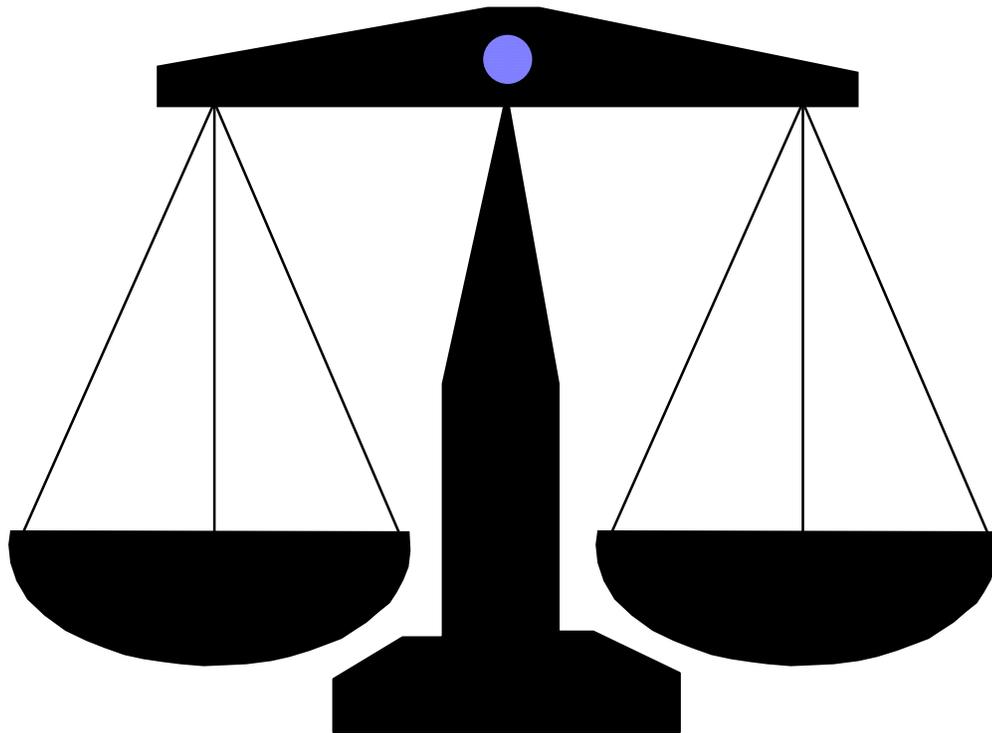


Medical Staff

General Rules & Regulations



Last Revision: October 18, 2021

RULES AND REGULATIONS OF THE MEDICAL STAFF
OF
PEACEHEALTH SOUTHWEST MEDICAL CENTER

Section 1 - General

1. Patients may only be admitted to the Medical Center by members of the Active Clinical, Courtesy, and Associate staff. Consulting staff may admit provided that an attending physician, who is a member of the Active Clinical staff, co-admits the patient and countersigns the admitting order within 72 hours.
2. Each patient admitted to the hospital must be seen by the attending practitioner within 24 hours of notification of admission, except critical care patients who must be seen within 4 hours of admission or sooner if warranted by the patient's medical/surgical condition.
3. Each patient shall be the responsibility of an attending licensed independent practitioner with appropriate privileges. The attending practitioner is the practitioner who performs the history and physical examination and will be responsible for the patient unless the responsibility is transferred by the attending practitioner by personally contacting another practitioner/group who agrees to accept the patient. Transferring responsibility for care must have the concurrence of the newly responsible practitioner and will be documented by entering a note on the order sheet in the patient's medical record. On the Psychiatric Services unit, the attending practitioner is the psychiatrist even when the physical examination is delegated to a consultant. In cases of practitioners without specific H&P privileges, the H&P will be performed and recorded by a member of the staff with appropriate privileges, which may include the attending anesthesiologist, to be identified on admission. Associate staff members may perform H&Ps when the patient is admitted for care within their delineated privileges; however, there must be clear documentation of collaboration with a member of the Active medical staff. Primary and ongoing responsibility for medical care of a patient which is outside the competence or delineated privileges of an Associate member shall be the responsibility of a collaborating practitioner.
4. When the attending practitioner is notified that a patient wishes to change practitioners, the practitioner may elect to have the patient relations coordinator, social services or the nursing supervisor intervene or negotiate with the patient/family if this intervention has not already occurred. If possible, the attending practitioner should take the responsibility to select another practitioner to be the attending, if agreeable with the patient/family wishes. If there is difficulty in finding another practitioner, the department chair will be asked to assign an appropriate attending practitioner. The department chair may select the city call physician. If so, the city call physician must be responsive to this request.

