MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS
OF
ST. MARY’S HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE 1

ADMISSIONS, DISCHARGE AND TRANSFER OF PATIENTS

1.1. Except in an emergency, no patient shall be admitted to the Hospital until after a provisional diagnosis has been made by the admitting physician.

1.1.1. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

1.1.2. The physician shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self-harm.

1.2. All patients shall have an attending physician.

1.2.1. In the case of a patient who applies for admission or who is an emergency patient and who has no attending physician, such patient shall be assigned to the member of the Active medical staff on duty on the service to which the illness of the patient indicates assignment.

1.3. The Hospital staff shall admit patients suffering from all types of diseases except severe mental disease and uncomplicated acute and/or violent alcoholics.

1.3.1. Since the Hospital does not have either a psychiatric service or a substance abuse service, patients with either of these conditions can be admitted only if there are emergent coexisting medical or surgical problems.

1.4. Patients shall be discharged only on written* order of a physician or an authorized Allied Health Professional.

1.5. When patients are transferred from ICU to another unit, all orders shall be canceled and new orders shall be written by the physician.

1.6. Prior to transfer to a nursing home, the attending physician should reissue orders for the patient.

* NOTE: All references to “written” entries into the medical record set forth in these Medical Staff Rules and Regulations shall be interpreted to mean written entries, appropriately issued verbal orders, as well as computer-keyed entries into the Electronic Medical Record when the relevant portion of the record exists in electronic form. See Article 2 of these Rules and Regulations for further detail.
ARTICLE 2
MEDICAL RECORDS

Section 2.1. General:

2.1.1. Only authorized individuals may make entries in the medical record. Electronic entries will be entered through the Electronic Medical Record ("EMR"). In emergency situations or when the EMR is not available, handwritten entries will be legibly recorded in blue or preferably black ink. All entries must be timed, dated and signed.

2.1.2. The attending physician will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

2.1.3. All documentation will be authenticated, dated and timed.

2.1.4. Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the EMR or written signatures or initials for handwritten entries. Signature stamps are not an acceptable form of authentication for written orders/entries. The practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy.

2.1.5. Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

2.1.6. All records and files shall be the property of the Hospital and shall not be removed from the Hospital’s jurisdiction and safe keeping without a proper court order, subpoena, or statute requiring same. In the case of readmission of a patient, all previous records shall be available for use by the attending physician. Any physician taking charts from the Hospital without permission shall be suspended until the chart is returned, or for any additional period of time that may be determined by the Medical Executive Committee of the Medical Staff.

2.1.7. Resident physicians may make entries into the medical record in accordance with the specific policies and procedures that have been duly adopted by the Graduate Medical Education Committee and the Board.
Section 2.2. Content of Record:

2.2.1. Medical records will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.

2.2.2. Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Hospital’s policies and procedures. Stamped signatures are not permitted in the medical record.

2.2.3. All medical records will document the information outlined in this paragraph, as relevant and appropriate to the patient’s care. This documentation will be the joint responsibility of the attending physician and the Hospital:

2.2.3.1. identification data, including the patient’s name, sex, address, date of birth, and name of authorized representative;

2.2.3.2. legal status (i.e., mental competency) of any patient receiving behavioral health services;

2.2.3.3. patient’s language and communication needs, including preferred language for discussing health care;

2.2.3.4. evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;

2.2.3.5. records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

2.2.3.6. emergency care, treatment, and services provided to the patient before his or her arrival, if any;

2.2.3.7. admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;

2.2.3.8. allergies to foods and medicines;

2.2.3.9. reason(s) for admission of care, treatment, and services;

2.2.3.10. diagnosis, diagnostic impression, or conditions;

2.2.3.11. goals of the treatment and treatment plan;

2.2.3.12. diagnostic and therapeutic orders, procedures, tests, and results;
2.2.3.13. progress notes made by authorized individuals;

2.2.3.14. medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

2.2.3.15. consultation reports;

2.2.3.16. response to care, treatment, and services provided;

2.2.3.17. relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

2.2.3.18. reassessments and plan of care revisions;

2.2.3.19. complications, hospital-acquired infections, and unfavorable reactions to medications and/or treatments;

2.2.3.20. discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice; and

2.2.3.21. medications dispensed or prescribed on discharge.

