or restraint use, safety garment use, emergency medication for behavioral emergency, sentinel events, unanticipated outcome or adverse drug reaction, witnessed seizure/fall or medical emergency. Restriction of patient rights must be accompanied by LP documentation explaining the need for such. |
| Telephone Orders | • Electronically authenticated within 72 working hours; exception telephonic orders for Seclusion/Restraint which must be electronically signed in 24 hours. |

Compliance with timelines is monitored. Unsatisfactory compliance with timeliness of completion of charting will trigger FPPE for documentation timeline compliance.

E. LP Orders and Medication Prescription

All Medical Staff members shall be familiar with and not use the prohibited abbreviations outlined in P&P IM-050-05.03. The use of undefined abbreviations/acronyms is prohibited.

All orders shall be entered by the LP via Computerized Provider Order Entry (CPOE) in the electronic health record (EHR). CPOE orders are electronically authenticated, and date/time stamped upon entry.

In the event of downtime procedures, orders will be written, in black or blue ink, clearly and legibly on approved order sheets. All orders shall be signed, dated and timed by the LP when they are written. Orders written and not signed by the LP will not be acknowledged by the nurse.

Medication orders must name the medication using its generic name, the amount to be given, the route of administration, the times to be given and whether PRN (as needed) or scheduled. All PRN medication orders must have a clear indication for use.

***Note:*** *You cannot write two PRN orders with the same indication. See Section iv. Medication Orders below for further details.*

The discontinuation or change of any medication order should have the medical decision making (justification/reason) documented in a progress note and in the "Comments" box within the EHR computerized order entry field for the medication order.

LP orders are required for admission, discharge, medications, treatments/consultations, therapeutic procedures/passes, and restriction of patient rights. LP orders are also required to change an admission diagnosis, legal status or transfer of patient to another unit/provider.

LP orders are not necessary for additional unit or personal privileges; those are to the discretion of the charge nurse. LP orders are not necessary for personal protective equipment those are to the discretion of the charge nurse.

i. Telephone Orders

Telephone orders may be given, under certain circumstances, to a licensed or registered nurse. The use of telephone orders during routine work hours is discouraged. Telephone orders shall be countersigned by an LP within

72 hours, except when they involve restraint and/or seclusion, in which case they must be signed by an LP within 24 hours.

ii. Patient Rights/Restrictions Orders
Patients have a right to unimpeded private and uncensored communication by mail, telephone, or visitation. LP orders which restrict patient's rights shall be documented in the clinical record with an explanation as to the therapeutic/safety benefit of the restriction. Restrictions in patient rights must be to protect the safety or well-being of the patient or others. Rights can be restricted if the rights "pose a threat.

iii. Medication Prescriptions
Prescriptive authority for medications is limited to physicians, ANP's, PA's who are members of the Medical Staff, or qualified in accordance with the Bylaws of the Medical Staff and are privileged by the Medical Staff and API Governing Body to prescribe medication at API. Resident/Fellow Physicians have prescriptive authority with co-signature by the Attending LP.

Doctoral level psychologists do not have prescriptive authority pursuant to licensing regulations within the State of Alaska.

Medical and Health Sciences students do not have prescriptive authority and cannot order medications for patients. Non-privileged consultants or visiting health care professionals not credentialed as API Medical Staff may not order medications. However, their recommendations for medications can and will be reviewed by an API LP to determine if initiation of the therapy is warranted.

iv. Medication Orders
Medication orders should be entered no later than 1500 (3:00 PM) on routine business days, Monday through Friday. Medication orders entered by CPOE after 1500 may not be filled until the following business morning. The API Pharmacy is open from 0900 to 1600, Monday through Friday. The Pharmacy staff reserve the right to not fill any orders that arrive after 1545 (3:45 PM). Medications orders entered after 1500 but requiring start prior to the following business morning will be limited to those supplied in the after-hours cart. It is the responsibility of Medical Staff to know what medications accessible after-hours are. Likewise, it is

the responsibility of the Medical Staff to have medication orders entered in a timely manner so as to not delay treatment to their patients.

Medication orders are generated from three (3) sources:

1. Psychotropic medications and medications intended to control side effects thereof, are ordered by the psychiatric LP staff which may include Psychiatrists, Psychiatric Advanced Nurse Practitioners, or Physician Assistants.
2. Non-psychiatric medications, for whatever purpose may be ordered by a LP (psychiatric or medical), Advanced Nurse Practitioner or Physician Assistant (PA-C).
3. Orders written by a PA-C must be counter-signed by an LP within 72 hours.
4. “Standing Medical Orders”, promulgated by the Medical Officer, are administered by nursing personnel under the auspices of the Medical Officer.

All PRN Orders shall indicate the reason(s) for the administration of the medication, the frequency, and in the case of psychotropic medications, the reason for its use as related to the diagnosis.

More than one medication cannot have the same PRN indication. If two or more medications are to be used for the same indication, the ordering LP must specify in the “Dose Instructions” box when to use which medication or in what order.

Example: 2 medications ordered for PRN insomnia
1st medication PRN for insomnia
2nd medication PRN for severe insomnia or insomnia does not relieve by 1st med

Example: 3 medications ordered for PRN pain
1st medication PRN for pain (general)
2nd medication PRN for pain not relieved by 1st med
3rd medication PRN for pain specific to location X

Pain Medications (controlled substances and uncontrolled) and antibiotics shall have a stop date entered at the time of order entry. This is to limit the potential overuse/misuse of these medications and to prompt re-evaluation in the post-treatment setting.

Medications are to be reviewed every 30 days of hospitalization a previously noted in documentation requirements. The Attending LP is expected to have an ongoing knowledge of all medications being prescribed and utilized by a patient. The psychiatric and medical officer staff are encouraged to collaborate closely on patients with significant polypharmacy (greater than 5 prescribed medications of any type, not including PRNs).

v. High Alert Medications

Certain medications require intense monitoring by pharmacy as well as the Attending LP or Medical Officer. Medications identified as High Alert include anticoagulants (warfarin, low molecular weight heparin, etc.), clozapine, and long acting injectables (LAIs) LPs prescribing High Alert medications should document at least once weekly the continued necessity for the medication and any note side effects/adverse events (or lack thereof).

Compliance with documentation of High Alert Medication use is a measure of OPPE.

vi. Due Medications

Certain medications require further monitoring by pharmacy for atypical patterns of use (Drug Utilization Evaluation/DUE). These medications (or combinations of medications) are not restricted but require additional documentation to explain necessity for use. DUE Medications include use of more than one antipsychotic medication concurrently; use of mood stabilizers with teratogenic potential in reproductive age women; use of non-FDA approve psychotropic medication in adolescent age patients or use of dysmetabolic-inducing antipsychotics in obese/diabetic patients. Additional DUEs may be developed and monitored as determined by the Medication Management and (MM) and Infection Control (IC) Committees. LPs prescribing DUE medications are expected to document justification (reason for use, measures in place to prevent negative outcomes, etc.) at least once a week in progress notes.

