GUAM MEMORIAL HOSPITAL AUTHORITY
ADMINISTRATIVE MANUAL

APPROVED BY:	RESPONSIBILITY:	EFFECTIVE DATE:	POLICY NO.	PAGE
PeterJohn D. Camacho, MPH Hospital Administrator/CEO	Hospital-wide	Interim Approved: August 25, 2017	A-IM500	1 of 13
TITLE: POLICY DEVELOPMENT, REVISION, APPROVAL, AND DISTRIBUTION				
LAST REVIEWED/REVISED: 08/2017				
ENDORSED:				

PURPOSE

To provide a systemic procedure for developing, reviewing, updating, approving, and distributing hospital policies.

POLICY

- Hospital policies contain information relative to policies, programs, standard procedures, regulations, requirements, committees, and other areas relative to overall hospital philosophy and operation.
- Guam Memorial Hospital Authority (GMHA) will maintain an up-to-date policy manual available to all staff members.
- The following basic principles regarding hospital policy must be observed in order to assure an effective and efficient program:
  - Must be written in clear and concise language and will have an expiration date not to exceed three years from the "Last Reviewed/Revised" date as indicated in the title block above; as changes to policy or procedures occur, policies are to be updated to reflect these changes (i.e., if a change occurs it is to be reflected in the policy as soon as possible)
  - Development of policies will be a collaborative process involving representatives from all areas that have responsibility to carry out the policy. Policy development or updates should be collaborated in such manner to ensure that all required concurrence is obtained to signature and distribution.
  - Hospital policies (those located in the Administrative Manual) are limited to those policies that affect multiple services, reflect a fundamental direction of the facility, or are related to high risk, high cost, or problem prove endeavors. Policies that affect a single service or department are to be maintained as service-level or department-level policies.

RESPONSIBILITES:

A. HOSPITAL ADMINISTRATOR/CEO

1. The Hospital Administrator/CEO shall have the following responsibility for hospital policies:

   a. Review the hospital policies prior to signature to ensure accuracy and content are consistent with the Centers for Medicare and Medicaid (CMS), The Joint Commission (TJC) and any licensing standards and local law/administrative rules.

b. Ensure appropriate and applicable third party standards and Territorial Statue are listed under the reference section in all polices.

c. Review and approve all hospital policies and ensure all employees follow all policies consistently.

B. ADMINISTRATION OFFICE

1. The Administration Office shall have the following responsibilities:

a. Issue policy numbers for new policies that will be included in the hospital's Administrative Manual.

b. Issue a current index of hospital polices.

c. Develop and maintain tracking/tickler system to ensure each policy (to include interim) is reviewed for renewal within established timeframes.

e. Review all hospital policies prior to signing to ensure consistent format and established guidelines are followed.

C. DEPARTMENT MANAGER

1. Department Directors shall have the following responsibilities:

a. Determine the need for a hospital policy versus a service/department level policy and procedure.

b. Review current overlapping policies, which can be incorporated into one policy through collaboration.

c. Assure technical accuracy of the contents of all policies originating from their service/department. It may be necessary to collaborate updating the policy with a number of services/department to ensure accuracy. The policy must be consistent with current standards and requirements of the Department of Public Health and Human Services, external surveying bodies such as Centers for Medicare and Medicaid Services (CMS) and The Joint Commission (TJC), local licensing bodies, and Territorial Law/Administrative Rules.

d. Issue policy numbers for new policies that will be included in the department's manual.

D. Human Resources shall review accuracy and content of hospital policies as applicable to personnel practices and bargaining unit contracts.

E. **NOTE FOR SERVICE/DEPARTMENT LEVEL POLICIES:** Division Heads shall review and approve service/department-level policies for those services/departments which they maintain oversight and responsibility of.

PROCEDURE

A. A Policy Review Meeting will be scheduled as needed to update existing policies for approval before the expiration of their three year review date (three years after the "Last

Reviewed/Revised" date). The Policy Review Meeting will consist of the following core group whenever necessary:

1. Director of Quality Management
2. JC Compliance Officer
3. All collaborating parties as listed on the policy
4. Other staff as needed

B. All hospital staff are encouraged to make suggestions to their managers for new policies or revisions to existing policies.

C. If a manager or Hospital Committee believes a suggestion for a new policy has merit, a draft will be prepared using the format described in *Attachment I*. Preparation of the draft shall be a collaborative process with input obtained from service/department managers who are knowledgeable about the subject matter and responsible for carrying out tasks addressed by the policy (*see Attachment IV, Certification Form*).

1. Prepare all new policies or existing polices, according to the **format shown in Attachment I.**

2. The individual who prepared the new policy draft will contact either the Administration Office or the department manager for a policy number.