2.2.4. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Hospital:

2.2.4.1. known significant medical diagnoses and conditions;

2.2.4.2. known significant operative and invasive procedures;

2.2.4.3. known adverse and allergic drug reactions; and

2.2.4.4. known long-term medications, including current medications, over-the-counter drugs, and herbal preparations.

2.2.5. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Hospital:

2.2.5.1. time and means of arrival;
2.2.5.2. record of care prior to arrival;

2.2.5.3. results of the Medical Screening Examination;

2.2.5.4. known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

2.2.5.5. conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

2.2.5.6. if the patient left against medical advice; and

2.2.5.7. a copy of any information made available to the practitioner or facility providing follow-up care, treatment, or services.

Section 2.3. Medical Histories and Physical Exams (“H&Ps”):

The requirements for histories and physicals, including general documentation requirements and timing requirements, are contained in Appendix A of the Medical Staff Bylaws. Information regarding completion of histories and physicals by oral and maxillofacial surgeons and podiatrists is located in Article 4 of the Medical Staff Credentials Policy.

Section 2.4. Progress Notes:

Progress notes giving a chronological picture and analysis of the clinical course of the patient shall be entered by the primary physician (or by a resident physician or authorized Allied Health Professional) as often as is determined by the condition of the patient, but not less than every other day.

Section 2.5. Pre-Operative Documentation:

2.5.1. The physician responsible for the patient’s care will thoroughly document in the medical record: (i) the provisional diagnosis and the results of any relevant diagnostic tests; (ii) a properly executed informed consent; and (iii) a complete history and physical examination (or completed short-stay form, as appropriate) prior to transport to the operating room, except in emergencies.

2.5.2. Except in an emergency situation, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

2.5.2.1. the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;
2.5.2.2. pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

2.5.2.3. the supervising physician or appropriately credentialed designee is in the Hospital; and

2.5.2.4. the procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in the Operative Procedure Site Verification and Time Out Protocol.

2.6. Operative Report:

2.6.1. An immediate post-operative/procedure note containing the information below must be entered in the medical record immediately after the procedure and authenticated by the surgeon. The note must record:

2.6.1.1. the names of the physician(s) responsible for the patient’s care and physician assistants;

2.6.1.2. the name and description of the procedure(s) performed;

2.6.1.3. findings, where appropriate, given the nature of the procedure;

2.6.1.4. estimated blood loss, when applicable or significant;

2.6.1.5. specimens removed; and

2.6.1.6. post-operative diagnosis.

2.6.2. In addition, a detailed operative procedure report must be dictated immediately after an operative procedure and entered into the record. The operative procedure report shall include:

2.6.2.1. the patient’s name and hospital identification number;

2.6.2.2. pre- and post-operative diagnoses;

2.6.2.3. date and time of the procedure;

2.6.2.4. the name of the surgeon(s) and assistant surgeon(s) responsible for the patient’s operation;

2.6.2.5. procedure(s) performed and description of the procedure(s);

2.6.2.6. description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;
2.6.2.7. findings, where appropriate, given the nature of the procedure;

2.6.2.8. estimated blood loss;

2.6.2.9. any unusual events or any complications, including blood transfusion reactions and the management of those events;

2.6.2.10. specimen(s) removed, if any;

2.6.2.11. prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

2.6.2.12. the signature of the surgeon.

Section 2.7. Discharge Summary:

2.7.1. A concise, dictated discharge summary will be prepared by the practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed within 15 days of discharge:

2.7.1.1. reason for hospitalization;

2.7.1.2. significant findings;

2.7.1.3. procedures performed and care, treatment, and services provided;

2.7.1.4. condition and disposition at discharge;

2.7.1.5. information provided to the patient and family, as appropriate;

2.7.1.6. provisions for follow-up care; and

2.7.1.7. discharge medication reconciliation.