Compliance with documentation of DUE Medications is a measure of OPPE.

vii. Discharge Medications

In planning for a patient's discharge from API, the Attending LP should confirm ability to comply or obtain medications in the outpatient setting. All requests for discharge medications should be documented on the discharge summary and submitted to the pharmacy for processing before 1500 (3:00 PM), Monday through Friday. It is the responsibility of the discharging LP to complete the request for discharge medications in a timely manner so as not to delay discharge. In the event a discharge is unexpected/unscheduled, and it is past 1500, the LP will need to arrange for discharge medications via the After-hours Pharmacy contacts (see P&P PT-060-01.14) or by providing the patient with a written prescription for their medications.

Patients with prescription resources such as Medicare, Medicaid or private insurer should be provided with a prescription for medications on discharge. In addition, these resourced patients may be discharged with up to 7 days' worth of medications to cover until the patient is able to have the prescriptions filled. Greater than a 7-day supply of discharge medications from API for patients resourced with Medicare, Medicaid or private insurer requires approval of the Medical Director.

Patients considered un-resourced for prescription medication costs may receive up to 14-day supply of medications upon discharge from API by LP request. Greater than 14-day supply requires approval of the Medical Director.

viii. Medications for Patients on Pass
Medical Staff are expected to plan accordingly for pass medications. Requests for pass medications are submitted to the pharmacy by CPOE and should be in by 1500 (3:00 PM) Monday through Friday. API is not able to provide pass medications on the weekends or holidays, nor after-hours when the pharmacy is closed. The Attending LP can utilize the After-hours Pharmacy contacts (as per P&P PT-060-01.14) for pass medications, however this is discouraged. It is the responsibility of the LP to plan accordingly for passes in a timely manner

ix. Patient's Own Medications
A patient's own medication may be utilized in the following circumstances:

1. A patient's own medication is non-formulary, but essential for patient condition (i.e., cannot be held/missed dose until pharmacy opens).
2. The patient's own medication does not have a suitable API formulary substitution.
3. The patient's own medication is identifiable. Identification of medication must be completed by a Medical Staff member (MD/DO, ANP, or PA) or by a member of the pharmacy staff. If after-hours/weekend/holiday, the medical staff member will utilize the medication identification guidelines provided by the pharmacy and document identification in medication order.

Identification of medications cannot be delegated to nursing staff as this is beyond the professional capacity as per the State of Alaska Nursing Board (Decision 10/2009).

In the event these circumstances are not met the Nursing Shift Supervisor (per the direction of the OD or Admitting LP) may obtain the essential medication from an outside pharmacy as per P&P PT- 060-01.14, "Emergency Medication After Regular Pharmacy Hours."

If the circumstances are not met and the medication is NOT essential, the identification of the medication can be postponed until Pharmacy staff are available and medical staff determine medication is needed during API Admission.

At any time, a patient's own medication cannot be identified without a doubt, it should never be dispensed.

Patient's own medication(s) are personal property and are inventoried on admission. The Attending LP will determine if it is safe to return the medications to the patient at discharge. If a medication is determined to be unsafe for return, the Attending LP must document the medical reasoning for such, and the medications are sent to Pharmacy for disposal. If the Attending LP determines the patient's own medications are no longer needed, the nursing staff will ask the patient if they would like the Pharmacy to destroy the medications. If the Attending LP does not have a valid reason to inhibit the return of the patient's property (i.e. no imminent risk/harm with use), the medications are to be returned to the patient upon discharge.

XV. Rules and Regulations Concerning Emergencies

The ASO, with whom the OD consults, may be a licensed RN, a clinical social worker, or other staff who has demonstrated clinical competency in the performance of these duties.

All LPs shall responsibly intervene in an emergency situation occurring within API. When an emergency occurs and a LP is required or intervenes outside the line of their authority, it is expected that the LP will exercise medical judgment commensurate with the emergency.

In the event of a disaster, all LPs on the campus of API are expected to report and respond to the Incident Commander or Medical Director for further instruction. In the event of a disaster during after hours, Medical Staff are expected to remain on stand-by in the event they are needed emergently on the campus of API. In responding to a disaster, the Medical Staff members will be identified by their API Staff Identification badge. Those responding without proper identification may be turned away from the premises.

All Medical Staff members will remain cognizant and familiar with the various emergency codes for API. Medical Staff are expected to respond as directed in facility emergency P&Ps EOC-100, EOC-400 and EOC-500.

All Medical Staff members are expected to be familiar with ICS-100 and the Incident Command System and updates as per the Alaska Division of Homeland Security & Emergency Management. ICS-100 training should be completed once.

XVI. Admission Rules and Regulations

A. Admission Policies

These Admission Rules and Regulations are not all inclusive but are intended to establish a minimum standard of medical investigation, examination, opinion and treatment during the initial stages of hospitalization.

The management of each Patient's care is the responsibility of a qualified, Licensed Practitioner (LP) with appropriate clinical privileges who is a member of the Medical Staff. Each member of the Medical Staff holding admitting privileges shall accept and abide by the admission criteria.

B. Admissions

Admissions to the Facility, when possible, should be arranged during regular duty hours. However, admission services are available 24 hours a day.

All persons referred for admission who are mentally ill, as defined in AS 47.30.915(14), and, as a result, are likely to cause serious harm to themselves or others, as defined in AS 47.30.915(12), and/or are gravely disabled, as defined in AS 47.30.915(9), shall be admitted to API when no less restrictive treatment alternative is available in the community consistent with the person's treatment needs. Admission shall, however, be subject to P&P PC 01-01.01, Capacity and Notification, and Medical Screening & Admission. Ref. API policy, ASSESS-050-07.01 Admissions

C. Criteria
Each patient admitted to the Facility must meet criteria identified in the Hospital's P&P ASSESS-050-07.01 "Admissions".

Patients must be above the age of 12 years old.

Intellectual disability, developmental disability, or both, epilepsy, drug addiction, and alcoholism do not per se constitute mental illness, although persons suffering from these conditions may also be suffering from mental illness.

D. Legal Status
Every patient admitted to and hospitalized at API shall have a proper and applicable legal status determined, as priority beyond emergency care or management of emergency situations. The patient's legal status must be documented on the Face Sheet of the Medical Record entered into the electronic health record as part of the admission order set. Changes in legal status require an order by the LP in the electronic health record.

