Boulder Community Health

Medical Staff

RULES & REGULATIONS

Boulder Community Health
Medical Staff Rules & Regulations

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SECTION 1. ADMISSION AND DISCHARGE OF PATIENTS

1.1. A patient may be admitted to the Hospital only be members of the Medical Staff or Allied Health Professionals having such admitting privileges. All practitioners shall be governed by the admitting policies of the Hospital.

1.2. Care of a patient admitted by a dentist is a dual responsibility involving the dentist and a physician member of the Medical Staff.

1.2.1. The dentist's responsibilities include:

a. a detailed dental history justifying hospital admission;
b. a detailed description of the examination of the oral cavity and pre-operative diagnosis;
c. a complete operative report;
d. orders and progress notes pertinent to the oral condition;
e. discharge orders;
f. a complete discharge summary.

1.2.2. The physician's responsibilities include

a. medical history pertinent to the patient's general health;
b. a physical examination; and
c. supervision of the patient's general health status while hospitalized

1.3. Whenever the medical care of a patient is transferred to another staff member, a note covering the transfer of responsibility must be documented in the medical record. (11/10/2014)

1.4. 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 statements shall be recorded as soon as possible. No patient will be placed in a hospital bed until an admission order is entered. (7/13)

1.5. Admission to the Critical Care Unit: if any question as to the validity of admission to or discharge from the Critical Care Unit should arise, that decision is to be made through consultation with the Medical Director of the Critical Care Unit.

1.6. Admission of Emergency Department Patients: The emergency physician and the admitting physician shall confer to determine whether to admit the patient. Once the decision to admit has been made, the admitting physician is responsible for the care of the patient, including admission and care orders. In those cases where a bed is available at the time of the decision to admit, the admitting physician shall not delay admission of the patient. (MEC 8/2012)

1.7. Patients shall be discharged only by order of the attending practitioner or his/her designee (i.e. PA/NP).

1.8. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. Policies with respect to release of dead bodies shall conform to local law.

1.9. Attending physicians will consider securing an autopsy in all deaths that meet the following criteria:

1.9.1. Any unexpected death;
1.9.2. Unexplained death following diagnostic or therapeutic procedure;
1.9.3. Death of a patient for whom a primary diagnosis had not been made;
1.9.4. Obstetric death, or
1.9.5. Family request.

1.10. An autopsy may be performed only when there is a written consent signed in accordance with hospital policy. All autopsies shall be performed by the Hospital pathologists or by a practitioner delegated this responsibility. The attending physician will be notified when an autopsy is to be performed on his/her patient. The complete protocol of the autopsy should be made a part of the hospital chart within 60 days following death. Autopsy findings will be reviewed by the appropriate department/section as a part of their quality improvement efforts. (5/2019)

SECTION 2. EMERGENCY CALL RESPONSIBILITIES

To ensure, to the fullest extent possible, the stability of the emergency call roster once it has been distributed, members of the Medical Staff serving on the emergency call roster will abide by the requirements and following procedures:

2.1. It is the responsibility of the Active Medical Staff to participate in emergency call as designated by the Medical Executive Committee, unless excused from all or part of this requirement by the MEC. It is also the responsibility of each member to maintain current clinical competence to meet this requirement or to insure applicable backup coverage.

2.2. Upon written request by the practitioner and after evaluating the call coverage availability for the applicable specialty, removal from call responsibilities will be considered for those members who have reached 55 years of age and have maintained 20 or more years of service at BCH or who have reach 60 years of age and have maintained more than 5 years of service at BCH. (9/19/11). Each request will be evaluated by the applicable Department before a decision is rendered by the Medical Executive Committee. In the event call coverage for a specialty becomes inadequate the MEC may require physicians who have previously been excused from call responsibility to resume those responsibilities, until that time adequate coverage is achieved. (3/23/2014, 4/21/2014)

2.3. Those members who become eligible and required to serve on the emergency call roster will be entered into the emergency call rotation after final Governing Board approval of their clinical privileges. (5/2019)

2.4. Members of the Medical Staff are required to serve on the emergency call roster. This responsibility includes:

2.4.1. Meeting state and federal regulations regarding screening, stabilization and transfer coverage.

2.4.2. Emergency management of patients throughout the Hospital (i.e., ED, CMC, Behavioral Health) as needed.

2.4.3. Call back response time within 30 minutes, by either the on-call practitioner or, if they are unavailable (i.e. in surgery), by their designee. Arrival response time appropriate to the clinical situation.

2.4.4. If a member fails to serve on his/her assigned day or does not find appropriate coverage, provided by a physician with clinical privileges at BCH, the following steps will be implemented as appropriate: (3/23/2014)

a. The Medical Staff President or Department Chair will meet or correspond with the physician and indicate this behavior is unacceptable. If a stipend is due the practitioner it will be rescinded for that day. In the event another practitioner was available to treat the patient, they may be eligible for the stipend payment. (5/2019)

2.5. While on call, if a member of the Medical Staff manages a patient in the ED or other areas of the Hospital, or a patient is referred to his/her office**,** that physician will be responsible for the stabilization and treatment of the presenting problems, including reasonable follow-up to provide continuity of care of the acutely presenting problem, without regard to the patient's ability to pay. (5/2019)

2.6. The on-call practitioner that provided an initial consultation shall be responsible for treating a patient returning to the Emergency Department with additional concerns or request for follow-up care, as long as the patient was discharged from BCH within seven (7) days, and unless direction of care is stipulated by the patient or the Emergency Department physician. (2/2007)

2.7. If the privileges of a Medical Staff member are suspended, it is his/her responsibility to find appropriate coverage for all emergency call responsibilities previously assigned.

