



MEDICAL STAFF BYLAWS, RULES AND REGULATIONS

PART I: MEDICAL STAFF BYLAWS

► PART II: MEDICAL STAFF RULES AND REGULATIONS

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RULES AND REGULATIONS OF THE MEDICAL STAFF OF BETHESDA MEMORIAL HOSPITAL (JULY 2010)

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A. ADMISSION AND DISCHARGE OF PATIENTS

For the purposes of this section of Rules and Regulations, the term PHYSICIAN also applies to other members of the Medical Staff of Bethesda Memorial Hospital, including, without limitation, physicians, osteopaths, dentists and clinical psychologists.

1. ADMISSION TO THE HOSPITAL

- a. The Hospital shall admit patients suffering from all types of diseases, except those who may present a threat to the health and safety of other patients or personnel or who have been classified by the President of the Hospital and the Chief of Staff to have a condition which is beyond the capabilities of the Hospital's facilities and resources. In these situations the patient will be stabilized to the best of the Hospital's ability and provisions for transfer of the patient to a facility with appropriate resources will be made.
- b. A patient may be admitted to the Hospital only by a member of the Medical Staff with admitting privileges and such admissions shall be governed by the admitting policies of the Hospital.
- c. The admitting physician shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports on the condition of the patient to the referring member and to relatives of the patient; unless that responsibility has been assigned to the attending physician as required by these Rules and Regulations.

When the primary responsibility for a patient's care is transferred from the admitting physician or one attending physician to another attending physician by mutual agreement, there shall be a formal transfer of service to the new attending physician, with the initial member dictating, when appropriate, an interim care summary. The new attending physician accepting the transfer then assumes all responsibility for the patient's care which includes the dictation and completion of the Medical Record.

Transfer of the primary responsibility of a patient's care shall be documented in the progress notes or on the order sheet in the Medical Record.

- d. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded within twenty-four (24) hours of admission.
- e. In any emergency case in which it appears the patient will have to be admitted from a member's office to the Hospital, the member shall, when possible first contact the admitting department to ascertain whether there is an available bed.
- f. Emergency admissions shall be consistent with the patient emergency admission criteria, 2a of these Rules and Regulations. Physicians admitting emergency cases shall be prepared to justify to the Chairman of the Emergency Department Committee and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis, and these findings must be recorded on the patient's chart within twenty-four hours after admission.

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- g. A patient to be admitted on an emergency basis who does not have a private physician may request any member in the applicable department or service to attend to him if such request is acceptable and agreeable to the selected member. Where no such selection is made, or when the selected member will not or cannot accept the patient, a member of the Staff on call in the department or service will be assigned to the patient.

2. PATIENT ADMISSIONS PRIORITIES:

The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities. These criteria shall be approved by the Medical Executive Committee.

When necessary, the Admitting Staff will admit patients on the basis of the following order of priorities:

- a. **Emergency Admissions:**
Admission for a medical condition such that the absence of immediate medical attention could reasonably be expected to result in any of the following:
 - (1) Serious jeopardy to the patient's health.
 - (2) Serious impairment of bodily functions.
 - (3) Serious dysfunction of any bodily organ or part.
 - (4) Serious jeopardy to the health of a pregnant woman or her unborn child.
- b. **Urgent Admissions:**
Admission for a medical condition with acute symptoms of sufficient severity that require services not available except in the Hospital inpatient setting, such that a delay in treatment may result in jeopardy to the patient's health, impairment to bodily functions, or dysfunction of any bodily organ or part.
- c. **Pre-Operative Admissions:**
This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chairman of the Department of Surgery will be requested to determine the priority of specific admissions.
- d. **Routine Admissions:**
This will include elective admissions involving all services.

3. ADMISSIONS TO THE SPECIAL CARE UNITS

Medical Staff members will adhere to the admission policies for the Special Care Units as developed by the Critical Care and Cardiovascular Services Committee of the Medical Staff, and approved by the Medical Executive Committee and by the Governing Body.