A list and explanation of the definitions of legal status for admission and hospitalization, and policy for admissions is set out in the previously cited in P&P ASSESS-030-06.5. Medical Staff members must be familiar with the legal status definitions and cooperate with the API paralegal and Assistant Attorney General to establish the proper legal basis for admission and ongoing hospitalization.

Voluntary: All patients coming to the Facility for admission are to be evaluated as to their ability to consent to enter the Facility in good faith on a voluntarily basis. Admissions on a voluntary status require approval of the Medical Director. After admission, patients may be changed from an involuntary legal status to a

voluntary legal status if the patient has the capacity to understand the rules and responsibilities of a voluntary admission, the decision to sign a patient in under voluntary status is made by patient's attending LP after discussion with patient to determine patient's capacity to make this choice. Consistent with Alaska state statute AS 47.30.803.

Judicial: Patients presented with involuntary commitment orders signed by a judge or magistrate (pending Superior Court Review) are to be admitted to API due to statutory obligation. Such involuntary commitment orders do not require the approval of an OD for admission.

E. Administrative Information

At the time of admission, the admission and disposition forms supplying identification data, administrative information, and authorization for hospitalization and treatment shall be obtained by the Admission Screening Officer (ASO). The ASO shall complete other significant information concerning the admission within the admission module of the EHR.

i. Admission Administrative Orders

Admission administrative orders (i.e., non-medication orders) shall include the unit to which the patient is admitted, the patient's legal status, dietary orders, any orders regarding Close Observation (see P&P PC-060-14, "Close Observation Status Scale") status, laboratory study orders, known allergies and any other orders deemed necessary or desirable.

ii. Admission Medication Orders

A current list of active and recent medications utilized by the patient, as well as known allergies, will be obtained by the ASO from the referral agency. Review and/or additional information regarding medication use will be obtained by the nurse obtaining admission orders. The initial/immediate medication reconciliation will be reviewed with the OD/Admitting LP and indicated in the admission orders as having been completed. This is to determine what, if any, medications are needed prior to the completion of the Admission Psychiatric Evaluation (APE). The accuracy and completeness of the initial medication reconciliation for orders and review for allergies is dependent on the level of cooperation from the patient and the reliability of the information source. If either is in question at the time of the APE, further efforts should be made to validate medication reconciliation

F. Admission Psychiatric Evaluations (APES)

Within 24 hours and preferably on the day of admission, the admitting LP will document in the clinical record the results of his/her evaluation of the patient's psychiatric status. This evaluation shall be documented in the patient's electronic health record within 24 hours of admission. Psychiatric assessments by providers outside of API or previous API admission assessments cannot be utilized to replace the APE requirement within 24 hours. Admitting LPs are expected to complete a new APE with each admission. The admission work up will include at least the following:

i. Legal Status: Information sufficient to identify the patient's legal status as it affects this admission.
ii. Chief Complaint: the patient's complaint or situation from his/her point of view. If appropriate, the complaints of others determined to be significant must be recorded.
iii. Present Illness: Documentation of present signs and symptoms as well as a description of the circumstances leading to this admission.
iv. Past Psychiatric History: Documentation of past admissions or treatment for both related and unrelated psychiatric illnesses.
v. Substance abuse history: Special inquiry into the patient's use or abuse of alcohol, prescription drugs, or drugs of abuse (including inhalants, nicotine, and caffeine) must be documented as either part of the psychiatric history or separately.
vi. Relevant social history: Important issues in the patient's family, social, recreational and occupational life should be mentioned.
vii. Patient's Assets: Assets and strengths that might be brought to bear on patient's treatment or discharge planning should be descriptive and must be documented.
viii. Mental status examination: A formal mental status examination sufficient to elicit an estimation of the patient's mental functioning and emotional state shall be completed and documented on admission. Documentation shall be as descriptive as possible for interpretation of the provisional diagnosis. Documentation must include at least the following:
    1. General appearance and behavior.
    2. Sensorium, affect, and mood.
    3. Cognitive functioning, including orientation in detail, memory in detail, including examples of recent and remote memory and the ability to register new information/exhibit executive function.
    4. Intellect including fund and knowledge and the examiner's estimation of the level of functioning.
    5. Thought process.
    6. Thought content including hallucinations or delusions; and,

7. Dangerousness to self, or others, or property.

ix. Assets and liabilities

x. Documentation of Dangerousness: The admitting LP is obligated to evaluate and document, the potential dangerousness of each patient in terms of self-harm and possible harm to others. A suicide risk assessment is performed by the ASO or admitting nurse on admission and the results should be noted by the LP.

xi. Provisional Working Diagnosis: Diagnostic impression shall be supported by the mental status examination. The diagnosis shall be made in accordance with the current diagnostic and statistical manual (DSM) of the American Psychiatric Association

~~xii. Initial Treatment Plan (ITP): The ITP (developed by nursing) shall be documented based upon the admitting LP's evaluation at the time of the patient's admission.~~

xiii. Certification of need for admission is provided by positive documentation that each patient's condition satisfies the facilities requirements for admission.

Compliance with timelines for APE is a measure of OPPE for psychiatric staff.

G. Physical Evaluation

An Admission History and Physical (H&P) shall be performed based on information obtained from direct observation/examination and a history and systems review.

This evaluation shall be documented in the patient's electronic health record within 24 hours of admission.

The Admission H&P must be completed and documented for each patient no more than 30 days prior to or 24 hours after hospital admission by a member of the Medical Officer Staff: the Medical Officer (MD/DO), PA, or ANP. Each organ system will be reviewed for symptoms and examined for objective findings. The elements of the Admission H&P should be consistent with a full multi-system review and exam, consistent with the Medicare Guidelines for Evaluation and Management of a CPT level 99233. The patient's nutritional status and BMI will be noted in the H&P. Special attention should be paid to the identification and validation of substance abuse/dependence, closed head injury or traumatic brain injury, and family/personal metabolic risk factors (heart disease, diabetes, hypertension, obesity). Any recommendations for medication/follow-up

intervention/preventive health screening to be performed post-discharge should be documented at the end of the H&P.

If an H&P from another facility is to be used, the Medical Officer staff will be responsible for reviewing and updating changes as needed. An outside H&P must be performed within 7 days of admission to be acceptable. The outside H&P must represent a thorough assessment equivalent to an H&P performed by API Medical Officer Staff. Outside H&Ps with limited historical or examination information should not be accepted.

A yearly physical exam is completed on long-term patients within 30 days prior to their admission anniversary date.