2.8. General surgery privileges include the obligation to provide general surgery and trauma call coverage; per the qualification criteria stated in these Rules & Regulations and the Medical Staff Bylaws.

2.9. Criteria for evaluating existing specialty call rosters and for potentially establishing new rosters for particular specialties will be:

2.9.1. Requests for new specialty call rosters should be submitted to the applicable department(s) for review and recommendation.

2.9.2. The department(s) recommendation will then be forwarded to the Emergency Medicine Department for review and recommendation by identifying: (5.2019)

a. Past and/or anticipated problems with adequate coverage for both the associated general call coverage and for the specialty coverage.

b. Volume of patients seen in the ER, which would fall under the general call coverage and specialty call coverage.

c. Potential coverage issues such as equipment, hospital staff availability, etc., as well as the potential impact on overall availability of practitioners for the associated general call. This is particularly important if the practitioners taking the specialty call would limit themselves to that call.

2.9.3. Based on the results of the above evaluation, the Emergency Medicine Department will inform the department(s) of its recommendation, whether favorable or unfavorable, and

both recommendations (from Emergency Medicine Department and the department) (5/2019) will be forwarded to the MEC for review and approval.

2.10. Criteria for granting requests for leave of absence from emergency call responsibilities will be:

2.10.1. Practitioners requesting a leave of absence from emergency call responsibilities must provide either a letter from their private physician summarizing the physical and/or mental basis of the request stating the length of leave necessary; or, a letter from the practitioner stating the specifics of the request, i.e. continuing education, travel, etc.

2.10.2. Practitioners are expected to provide documentation of coverage for the remainder of his/her emergency call responsibilities for the current scheduled call period, not to exceed four months, before a change in status is granted.

2.11. Practitioners terminating membership and privileges are expected to provide documentation of coverage for the remainder of his/her emergency call responsibility for the current scheduled call, not to exceed four months, before termination is accepted.

All requests to deviate from responsibilities outlined in the Medical Staff Bylaws, rules, regulations and manuals or any requests to be excused from service on the emergency call roster must be made in writing and approved by the MEC.

SECTION 3. ANESTHESIA SERVICES

3.1. The purpose of this Rule and Regulation is to ensure uniformity of care provided to patients receiving anesthesia services by Anesthesiologists, Anesthesiologists Assistant (AA) and Non-Anesthesiologists. Anesthesia services at Boulder Community Health (BCH) will be under the purview of the Director of Anesthesia Services, who has the responsibility and authority for developing policies and procedures governing the provision of all categories of anesthesia services, including specifying the minimum qualifications for each category of practitioner who is permitted to provide Anesthesia Services.

The Hospital's Governing body, on the recommendation of the MEC, approves the function of the specific anesthesia service privileges, including type and complexity of procedures, for each practitioner who furnishes anesthesia services, addressing the type of supervision required, if applicable.

3.2. Qualifications for the Director of Anesthesia Services: The qualifications for the Director of Anesthesia Services will be approved by BCH's Governing Board. The Director will have the authority and responsibility for planning, directing and supervising all activities of the anesthesia service. The Director will be responsible for evaluating the quality and appropriateness of the anesthesia patient care and directing the administration of all anesthesia services throughout the Hospital (including all departments in all campuses and off-site locations where anesthesia services are provided). The Director will have a degree in Medicine (MD) or Osteopathy (DO) and be board certified in anesthesiology. They will have a current, full and unrestricted license to practice medicine in Colorado, and will have a current unrestricted DEA registration (schedules II-IV). They will be a member of the Active Medical Staff of BCH in good standing with unrestricted privileges in anesthesiology. The Director will typically be the Section Chair of

Anesthesiology/Periops or an anesthesiologist designated by the section chair to serve in that capacity. (5/2019)

3.3. Documentation/Monitoring: Procedures and treatments that include sedation require a review of the patients' pertinent medical history, informed consent from the patient or patient/guardian, monitoring of the patient, and provision of immediate response to emergent situations. The monitoring occurs prior to the procedure, during the procedure, and through the recovery process. At a minimum, the monitored parameters during the procedure include level of sedation, ventilatory function, expired CO_2 monitoring, pulse oximetry, and hemodynamics. Individuals responsible for patients receiving procedural sedation medications will understand the dosing, side effects and reversal agents for any medications they use. Certain medications, such as those without a reversal agent, must be given according to a protocol proven to be safe in nationally recognized literature and/or approved by the Director.

3.4. Clinical Privileges: Clinical privileges in Anesthesiology are granted to physicians and AAs under the supervision of the Anesthesiologist, to administer general anesthesia who are qualified by training to render patients insensible to pain and to minimize stress during surgical, obstetrical and certain medical procedures. Clinical privileges for Anesthesia Services are also granted to practitioners who are not anesthesia professionals to administer sedative and analgesic drugs to establish a level of minimal, moderate or deep sedation. Analgesia and anesthesia comprise a continuum of states ranging from general anesthesia, deep sedation, moderate sedation, and minimal sedation. (MEC/BOD 4/2015)

3.5. Rescue Capacity: Because sedation is a continuum, it is not always possible to predict how an individual patient will respond. Hence, practitioners intending to produce a given level of sedation should be able to rescue patients whose level of sedation becomes deeper than initially intended. Rescue requires an intervention by a practitioner with expertise in airway management and advanced life support. Individuals administering moderate sedation should be able to rescue patients who enter a state of deep sedation, while those administering deep sedation should be able to rescue patients who enter a state of general anesthesia.