The original attending practitioner will retain responsibility until the new practitioner agrees to assume care of the patient. When a practitioner is replaced, departmental chart review may be initiated.

5. No patient shall be admitted to the Medical Center until a provisional diagnosis or valid reason for admission has been stated.

6. Each member of the Active and Courtesy medical staff shall provide for continuous coverage for his/her patients and respond appropriately to emergencies or designate a member of the Active/Courtesy Medical Staff for coverage during his/her absence or unavailability. The designee shall have comparable privileges.

Members of the medical staff are required to have a plan for coverage for their patients and practices at all times. In most cases, that plan includes a call-sharing arrangement with one or more other members of the medical staff who have comparable privileges, with agreement that at least one member of the call group is available on call at all times. Any other arrangement must be reviewed by the Credentials Committee for feasibility. The call coverage plan shall be documented by the applicant during the initial appointment and reappointment process. The practitioner will be responsible to communicate to the Medical Staff Office, any changes which result in the termination of a call-sharing arrangement.

In case of unavailability of the physician and designee, the nurse supervisor, the CEO or the president of the medical staff may notify the chair of the department concerned, who shall have the authority to call upon any member of the Active/Courtesy medical staff to cover in such an event.

It is the expectation of the medical staff that the physician who is on call will respond to emergencies either in person or by phone to calls or pages to the hospital within 20 minutes of page and be onsite, if required, within 45 minutes (a longer response time may be reasonable when the individual paging the physician specifically states that the call is not an emergency and that a response can be delayed for a specific period of time).

7. City call is intended to provide:
 - a. an attending physician and outpatient follow-up care for medical patients requiring admission who do not currently have an established relationship with a primary care practitioner (PCP),
 - b. an attending physician for patients requiring specialty admission who do not currently have an established relationship with a practitioner whose scope of practice includes care for the presenting problem or with a PCP who has an established referral preference with a practitioner who is willing to admit the patient,
 - c. specialty consultation for admitted patients, observation patients, or patients at the Emergency Department of the Medical Center Campus of PHSW who do not currently have an established relationship with a practitioner whose scope of practice includes care for the presenting problem or with a PCP who has an established referral preference with a practitioner who is willing to provide consultative service, and/or outpatient medical follow-up care for the specific presenting problem, after a visit to the Emergency Department of the Medical Center Campus of PHSW, for patients who do not currently have an established relationship with a primary care practitioner (PCP) or with a practitioner whose scope of practice includes care for the problem which brought the patient to the ED.

A physician who would otherwise be required to provide city call services may arrange for another physician on the Active or Courtesy staff, with comparable privileges or practicing the same specialty, to provide city call services for patients in his or her stead.

City call is intended to provide an attending physician for Medical Center patients and/or medical follow-up care for the specific medical problem that brought the patient to the

Emergency Department, for patients who do not currently have an established relationship with a primary care practitioner (PCP) or with a practitioner whose scope of practice includes care for the problem which brought the patient to the ED.

A PCP is defined to be one of the following:

- a. Family medicine physician
- b. General internist
- c. Pediatrician
- d. PA or ARNP associated with a primary care physician
- e. Any other specialist (e.g., OB/GYN) or subspecialist (e.g., pulmonologist) who is providing on-going primary care services for that patient in the absence of another primary care practitioner
- f. A primary care relationship is not established by a prior consultation with a specialist except as in Item e. above

City call will generally be assigned equally, in rotation, among those in a given specialty. However, those within a specialty may, by unanimous agreement, establish an alternate method of determining the call rotation.

Call requirements may also be waived under special circumstances. Such waivers for OB/GYN, family medicine, cardiac and vascular, general internal medicine, and pediatrics require a 50% response rate of the voting members for a valid vote, with approval of 90% of the department members affected. For surgical specialty and medical subspecialty call, the approval must be unanimous with 100% response. All waivers from city call may be appealed to the department and/or the Executive Committee.

Practitioners practicing radiology, pathology, emergency medicine, radiation oncology, rehabilitation medicine, anesthesiology or retina sub-specialists in ophthalmology and cardiac surgery shall not be included in the city call rotation. Physicians in the hospital's contracted Inpatient Physician Service will not be listed on the city call list for outpatient follow-up.