In the event a patient refuses to comply with an Admission H&P, either interview or physical examination, the examiner will document the refusal. The examiner shall document as much of the history as possible from chart/information review, collateral sources (with permission), and perform as much physical examination as possible by direct observation or by physical interrogation as permitted/tolerated by the patient. The Medical Officer Staff shall re-attempt the H&P at least once during the first week of admission. In the event a patient decides to comply with the H&P later during hospitalization, it will be completed at the discretion of the Medical Officer staff and as time permits.

All patients with co-morbid risk or ongoing medical conditions that warrant further work-up or medications will be communicated to the Medical Officer for follow-up via hand-off communications. The Medical Officer ultimately assumes the responsibility of medical (non-psychiatric) care of all patients at API. If the initial H&P is not conducted by the Medical Officer, it is the responsibility of the medical staff member completing the H&P to communicate essential findings warranting follow-up or management to the Medical Officer.

Often patients admitted to API do not have medical continuity services prior to admission, thus the inclusion of a summary of medical history and current medical conditions is a vital source of information for outpatient follow-up, as well as providing continuity of care on future API admissions.

H. Laboratory Studies

Admission laboratory studies, ordered at API, may include CBC with differential, urinalysis, blood chemistry screen, TSH Screen, fasting lipid panel, pregnancy testing, and a urine drug screen (when indicated). All patients shall be screened

for Tuberculosis exposure as per P&P PT-50-23 “Standing Orders and Medical Protocols” and P&P IC-300 “Tuberculosis Exposure Control Plan”. All adolescent patients shall be screened for Gonorrhea and Chlamydia infection as per P&P PT 50-23 “Standing Orders and Medical Protocols”.

Pre-admission laboratories are not required for admission to API. The performance and review of any laboratory or study prior to presentation for admission to API is to the discretion of the medical care provider performing the evaluation for medical clearance. A statement of medical clearance by an LP is expected of any patient referred from another medical facility or setting, patients with involuntary commitment orders also require medical clearance prior to admission to API. Concerns over abnormalities of laboratories or studies performed prior to admission should be addressed to the OD or to the Medical Officer Staff. Abnormal laboratories in the setting of no acute/emergent medical conditions are not criteria to deny admission. Any medical staff member denying admission on the basis of laboratory results should be prepared to explain the reason for the denial with the referring medical facility.

Admission laboratory studies may be omitted or modified at the discretion of the Attending LP or Medical Officer Staff member. Such situations may include: a patient discharged from the API in the past 30 days (assuming adequate and relatively recent laboratory studies prior to discharge); patients transferred from other hospitals with adequate and appropriate laboratory studies, photocopied results of which accompany the patient; and/or patients admitted who have recent and adequate laboratory studies, photocopied which accompany the patient. Other laboratory examinations will be ordered, as necessary, during ongoing assessment of the patient.

XVII. Rules and Regulations Regarding Patient Clinical Services

The Chief Executive Officer (CEO) delegates to the Medical Director to work in collaboration with the Director of Clinical Services and Director of Nursing in development of clinical programs and services.

Inpatient care shall be planned and provided by a multidisciplinary treatment team. All members of the treatment team shall sign their patient’s treatment plan verifying participation in the plan. The coordination of the WRP is the responsibility of the treatment team social worker. The LP supervises all care provided to the patient.

A. Prescribing Medications

Medications should only be prescribed in accordance with facility protocol for informed consent. The Attending LP is responsible for obtaining and documenting informed consent for psychoactive medications. Any LP prescribing meds assumes the responsibility for informed consent. The prescribing LP assumes the responsibility for performing a medication interaction screen with initiation of new medication(s). The prescribing LP also assumes the responsibility to correctly acknowledge any medication warnings (pop-ups) generated by the computerized physician order entry in the EHR. Significant changes in medications (discontinuation, initiation or rapid/high dose titration) should be documented in a progress note or via the "comment" box query in the EHR medication order program.

B. LP Orders

In addition to LP orders under Section III-E, at any time, the Attending LP responsible for a patient may request another member of the medical staff to review the patient's clinical record and/or write orders. Nursing personnel will carry out those orders. This is under the auspice of Shared Responsibility of Medical Staff as previously described.

All orders are to be entered electronically by Computerized Provider Order Entry (CPOE) and electronically dated, timed, and signed by unique LP Personal Identification Number (PIN) entry. All telephone orders are to be reviewed and signed electronically by the LP within 72 hours of the order being given.

In the event of downtime procedures requiring handwritten orders: illegible or improperly written orders shall not be initiated until rewritten, or the order is clarified with the ordering LP and understood by the nurse responsible for patient's care.

All telephone orders regarding seclusion and restraint shall be signed within 24 hours, in accordance with the P&P SC-302.1b "Seclusion and Restraint".

Telephone orders are discouraged during routine work hours. However, orders may be given by telephone to a Registered Pharmacist or Registered Nurse where, in the opinion of the LP, the requirement for expeditious care or treatment, including the need for medication exists, and the clinical problem to be addressed does not demand prior examination of the patient before care or treatment is initiated.

No patient shall be discharged without an Attending LP order, including a voluntary patient requesting discharge against medical advice (AMA).

C. Standing Orders

Standing orders shall be formulated by conference between the Medical Staff and the Departments of Nursing and Pharmacy. Such orders shall be changed only after approval of Medical Staff members. Standing orders may be initiated by nursing staff without specific contact/approval of the LP. It is the responsibility of the nurse initiating standing orders to review the patient allergies and medical history for contraindications to the standing order medication. Standing orders shall be signed in the EHR by the Attending LP or the Medical Officer within 72 hours of the order.

The permission to initiate the availability of admission orders is the responsibility of the Admitting LP.

If a patient's medical condition warrants LP examination prior to medication administration, standing orders should not be initiated.

Standing orders can be discontinued at any time by the Medical Officer staff or the Attending LP.

Further details for Standing Orders may be reviewed in P&P PT 50-23 "Standing Orders and Medical Protocols".

D. Treatment Planning Process

The Treatment Plan (TP) at API is person-centered and utilizes whenever possible, input and direction from the patient and family. API believes that the definition of "Recovery" is based on an individual's preferences and perceptions and cannot be defined exclusive of the patient.

The Vision of API is: An Alaska where everyone receives the care they need when they need it, without judgment.

All Treatment Plans shall be prepared according to written procedures.

i. Initial Treatment Plan (ITP) and Review

The Treatment Planning process begins at the initial encounter with the patient and gains depth and breadth during the hours and days subsequent to admission. The preliminary plan of care shall be based on observation

of all staff as documented in the clinical record as well as verbal contributions to the understanding of the case.