If any question as to the validity of admission to or discharge from the Special Care units should arise, that decision is to be made through consultation with the appropriately designated member or chairman of the Critical Care and Cardiovascular Services Committee.

4. DOCUMENTATION REQUIRED FOR ADMISSION OR CONTINUED STAY

The attending member must document sufficient information in the medical record to substantiate the need for admission or continued stay. The review process for appropriateness of admission or continued stay are defined in the Utilization Review Plan of this Hospital.

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5. PATIENT TRANSFERS

Transfer priorities shall be as follows:

- a. From general care area to Special Care Unit.
- b. From Emergency Room to Special Care Unit.
- c. From Obstetric patient care area to appropriate care area, when medically indicated.
- d. From Special Care Unit to general care area.
- e. From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

6. POTENTIALLY SUICIDAL PATIENT

For the protection of patients, the medical and nursing staffs and the Hospital, certain principles are to be met in the care of the potentially suicidal patient:

- a. Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff.
- b. Any patient known or suspected to be suicidal will be placed on the unit appropriate for provision and constant supervision of any required medical care.

7. DISCHARGE FROM THE HOSPITAL

Patients shall be discharged only on order of an attending member(s). When a patient is to leave the Hospital against the advice of the attending member(s), the patient or the responsible party shall be asked to sign a release from responsibility on behalf of the Hospital and the attending member. A notation of the patient's leaving the Hospital against the advice of the member, or without proper discharge shall be made part of the patient's medical record, including the release from responsibility or, where applicable, an explanation of the failure to obtain such a release.

8. EXPIRATION IN THE HOSPITAL

In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

9. AUTOPSIES

Medical Staff members shall attempt to secure permission for an autopsy in all cases in which there is an unusual death or in cases that have medical-legal or educational interest. Since autopsies are not performed at Bethesda Memorial Hospital, the Nursing Administrative Supervisor will refer the family to the University of Miami, or to a private service of the family's choice.

Medical Examiner cases shall be referred to that office whenever appropriate, in accordance with Patient Services policies No. 2.289 and No. 2.290.1.

B. MEDICAL RECORDS

1. CONTENTS

The attending physician shall be responsible for the patient's care and documentation in the medical record for each patient. The medical record shall contain sufficient

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information to identify the patient, support the diagnosis, justify the treatment, document the course and results accurately and facilitate continuity of care among healthcare providers. Each medical record shall contain at least the following: the patient's name, address, date of birth, and the name of the legally authorized representative; the patient's legal status, for patients receiving mental health services; emergency care provided to the patient prior to arrival, if any; the record and findings of the patient's assessment; a statement of the conclusion or impressions drawn from the medical History and Physical Examination; the diagnosis or diagnostic impression; the reason(s) for admission or treatment; the goals of treatment and the treatment plan; evidence of known advance directives; diagnostic and therapeutic orders, if any; evidence of informed consent for procedures and treatments for which informed consent is required by organizational policy; all diagnostic and therapeutic procedures and tests performed and the results; all operative and other invasive procedures performed, using acceptable disease and operative terminology which includes etiology, as appropriate; progress notes made by the medical staff and other authorized individuals; all reassessments, when necessary; clinical observations of the response to the care provided; consultation reports; every medication ordered or prescribed for an inpatient; every dose of medication administered and any adverse drug reaction; every medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge; all relevant diagnoses established during the course of care; and any referrals and communications made to external or internal care providers and to community agencies.

2. ADMISSION NOTES

Upon admission to the hospital, a patient's medical record should include either an admission note and/or a complete Medical History and Physical Examination (H&P). Information obtained prior to admission shall be included in the medical record if the information is to be relied upon to document the medical necessity and appropriateness of the admission, surgery or other services provided. The responsible physician shall record and authenticate a pre-operative diagnosis prior to surgery. An admission note, signed, dated, timed, signed and recorded at the time of admission (or within 24 hours) should contain an assessment of the patient's condition and problem requiring admission, pertinent recent patient history, current physical findings, a provisional diagnosis and plan of care.