3.6. Anesthesia services provided at BCH include: Anesthesia exists along a continuum. For some medications, there is no bright line that distinguishes when their pharmacological properties bring about the physiologic transition from the analgesic to the anesthetic effects. Furthermore, each individual patient may respond differently to different types of medications. The distinctions of the various types of "anesthesia services" offered at BCH can be found in the Anesthesia Services policy.

3.7. Continuous Quality Improvement: The purpose of the continuous quality improvement program is to reduce patient risk and improve quality of care for patients undergoing sedation or deep sedation/analgesia. The Licensed Independent Practitioner(LIP), Anesthesiologists Assistant (AA), Registered Nurse (RN), Physician Assistant (PA) or Nurse Practitioner(NP), involved in the administration of sedation or anesthesia is responsible for reporting adverse events in a timely manner via the patient safety event reporting system. See Anesthesia Services policies for a list of adverse events requiring submission of a safety event. (5/2019)

3.8. References: The use of pharmacologic agents for procedural sedation at BCH is standardized in accordance with guidelines from the Center of Medicare/Medicaid Services (CMS), American Society of Anesthesiologists (ASA), American College of Emergency Physicians (ACEP), American Society for Gastrointestinal Endoscopy (ASGE), American Psychiatric Association (APA), and other nationally recognized authorities.

3.9. Anesthesia Services by non-anesthesiologists are delineated in the following hospital policies:
- 3.9.1. Moderate Sedation by Non-anesthesiologists;
- 3.9.2. Deep Sedation by Non-anesthesiologists;
- 3.9.3. General Anesthesia, (MEC/BOD 4/2015.)

3.1. The scope of anesthesia services provided, locations, sedation levels, and continuous quality improvement program requirements are delineated in hospital policy Anesthesia Services. (MEC / BOD 6/2011)

SECTION 4. TRAUMA SERVICES

(BOD 2/2013, BOD 1/2015, 10/2015)

4.1. The Board of Directors and Medical Staff of Boulder Community Health support the establishment of Level II Trauma Services and are committed to providing ongoing specialty care to maintain optimal treatment of the trauma patient.

4.2. Trauma Services, which represents a structure of care of injured patients, includes personnel and other resources necessary to ensure appropriate and efficient provider of care. Trauma services is comprised of Board Certified General Surgeons, Orthopedic Surgeons, Neurosurgeons, Emergency Medicine physicians and other sub specialists directly involved in the care of the trauma patient. Trauma services reports directly to the MEC via the Trauma Medical Director and shall be governed by the Rules and Regulations of the Medical Staff and associated manuals/documents.

4.3. Promptly available – "promptly available" as delineated throughout this section is defined as "within 30 minutes of notification".

4.4. Pre-hospital Trauma Care **–** The Trauma Service participates in the development and improvement of pre-hospital care protocols and patient safety programs.
- 4.4.1. The Trauma Medical Director is involved in the development of the trauma facility's divert protocol as it affects the trauma service.
- 4.4.2. A trauma surgeon shall be involved in any decision regarding divert as it affects the care of the trauma patient.
- 4.4.3. The EMS Medical Director shall participate in pre-hospital peer review/performance improvement.

4.5. Inter-facility Consultation and Transfers Requirements
- 4.5.1. Direct physician-to-physician contact is performed in the process of transferring a patient between facilities.

4.5.2. Decisions to transfer patients shall be based solely on the clinical needs of the patient and not the requirements of the patient's specific provider network or the patient's ability to pay.

4.6 Responsibility for Trauma Patients: The Trauma Service shall maintain oversight of the patient throughout the course of hospitalization; the trauma surgeon shall retain oversight of the patient while in the ICU.

4.7. Appointment to the Trauma Services: Appointment is limited to surgeons and other providers Board Certified by a recognized ABMS/AOA member board (or must attain ABMS/AOA member board certification within five (5) years of completion of training program) and maintenance thereof; an unrestricted Colorado license; unrestricted privileges in their respective specialty; and, accrual of 16 hours trauma CME annually as designated.

4.8. Medical Director of Trauma Services: The qualifications for the Director of Trauma Services, approved by BCH's Governing Board, will include at a minimum:

4.8.1. A degree in Medicine (MD) or Osteopathy (DO);
4.8.2. A current, full and unrestricted license to practice medicine in Colorado;
4.8.3. A current unrestricted DEA registration;
4.8.4. Board Certified in General Surgery by a recognized ABMS or AOA member board;
4.8.5. Be a member of the Active Medical Staff of BCH with unrestricted privileges in general surgery;
4.8.6. The Trauma Medical Director will also:
   a. Be able to demonstrate membership and active participation in state and either regional or national trauma organizations;
   b. Participate on the trauma surgery call panel;
   c. Have successfully completed an ATLS course and accrue an average of 16 hours verifiable, external trauma-related CME annually, including no less than one national meeting every three years;
   d. Chair the Multidisciplinary Trauma Services Committee and the Peer Review/ Performance Improvement Committee;
   e. Serve as the Trauma Services representative to the MEC;
   f. Serves as co-director of the ICU and is responsible for setting policies and administration needs related to trauma ICU patients.