The Initial Practitioner Treatment Plan (IPTP) is formulated and written as part of the psychiatric evaluation performed by the Attending LP during the admission process. This treatment plan is the working guideline to the care of the patient until the Master Treatment Plan (MTP) can be completed by the team.

It is important that the individual members of the treatment team engage the patient and perform assessments in an independent manner, however, ultimately, MTP development should be conducted as a group interview process.

The MTP shall be written in collaboration with the Treatment Team, to include the Attending LP, or in his/her absence, by the covering LP within 72 hours of hospitalization. It is intended that there be three (3) days of cohesive multidisciplinary observation of the patient so that interventions are refined and tentative approaches to the patient's situation described.

The MTP shall be written in collaboration with the Treatment Team, to include the Attending LP, or in his/her absence, by the covering LP within 72 hours of hospitalization. It is intended that there be three (3) days of cohesive multidisciplinary observation of the patient so that interventions are refined and tentative approaches to the patient's situation described.

In the event that a patient is determined to no longer need psychiatric stabilization in less than 72 hours, a formal MTP does not need to be completed. The IPTP formulated by the LP upon completion of the Admission Psychiatric Evaluation will stand as the documentation of the multidisciplinary treatment planning, in conjunction with the documentation of discharge planning and completion of the nursing admission assessment.

ii. Master Treatment Plan (MTP)
    1. Standard of Care
       Each patient hospitalized for greater than three days shall have a written, periodically reviewed, amended and individualized multidisciplinary Master Treatment Plan.

2. Timeline
    a. By the third (3rd) day of hospitalization (but not in excess of 72 hours), a Master Treatment Plan shall be determined as a result of informal observation as well as specific formal evaluation. The Treatment Planning process in all of its stages subsequent to the admitting LP evaluation must be both individualized and multidisciplinary. Treatment Plans are to be patient centered with a focus on recovery and with full patient and family (if possible) participation.

       The Master Treatment Plan must be developed by ~~the Plan Coordinator, in concert, and with full participation in and~~ multidisciplinary treatment team final approval of the attending LP. This approval must be signed in a timely fashion

    b. The Master Treatment Plan shall be put into effect within 72 hours of admission.

3. Formulation of MTP
   In addition to the input gathered by the various members of the treatment team independently, the Treatment Plan shall be derived from the following specific and formal assessments:
    a. Admission Psychiatric Evaluation.
    b. Admission Medical History and Physical Examination.
    c. All nursing assessments during the first 24 hours.
    d. The activities assessment by clinical support services staff, to include occupation and/or rehabilitative assessment, if necessary.
    e. Psychosocial assessment.
    f. Psychological evaluation, if ordered and completed.
    g. Information obtained from his/her participation in previous treatment
    h. The patients expressed goals
    i. Roles and Responsibilities of the Treatment Plan
    j. Each clinical care team will have a designated member as the Treatment Plan coordinator, as outlined in treatment plan policy. This coordinator is responsible for tracking the review.

k. The Team Nurse is responsible for gathering information and editing the MTP as per the designated sections of responsibility. This includes the Goal Statements, Problem Identification, and Symptom Scales.
l. The Attending LP is responsible for the diagnoses and legal status sections as well as the initial plan (as part of the APE). The LP is ultimately responsible for the care of the patient during the admission but is not solely responsible for the Treatment Plan. The LP's role is to review the ongoing problems, objectives and actions and to remark on the progress towards completion of such during the admission via progress notes and treatment team meetings. The LP is also responsible for identifying discharge barriers to the coordinator as part of discharge planning as well as for MTP updates.
m. All treatment team members (as applicable) are responsible for GOAL FORMULATION, interventions and objectives as assigned during the MTP reviews. Progress notes by these additional team members should include patient's progress toward the assigned objective as well as identification of discharge barriers or barriers to completion of the objective. Any additional treatment team members with direct patient engagement assignments via MTP are also expected to be present during MTP reviews and sign the MTP as well.

4. Elements of MTP

The Treatment Plan shall document the following elements:

a. The patient's problems expressed in behavioral terms including the patient's assets and liabilities as they relate to treatment potential or approaches.
b. A working diagnosis.
c. Goals which are recovery based, relate to the problems listed, and are clearly measurable for completion.
d. Objectives related to goals are set for the patient within a time frame for expected improvement or attainment.
e. Interventions expected to result in objective attainment of goals, which are clearly measurable for completion and compliance.

f. Specifically identified personnel to perform the various interventions.
g. Frequency of treatment interventions.
h. Documentation of the patient's participation in the development of and understanding of the individual's treatment plan.
i. Documentation of the family's participation (as applicable) in the treatment plan.
j. Discharge criteria.

iii. Treatment Plan Updates

The treatment team shall meet once a week to review the current treatment plan and update the goals/objective/interventions as necessary. The treatment team members should document their interactions with the patient and assessment of completion of objectives/interventions and progress towards goals. Barriers to completion should be identified as applicable. New medical or behavioral problems that require routine management/follow-up should be added to the problem list.

During this weekly update, the Treatment Team should meet with the patient to review the status of the treatment plan, using the patient's (and family's) input as much as possible to maintain a patient-centered focus to the plan.

These revisions to the treatment plan shall be documented. The Attending LP still needs to document progress towards identified goals, barrier identification, new goals as applicable in routine progress notes.

The updated treatment plan will be filed in the paper (hard copy) unit chart for the patient.

E. Progress Notes in Addition to MTP Documentation

Documentation in progress notes giving pertinent chronological report of the patient's course shall describe changes in the patient's condition and the results of treatment according to the treatment plan. Progress notes in the EHR shall follow Documentation Standards as outlined previously. This would include such topics as:

Commentary on the patient's condition, response to treatment, side effects management of side effects, comorbid conditions, significant laboratory findings,

medication regimen, major changes in medication regimen, contacts with other care givers, contact with significant others, etc. In addition, progress towards goals and objectives as defined by the treatment plan should be commented on by the LP at least once per week.

F. Medical Consultation

Patients with medical problems exceeding the resources of the Medical Officer Staff and/or API and requiring diagnosis and/or treatment shall be referred to appropriate consultants. Requests for consultation may be routine or urgent but, by definition, are not considered emergencies.

Consultations for medical conditions that do not have direct impact on acute care, or the acute psychiatric condition should be deferred to post-discharge, except in the case of patients who have been at API > 6months, in which long term follow-up is indicated.

Consultations to rule out pathology or diagnoses require additional information in the Consult Request form so as to allow the consultant a thorough understanding of the concern to be evaluated. It is the responsibility of the LP requesting the consultation to clearly state what the consultation is for either in both the EMR order and on the consultation paperwork. Any questions for clarification will be directed to the ordering provider, including ~~urgent~~ phone calls by outside providers inquiring about why a patient is to be seen.