3. HISTORY AND PHYSICAL EXAMINATION

The History and Physical Examination shall include all pertinent studies and observations that support or justify the admission. It shall contain the chief complaint, details of present illness, relevant past history including current medications, allergies, social and family history, and an appropriate systems review. A comprehensive physical examination covering each body system with particular attention to the system responsible for admission is required. All pertinent normal and abnormal findings shall be documented by the responsible physician. The conclusions or impressions and plan of care shall conclude the report.

A History and Physical Examination may be performed by a doctor of medicine or osteopathy, or by an appropriately privileged and licensed Allied Health Professional on the Hospital staff. In addition, Oral & Maxillofacial Surgeons may perform the History and Physical Examination for maxillofacial surgery admissions according to the parameters in the Medical Staff Bylaws.

In regards to timing, the History and Physical Examination shall be recorded within thirty (30) days prior to admission and no more than twenty-four (24) hours after admission.

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For surgical admissions, the History and Physical Examination shall be included in the medical record prior to surgery except in extreme emergencies as detailed below. If the H&P is recorded prior to the day of admission, an update that includes any relevant changes in the patient's condition must be entered in the record prior to surgery. This update shall be completed by a member of the Medical Staff qualified to perform History and Physical examinations.

4. HISTORY AND PHYSICAL EXAMINATION PRIOR TO SURGERY

A History and Physical Examination shall be included in the medical record prior to surgery, except in extreme emergencies. When the History and Physical Examination is not recorded before an operation, the procedure shall be cancelled unless the attending physician states in writing that such delay would be detrimental to the patient.

In addition to the H&P, an anesthesia examination is required on patients undergoing spinal or general anesthesia. It will include the type of anesthesia planned and the risks of anesthesia explained by a person qualified to administer it. Post-anesthesia evaluation must be documented no later than 48 hours after surgery or after procedures requiring anesthesia services.

5. EXTENT OF HISTORY AND PHYSICAL EXAM FOR AMBULATORY SURGERY

The extent of the physical examination required will depend upon the procedure to be performed and the anesthesia used. The following guidelines should be used:

No Anesthesia, Topical, Local or Regional Block: Assessment of mental status, vital signs and an examination specific to the proposed procedure. It must include a list of current medications, allergies, and co-morbid conditions. Pertinent details justifying the planned procedure shall also be included.

I.V. Sedation: As above, but also including examination of heart and lungs, and post-anesthesia evaluation.

General, Spinal or Epidural Anesthesia: A complete History and Physical examination and post-anesthesia evaluation as detailed in Section 3 above.

6. HISTORY AND PHYSICAL EXAMINATION FOR HBO/WOUND CARE SERVICES

A History and Physical Examination shall be recorded prior to the start of treatment. Each examination shall include the components as originally established by the HBO Committee and updated as may be required by regulatory agencies. Special attention should be given to cardiovascular, respiratory and neurological assessments, as well as eustachian tube function, and to the specific indications for the proposed therapy.

7. PRENATAL RECORDS FOR OBSTETRICAL CASES

The obstetrical record shall include any existing prenatal records that the obstetrician considers relevant, including the prenatal history and physical examination. A legible and reproducible copy from the obstetrical physician's office record is acceptable. In addition, an interval note shall be written reflecting any pertinent changes.

8. PROGRESS NOTES

The attending physician, or the covering attending physician, is required to see the patient on a daily basis and to write daily, dated, timed and signed progress notes in the record. Progress notes shall be sufficient to permit continuity of care and transferability by giving a pertinent chronological report of the patient's course in the hospital, reflect any change in condition, response to treatment, family/patient wishes, Do Not Resuscitate notes,

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status at discharge, continuing observations of the patient's progress and contain appropriate informed consent discussion. Abnormal values and the rationale for the medical management shall be fully explained. Wherever possible, each of the patient's clinical problems should be identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

9. OUTPATIENT TREATMENT PROGRESS NOTES

Progress Notes shall be completed by the physician for each patient visit at the time of visit. Progress Notes shall be dated, timed, signed and recorded sufficient to identify the chief complaint or reason for the encounter, clinical findings, diagnosis or medical impression, studies ordered, therapies administered, disposition, recommendations and instructions given to the patient as appropriate to the care of the patient. Each Progress Note shall be authenticated by the practitioner.