At their option, those physicians sixty (60) or more years of age, or fifty-five (55) or more in the case of general surgeons, or as determined by each clinical department, may be excused from city call.

- a. It is a condition of Active Clinical Medical Staff membership that a physician shall be responsible for providing services on the city call rotation. In addition, when Courtesy Staff members within a specialty group have a total of six contacts in aggregate within a year, they will become responsible for one turn in the city call rotation. A contact is defined as care delivered by a specialty group to a single inpatient or outpatient admission, which includes admission, follow-up rounding, consultation, procedure, and discharge, by a physician on courtesy staff. Care by physicians on different specialties within a multispecialty group may constitute a contact for each of the specialties involved.

Additional turns will be assigned for each increment of six contacts until the number of turns reaches the number of Courtesy Staff members in the group.

If a contact results from assignment of a patient through city call, it will not count toward acquiring another city call turn. If a call group includes both Active and Courtesy staff members, only contacts by the Courtesy staff members in the group will be counted. If a Courtesy staff member subsequently joins the Active medical staff, his or her previous contacts will be deleted from the aggregate.

For the purposes of this section, a group is defined as two or more physicians of similar specialty or with comparable privileges sharing call.

A physician who would otherwise be required to provide city call services may arrange for another physician on the Active or Courtesy staff, with comparable privileges or practicing the same specialty, to provide city call services for patients in his or her stead.

- d. The period of responsibility for city call begins at 0700 hours and continues until 0659 hours the next day. During this period, patients eligible for assignment under the city call system shall be assigned to one of the following specialties or subspecialties at the discretion of the Emergency Department practitioner:
- (1) Dermatology
 - (2) Family Medicine
 - (3) Internal Medicine
 - (4) Cardiology
 - (5) Gastroenterology
 - (6) Infectious Disease
 - (7) Nephrology
 - (8) Oncology
 - (9) Pulmonology
 - (10) Neurology
 - (11) Pediatrics
 - (12) General Surgery
 - (13) Orthopedic Surgery
 - (14) Psychiatry
 - (15) Neurosurgery
 - (16) ENT Surgery
 - (17) Ophthalmology
 - (18) Urology
 - (19) Plastic Surgery
 - (20) Oral Surgery
 - (21) Podiatry
 - (22) Obstetrics
 - (23) Gynecology
- e. When such service is available, physicians taking city call in primary care may elect to have adult medicine patients admitted and followed by the Inpatient Physician Service. It remains the responsibility of the physician listed on city call on the day of admission to provide post hospital care for these patients.

The appropriate timing of follow-up is determined at the discretion of the discharging physician. The city call physician is responsible for assuring access to follow-up care within the recommended time period.

The city call physician remains responsible for the care of the patient until such time as the acute problem or the acute exacerbation of the patient's chronic medical condition is resolved and the patient is formally discharged from the physician's practice.

If the patient is discharged with home health or hospice services, the city call physician is responsible for monitoring those services for 60 days or until other arrangements are made by the physician. In these situations, it is expected that the discharging physician will make contact with the city call physician before discharge.

- f. Patients who require follow-up from the Emergency Department will be assigned a physician from the city call list as appropriate to the patient's medical problem. It will be the responsibility of the assigned city call physician to offer follow-up care for that specific medical problem that was stabilized in the ED, without regard to the patient's payment status. It will be the patient's or the patient's caretaker's responsibility to contact the assigned practitioner's office within 72 hours to arrange for necessary follow-up appointments. Patients returning to the Emergency Department prior to contacting the assigned city call physician, or patients who fail to keep the follow-up appointment with the assigned city call physician and return to the Emergency Department, will be re-entered into the city call system as an unassigned patient (except when the city call physician has assumed patient care by telephone instructions with the patient).
- g. A patient may be discharged from a practice via a formal letter to the patient with a copy in the Medical Center chart. The patient will then be eligible for disposition through the city call system. The physician on call must accept the patient for admission or follow-up even if that physician is a member of a practice which has discharged the patient.
- h. A city call patient, who requires evaluation or hospitalization within 60 days of discharge from previous hospitalization, shall be assigned to the previous discharging practitioner or group. After 60 days, the patient will be returned to the city call pool for assignment.
- i. A patient who has an established relationship with a PCP shall not be eligible for outpatient disposition under the city call rotation. Should the patient's PCP require assistance from a subspecialist or specialist in caring for that patient, it is expected that the PCP's usual referral pattern will be used in obtaining such outpatient consultations.
- j. When a patient requires admission to the Medical Center for acute care, the patient will be evaluated by the designated admitting physician who must then directly request consultation from specialists or subspecialists as necessary.