4.9. Essential Duties and Responsibilities

4.9.1. Develops Trauma Services physician team into a cohesive, collaborative, consistent team, meeting or exceeding American College of Surgeon (ACS) expectations. Has and exercises authority as necessary to correct deficiencies in trauma care or exclude from trauma call physicians who do not meet specified criteria.
4.9.2. Acts as the conduit for communication, representation and leadership for the physicians and mid-levels participating in the care of the trauma patients.
4.9.3. Coordinates with nursing, educators, and support services for system development, problem solving and best practice.
4.9.4. Assures continuity of care through development of care guidelines, active participation in the Process Improvement Patient Safety (PIPS) Plan, peer review, and case review.

4.9.5. Along with the Trauma Program Manager (TPM), has oversight for PIPS including dashboard, metrics, trauma registry, reporting peer review, education and follow-up.
4.9.6. Completes OPPE evaluations for participation, contributions and clinical performance of Trauma Surgeons. Recommends renewals, modifications or termination of contracts and credentialing. Provides documentation to support recommendation.
4.9.7. Addresses problem behaviors and quality of care issues directly with surgeons. Documents incidents, changes and resolution on OPPE or through the Medical Staff Department. Escalates care issues to PPRC and Medical Staff leadership for corrective action and suspension of duties if warranted. Follows Medical Staff Rules and Regulations for suspending or removing surgeons from the call schedule.
4.9.8. Provides administrative oversight to physician liaisons for meeting their position expectations, communication, and system improvements needed for best care.
4.9.9. Assures participation of on-call trauma surgeon in ICU rounds, responds to care related concerns identified by the trauma manager, coordinators or nurses, and works directly with surgeons as needed to resolve care concerns.
4.9.10. Trauma Medical Director is co-director of the ICU.
4.9.11. Provides input for hiring and performance of trauma staff, operating and capital budget needs and other operations as requested.
4.9.12. Assures trauma service meets criteria for trauma designations as outlined by the American College of Surgeons and the State of Colorado and assists in the preparation of the application for the trauma center designation process.
4.9.13. Develops education program for trauma surgeons and providers, provides education and assists nurse educators to develop nursing education plan.
4.9.14. Provides feedback to outreach BCHs/physicians and referring agencies as appropriate.
4.9.15. Committee Participation
    g. Chairs the Trauma Service Committees.
    h. Represents Trauma Service
        i. Trauma and Surgery Committee;
        ii. Professional Peer Review Committee (PPRC);
        iii. Medical Executive Committee;
        iv. Other applicable and ad hoc meetings as requested by facility administration or designee.
    i. Participates on trauma operation meetings.
4.9.16. Provides in-service and community outreach programs as requested.
4.9.17. Along with TPM, is liaison with other trauma centers and trauma medical directors/professionals.
4.9.18. Participates in local, state and national trauma activity as appropriate.
4.9.19. Is familiar with organization, department and job specific environment of care areas, including life safety, utilities management, hazardous materials communications, emergency preparedness, infection control and medical equipment failure.
4.9.20. Adheres to standard precautions as appropriate, examples of which may include:
    j. The use of protective barriers, as appropriate (e.g., gloves, masks, gowns, pocket masks, and/or safety glasses);
    k. Handling and disposing of infectious waste appropriately; and
    l. Hand washing as appropriate

4.10. Performance Improvement - Performance improvement decisions are made by consensus in the Trauma Multidisciplinary Committee (TMC). This process encourages discussion and input from both trauma surgeons as well as involved subspecialists; however, final decision-making authority lies with the trauma medical director.

4.10.1. Performance improvement shall be supported by a reliable method of data collection that consistently obtains valid and objective information necessary to identify opportunities for improvement. The results of analysis shall define corrective strategies and shall be documented.

4.10.2. The trauma performance improvement program is coordinated with the hospital-wide program and will include:

m. Identified problem trends shall undergo peer review by the Peer Review/Performance Improvement Committee.

n. The care of children (<15 y/o) admitted with a single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam is overseen by a pediatric-specific peer review/performance improvement process.

o. The care of children (<15 y/o) admitted with other than a single extremity orthopedic fracture or minor head trauma with a negative computed tomography exam is overseen by a pediatric-specific peer review/performance improvement process which includes pediatric-specific process filters and outcome measures.

p. Physician availability to the trauma patient in the ICU shall be monitored by the Peer Review/Performance Improvement Committee.

4.11. Multidisciplinary Trauma Committee**:** A Multidisciplinary Trauma Committee, chaired by the Trauma Medical Director or his designee, exists to address trauma program operational issues and continuously evaluates the trauma program's processes and outcomes. The composition, duties and meeting requirements are outlined in the Medical Staff Organization and Functions Manual.

4.12. Performance Improvement/Peer Review Committee: A Performance Improvement/Peer Review Committee, chaired by the Trauma Medical Director or his designee, exists to address trauma program operational issues and continuously evaluates the trauma program's processes and outcomes. The composition, duties and meeting requirements are outlined in the Medical Staff Organization and Functions Manual.