10. DIAGNOSTIC TESTING REQUIRING PHYSICIAN INTERPRETATION

a. Inpatient diagnostic tests such as Pulmonary Function Study, EKG, EEG, Holter Monitor, Echocardiograms, Stress Echocardiograms, Stress EKGs, Tilt Table testing and imaging studies such as MRI, Radiographic and Nuclear Medicine studies shall be dictated within twenty-four (24) hours of completion of the testing, unless there are extenuating circumstances.

b. A stat echocardiogram must be ordered by a cardiologist who is available for immediate review of the echocardiogram. It shall be performed by the technician within 30 minutes of the order and reviewed by the interpreting cardiologist within 30 minutes of completion. The preliminary findings shall be written in the progress notes at the time of this review. The final dictated report will be the responsibility of the Echo Reading Panel.

c. Outpatient diagnostic tests such as those in paragraph A above shall be dictated within forty-eight (48) hours of completion of the testing, unless there are extenuating circumstances.

d. Sleep studies shall be dictated within seventy-two (72) hours.

e. In the case of imaging that requires comparison to outside images that are not immediately available, the physician shall dictate within forty-eight (48) hours and document in the report that comparison films were not available. If such studies subsequently become available, an addendum should then be dictated. Failure to complete interpretations within stated timeframes will cause the medical record to be incomplete.

11. OPERATIVE/HIGH-RISK PROCEDURE DOCUMENTATION

a. The immediate post operative/post procedure progress note must be completed before the patient is transferred to the next level of care. If the practitioner performing the procedure accompanies the patient to the next unit or area of care, the report may be written in the new unit or area of care.

The immediate post-operative note must include the name of the primary surgeon and his or her assistant(s), the procedure performed and a description of each procedure finding, estimated blood loss, specimen(s) removed and the postoperative diagnosis and be dated, timed and signed.

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This note must be completed before any subsequent procedures or surgeries are performed.

- b. Operative reports shall be dictated within two (2) business days upon completion of the operative or other high-risk procedure. If the report is not completed by noon on the third business day, it will be considered to be delinquent and the physician subject to suspension.

The complete report must include a detailed account of the findings at surgery, the technical procedures used, the specimen(s) removed, the post-operative diagnosis and the name of the primary surgeon and any assistants and be dated, timed and signed. A complete report shall be required for procedures performed in the operating room, endoscopic suite, cardiac catheterization lab and EP lab.

12. CONSULTATION REPORTS

A Consultation Report shall be dated, timed and signed, and show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's findings and recommendations. Consultation reports shall be dictated or written by the consultant immediately following the consultation or no later than twenty-four (24) hours after such time. This report shall be made a part of the patient's record. It should be made clear in the record whether the consultant is merely rendering an opinion and suggestions on therapy and procedures, or if the consultant is assuming responsibility for the care of the patient. The Consultation Report shall be authenticated by the author.

13. PRE-PRINTED ORDERS

A member's pre-printed orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the member.

14. PRINCIPAL DIAGNOSIS

The attending physician shall sign an Abstract which lists the principal diagnosis, secondary diagnoses and major procedures performed. An Abstract may be signed shortly before or at the time of discharge of all patients.

15. DISCHARGE CLINICAL RESUME (DISCHARGE SUMMARY)

A discharge summary shall be dictated or written on all patients at the time of discharge except for normal newborns. For normal newborns the discharge summary information is recorded on the Newborn Nursery Physician Record. This summary shall be dated, timed and signed, and shall concisely recapitulate the reason for hospitalization, significant findings, all diagnoses, and procedures performed and treatment rendered, condition on discharge, and specific instructions given to the patient and/or family. These instructions shall relate the physical activity, medication, diet, and follow-up care. Discharge Orders and Patient Instruction forms shall be considered part of the discharge summary and final progress note.

In the event of a patient's death, a final progress note shall be added to the record which indicates the events leading up to the patient's demise.