3. A Policy Review Meeting to review the policy, if necessary, will then be coordinated/scheduled by the policy's originator.

D. The Human Resources Administrator will review policies that may impact employee bargaining unit contracts or personnel policy.

E. The policy will then be routed to the necessary parties for signature (*see Attachment III* for service/department level routing requirements).

F. After approval, policies will be forwarded to the Administration Office to update the computerized policy manual and distribute to all appropriate personnel and hospital policy manual. Indexes will be updated and distributed as needed.

G. Owning departments or committees are encouraged to develop and distribute additional materials relevant to the policy at the same time a new or revised policy is distributed. These additional materials should be designed to help those affected by the policy implement its requirements. Recommended additional materials include Frequently Asked Questions, any forms or data gathering materials, and training or educational materials (such as PowerPoint slides). In addition, the owning department or committee should schedule Webcast or live trainings, as appropriate. Note: In some cases, the owning departments or committees may differ from the policy's originator, for example, those policies created as a result of executive mandates from the Governor of Guam, law, regulatory requirements, etc.

H. See Attachment II for Hospital Policy Review and Approval Process quick reference.

I. See Attachment VI for Interim Approval of GMHA Policies and Procedures.

J. Distribution of all policies will occur via the hospital's email delivery system. See *Attachment VI* for the *Sample Policy Distribution Email*.

RESCISSION:

Policy A-IM500, *Policy Development, Revision. Approval, and Distribution* of the Administrative Manual made effective June 26, 2012.

ATTACHMENTS:

I. **GMHA POLICY TEMPLATE**
II. **SERVICE/DEPARTMENT-LEVEL POLICIES & PROCEDURES/BYLAWS REQUIREMENTS**
III. **CERTIFICATION FORM FOR APPROVAL**
VI. **PLANS & PROGRAMS REQUIRING ANNUAL REVIEW AND EVALUATION**
V. **INTERIM APPROVAL OF GMHA POLICIES & PROCEDURES**
VI. **POLICY CIRCULAR FORMAT**

ATTACHMENT I

GUAM MEMORIAL HOSPITAL AUTHORITY
NAME OF MANUAL

APPROVED BY:	**RESPONSIBILITY:**	**EFFECTIVE DATE:**	**POLICY NO.**	**PAGE**
Name Title	Department or Committee or Hospital-wide	Leave Blank *(Compliance Officer will insert after policy has received final approval)*	Compliance Officer will provide for new Hospital Policies OR If service/dept. level, use Dept. Code #	1 of XX
TITLE: POLICY TITLE				
LAST REVIEWED/REVISED: MM/YYYY				
ENDORSED: Committee MM/YYYY, Committee MM/YYYY, etc.				

PURPOSE:

A brief statement describing the reason the policy is being enacted.

POLICY:

A general statement describing a consistent course of action to be followed in order to attain a desired outcome or goal. This should be a brief statement regarding the hospital's policy on the subject matter without a complete, detailed explanation of responsibilities or procedures.

DEFINITIONS:

Definition: A descriptive statement for terms used in the policy or procedure that may not be clearly understood by the reader. Underline the term being defined.

RESPONSIBILITIES:

List persons, by position, who are primarily responsible for key aspects of the policy. Specify who is responsible for carrying out which requirement of the policy.

PROCEDURE:

I. BOLD/CAPS

A. UNDERLINE/CAPS

1. Upper/lower case
   a. Upper/lower case
      i. Upper/lower case

REFERENCE(S):

List applicable statute, regulations, standards or sources of information used to develop the policy.

RELATED POLICY(IES):

List all policies referenced within the policy or are related to this particular policy. When one of the policies listed in this section is updated, all the policies shall be reviewed to ensure currency.

RESCISSION(S):

Identification by number, title, manual it is found in, and effective date of any policy replaced by this policy.

ATTACHMENT(S):

I. A BRIEF LISTING OF FORMS OR OTHER DOCUMENTS RELATING TO THE POLICY.

Additional Formatting Instructions		
Page Set-up	Margins	Top: 0.5”
		Bottom: 0.5:
		Left: 1”
		Right: 1”
	Paper	Letter, 8.5” x 11”
	Layout	Select “Different First Page” Header: 0.5” -Beginning on 2nd Page -“Policy #” -“Page x of y
Font	Type	Times New Roman
	Size	11 point

ATTACHMENT II

SERVICE/DEPARTMENT-LEVEL POLICIES & PROCEDURES/BY-LAWS REQUIREMENTS

IN ALL CASES, IT IS EXPECTED THAT INPUT WILL BE SOUGHT FROM KEY STAKEHOLDERS. EVIDENCE OF THIS WILL BE PROVIDED VIA A SIGNATURE ON THE REVIEW AND ENDORSEMENT CERTIFICATION FORM.