If the consultant agrees, the consultation may be used as the admission History and Physical. Necessary elements of the H&P (as noted in Section 2, Item 1.a.) not

performed as part of the consultation must be completed by the city call physician of record.

- k. When inpatient, observation, or Emergency Department consultation is required, the consulting physician is encouraged to consult colleagues in the PCP's or the admitting physician's usual referral pattern, but have the option of consulting anyone on the medical staff in the patient's best interest. The specialists are encouraged to provide service when requested. However, if the consultant does not wish to accept the case, consultation becomes the responsibility of the specialist on the city call list at the time the consult is requested. General internal medicine consultations can be obtained from the Inpatient Physician Service and outpatient follow-up responsibility is then determined through the internal medicine city call list from the day and time of the consultation.
8. The city call schedules will be completed on a rotational basis and will be distributed no less than one month in advance.
 - a. When a physician is on call for his/her specialty as listed on the city call schedule for the Emergency Department and there is a conflict with the date(s) assigned (vacations, etc.), it is his/her responsibility to arrange for coverage for the assigned date(s).
 - b. In unusual circumstances in which the physician is unable to arrange coverage for his/her city call, he/she shall contact the department chair.
 - c. Changes to call schedules will be communicated to the designated hospital department which maintains the call schedules according to policy.
 - d. Once the city call schedule is mailed, a change in staff status will not relieve the physician from the city call assignments, i.e., the physician or his/her group will have the responsibility for fulfilling the city call assignment until publication of the following city call schedule.
 - e. Change in privilege status, mailing address, phone number, etc., should be communicated to Medical Staff Services.
 - f. In cases in which city call is assigned by group rather than by individual physician, the physician on-call for the group is responsible regardless of his/her age and staff status, i.e., Courtesy or Active.

Revised & Approved:

Executive Committee: 3/6/07, 2/5/08 & 5/6/08, 7/6/10, 11/01/11, 4/3/12

Active Medical Staff Vote: 5/20/08, 6/20/10, 12/19/11, 5/29/12

Board of Directors: 3/21/07, 5/21/08, 7/21/10, 4/18/12, 6/18/12

Section 2 - Medical Records

All attending practitioners shall be responsible for the preparation of a complete and legible medical record for each patient. All medical records shall contain sufficient information to identify the patient, support the diagnosis, justify the treatment, document the course and results, and facilitate continuity of care.

1. A complete medical record contains information reflecting the patient's condition on arrival, initial diagnosis, test results, in hospital treatment and therapy, in hospital progress and complications, and final diagnosis. The history and physical, operative report, consultations and discharge summary must be authenticated.
2. Autopsies
 - a. Autopsies may be performed only on written consent in accordance with state law. Autopsies shall be performed in all deaths that meet the coroner's criteria for required autopsies or on request of the attending practitioner if the autopsy is done at PHSW. The autopsy may be done at the coroner's office or PHSW.
 - b. Provisional anatomic diagnoses will be recorded on the medical record within seventy-two (72) hours and the completed protocol shall be made part of the record within one (1) month and copies provided to the attending practitioner.
3. Resident Records
 - a. All patients admitted to the care of the resident staff will also have an attending practitioner who has appropriate privileges to care for the patient. The attending practitioner of record is responsible for the timely completion of the record.
 - b. The resident practitioner may make any and all entries into the medical record. A minimum of one progress note daily will be recorded on patients being followed. The attending practitioner will co-sign history and physicals, discharge summaries and any procedure or operative dictation.
 - c. Resident documentation will meet the standards of record keeping as outlined in these rules and regulations.
4. Practitioner Notification of Incomplete H&Ps and Operative Reports
 - a. The practitioner will be notified at discovery of an absent or incomplete history and physical and/or operative report. If the report remains incomplete at four calendar days after notification, the practitioner will receive notification by confirmed fax or certified letter from the vice president of medical affairs or the medical staff president that he/she may face suspension. The report must be completed within three calendar days of this notification or the practitioner will be suspended from the medical staff following the same process as outlined in 5(c) 1 and 2 below.
 - b. In cases of disagreement between Medical Records staff and the practitioner on completion of the report or charts, the report will be referred to the vice president of medical affairs.