2.7.2. A short-stay form or discharge progress note may be used to document the discharge summary for routine obstetrics admissions, a patient discharged from antepartum service, a patient admitted for less than 48 hours, and a newborn services short admission for less than 48 hours.

Section 2.8. Discharge Instructions:

2.8.1. Upon discharge, the attending physician, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged
and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated.

2.8.2. Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or representative cannot read and understand the discharge instructions, the patient or representative will be provided appropriate language resources to permit him or her to understand.

2.8.3. The attending physician, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient’s needs after discharge, when indicated.

2.8.4. When the Hospital determines the patient’s transfer or discharge needs, the attending physician, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient’s family when it is involved in decision-making and ongoing care.

2.8.5. When continuing care is needed after discharge, the attending physician, along with the Hospital staff, will provide appropriate information to the other health care providers, including:

2.8.5.1. the reason for discharge;

2.8.5.2. the patient’s physical and psychosocial status;

2.8.5.3. a summary of care provided and progress toward goals;

2.8.5.4. community resources or referrals provided to the patient; and

2.8.5.5. discharge medications.

Section 2.9. Delinquent Medical Records:

2.9.1. A medical record shall not be permanently filed until it is completed by the responsible physician or it is ordered to file by the committee responsible for the medical record function.

2.9.2. The patient’s medical record shall be as complete as reasonably practical at the time of discharge, including progress notes, final diagnosis, and the clinical resume work sheet completed.

2.9.3. A reminder shall be placed on any chart deficient in the H&P during the next working day after which such deficiency occurs. If such H&P has not been written or dictated upon the expiration of 72 hours, a written report shall be sent to the committee responsible for the medical records function with a copy of such
report to the physician responsible for the H&P and the practitioner’s clinical privileges may be deemed to have been automatically relinquished in accordance with the Medical Staff Credentials Policy.

2.9.4. All medical records should be completed within fifteen (15) days after the date of discharge, or fifteen (15) days after essential reports have been received and placed into the record, whichever shall last occur. The Health Information Management Department shall determine those medical records that are incomplete after the time period specified above and promptly notify the practitioner of such incomplete medical records. If after such notice the medical records remain incomplete thirty (30) days post discharge, the practitioner’s clinical privileges may be deemed to have been automatically relinquished in accordance with the medical staff Credentials Policy.

2.9.5 Provider Queries will be generated when additional documentation or clarification is needed for coding or quality.

2.9.5.1 All Provider Queries must be met with a response.

2.9.5.2 Responses to Provider Queries must be provided in a timely fashion.

2.9.5.3 Provider Queries will be included in the Medical Record completion requirements and considered during Deficiency/Delinquency and Relinquishment Processes.

2.9.6. Delinquent practitioners must coordinate coverage for their patients until such time as delinquent records are complete. Health Information Management (“HIM”) will notify Patient Registration, Scheduling, Surgery, Nursing Administration, and One Call shall be notified of all relinquishments and reinstatements.

2.9.7. Quarterly reports of such relinquishments shall be sent to the committee responsible for the medical record function for additional action by the Medical Executive Committee as appropriate.
ARTICLE 3

MEDICAL ORDERS

Section 3.1. General:

3.1.1. Whenever possible, orders will be entered directly into the EMR by the ordering practitioner utilizing the Computerized Provider Order Entry (“CPOE”). Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient’s EMR via the CPOE in accordance with Hospital policy.

3.1.2. All orders (including verbal/telephone orders) must be:

3.1.2.1. dated and timed when documented or initiated. Outpatient orders are not required to be timed;

3.1.2.2. authenticated by the ordering practitioner. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that are made in emergency situations or when the CPOE is unavailable and have been previously authenticated via written signatures or initials; and

3.1.2.3. documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering practitioner and are understood by the appropriate health care provider.