16. AMBULATORY SURGERY DOCUMENTATION

The ambulatory medical record should be legible, complete, and contain a History and Physical Examination (H&P) appropriate for the ambulatory surgery to be performed. (See Item 6 for details relating to the History and Physical Examination.)

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The record shall contain the results of examination, procedures and treatment which together with indications/symptoms establish the justification for the ambulatory surgery.

The medical record shall contain, additionally, all medications and dosages, allergies, comorbid conditions and informed consent.

The medical record shall contain the discharge diagnosis, instructions, medications and dosage, follow-up visit, care arrangements, referrals, consultations and other significant events such as the transfer of a patient. Documentation should support the diagnoses and procedure code(s) billed.

17. ENTRIES IN THE MEDICAL RECORD

Only individuals authorized by Hospital policy shall make entries in the medical record.

The author of each medical record entry (whether hand written, typed or transcribed) shall be clearly identified. The entry must be dated, timed and signed by the author, either hand written or electronically.

Electronic signatures will be date- and time-stamped. Use of an electronic signature shall be restricted to the individual author.

18. SYMBOLS AND ABBREVIATIONS

All clinical documentation shall be written in a clear, understandable manner. Use of abbreviations, symbols and acronyms is strongly discouraged. A list of unacceptable abbreviations that are never to be used without confirmation of the intended meaning and a list of abbreviations acceptable for use in the ordering of medications is found in Operations Regulation #1027.

19. RELEASE OF MEDICAL INFORMATION

Written consent of the patient or legally qualified representative is required for release of medical information to persons not otherwise authorized to receive this information.

20. SAFEKEEPING AND CONFIDENTIALITY OF PATIENT RECORDS

Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the President of the Hospital, or his designee. In case of readmission of a patient, all previous records shall be available for the use of the attending member. This shall apply whether the patient is attended by the same member or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the member for a period to be determined by the Medical Executive Committee. All records and their contents are confidential and must be kept secure pursuant to the Health Information Portability and Accountability Act ("HIPAA") and related Hospital privacy and security policies.

21. COMPLETED MEDICAL RECORD DEFINED

The medical record is complete when its contents reflect the diagnosis, diagnostic test results, therapy, patient's condition and hospital progress, and condition at discharge. The complete medical record must contain all forms, documents, protocols and order sets as required. All entries shall be authenticated when necessary. The record shall not be complete until the responsible physician has appropriately documented all specific information to meet the requirements of regulatory agencies. The medical record shall

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not be permanently filed until it is completed or is ordered filed by the Chairman of the Performance Improvement Committee.

22. DELINQUENT MEDICAL RECORDS DEFINED

When possible, the patient's medical record shall be completed at the time of discharge, including any required clinical resume or final progress notes.

Medical records shall be considered delinquent if they remain incomplete thirty (30) days after the date of discharge. A temporary suspension shall be imposed automatically for failure to complete delinquent medical records as defined in the Medical Staff Bylaws.

C. GENERAL CONDUCT OF CARE

1. SIGNED CONSENT FORM

A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission except in emergency situations. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of, specific risks, benefits and possible side effects inherent in any special treatment or surgical procedure shall be obtained. This consent shall be signed by the physician prior to initiation of any surgical or invasive procedure.

2. TREATMENT ORDERS

All orders for treatment shall be in writing and authenticated by the appropriately authorized member.

Orders shall be dated, timed and signed, and written clearly, legibly and completely. Orders that are illegible or improperly written shall not be carried out until rewritten or understood by the nurse. The use of "Renew," "Repeat," and "Continue Orders" are not acceptable when used alone.

3. VERBAL ORDERS

Verbal orders for treatment may be dictated by a physician or by a physician-sponsored Physician Assistant (P.A.), Advanced Registered Nurse Practitioner (A.R.N.P.) or Certified Nurse Midwife (C.N.M.) to a duly authorized person functioning within their sphere of competence. All orders thus dictated shall be dated, timed, and authenticated on the order sheet with the name of the ordering physician and P.A., A.R.N.P. or C.N.M. as applicable, per the name of the person who took the order. The ordering physician shall authenticate such orders as soon as possible and no later than 48 hours. It is acceptable for another physician who is responsible for the patient's care to authenticate the verbal order for the ordering physician. No verbal orders shall be accepted for chemotherapy drugs.