Manual	Division Head Review	Med Staff Dept.	Committee	MEC	EMC	BOT Sub-Committee	BOT
Institutional Review Board	Medical Director		IRB	Yes	Yes	JCPAC	Yes
Ethics Committee	HA/CEO		Ethics	Yes	Yes	JCPAC	Yes
BOT Bylaws					Review ONLY	GBSP	Yes
Volunteer Bylaws	AAO				Yes	JCPAC	Yes
Personnel Rules & Regulations	AAO		CSC (once approved by BOT)		Yes	Human Resources	
Safety & Security Manual	AAO		EOC				
Department Level Safety Policies			EOC				
Emergency Preparedness Manual	AAO		EOC				
Infection Control Manual	Medical Director	ICC					
Department-level IC Policies	Division Head	ICC					
Employee Health Manual	Medical Director	ICC—Only those related to Infection Control			Yes		
OPERATIONS DIVISION							
Central Supply Receiving	AAO						
Materials Management	AAO						
Planning	AAO						
Personnel (Department-level	AAO						
Environmental Services	AAO						
Facilities Maintenance	AAO						
Security	AAO						
Guest Relations	AAO						
Communications	AAO						

Information Services	AAO						
FISCAL SERVICES							
Accounting	CFO				Yes		
Budget	CFO				Yes		
Patient Affairs	CFO				Yes		
Patient Registration	CFO						
Medical Records	CFO		HIMC—Only those pertaining to medical record documentation.		Yes		
Medical Library	AAO		Library CME				
PROFESSIONAL SUPPORT							
Respiratory Care	Pro-Support Director		Special Care				
Dietetic Services	Pro-Support Director	Family Practice					
Laboratory/Pathology	Pro-Support Director	Tissue & Transfusion					
Pharmacy	Pro-Support Director	Pharmacy & Therapeutics					
Rehabilitative Services	Pro-Support Director	Surgery Medicine					
Special Services	Pro-Support Director	Radiology Medicine					
Education	Pro-Support Director						
Spiritual Care	Pro-Support Director						
Social Services	Pro-Support Director	Family Practice					
NURSING SERVICES							
Nursing Services Manual	Nursing Director			Yes—Only those affecting the medical staff.			

Emergency Room	Nursing Director	Emergency Medicine					
ICU/CCU	Nursing Director		Special Care				
Hemodialysis	Nursing Director		Special Care				
Labor & Delivery	Nursing Director	OB/GYN Pediatrics					
Medical Telemetry	Nursing Director		Special Care				
Pediatrics/PICU	Nursing Director	Pediatrics					
Nursery (All Levels)	Nursing Director	Pediatrics					
OB Ward	Nursing Director	OB/GYN Pediatrics					
OR/PACU	Nursing Director	Surgery Anesthesia					
Medical-Surgical	Nursing Director	Medicine					
Surgical	Nursing Director	Medicine Surgery					
Skilled Nursing Unit	Nursing Director	Medicine					
MEDICAL SERVICES							
Medical Staff Office	Medical Director						
Quality Management	Medical Director		PIC	Yes	Yes	Q&S	
Risk Management	Medical Director				Yes		
Performance Improvement Plan	Medical Director		PIC	Yes		Q&S	
MEDICAL STAFF							
Medical Staff Bylaws	Medical Director		Bylaws	Yes	Review ONLY	JCPAC	Yes
Rules & Regulations	Medical Director	All		Yes	Review ONLY	JCPAC	Yes
OTHER(S):							
Medication Policies *Note: A review by the Pharmacy Dept. head is required.*	Pro-Support Director	Pharmacy & Therapeutics					

Key:

EMC	Executive Management Council	PIC	Performance Improvement Committee	GBSP	Governance, Bylaws, and Strategic Planning Committee
MEC	Medical Executive Committee	CSC	Civil Service Commission		
IRB	Institutional Review Board	BOT	Board of Trustees		
EOC	Environment of Care	JCPAC	Joint Conference & Professional Affairs		
ICC	Infection Control	Q&S	Quality & Safety		

ATTACHMENT III

GUAM MEMORIAL HOSPITAL AUTHORITY
REVIEW AND ENDORSEMENT CERTIFICATION

The signatories on this document acknowledge that they have reviewed and approved the following:

□ Bylaws Submitted by Department/Committee: _____

□ Rules & Regulations Policy No.: _____

□ Policies & Procedures Title: _____

Reviewed/Endorsed	**Date**	**Signature**
Title	*Name* *Title*	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name* *Title*	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name* *Title*	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name* *Title*	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name* *Title*	
Reviewed/Endorsed	**Date**	**Signature**
Title	*Name* *Title*	

***Use more forms if necessary. All participating departments/committees in developing the policy should provide signature for certification prior to submitting to the Compliance Officer.**

ATTACHMENT IV

The following plans and Programs require ANNUAL review and evaluation:

- Safety Management plan
- Security management Plan
- Hazardous Materials and Waste management Plan
- Emergency Management Plan
- Fire Safety Plan
- Medical Equipment Management Plan
- Utilities Management Plan
- Patient Safety Program
- Infection Control Program
- Performance improvement Plan
- Strategic Plan
- Long-Term Capital Expenditure Plan
- Others, as deemed necessary, will be added to this list and will be communicated throughout the hospital via Policy Circular

ATTACHMENT V

INTERIM APPROVAL OF GMHA POLICIES & PROCEDURES

1. Each policy and procedure will have a preliminary examination by the Administration Office to insure that it contains all the essential elements (that is, compliance with consistent format and established guidelines)

    a. Only those containing all of these elements will be considered for interim approval.

        i. Any shortcomings will be brought to the attention of the policy's originator.

        ii. An unacceptable policy and procedure may be resubmitted after major revision.

2. A written and supported justification for interim approval must accompany the policy and procedure.

3. If the policy is acceptable, interim approval may be given at the discretion of the Hospital Administrator/CEO and as permitted by regulatory agencies.

4. Interim approval of any policy has to be reported to the Executive management Council (EMC) at its next meeting and EMC must concur.

    a. The interim approval is valid as long as no substantive changes are made to the policy and procedure by EMC.

    b. Interim approval is only valid for a time period of **no longer than 90 days** after it is granted.

    c. It is expected that the policy and procedure will be submitted for official approval through the relevant departments and committees (see Attachment III) while it is approved on an interim basis.

5. It is the responsibility of the identified responsible party(ies) to adequately supervise the implementation of the policy and procedure and to ensure compliance as approved. This individual(s) should be prepared to report this information to EMC at its request.

6. The Hospital Administrator/CEO may revoke his/her approval at any time for just cause (e.g., non-compliance, adverse reactions, change in law, etc.). It is also to be understood that even if EMC has reviewed and approved a policy and procedure, it retains the right to reconsider it, request for further information or even revoke approval at any time.

ATTACHMENT VI

POLICY DISTRIBUTION
SAMPLE E-MAIL

SAMPLE E-MAIL
FOR USE BY COMPLIANCE OFFICER/DEPARTMENT MANAGERS/COMMITTEES WHEN DISTRIBUTING NEW/REVISED POLICIES

[Insert date here]

TO: [Insert name of recipients]

FROM : [Insert name of "owner" department or committee]

SUBJECT: Policy Manual, Number & Name, (New/Revised)

Please find Guam Memorial Hospital Authority's policy [insert name and number] which has been approved by [insert name of final signatory body, ie, title block signatory], and is effective [immediately/or insert date]. This policy has been posted on the GMHA Website.

The significant issues addressed in this [policy/revision] include:

 [Insert brief bullet-points description of the policy purpose and/or revisions]

Also attached are the following additional materials, which may be used to help implement this policy:
 [Insert list of additional materials with brief description or purpose]

Please notify appropriate departments and personnel of this policy/change. A copy of this memo and policy should be forwarded to [list suggested departments]. For additional information or clarification, you may contact [insert name of policy "owner"] at [contact information].

[ATTACH POLICY]
[ATTACH ADDITIONAL MATERIALS]

GUAM MEMORIAL HOSPITAL AUTHORITY
Administration Office
850 Governor Carlos G. Camacho Road
Tamuning, GU 96913

MEMORANDUM

TO: PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO

FROM: Theo Pangelinan
Administrative Assistant

DATE: August 24, 2017

SUBJECT: REQUEST FOR INTERIM APPROVAL OF POLICY A-IM500

This is to request interim approval of Policy No. A-IM500, Policy Development, Revision, Approval, and Distribution of the Administrative Manual.

Interim approval of this policy would serve as a tool for departments to reference as work is done to conduct a mandatory review of all policies and procedures in reference to your Informational Circular 2017-124 directive.

With your approval, this policy will be made effective August 25, 2017 for a period of 90 days.

Sincerely,

Theo M. Pangelinan

[ ] Approved [ ] Disapproved

PeterJohn D. Camacho, M.P.H.
Hospital Administrator/CEO