3.1.3. Orders for tests and therapies will be accepted only from:

3.1.3.1. members of the Medical Staff;

3.1.3.2. allied health professionals who are granted clinical privileges by the Hospital, to the extent permitted by their licenses and clinical privileges; and

3.1.3.3. other individuals not on the Medical Staff who have been granted permission to order services pursuant to Hospital policy.

3.1.4. The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not acceptable.

3.1.5. Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering physician at the
expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

3.1.6. Allied Health Professionals may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the Hospital. All orders issued by an allied health professional will be countersigned/authenticated by the supervising physician by the close of the medical record.

3.1.7. Resident physicians may issue orders only in accordance with the specific policies and procedures that have been duly adopted by the Graduate Medical Education Committee and the Board.

Section 3.2. Medication Orders:

All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered. All PRN medication orders must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

Section 3.3. Verbal Orders:

3.3.1. A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner or if a delay in accepting the order could adversely affect patient care.

3.3.2. All verbal orders will include the date and time of entry into the medical record, identify the names of the individuals who gave, received, and implemented the order, and then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient. Any alerts prompted by the electronic system will be resolved by the physician while on the telephone.

3.3.3. For verbal orders, the complete order will be verified by having the person receiving the information record and “read-back” the complete order (RAV).

3.3.4. Authentication will take place by the ordering practitioner, or another practitioner who is responsible for the patient’s care in the Hospital, (i) before the ordering practitioner leaves the patient care area for face-to-face orders, and (ii) within 30 days after discharge if the order is documented using RAV. If the order was
not documented using RAV, the order shall be signed, dated and timed within 48 hours.

3.3.5. The following are the personnel authorized to receive and record verbal orders within their scope of practice and delineation of privileges:

3.3.5.1. a licensed practice nurse, a registered nurse, or an advance practice registered nurse (“APN”);

3.3.5.2. a pharmacist who may transcribe a verbal order pertaining to medications and monitoring;

3.3.5.3. a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

3.3.5.4. a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments;

3.3.5.5. a radiology or imaging technologist (i.e., nuclear medicine, diagnostic medical sonographer) who may transcribe a verbal order pertaining to tests and/or therapy treatments in their specific areas of expertise;

3.3.5.6. an occupational therapist who may transcribe a verbal order pertaining to occupational treatments;

3.3.5.7. a speech therapist who may transcribe a verbal order pertaining to speech therapy; and

3.3.5.8. a dietician who may transcribe a telephone/verbal order pertaining to diet and nutrition.

Section 3.4. Standing Orders and Protocols:

3.4.1. For all standing orders and protocols that permit treatment to be initiated without a prior specific order from the attending physician, review and approval of the Medical Executive Committee and the Hospital’s nursing and pharmacy departments is required. Prior to approval, the Medical Executive Committee will confirm that the standing order or protocol is consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take appropriate steps to ensure that there is an annual review of such orders and protocols. All standing orders and protocols will identify well-defined clinical scenarios for when the order or protocol is to be used.

3.4.2. If the use of a standing order or written protocol has been approved by the Medical Executive Committee, the order or protocol will be initiated for a patient
only by an order from a practitioner responsible for the patient’s care in the Hospital and acting within his or her scope of practice.

3.4.3. When used, standing orders and protocols must be dated, timed, and authenticated promptly in the patient’s medical record by the ordering practitioner or another practitioner responsible for the care of the patient.

3.4.4. The attending physician must also acknowledge and authenticate the initiation of each standing order or protocol after the fact, with the exception of those for influenza and pneumococcal vaccines.
ARTICLE 4

AUTOPSIES

4.1. Every member of the Medical Staff is expected to be interested in securing autopsies.

4.1.1. There should be consideration for performance of an autopsy under the following circumstances. The attending physician should use his discretion in obtaining autopsy permits. Autopsies are to be obtained only by the attending physician.