4.13. Clinical Functions - Anesthesiology

4.13.1. There is a designated anesthesiologist to serve as the anesthesia liaison to the trauma service.

4.13.2. Anesthesiology services shall be promptly available 24 hours/day for emergency operations and airway problems in the injured patient.

4.13.3. Anesthesiologists on the call panel are regularly involved in the care of the trauma patient.

4.14. Clinical Functions - Emergency Medicine

4.14.1. There is a designated Emergency Department Physician Director

4.14.2. A physician is present in the Emergency Department at all times (3/2015).

4.14.3. There is a designated Emergency Medicine physician to serve as the Emergency Medicine Physician Liaison to the trauma service (the EMS Medical Director may serve in this role).

4.14.4. The performance of all Emergency Physicians on the trauma panel shall be reviewed annually by the Emergency Medicine Physician liaison to the trauma service.

4.14.5. Emergency physicians on the call panel shall be regularly involved in the care of the injured patient.

4.14.6. All Emergency Physicians on the trauma panel shall have completed an ATLS course at least once. Physicians certified by ABMS/AOA Boards other than Emergency Medicine who treat trauma patients in the Emergency Department shall remain current in ATLS.

4.15. Clinical Functions - General Surgery

To assure timely and quality care and to maintain ACS Level 2 verification the responsibilities for the trauma surgeons taking call are listed below. These are defined by the ACS and State of Colorado for expected level of care, timely response, commitment and leadership for care standards.

4.15.1. On-call coverage commences at 0700 and runs for 24 hours. Patient handoffs occur with direct surgeon-to-surgeon communication at the beginning of the new on call shift.

a. Complete assessment and documentation on all patient consults, admit or managed prior to handoff. (Orders, consultation notes, H&Ps, progress notes, operative reports, discharge summaries, etc.).

4.15.2. The surgeon on primary call at Boulder Community Health shall not have call responsibilities at any other facility for the period of time they are on call**.** Surgeons on backup call at Boulder Community Health may take primary call at another facility.

4.15.3. The on-call surgeon shall respond physically to all full trauma activations within 15 minutes of notification, and to other consultation requests in a timely manner commensurate with the acuity of the clinical problem and satisfactory to the referring provider. The trauma surgeon will be notified of all activations.

a. All patients who arrive as an activation (any level), if not admitted to the trauma surgeon, will have an evaluation by the trauma surgeon on the day of admission.

4.15.4. The progress note should reflect late discharge decision making.

4.15.5. Scheduling surgeries must balance with response time expectations. Scheduled cases should not interfere with patient rounds, discharges, ICU multidisciplinary rounds and consultations. During scheduled surgery, the ED should be notified of a backup surgeon for activations.

4.15.6. Patients admitted to the ICU will be seen by the surgeon in the ED.

4.15.7. Admit all multisystem trauma patients to the trauma service. Multisystem trauma patients remain on trauma service until discharge or transfer.

4.15.8. Manage all trauma patients who are admitted to or managed in consultation by the trauma service, regardless of the patient's ability to pay or payer source.

4.15.9. Attend and participate in multidisciplinary ICU rounds when trauma service patients are in ICU. Exception for emergent, urgent trauma or acute care surgery patient in OR or ED.

4.15.10. Discuss patient and service issues with trauma coordinator daily.

4.15.11. Resolve all trauma related issues prior to discharging or transferring patients off of the trauma service.

4.15.12. Provide post-surgery follow-up care for trauma patients, regardless of the patient's ability to pay or payer source.

4.15.13. Attend at least 50% of Multidisciplinary Trauma Committee meetings per year, 75% desired.

4.15.14. Attend 50% of quarterly trauma surgeon meetings per year, 75% desired.

4.15.15. Actively participate in the trauma program's internal educational program, including adherence to documentation (competency survey questions) requirements.

4.16. Clinical Functions - Neurosurgery

4.16.1. There is a designated neurosurgeon to serve as the neurosurgery liaison to the trauma service.

4.16.2. When requested, an attending neurosurgeon shall be promptly available to the trauma services.

4.16.3. Qualified neurosurgeons shall be regularly involved in the care of the head and spinal cord injured patient.

4.16.4. If neurosurgeons take call at more than one facility (either trauma or non-trauma) at a time, written primary and back-up call schedules are required.

4.17. Clinical Functions - Orthopedic Surgery

4.17.1. There is a designated orthopedic surgeon to serve as the orthopedic liaison to the trauma service.

4.17.2. Orthopedic team members have a dedicated call panel.

4.17.3. If the on-call orthopedic surgeon on-call is unable to respond promptly, a backup on-call orthopedic surgeon must be available or there is in place a contingency plan that includes transfer agreements with another designated Level I or II facility.

4.17.4. Orthopedic surgeons on the call panel are regularly involved in the care of the trauma patient.

4.17.5. In conjunction with the trauma team leader, the orthopedic surgeon on call is responsible for the development and coordination of the management strategy of all axial and appendicular musculoskeletal injuries so that the overall goals of patient care are not forgotten.

4.17.6. Following the acute treatment phase, the orthopedic surgeon is delegated the responsibility of rehabilitation, co-coordinating transfers and providing long-term follow-up care of fracture-related problems.

4.18. Clinical Functions - Radiology

4.18.1. There is a designated radiologist to serve as the radiology liaison to the trauma service.

4.18.2. A qualified radiologist shall be promptly available 24 hours/day either in person or by teleradiology, when requested for the interpretation of imaging studies or interventional procedures.