5. Chart Completion: Whenever possible, the patient's medical record, including progress notes, final diagnosis and discharge summary shall be completed at discharge. Charts are expected to be completed within 2 weeks of discharge. If the practitioner assigned to dictate the discharge summary disagrees with the assignment, he/she is responsible for requesting removal of the assignment within 14 days. If no notification is made to Health Information Services; within 14 days of the assignment, the physician will be responsible for completing the discharge summary.
 - a. If any chart remains incomplete at 2 weeks, the practitioner is notified by Medical Records. The method of notification will be predetermined by the practitioner. Any further actions necessary will be based on the date of this notification.
 - b. If any chart remains incomplete at 3 weeks, the practitioner will receive notification by confirmed fax or mail or email that he/she may face suspension from the medical staff.
 - c. If any chart remains incomplete at 4 weeks, the practitioner will be notified by a confirmed fax or certified letter from the president of the medical staff of suspension of admitting and surgical privileges.
 - 1) Physicians who are on suspension cannot admit nor perform or schedule surgeries. Likewise they cannot admit from the Emergency Department. If they are on city call, they are responsible for arranging coverage and if unable to do so, the issue will be referred to the Department Chair. They may attend patients already hospitalized.
 - 2) If this is the first such offense for the practitioner during his/her tenure on the Medical Staff, the suspension will be lifted upon completion of charts and reports.
 - 3) For subsequent offenses, the length of the suspension will be two weeks.
 - d. Continued lack of timely documentation by an individual practitioner will result in referral to the clinical department with a profile of the practitioner's documentation pattern.
 - e. Physicians or other practitioners leaving PHSW staff membership shall make every reasonable effort to complete all patient medical records prior to the effective resignation date. These individuals shall make arrangements for a designated associate to complete the records that are determined to be incomplete after their departure. If records which are known prior to the physician's departure to be incomplete remain uncompleted, or if an associate is not designated to address incomplete charts, a letter to this effect will be placed in the practitioner's file and will be part of his/her credentials reference file.
6. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record.
7. Electronic signatures through clinical computer systems are accepted as authentication.
8. All members of the medical staff shall utilize the hospital's secure electronic system at the site of care or remotely whenever possible to place orders for medications and other services. Orders shall be authenticated through the use of an electronic signature

9. Only those symbols and abbreviations which are approved by the medical staff may be used.
10. The final diagnoses shall be recorded in full at the time of discharge.
11. A discharge summary shall be a part of the medical record of the patient hospitalized over forty-eight (48) hours, excluding routine obstetric patients. The attending physician is responsible for the completion of the discharge summary. A death summary must be dictated on all patients expiring regardless of length of stay, except for respite care patients. The content shall be sufficient to justify the diagnosis and treatment. This shall be the responsibility of the attending practitioner. Any clinically significant results of diagnostic studies must be acknowledged in the progress notes or the discharge summary. Discharge summaries shall be dictated.
12. Surgical, endoscopic and invasive diagnostic procedures shall have reports dictated and completed as soon as possible following the surgery/procedure, in no case longer than twenty-four (24) hours. Operative reports will contain a description of the findings, the technical procedures used, the specimen removed, the postoperative diagnosis, estimated blood loss and the name of the primary surgeon and any assistants.
13. An operative progress note shall be entered in the medical record after surgery to provide pertinent information for use by any individual who is required to attend the patient. It shall be entered immediately after surgery and will include the following elements: post operative diagnosis, procedure, surgeon, assistant, estimated blood loss, when applicable specimens removed and findings.
14. Progress notes should be recorded at pertinent time intervals sufficient to permit continuity of care and transferability and shall be written at least daily for all patients except for patients admitted to the inpatient rehabilitation unit. In the inpatient rehabilitation unit, patients are seen a minimum of five days a week. Further contact with patients would be determined by the medical and rehabilitation needs of the individual patient. There will be a 24-hour-per-day, seven-day-a-week availability of medical care within a 30 minutes response time.
15. Diagnostic Imaging reports must be dictated within 24 hours following performance of the test and signed within 48 hours.
16. PHSW clinic records must follow department specific guidelines for chart completion.
17. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
18. For purposes of definition, a medical record shall denote all information, notes and reports compiled in the normal course of business in the care and treatment of a patient. The patient's medical record shall remain in the patient care area where the patient is currently being treated. Original medical records of patients treated are the property of the Medical Center and shall not be removed from custody except by court order, subpoena, or statute. Unauthorized removal of charts from the Medical Center is grounds for suspension of the practitioner for a period of time to be determined by the Executive Committee of the