4.1.1.1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.

4.1.1.2. Deaths in which the cause is not known with certainty on clinical grounds.

4.1.1.3. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death and provide reassurance to them regarding the same.

4.1.1.4. Unexpected or unexplained deaths occurring during or following any dental, medical, or surgical diagnostic procedures and/or therapies.

4.1.1.5. Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction such as the following:

- persons dead on arrival at the Hospital;
- deaths occurring in the Hospital within 24 hours of admission;
- deaths in which the patient sustained or apparently sustained an injury while hospitalized.

4.1.1.6. All obstetric deaths.

4.1.1.7. All neonatal and pediatric deaths.

4.1.1.8. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.

4.1.1.9. Deaths known or suspected to have resulted from environmental or occupational hazards.
4.1.2. No autopsy shall be performed without written consent of a relative or legally authorized agent.

4.1.3. All autopsies shall be performed by the Hospital pathologist or by a physician delegated this responsibility.

4.1.4. When an autopsy is performed, the provisional anatomic diagnosis should be reported in the medical record within three days and the complete protocol should be made a part of the record within 90 days. If such information is not documented timely, notification of the Practitioner and Chief Executive Officer for chart delinquency shall apply after 90 days.
ARTICLE 5

EMERGENCY CALL COVERAGE REQUIREMENTS

Section 5.1. General:

5.1.1. Chiefs of the clinical departments of the Medical Staff of the Hospital will furnish the Hospital with monthly rosters of specialists on call each day.

5.1.1.1. Emergency Room physicians have the right and duty to consult with members of the Medical Staff of the Hospital on call when examination and treatment may exceed the scope of the Emergency Room Physician’s knowledge and experience.

5.1.2. In view of the “call system” evolved by practicing physicians, it shall be mandatory in the case of service patients both inpatients and outpatients, that a physician sign out only to another physician of the same department, as is determined by his staff privileges.

5.1.3. All patients presenting themselves to the Emergency Room of the Hospital will be seen by an appropriate practitioner.

5.1.3.1. If a patient has a private physician and arrangements have not been made to meet his/her private physician at the Emergency Room, the Emergency Room Physician or his designee will promptly conduct a medical evaluation of the patient.

5.1.3.2. If the patient has no private physician and does not desire one to be called, examination and treatment shall be rendered by the Emergency Room Physician.

5.1.3.3. Patients will be referred in accordance with the policies of the Medical Staff.

5.1.4. Whenever a practitioner’s admitting prerogatives and clinical privileges are relinquished, the chief of the department to which the practitioner is assigned shall be notified by the Administrator or his designate of such action in order that alternative arrangements can be made to fulfill service call and other departmental obligations.

Section 5.2. Medical Screening Examinations:

5.2.1. 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 who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

5.2.1.1. Emergency Department:

5.2.1.1.1. members of the Medical Staff with clinical privileges in Emergency Medicine;

5.2.1.1.2. other Active Staff members;

5.2.1.1.3. resident physicians; and

5.2.1.1.4. appropriately credentialed allied health professionals.

5.2.1.2. Labor and Delivery:

5.2.1.2.1. members of the Medical Staff with OB/GYN privileges;

5.2.1.2.2. Certified Nurse Midwives with OB privileges; and

5.2.1.2.3. Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

5.2.2. The results of the medical screening examination must be dictated within 48 hours of the conclusion of an Emergency Department visit.
ARTICLE 6
CONSULTATIONS

Section 6.1. Requesting Consultations:

6.1.1. The attending physician shall be responsible for requesting a consultation when indicated and for calling in a qualified consultant.

6.1.2. Requests for consultations shall be entered in the patient’s medical record including the reasons for the consultation request. For urgent consults, the ordering provider must personally speak with the consultant to provide the patient’s clinical history and the specific reason for the consultation request.

6.1.3. Failure by an attending physician to obtain consultations as set forth in this Section will be reviewed through the professional practice evaluation policy or other applicable policy.