Consult requests are monitored by the Medical Director. The Medical Director reserves the right to limit outside, non-emergent, consultations.

In regard to medical consultation P&P PC-030-12 “Consults for Provision of Care Outside API” shall be followed.

G. Emergency Care

Emergency is defined as an abrupt event or condition which without immediate medical intervention, is expected to result in death or serious harm to patient or API personnel.

If such an emergency occurs, the LP is expected to do all in his/her power to save a life or prevent serious harm, regardless of his/her privileges. API Medical Staff are required to be current with Basic Life Support skills through Hospital Education.

Staff shall follow the P&P PC-06-05 “Deteriorating Physical Status, Medical Emergencies, and code Blue Response”.

H. Risk of Behavior Emergency

When it is believed that suicide and/or elopement behavior is likely or imminent by a patient, or when a patient’s history, condition or behavior strongly suggest the likelihood of assaultive behavior, the Medical Staff member should seek interventions that would reduce such risk, document their observations and interventions, and order a clinically appropriate Close Observation Status, in accordance with the PC-060- 14.

I. Unusual Occurrence Reports

A variety of untoward events may be considered “incidents” at the facility and shall be reported on an “Unusual Occurrence Report” form. All occurrence reports shall be routed through the Safety Officer to Administration. If further investigation is warranted, the results will be reported to the Risk Management Team, and on to Medical Staff for peer review and participation in Quality Improvement initiatives as appropriate.

An “Unusual Occurrence Report” is confidential, protected document and not part of the patient’s medical record. The UOR shall not be documented nor referenced in the patient’s medical record. Further details for the completion and review of UORs can be found in P&P LD-02-06.

J. Communication with Outside Sources

If a Medical Staff member receives communications related to a current patient, the medical staff member should seek confirmation of ability to release information prior to any discussions. All Department of Family and Community Services (DFCS) employees and API contracted staff are expected to complete HIPAA training and maintain vigilance for exposure of patient identifiable information in emails, telephone calls, or other forms of written or electronic communications. If there are questions related to reporting breach of confidentiality or parameters to protecting information, medical staff members should seek clarification from the Director of Health Information Management Systems (HIMS).

Consideration should be given to collegial dialogue with community health care providers so as to develop a collaborative discharge plan. Communication with other health care providers is permissible under HIPAA to manage health care and

related services, including coordinating health care; consultation with other health care providers; and referral of patients. This includes continuity of care issues.

K. Seclusion and Restraints

Seclusion or restraint is an emergency measure to prevent actual harm to the patient or other people and not a routine part of a treatment regime. In particular, seclusion and restraints are not to be used as

aversive techniques. In all instances of use, the P&P SC-030-02.01b “Seclusion and Restraint” will be followed. All LPs require S/R privileges to order S/R, or be under the supervision of an LP who is privileged in S/R.

Seclusion is defined as a procedure which involuntarily isolates the patient to a specific room or area designed for the purpose of removing him or her temporarily from the unit community and external stimuli. Closing or locking a door is not required for the patient to be considered in seclusion.

Restraint is defined as a physical, medication or mechanical device used to restrict the free and normal movement to the patient's body. This does not include mechanisms used to assist a patient in obtaining and maintaining body function, such as safety equipment or orthopedic device.

All orders for seclusion and/or restraint must be based upon an LPs or unit RN’s assessment of the patient and the situation. All orders for seclusion and/or restraints must be timed, dated, and signed and shall include the maximum period of time that the seclusion and/or the restraint was employed, the type of restraint utilized, the reason for their employment, and the inadequacy of less restrictive interventions.

In each case, the LP must prepare a ~~progress~~ note documenting in reasonable detail the patient’s status and the conditions which gave rise to the seclusion and/or restraint order and the reasons for the order. Additionally, the note should document the understanding of the use of seclusion and/or restraint, and behaviors expected for release from seclusion and/or restraint. This documentation should be performed <24 hours from the time of the incident.

PRN orders for seclusion and/or restraints shall not be permitted.

Under emergency or urgent circumstances, when an LP is unable to immediately assess a patient, the assessment may be carried out through discussion with the

Nursing Staff and a telephonic order may be given. A telephonic order for seclusion and/or restraints must be signed by an LP within 24 hours and a progress note prepared as soon as possible.

In no case shall seclusion and/or restraint initiated by a Registered Nurse exceed four (4) hours without a face-to-face LP or trained nurse assessment of the patient and an LP order for continuation.

If a patient remains in Seclusion or Restraint for more than 12 hours or experiences 2 or more separate episodes of Seclusion or Restraint within 12 hours, the Medical Director is notified. The Medical Director is notified every 24 hours thereafter if the situation remains unchanged. The Medical Director at this point will meet with the Treatment Team to review and revise the patient's Treatment Plan and determine if there is a need to develop a specialized, Individual Behavior Program.

Any Restraint or Seclusion order must indicate the time frame for re-evaluating the treatment and continued use of seclusion and/or restraints.

A Registered Nurse must assign a responsible person for continuous care of the restrained or secluded patient. This care must include regular evaluations, including vital signs and the offering of regular meals and fluids and use of bathroom facilities.

L. Death

The Joint Commission classifies API as a "Level IV" hospital for emergency services. Under this level designation, API staff render lifesaving first aid and refer care to the nearest acute general care hospital or physician capable of providing needed services.

Further direction for response to demise of a patient at API is noted in P&P LD-020.06.01 "Sentinel and Unanticipated Adverse Events".

In the event of an accidental or unexpected death or death as a result of suicide or assault the Medical Examiner is to be notified, the Medical Director or designee is responsible for carrying out this duty. Further details are noted in P&P LD-020-.06.01 "Sentinel and Unanticipated Adverse Events".

An autopsy is completed at the discretion of the Medical Examiner.

XVIII. Discharge of Patients Rules and Regulations

All patients discharged from the Facility must be evaluated as no longer meeting criteria for continued hospitalization on an involuntary basis.
All patients discharged from the Facility must be discharged in accordance with a Discharge Plan which is prepared by the treatment team.

Discharge planning shall actively solicit and incorporate input from the referring and/or receiving facility/caregivers, the patient, the patient's family and/or significant others. And other relevant parties as apply. The Team social worker is primarily responsible for all elements of discharge. Any patient not currently hospitalized under criminal statutes may be discharged when he or she is no longer evaluated to meet criteria for admission. Optimally, the discharge plan is agreed to by all parties including the patient, API clinicians, and the outpatient treatment clinicians.