Licensed Registered Nurses (R.N.) are authorized to accept verbal orders. Pharmacists, qualified Respiratory Therapy personnel, Licensed Physical Therapists (R.P.T., L.P.T., P.T.), Licensed Occupational Therapists (O.T.R.), Certified Speech Pathologists (C.C.C./S.P.), Registered Dietitians and Registered Radiology Technologists are authorized to accept verbal orders within their respective departments. All verbal or telephone orders will be "read back" to the ordering physician by the licensed professional taking the order. Critical Values, once confirmed, will be read back to verify correct communication.

4. CANCELLED ORDERS

All previous orders are cancelled when patients go to surgery.

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5. MEDICATION ORDERS

- a. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations.

Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

6. CONSULTATIONS

- a. Any qualified member with clinical privileges in this Hospital can be called for consultation within his area of expertise.
- b. Except in an emergency, consultation is required in the following situations:
 - (1) When the patient is not a good risk for operation or treatment.
 - (2) Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
 - (3) Where there is doubt as to the choice of therapeutic measures to be utilized.
 - (4) In unusually complicated situations, where specific skills of other health care practitioners may be needed.
 - (5) When requested by the patient or his family.
- c. The attending member is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit the consultant to evaluate the patient, except in an emergency. The consultant shall evaluate the patient within twenty-four (24) hours after contact, unless the ordering physician specified otherwise.
- d. When an urgent or STAT consult is requested, it is the responsibility of the ordering physician to personally contact the consultant whenever feasible.

7. VERBAL COMMUNICATION

Physicians and all Hospital personnel are required to communicate with each other in English, only, in all clinical situations. Speaking in other languages is permitted for personal reasons that are not hospital related.

8. POTENTIALLY LIFE OR LIMB THREATENING SITUATIONS

If it is determined by a member of the nursing staff, after consultation with the attending member or his designee and the nursing supervisor, that a potentially life or limb threatening situation has not been resolved by the attending member or his designee, it shall be the responsibility of the nursing supervisor to immediately contact the appropriate Clinical Department Chairman or his designee.

It shall be the responsibility of the Department Chairman to assess the situation and if required, to act immediately to resolve the situation. If such action by the Department Chairman includes contacting another member, such contact shall be made directly medical staff member to medical staff member and not through a third party.

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In the absence of the appropriate Clinical Department Chairman or his designee, the nursing supervisor shall contact an officer of the Medical Staff using the following order: Vice Chief of Staff, Immediate Past Chief of Staff /Secretary-Treasurer.

9. ADHERENCE TO POLICIES AND PROCEDURES

The Medical Staff will participate in, and adhere to, Hospital policies, Procedures, Plans and Programs that have been approved by the Medical Executive Committee, or developed in collaboration with appropriate members of the Medical Staff. These will include, but not be limited to the Performance Improvement Plan, Utilization Review Plan, Infection Control Program, Disaster Plan, Safety Program and Risk Management Program.

D. EMERGENCY SERVICES

1. EMERGENCY DEPARTMENT AND SERVICE CASES

a. PARTICIPATION -

All members of the Medical Staff, except those excused by their staff category as defined in the Medical Staff Bylaws or excused by the Medical Executive Committee shall be required to participate in the Emergency Department On Call Coverage Schedule.

b. ON CALL SCHEDULE OF COVERAGE -

To ensure the orderly referral of emergency patients, the Chairman of the Emergency Department Committee will formulate and provide at monthly intervals the Emergency Department On Call Schedule of Coverage.

c. DURATION OF ON CALL COVERAGE SCHEDULE -

When a medical staff member is scheduled for a particular day/date for the Emergency Department On Call Coverage Schedule, he is on call from 7:00 a.m. the day of call until 7:00 a.m. the following morning.