4.18.3. Diagnostic information must be communicated in written form and is promptly available.

4.18.4. Critical information that is deemed to immediately affect patient care is verbally communicated to the trauma team.

4.18.5. The preliminary report is permanently recorded. The final report will accurately reflect the chronology and content of communications with the trauma team, including changes between the preliminary and final interpretation.

4.19. Trauma Liaisons: **(**4/2013 BOD)

4.19.1. The following specialty groups will have designated liaisons to the trauma service:

a. Anesthesiology;
b. Emergency Medicine;
c. Neurosurgery;
d. Orthopedic Surgery;
e. Radiology.

4.19.2. Duties of the trauma liaisons include:

a. Adequate attendance (>50%) at the Multidisciplinary Trauma Committee required, 75% is desired.
b. Adequate attendance (>50%) at the Peer Review/Performance Improvement Committee required, 75% is desired.
c. Each liaison will provide ongoing professional practice evaluations (OPPE) every 8 months on the individual performance of their respective specialty providers on the trauma panel.
d. Each liaison ensures dissemination of information from the Multidisciplinary Trauma Committee to his specialty group.
e. The trauma service liaison shall accrue an average of 16 hours annually of verifiable, external trauma-related CME or 48 hours in the three years before the designation site review (radiology liaison exempt).
f. All other trauma panel members shall be reviewed every 8 months by their respective liaison or designated representative to assure compliance with the Trauma Services CME policy.
g. Each liaison will be available to the trauma medical director for committee issues that arise in their department.

4.20. Other Surgical Specialties: A full spectrum of surgical specialists on staff includes, but is not limited to: thoracic, peripheral vascular, obstetric, gynecological, otolaryngologic, urologic, ophthalmologic, facial trauma, spine and plastic. Call coverage also includes plastic surgery, hand surgery and treatment of spinal injuries.

4.21. Medical Consultants: The following medical specialists on staff will include cardiology, infectious disease, internal medicine, pulmonary medicine and nephrology.

SECTION 5. MEDICAL RECORDS

5.1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data, chief complaint, personal history, family history, history of present illness, physical examination, a statement of conclusions or impressions drawn from the admission history and physical examination, a statement of the rationale for the course of action planned, a detailed

description of the course of action planned, special reports such as consultations, clinical laboratory and radiology services, assessment of the patient's emotional, behavioral and social status and others; provisional diagnosis, rationale for and a detailed description of the medical or surgical treatment; an inventory by body systems, operative report; pathological findings; progress notes; final diagnosis; condition on discharge, including infections; summary and discharge plan; clinical resume; and autopsy report when performed; and in programs for children or adolescents consideration of educational needs and evaluation of developmental age factors, as appropriate.

5.2. For psychiatric services, case managers must follow documentation requirements delineated within their scope of privileges. For psychiatric outpatient programs, a standardized assessment tool will be utilized and followed. For psychiatric outpatient programs, history and physicals must be completed within 30 days of admission to be acceptable.

5.3. History and Physicals – See Bylaws Section 13.

5.4. Pertinent Progress Notes shall be dated, timed and recorded at the time of observation, sufficient to permit continuity of care and transferability. Progress notes shall be documented daily on all inpatients. Progress notes may be documented by Advanced Practice Professional who have privileges to do so. (5/2019)

5.5. An Advanced Practice Provider, at the discretion of the Emergency Department physician, may perform initial assessments on Emergency Department patients**.** The Advanced Practice Provider must initiate immediate contact to his/her collaborating physician to assume treatment of critical patients, as clinically necessary to assure delivery of appropriate care to an individual patient. (5/2019)

5.6. The admitting physician is required to provide an initial assessment for patients admitted to the ICU within 2 hours of being notified of admission to ICU or within 1 hour of transfer from lower acuity floor, accept in extenuating circumstances. If a patient requires immediate physician attention, the ICU nurse, the ED physician or the Medical Director of the ICU can, at their discretion, notify the admitting physician of the immediate need to see the patient. The physician extender may round on ICU patients and facilitate follow-up care once the physician has evaluated the patient. (MEC 5/2009, 7/2014, 3/2021).

Note: "Advanced Practice Professional" is a general term that identifies the following practitioners: Nurse Practitioners (NP), Physician Assistants (PA), Anesthesiologists Assistant (AA), Certified Nurse Midwives (CNM), Registered Nurses (RN). (5/2019)

5.7. All orders for treatment shall be in writing or electronic. When a telephone or verbal orders must be used, they must be dated, timed and authenticated by the ordering physician/ authorized practitioner within 48 hours after the time the order is made, unless the RN or delegate receiving the verbal or telephone order verifies the order by immediately reading it back to the ordering physician/ authorized practitioner, who shall at that time verify that the read- back order is correct. The individual receiving the verbal or telephone order shall record in writing that the order was read back and verified. If the read- back and verify process is followed, the verbal or telephone order shall be authenticated within thirty days after the date of the patient's discharge (revised 5/2010). The physician who has been assigned primary care may authenticate all verbal orders of previous

physicians. A physician assistant (PA) or nurse practitioner (NP), may also authenticate a physician's verbal order only if the order is within his/her scope of practice and the patient is under his/her care. Authentication may include signatures, identifiable initials or computer entry. Verbal orders (telephone or oral) should be accepted only by personnel as defined within RC.1007.ORG Provider Orders: Verbal and Telephone (10/2009; 6/2012) (CO HB1229) (3/2018), (5/2019)