A. Legal Status and Discharge

i. Voluntary Patients
Shall be evaluated and released at their request, even if against medical advice, unless it is felt that the patient's mental condition may render him/her committable under the appropriate mental health statutes. In such case, an "AMA Hold" may be initiated by the LP on duty. pursuant to the P&P COC-030-13 "Discharge Release of Patients".

If a voluntary patient requests discharge before maximum benefit of hospitalization has been obtained, a LP shall make a decision as to whether or not a discharge against medical advice is safe. If, in the opinion of the responsible LP, the patient is not committable, he/she should be discharged in accordance with the previously cited P&P COC-030-13 "Discharge Release of Patients".

ii. Patients Involuntarily Hospitalized (Civil Statutes)
Examples of this include patients hospitalized under POA, Ex Parte, or T-47 commitment status.

Any patient under civil statute hospitalization may be discharged at the discretion of the Attending LP (i.e., when no longer meeting involuntary commitment criteria). However, in the case of patients under T-47 commitment status, the Alaska Court System will be notified of the discharge by the API paralegal or designee. The legal status does not need to be changed to voluntary to facilitate a discharge.

If an involuntarily committed patient is deemed by the court to be released (i.e. no longer meeting commitment criteria) and/or the involuntary commitment has timed out and the Attending LP is of the opinion that the patient would benefit from further hospitalization, the "AMA Release from involuntary status" form is to be utilized. See P&P: COC-030-13 "Discharge Release of Patients" for further details.

iii. Title 12 Patients
Shall be released only upon court order by the Attending LP.

iv. Pending Criminal Charges
Patients who are admitted to the Facility with criminal charges pending against them shall be released in accordance with the specifications of the court order for evaluation or other court orders. Notification of appropriate personnel shall be performed prior to discharge.

v. Duty to Warn
In some instances, patients may be discharged from the Facility who are believed to have potential for violence which may be directed toward a specific person, persons or group. In such cases P&P LD-020-08 "Duty to Warn" should be followed.

B. Discharge Procedures

i. Discharge Summary Documentation (formerly known as the DRO)
The Attending LP must begin and finalize a discharge summary of an individual prior to actual discharge of the patient. If the day of actual discharge is not an Attending LP workday (RDO), a day of discharge assessment by the covering LP/OD is due prior to discharge from the facility. The discharge summary shall include:

1. the course in hospital detailing medication titrations, lab studies, behavioral interventions, and progress towards resolution of symptoms
2. the final diagnoses in the nomenclature of the current DSM
3. an accurate listing of medications to be continued after discharge, including PRNs or any titration schedules that need to be followed
4. recommendations for continuity of care including medical and psychiatric follow up needs a statement of prognosis include if particular events (medication compliance, abstinence from substances of abuse) would change prognosis

XIX. Confidentiality and Safeguarding of Medical Records Rules and Regulations
The medical record is a confidential, privileged document. Information shall be released only in accordance with the P&P IM-050-05.01, “Release of Information”.

Unauthorized removal of a chart from API is grounds for a disciplinary action and may result in a temporary suspension of privileges for the participant pending a full disciplinary investigation under the Medical Staff By- Laws.
Medical records shall be removed from API’s jurisdiction and safekeeping only in accordance with a court order.

Written consent of the patient shall be required before the release of written medical information to persons not otherwise authorized to receive that information.

A. Electronic Communication
Any electronic mail communications with patient identifiable information (including initials, date of birth, physical description, etc.) must be conducted via an encrypted message service. This is per policy. Medical staff should not exchange patient personal information via any other agencies’ encrypted messaging service.

No patient information may be communicated by texting (cellular phones).

B. Pictures and Video
Smartphone applications that capture video or images may not be utilized to document patient care without the written permission of the HIMS Director and API CEO. Photographs are not to be taken within API patient care areas, unless to capture images of such things as damage to a unit or for other work-related purposes that do not involve images of patients or protected health information. Doing such may be considered a breach of patient confidentiality and subject to disciplinary action.

C. Cellular Phone Use
Conversations, personal or patient care related, via cell phone should be conducted in private settings. Conversations via cellular phone should not be conducted in patient unit hallways or during patient care meetings with the patient present. All API Medical Staff members are expected to conduct themselves in a professional manner in patient common areas as well as in front of patients by role modeling confidentiality to others.

XX. Ongoing Professional Performance Evaluation (OPPE), Focused Performance Evaluation (FPPE), and Peer Review Rules and Regulations

The organized Medical Staff have defined the circumstances and measurable events that will be monitored and evaluated for all LPs and Advanced Practice professionals granted privileges at API. The Ongoing Professional Practice Evaluation (OPPE) is continuous for the duration of practitioner's privileges at API.

The organized Medical Staff have also defined the circumstances that require monitoring and evaluation of professional performance for practitioners that do not have documented evidence of competency for performing the privilege(s) requested at API. This process is also used when a question arises regarding a currently privileged practitioner's ability to provide safe, high quality patient care. The Focused Professional Practice Evaluation (FPPE) process is time limited.

Failure to comply with OPPE or FPPE may result in revocation or suspension of privileges as outlined in the Medical Staff Bylaws. Findings from FPPE or OPPE suggesting unsafe practices or suggestive of unacceptable behaviors may result in disciplinary investigation and/or administrative actions as noted in Articles7 and 8 of the Medical Staff Bylaws.

A. Ongoing Professional Practice Evaluations (OPPE)

The Medical Staff will engage in OPPE to identify professional practice trends that affect quality of care and patient safety. Every 6 months medical staff will undergo an OPPE, the biannual evaluation of Medical Staff for the purpose of assessing a practitioner's clinical competence and professional behavior, the information gathered during this process may be factored into decisions to maintain, revise, or revoke existing privileges and may be utilized during the three-year license and privilege renewal cycle. Ongoing Professional Practice Evaluation is a structured, standardized assessment used to identify professional practice trends amongst the API Medical Staff (Active and Associate categories). The OPPE includes but is not limited to: review of documentation for medical decision making, review of use of pharmaceutical prescribing, review of documentation supporting diagnosis, observation of patient or staff interactions, directly and/or through discussion with other staff members. The Medical Director or designated member of the Medical Staff may conduct an OPPE. OPPE criteria are defined by the Medical Staff and are reviewed and approved by the Medical Director.

i. The OPPE is conducted by chart review.
    1. An appropriate Medical Staff member appointed by the Medical Director will review at least 5 client cases from time of admission

to time of discharge for the past 6 months and rate the performance of the provider utilizing the API Medical Staff FPPE/OPPE form.