2. EMERGENCY DEPARTMENT ON CALL COVERAGE RESPONSIBILITIES

a. PRIVATE PATIENTS -

Medical staff members shall not refer their private patients to the Emergency Department for coverage by the assigned member when they are not available for practice, unless it is for referral or consultation to a member at such member's request.

b. AVAILABILITY -

A medical staff member on Emergency Department call should be readily available via telephone or in person. Response time for the on call member is thirty (30) minutes from initial contact. If, in the opinion of the Emergency Department physician, the member's presence is needed in the Emergency Department, he should be in the department within thirty (30) minutes after contact.

c. SUBSTITUTIONS FOR E.R. COVERAGE -

The member assigned to provide the coverage is responsible for securing a qualified substitute, AND providing appropriate notification of the change.

Notification of change must be made in writing to the Chairman of the Emergency Department Committee in care of the Medical Staff Office of the Hospital AND to the Emergency Department head nurse.

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Such written notification must be received by the Chairman of the Emergency Department Committee and the Emergency Department nurse manager at least twenty-four (24) hours prior to the effective date of the change. Telephone notification of substitutions cannot be accepted by the Medical Staff Office or by the Emergency Department head nurse.

As stated in 9.4-4 of the Medical Staff Bylaws, the member shall maintain responsibility for Emergency Department Call as assigned and may not request Call to be covered by a physician on suspension. If a physician suspended for medical records delinquency is on E.R. Call, emergency admissions through the Emergency Department shall be permitted but shall be subsequently reviewed.

3. EMERGENCY DEPARTMENT ADMISSIONS AND CONSULTATIONS

a. EMERGENCY DEPARTMENT ADMISSIONS -

The Emergency Department patient who, in the opinion of the Emergency Department physician, needs to be admitted will be assigned to the On Call Medical Staff member who is covering that area of service that day.

If the On Call Medical Staff Member questions the necessity for the patient's admission, the member is required to personally evaluate and examine that patient within the parameters of the established appropriate response time.

The On Call Medical Staff Member then will assume full responsibility for the patient and will make final written disposition of the care, including admission, transfer or discharge, based on his evaluation. This responsibility will include rendering care while the patient is at Bethesda Memorial Hospital. In the instance of a patient for transfer, the On Call Medical Staff Member is responsible for the patient's care until the patient leaves Bethesda Memorial Hospital.

b. EMERGENCY DEPARTMENT CONSULTATIONS -

The member on call in the Emergency Room at the time the order is placed shall be obligated to accept emergency consultations including those requested for in-patients.

4. RETIREMENT FROM EMERGENCY DEPARTMENT DUTY

Two causes shall be recognized for retirement from Emergency Department and Service Assignment:

a. ILLNESS -

Illness, which in the judgement of the Medical Executive Committee, is severe enough to warrant retirement from Emergency Department duty.

b. RETIREMENT -

(1) A member of the Medical Staff appointed to the Staff before September 1, 1990, who has served a minimum of ten (10) years Emergency Department duty, and has reached the age of fifty (50) may then elect to be removed from the Emergency Department roster by making his desire known in writing to the Medical Executive Committee.

(2) A member of the Medical Staff who has served fifteen (15) years Emergency Room duty, may request, in writing, to be excused from such obligation. The Medical Executive Committee shall be responsible to grant or deny such a request based on the needs of the Emergency Room at the time the request is submitted. If the needs for Emergency Room

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Staffing change, the Medical Executive Committee shall be permitted to recall these members previously excused from providing Emergency Room call coverage.

5. EMERGENCY DEPARTMENT -

a. EMERGENCY DEPARTMENT COMMITTEE

(1) Composition of Committee

The Emergency Department Committee shall be appointed annually by the Chief of Staff as specified in the Committee Manual of the Medical Staff.

(2) Purpose of the Committee

The Emergency Department Committee shall conduct investigations of cases of Medical Staff members who have questionably neglected duties or responsibilities while assigned to the Emergency Department or Service Cases, or violated Emergency Department policies regarding Emergency Department On Call responsibilities. Upon conclusion of this investigation, any recommendation for corrective action will be forwarded to the Medical Executive Committee.