- medical staff. Removal of records by court order which involves potential litigation will require notification of the practitioner by the Medical Center as a matter of courtesy.
19. If it is necessary for a correction to be made in the record of a patient currently hospitalized, the accepted practice shall be to line out the incorrect data with a single line in ink, date the lining out, and initial it. Under no circumstances shall the record be altered after completion of the medical record; however, an addendum may be added to the record as long as it is dated currently and signed by the person making the addition.
 20. Access to medical records shall be afforded to members of the medical staff, allied health professionals, and other, for research and audit, consistent with preservation of the confidentiality of personal information. Application by those interested should be submitted, in writing, to the CEO or chair of the clinical department or president of the medical staff and should include the subject or purpose of the chart review and the time period or number of patients to be reviewed.
 21. Medical records shall not be permanently filed until completed by the responsible practitioner or until ordered filed by the President of the Medical Staff or his/her designee.

Section 3 – General Conduct of Care

1. Patients shall be discharged only upon a written or verbal order of the attending practitioner or designee. Should a patient wish to leave the Medical Center against advice, an “Against Medical Advice” form must be signed. If a signature cannot be obtained, a notation of the incident shall be made in the patient’s medical record.
2. Restraint or seclusion use may be ordered by a licensed independent practitioner or a physician assistant. Orders for restraints or seclusion may only be used in emergent situations where there is an immediate physical danger to the patient, staff or other patients. Seclusion or restraints will be ordered and employed in a manner consistent with an approved Medical Center-wide policy/procedure. PRN restraint orders will be considered invalid and will not be implemented. The practitioner will be contacted to authorize the preprinted restraint or seclusion order.
3. Informed consent requires that the patient has been informed of the procedure/treatment, the alternative treatments and the risks. The responsibility for obtaining informed consent lies with the practitioner performing the medical or surgical intervention. In most situations the responsible party will be a physician. However, when another healthcare professional, such as a physician’s assistant, nurse practitioner, or dentist is the treating practitioner, responsibility for obtaining informed consent may fall to him or her. If consent has been acquired by the practitioner, obtaining the signature on the consent form may be delegated to another member of the healthcare team. Consents must be obtained in accordance with WA State and Federal law requirements for surgical, diagnostic or other procedures involving significant possible risk, procedures involving high radiation exposure, procedural sedation and blood administration. When an emergency procedure/treatment is required for a minor or incompetent patient, reasonable efforts shall be made to reach the patient’s parents, guardians or next of kin. If consent cannot be obtained, the circumstances should be fully explained on the patient’s medical record.
4. All medical record entries and orders for treatment shall be written clearly, legibly and completely and include date and time of entry, or be dictated only to a duly authorized person. Duly authorized persons, confined to their realms of operation, shall include designated employees of the Diagnostic Imaging, Cancer Center, Laboratory, and Rehabilitation Services, and registered dietitians, registered pharmacists, respiratory therapists, licensed nurses, registered nurses or others authorized by Administration and the medical staff.

Dictated orders include verbal orders that are defined as those transmitted face to face and telephone orders which are dictated by an ordering provider who is not present in person.

Verbal and phone orders will be taken following approved nursing protocols and hospital policies and procedures. All telephone or verbal orders will be read back to the practitioner for confirmation.

Verbal orders shall be accepted only in emergent situations or to avoid interrupting a procedure.

Telephone orders or verbal orders received and recorded in this manner are considered official when dictated. Authentication for all medication orders is required within 48 hours of the order and must include signature, date and time the signature was written. All other telephone and verbal orders must be authenticated within 30 days of the order.

Practitioners in a group practice, or covering physicians, may sign orders for each other.

Preprinted orders will be utilized in the following formats:

With the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician approved hospital policy after an assessment of contraindications, orders for drugs and biologicals must be documented and signed by a practitioner who is authorized to write orders by hospital policy and in accordance with State law and who is responsible for the care of the patient.