2. The API Medical Staff FPPE/OPPE form rates the performance of the provider in five general competencies.
    a. Patient Care
    b. Medical/Clinical Knowledge
    c. Interpersonal and Communication Skills
    d. System-Based Practice
    e. Professionalism

ii. The Medical Director reviews the results of the completed API Medical Staff OPPE forms, including comments made by the reviewer, the outcome of the OPPE is documented and will be filed in the Medical Staff member's supervisory files and all such information may be included in consideration of the Medical Staff member's re-appointment, continuation of Medical Staff privileges.

iii. If concerns arise from the results of the OPPE, the Medical Director has the authority to:
    1. Assign additional performance monitoring to further assess competence, practice behavior. A practitioner may be subject to a FPPE when issues affecting the provision of safe, high-quality patient care are identified during the OPPE process. Decisions to assign a period of performance monitoring or evaluation to further assess current competence must be based on the evaluation of an individual's current clinical competence, practice behavior, and ability to perform a specific privilege.
    2. Institute a Performance Improvement Plan, which may include the following:
        a. Education
        b. Proctoring/Assistance for defined privilege
        c. Goal setting for improvement and defining how these goals are measured
        d. Counseling
        e. Practitioner assistance programs
        f. Suspension of a specific privilege

If it is the recommendation of the Medical Director to revoke a specific privilege or credentialing, any actions will be determined through the API Governing Body.

Further details for OPPE are identified in P&P, MS 040 “Medical Staff Performance and Quality Improvement through FPPE and OPPE Process”

B. Focused Professional Practice Evaluation

Following initial appointment, every Medical Staff member’s performance will be subject to an FPPE, an enhanced surveillance method to evaluate the privilege-specific competence of new Medical Staff members, an FPPE may also be initiated on a Medical Staff member due to concerns arising about that staff member’s ability to provide safe, high quality patient care. The FPPE is conducted by chart review. The FPPE is a formal review of an LP’s care towards patients, it includes, but is not limited to proctoring, review of documentation for medical decision making, review of use of pharmaceutical prescribing, review of documentation supporting diagnosis, observation of the provider’s interactions with patients and staff, directly and/or through discussion with other staff members. FPPE criteria are defined by the Medical Staff and are reviewed and approved by the Medical Director.

i. The FPPE is conducted by chart review.

1. During the first month of a new Medical Staff member’s appointment an appropriate Medical Staff member appointed by the Medical Director will review at least 5 client cases from time of admission to time of discharge and rate the performance of the provider utilizing the API Medical Staff FPPE/OPPE form, the reviewer will then review at least 1 client case from time of admission to time of discharge each month for the following 5 months, again rating the performance of the provider utilizing the API Medical Staff FPPE/OPPE form for a minimum of 10 client case reviews during the 6 months of the FPPE.

2. The API Medical Staff FPPE/OPPE form rates the performance of the provider in five general competencies.
    a. Patient Care
    b. Medical/Clinical Knowledge
    c. Interpersonal and Communication Skills
    d. System-Based Practice
    e. Professionalism

ii. The Medical Director reviews the results of the completed API Medical Staff FPPE forms, including comments made by the reviewer, the outcome of the FPPE is documented and will be filed in the Medical Staff

member's supervisory files and all such information may be included in consideration of the Medical Staff member's re-appointment, continuation of Medical Staff privileges.

iii. If concerns arise from the results of the FPPE, the Medical Director has the authority to:
    1. Assign additional performance monitoring to further assess competence and practice behavior. A practitioner may be subject to an additional period of FPPE when issues affecting the provision of safe, high-quality patient care are identified during the initial FPPE process.

    2. Institute a Performance Improvement Plan, which may include the following:
        a. Education
        b. Proctoring/Assistance for defined privilege
        c. Goal setting for improvement and defining how these goals are measured
        d. Counseling
        e. Practitioner assistance programs
        f. Suspension of a specific privilege

Assigning of additional FPPE is at the discretion of the Medical Director. The initiation of an FPPE may include but is not limited to:

i. an unsatisfactory Ongoing Professional Practice Evaluation (OPPE);
ii. in response to a complaint by another Medical Staff member;
iii. in response to complaint by MEC;
iv. in response to complaint by CEO or API Governing Body;
v. or in response to complaint by another member of API Senior Management and deemed founded by the Medical Director.

The results of a FPPE may be used to substantiate a complaint or to prove it unfounded. The process of FPPE does not indicate a formal investigation of competency or performance, however if significant negative outcomes are identified by FPPE, formal investigation may be pursued by the MEC. An FPPE may be conducted by the Medical Director, a Medical Staff member as assigned by the Medical Director or an outside (independent, third-party) reviewer. Further details for FPPE are identified in P&P, MS 040 "Medical Staff Performance and Quality Improvement through FPPE and OPPE Process"

C. Proctoring
Proctoring is part of the Focused Professional Practice Evaluation and Ongoing Professional Practice Evaluation. It may be real-time observation of a practitioner, e.g. observation of clinical history and physical, review of treatment planning, treatment orders, and patient interactions, it may also be performed using retrospective approaches (e.g. case, medical record review).

D. Failure to Comply
Failure to comply with OPPE, FPPE, Peer Review or Proctoring may result in disciplinary action and/or the removal of Medical Staff privileges.

XXI. Amendments to the Rules and Regulations
Additions or clarifications to information within the Rules and Regulations can be added as Amendments. The addition of such information is at the discretion of the Medical Director upon review and approval by the MEC. Upon review of the Rules and Regulations, any listed Amendments will be incorporated into the main body of the document. The updated document will then require review and signature into effect by the Medical Director/Chief of Psychiatry/President of the Medical Staff and CEO.

In the event significant changes or deletions need to be immediately incorporated into the Rules and Regulations, the Medical Director will present the changes/deletions to the MEC for vote of approval and will immediately incorporate the changes into the main body of the document. The updated document will then require review and signature into effect by the Medical Director/Chief of Psychiatry/President of the Medical Staff and CEO.

At no time can the Medical Staff Rules and Regulations be changed without the prior approval of the voting members of the Medical Staff through the MEC.

XXII. Approval
Signed Original on File in Medical Staff Office

XXIII. Amendments
Revised: _____
Original: January 2026

XXIV. Approval

Approved on the ____ day of _____ 2026 by the Governing Body

Dated: _____ _____

Robert Long, MD, Medical Director/Chief of Psychiatry

Dated: _____ _____

Kenneth Cole, Chief Executive Officer

Dated: _____ _____

Elizabeth King, Co-Chair, API Governing Body

Dated: _____ _____

Tracy Dompeling, Deputy Commissioner (or designee)