The involved member will be given the opportunity to explain his possible neglect of duty to the Medical Executive Committee. If, in the opinion of the Medical Executive Committee, the Staff member is found derelict of duties, the Medical Executive Committee may recommend to the Governing Body prompt action including possible suspension of all privileges.

Failure to appear before the Medical Executive Committee when requested to do so, except in extraordinary circumstances as determined by the Medical Executive Committee, shall be admission of neglect; and the Committee shall recommend to the Governing Body total severance of Staff membership.

When privileges have been suspended on three (3) occasions in a twelve (12) month period, the Committee shall unequivocally recommend to the Governing Body prompt and total severance of Staff membership. The Secretary, or his designate, shall keep a record of the number of suspensions of each member with the dates of suspension in a twelve (12) month period.

Any staff member to whom a suspended member may refer patients for admission, including associate or partner of the suspended member, shall be responsible for the care of the patient independently and in such manner as to avoid censorship by the Medical Executive Committee. He shall in no way permit the suspended member to practice medicine directly or indirectly in this Hospital.

b. POLICIES AND PROCEDURES

The duties and responsibilities of all personnel serving patients within the Emergency area shall be defined in appropriate written policies and procedures relating specifically to this outpatient facility.

These policies and procedures shall be developed by the Emergency Department Committee of the Medical Staff, and shall be approved by the Medical Executive Committee and by the Governing Body.

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c. MEDICAL RECORD

- (1) An appropriate medical record shall be kept for every patient receiving emergency services. The record shall include:
 - (a) Adequate patient identification.
 - (b) Information concerning the time of the patient's arrival, means of arrival and by whom transported.
 - (c) Pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital.
 - (d) Description of significant clinical, laboratory and imaging findings.
 - (e) Diagnosis.
 - (f) Treatment given.
 - (g) Condition of the patient on discharge or transfer, or if the patient leaves AMA.
 - (h) For emergency patient transfers to other organizations the record shall include reason for transfer, stability of patient, acceptance by the receiving organization and responsibility during transfer. Relevant clinical information shall accompany the patient.
 - (i) Conclusions at the termination of treatment and final disposition, including instruction given to the patient and/or his family relative to necessary follow-up care.
- (2) Each patient's medical record shall be authenticated by the member in attendance who is responsible for its clinical accuracy.
- (3) There shall be a monthly review of Emergency Department medical records by the Medical Director or his designee.

E. IMAGING SERVICES

All X-ray films and other records of the Radiology Department shall remain the property of the Hospital and shall be kept on file as part of the record. Films may be disposed of after an appropriate interval at the direction of the Medical Director of Radiology and the President of the Hospital. A member in attendance may take films from the Hospital for the purpose of consultation. The member borrowing such films or records shall agree to return them within thirty (30) days to the Radiology Department.

F. HOSPITAL DEPARTMENTS/SERVICES

The following Hospital Departments for support services are under the direction of a Medical Director who is a member of the Medical Staff. The Medical Director's duties are defined in the Policy and Procedure Manual of the individual department, which is maintained in that department.

1. IMAGING SERVICES
2. EMERGENCY MEDICINE
4. CLINICAL AND ANATOMICAL LABORATORY
5. RADIATION ONCOLOGY
6. RESPIRATORY CARE (MEDICAL ADVISOR)
7. ANESTHESIA SERVICES
8. BETHESDA HEART INSTITUTE
9. WOUND CARE/HBO

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G. MEDICAL STAFF MEETINGS

1. ANNUAL MEETING -
The Annual meeting of the Medical Staff shall take place on the third Tuesday of May. Notice regarding time and place shall be mailed to each member of the Staff at least two (2) weeks in advance.

2. GENERAL STAFF MEETINGS -
The Chief of Staff shall call Regular business meetings of the Staff two_(2) times per year. Notice regarding time and place shall be mailed to each member of the Staff at least two (2) weeks in advance.

BYL/RULES & REGS CURRENT 07/2010