5.8. Practitioner's orders must be clear, and complete, and comply with hospital policies if written, legible. (5/2019)

5.9. Medication orders shall comply with Hospital policy MM.1009: Medication: Order Management (5/2019)

5.10. Patient(s) who are determined to have an emergency medical condition shall be provided with stabilizing treatment, as required by EMTALA, and shall be transferred or discharged as necessary in accordance with the BCH EMTALA Policy. PC.2069: Transfer to another Acute Care Facility. (5/2019)

5.11. All orders for admitted patients that undergo surgery, or any other procedure that changes the patient's course, will be reviewed by the provider to ensure post-procedure orders reflect any applicable changes in care. (3/21/2018)

5.12. Reconciliation of medications needs to take place any time a patient is transferred to another level of care.

5.13. An Operative Report of Other Procedural Report is dictated or written immediately after any surgery, invasive procedure or other procedure or treatment which is non-routine, has risks associated with it of which the patient must be aware and for which informed consent is required. The report includes the following information: the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed or altered, estimated blood loss and postoperative diagnosis. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. This progress note should contain, at a minimum, comparable operative report data as delineated above. (MEC 5/2012) (5/2019)

5.13.1. Procedures not requiring an operative report (this list is not all inclusive): (12/2013)

a. Arterial Line Insertions;
b. Bedside Tissue Debridement;
c. Bone Marrow Biopsy;
d. Blood patches;
e. Breast biopsy (ultrasound, stereotactic, MRI);
f. Breast hookwire localization (ultrasound, mammography, MRI);
g. Central Line Insertions;
h. Chest tube placement (without moderate sedation);
i. Fine needle aspiration (breast, thyroid, salivary gland, lymph nodes);
j. Imaging guided musculoskeletal procedures (i.e. PRP);
k. Intrathecal chemotherapy;
l. Joint injections via fluoroscopy, CT or ultrasound (spine and extremities);
m. Lumbar puncture (including fluoroscopic guided);
n. Myelogram;

o. Needlepoint Aspiration (joint, tissue);
p. Nuclear medicine therapeutic dose administration;
q. Paracentesis;
r. PICC placement;
s. Pseudoaneurysm thrombin injection (ultrasound guided);
t. Regional Blocks;
u. Thoracentesis;
v. Transesophageal electrocardiography cardioversion procedures. (5/9/2018)

NOTE: The dictated report is immediately available on LHR.

5.14. The anesthesia record shall include: Pre-Anesthesia Note: A preoperative evaluation, including airway assessment, will be made and positive findings recorded by the anesthesiologist prior to the induction of anesthesia. Anesthesia Record: There shall be a proper recording of anesthesia monitoring and conduct of anesthesia including agents, medications, methods, fluids including blood and blood components, etc. on an approved anesthesia record form. Recording the Post-Anesthetic Visits: There shall be at least one note describing the presence or absence of anesthesia related complications. The medical record shall reflect which physician was responsible for the patient's release when there has been no order written or verbal release authenticated by the responsible physician. The AA's chart notes should include the name of the supervising anesthesiologist and date of anesthesia service.

5.15. All entries on the patient's medical record must be legible, complete, dated, timed and, authenticated. The physician who has been assigned primary care may date, time and authenticate all verbal orders of previous physicians. A PA or NP, may also authenticate a physician's verbal order only if the order is within his/her scope of practice and the patient is under his/her care. All dictated reports shall be accurately stated and authenticated either by written signature or identifiable initials via electronic authentication. (revised 10/2009)

5.16. A discharge clinical summary shall be written or dictated on all medical records of patients hospitalized upon discharge from the facility**.** A brief, pertinent discharge/disposition note should be written on all patients transferred to another level of care within the facility, to include the rationale for admission to that level of care. (5/2019) The discharge clinical resume should include the following information:

5.16.1. the reason for admission;
5.16.2. significant findings;
5.16.3. procedures performed and treatment rendered;
5.16.4. the patient's condition at discharge;
5.16.5. instructions to the primary care provider, patient, and family

Discharge summaries completed by a qualified PA must be reviewed and countersigned by a member of the medical staff before it can become a part of the medical record. Discharge summaries completed by a qualified NP do not require a physician review and/or counter signature unless required by the NP's employment agreement. (6/2012, 10/2015).

5.17. Records may be removed from the Hospitals' jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records shall not otherwise be taken out of the Hospital without permission of the Chief Executive Officer.

5.18. Access to all medical records of all patients, both past and present, shall be afforded to members of the medical staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients and the practitioners. All such projects shall be approved by the MEC before records can be studied. Former members of the Medical Staff shall be permitted access to the information from the medical records of their patients covering all periods during which they attended such patients in the hospital. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

5.19. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Director of Medical Records.

SECTION6. DOCUMENTATION TIMELINESS

6.1. A medical record is complete when

- 6.1.1. Its contents reflects the patient's condition on arrival, diagnosis, test results, therapy, condition and in-hospital progress, and condition at discharge;
- 6.1.2. Its contents are assembled and authenticated;
- 6.1.3. All final diagnoses and complications are recorded.