6.1.4. Where a consultation is required for a patient in accordance with this Article or is otherwise determined to be in the patient’s best interest, the CMO, the President of the Medical Staff, or the appropriate department chief shall have the right to call in a consultant.

Section 6.2. Responding to Consultation Requests:

6.2.1. Any individual with clinical privileges can be asked for consultation within his or her area of expertise. Individuals who are requested to provide a consultation are expected to respond in a timely and appropriate manner.

6.2.2. For non-critical care consults, the physician who is asked to provide the consultation is expected to do so within 24 hours (as a general guideline) unless a longer time frame is specified by the individual requesting the consultation. For critical care consults, the attending physician and consultant shall agree on a specific time frame for the consultation to be performed.

6.2.3. The physician who is asked to provide the consultation may ask an allied health professional with appropriate clinical privileges to see the patient, gather data, and order tests. However, such evaluation by an allied health professional will not relieve the consulting physician of his or her obligation to personally see the patient within the appropriate time frame, unless the physician requesting the consultation agrees that the evaluation by the allied health professional is sufficient.

6.2.4. Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed through the peer review process or other applicable...
policy unless one of the following exceptions applies to the physician asked to provide a consultation:

6.2.4.1. the physician has a valid justification for his or her unavailability (e.g., out of town);

6.2.4.2. the patient has previously been discharged from the practice of the physician;

6.2.4.3. the physician has previously been dismissed by the patient;

6.2.4.4. the patient indicates a preference for another consultant; or

6.2.4.5. other factors indicate that there is a conflict between the physician and the patient (i.e., the patient in question has previously initiated a lawsuit against the physician) such that the physician should not provide a consultation.

To the extent possible, if the requested physician is unable to provide a consultation based on the aforementioned criteria listed above, then the requesting physician should find an alternate consultant. If the attending is unable to do so, then the CMO, the President of the Medical Staff, or the appropriate clinical department chief can appoint an alternate consultant.

Section 6.3. Recommended and Required Consultations – General Patient Care Situations:

6.3.1. Consultations are recommended in all non-emergency cases whenever requested by the patient, or the patient’s personal representative if the patient is incompetent.

6.3.2. Consultations are required in all cases which, in the judgment of the attending physician:

6.3.2.1. the diagnosis is obscure after ordinary diagnostic procedures have been completed;

6.3.2.2. unusually complicated situations are present that may require specific skills of other practitioners;

6.3.2.3. the patient exhibits severe symptoms of mental illness or psychosis such that the attending physician determines that consultation is necessary to provide appropriate care of the patient;

6.3.2.4. the patient is not a good medical or surgical risk; or
6.3.2.5. except in an emergency situation, for curettages or other procedures by which a known normal intrauterine pregnancy may be interrupted.
ARTICLE 7

DEPARTMENTAL RULES AND REGULATIONS

(a) Clinical departments may develop department-specific rules and regulations to the extent that they are consistent with all duly adopted Medical Staff and Hospital bylaws, rules and regulations, policies and procedures.

(b) Departmental rules and regulations shall be forwarded to the Medical Executive Committee for review and recommendation to the Board for final action. All such departmental rules and regulations shall only be effective upon approval of the Board.

(c) Duly adopted departmental rules and regulations shall be appended to these Medical Staff Rules and Regulations. To the extent any departmental rules and regulations are inconsistent with these Bylaws, they are of no force or effect.
ARTICLE 8

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 9 of the Medical Staff Bylaws.
ARTICLE 9

ADOPTION

These Medical Staff Rules and Regulations are adopted and made effective upon approval of the Board, superseding and replacing any and all other Bylaws, Rules and Regulations of the Medical Staff or Hospital policies pertaining to the subject matter thereof.

Originally adopted by the Medical Staff: December 1981
Revisions adopted by the MEC: May 12, 2015
Reviewed & Accepted As Is by the MEC: November 10, 2015
Reviewed & Accepted As Is by the MEC: December 11, 2018
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