- a. Protocols – Protocols are developed and approved by the clinical department(s) involved.
 - b. Preprinted Orders – Preprinted orders will be printed on an order sheet and do not require approval of the Medical Executive Committee. Preprinted orders will be utilized for a specific practitioner or group of practitioners and for a specific diagnosis.
 - c. Standing Orders – Standing orders will be preprinted on an order sheet and require approval via medical staff committees. Standing orders are not modified and will be utilized for a specific procedure/diagnosis. Standing orders will be initiated automatically.
5. All previous orders are canceled when a patient goes to ICU/CCU from the general patient care areas or from the ICU/CCU to the general patient care area. Upon transfer from these areas, new orders need to be written. If the transfer from special care unit (ICU) is for Medical Center convenience, the practitioner may verbally continue same orders. However, within 24 hours, orders must be reviewed, rewritten and signed by the attending practitioner.
 6. Pre-Operative Assessment: Except in emergencies, the pre-operative diagnosis, required laboratory tests, admission history, a physical examination and an evaluation of the overall medical risk must be recorded on the patient's medical record prior to any surgical procedure. In an emergency, the practitioner shall make at least a note regarding the patient's medical condition prior to induction of anesthesia and the start of surgery.
 7. Pre-Sedation Assessment:
 - a. A procedural sedation plan will be documented prior to the procedure. The plan will include the American Society of Anesthesiologists (ASA) score, and an airway, heart and lung assessment.
 - b. Post-operative documentation records, post-anesthetic follow-up of the patient's condition, any unusual events or complications or management of such events shall be documented.

8. All drugs and medications administered to patients shall be approved by the Pharmacy and Therapeutics Committee of the medical staff. Experimental drugs shall be used in full accordance with the "Statement of Principles Involved in the use of Investigational Drugs in Medical Centers" and all regulations of the Federal Drug Administration.
9. Consultation is required in the treatment of a patient when the attending practitioner does not have clinical expertise or possess specific clinical privileges required for the patient's condition or problem. In this situation, the practitioner may refer the patient to another practitioner for complete care or may continue to give care for those diseases for which he/she has clinical privileges. Consultation by a member of the Psychiatric Consultation and Liaison Team is mandatory in threatened or attempted suicide.
10. The requesting provider is responsible for notification of the consultant. The attending practitioner should contact the consultant directly.

Communication with the consultant should clearly define when the requesting provider would like the consultant to see the patient. Communication should utilize the SBAR format which includes describing the Situation, giving information on the Background, providing your Assessment and stating your Request/Recommendations. The request/recommendation should be clearly stated so the consultant understands when they need to evaluate the patient.

After the consultation is completed, the consultant should call the requesting provider along with dictating or writing a note if the consultant identifies medical necessity which warrants immediate follow-up for an acute condition.

11. When a nurse has reason to doubt the appropriateness of care, verbal or phone order provided to a patient or feels that consultation is needed, he/she shall call this to the attention of the nurse in charge, who in turn will call the attending practitioner or his/her designee. If the matter is not resolved, the nurse in charge will contact the nursing supervisor, who will again call the attending practitioner or his/her designee. If, again the matter is not resolved, the nursing supervisor will contact the chairman of the clinical department or his/her designee. The chair of the clinical department, the medical director of the department, if applicable, or his/her designee may require the attending practitioner to obtain consultation (See Item 9 above).

Section 4 – Medical Screening Examinations

1. Medical Screening Examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified Medical Personnel (“QMP”) who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:
 - a. Emergency Department:
 - i. members of the Medical Staff with clinical privileges in Emergency Medicine;
 - ii. other Medical Staff members with appropriate privileges;
 - iii. appropriately credentialed Advance Practice Professionals; and
 - b. Labor and Delivery:
 - i. members of the Medical Staff with obstetric privileges;
 - ii. Certified Registered Nurse Midwives with obstetric privileges; and
 - iii. Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.
2. The results of the medical screening examination must be completed within 24 hours of the conclusion of an Emergency Department visit. Results must be completed prior to patient transfer to another facility.

Revised:

9/98, 7/99, 6/00, 4/01, 702, 9/04, 2/06, 5/21/08, 12/16/09, 7/21/10

Medical Executive Committee Approval: 4/6/04, 9/7/04 & 10/5/04, 12/6/05, 2/5/08 & 5/6/08, 12/1/09, 7/6/10, 2/7/12, 4/3/12; 11/13/2018; 10/12/2021

Medical Staff Vote Approval: 6/8/04, 11/30/04, 2/10/06, 5/20/08, 11/2/09, 6/20/10, 12/31/11, 5/29/12, 2018 revision - vote NA per new bylaws

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