6.2. A medical record shall be considered incomplete

- 6.2.1. if any entries are missing, and practitioners will be notified at 4 days after analysis and collation of incomplete records. Records which are incomplete upon 14 days will be considered delinquent. In the event a practitioner's medical records remain incomplete after 14 days and the process set forth in Section 6.6 has been followed the practitioner's clinical privileges will be automatically relinquished.
- 6.2.2. in the event a medical record is flagged as a complex chart the provider(s) of record will be asked to answer HIMs queries perhaps even prior to discharge or to complete the charts as soon as possible. (3/2021)
- 6.2.3. Appropriate notification to the Medical Records Department, prior to a practitioner's vacation or out-of-town travel lasting more than three days, or upon return from an illness lasting more than three days, will stay the timeliness of the completion of records. (4/18/2018)

6.3. A relinquishment for incomplete medical records is defined as a "non-admit status" for the practitioner. Under this status, the practitioner may not perform any clinical activities within the hospital, except those related to continuity of care for patients admitted prior to obtaining this status. The practitioner may not work an assigned shift (i.e. Anesthesiology, Radiology, ED, etc.) and may not admit a new patient or perform same-day/outpatient surgery, cardiac caths, etc. despite previous scheduling for treatment/ procedures. The practitioner may not schedule any surgeries/caths. Orders for diagnostic testing (i.e. imaging, lab, etc.) will be accepted.

6.4. The practitioner, designated as "non-admit status" is responsible for arranging alternative coverage for all assigned work shifts or scheduled ER Call.

6.5. Transfer of care or requests for consultations may not be accepted by a practitioner who has relinquished his/her privileges. However, the practitioner with relinquished privileges must continue to provide care for patients who have been previously admitted to an inpatient service. The practitioner continues to be responsible for these patients. This relinquishment or "status" will remain in effect until all delinquent medical records have been completed, as verified by the Medical Records Department.

6.6 Notification Process. The Medical Records Department monitors completeness of records on a daily basis and notifies practitioners of required work on a weekly basis. This Department works diligently with practitioners to ensure the timely completion of records.

6.6.1 On day 7, practitioners will receive a *Friendly Reminder* in their EPIC in basket to complete outstanding records. If any records remain incomplete, (3/2021)

6.6.2 On day 14, practitioners will receive a *Gentle Reminder* in their EPIC in basket to complete outstanding records. If any remain incomplete, (3/2021)

6.6.2. On day 21, practitioners will receive an *HIMs Alert Letter* to preferred email and a phone call from HIMS. The office /Practice Manager will be alerted of outstanding records. The Medical Records Department will notify all departments via group email of the practitioner's status. If remain incomplete, (3/2021)

6.6.3. On day 28, a *Warning Letter* will be sent and a call from the President of the Medical Staff or Chair of your Department will be placed to practitioner. Office Manager/Practice Manager alerted by phone of current deficient records too If remain incomplete, (3/2021)

6.6.4. On day 30, a *Pre-Suspension Letter* and call to practitioner from HIMs will be placed. If remain incomplete, (3/2021)

6.6.5. On day 31, Suspension Letter sent to practitioner. (3/2021)

6.6.6. Upon completion of all delinquent records, the Medical Records Department will notify appropriate Departments via group email that the relinquishment has ended.

6.7. Corrective Action Process. Steps may be may be necessary to correct behavior when a practitioner fails to modify his practice patterns sufficiently to comply with this policy. Repeated relinquishments and multiple requests for waivers will be viewed as an unwillingness to support a collaborative atmosphere in the delivery of patient care and this behavior could be determined as disruptive to hospital operations.

6.7.1. A supportive letter or phone call offering support of helpful strategies from medical staff leadership to any practitioner who relinquishes his/her privileges twice in a rolling twelve-month period. The intent of this letter will be to ensure that the practitioner understands the ramifications of non-compliance with this policy and to provide assistance in developing appropriate behaviors.

6.7.2. Upon a third relinquishment in a rolling twelve-month period, the practitioner will receive a letter of reprimand from medical staff leadership. This letter will also serve as a warning of the consequence of a fourth relinquishment. Further, upon application for reappointment, practitioners with three relinquishments in a twelve-month period may

be granted a “conditional” reappointment to the medical staff. This conditional appointment will result in a change of standing on the medical staff (i.e. responses to queries from external sources, such as hospital/managed care affiliations, will not include the statement of “the practitioner is in good standing” with this institution).

6.7.3. Four relinquishments within a rolling twelve-month period will result in a voluntary resignation of the practitioner's medical staff membership and/or clinical privileges. Requests for re-instatement will require submission of a full application/fee, and the practitioner may not be eligible for temporary privileges. Reinstatement may also be granted as a “conditional appointment” with further stipulations.

6.7.4. Failure to complete delinquent medical records within three weeks after a relinquishment became effective, shall be deemed a voluntary resignation of the practitioner's medical staff membership and clinical privileges requiring full reapplication and fees in order for reinstatement to be considered.

6.8. Appeal process.

6.8.1. A waiver of relinquishment of privileges may only be requested under extreme circumstances preventing the completion of records. The practitioner must request this waiver directly from the President of the Medical Staff his designee, who will consider the request based upon the nature and acuity of the immediate need for patient care and the practitioner’s prior good faith efforts to regularly complete his records.

6.8.2. A waiver of voluntary resignation may only be requested under extreme circumstances preventing the altering of behavior to comply with this policy. The practitioner must request this waiver directly from the President of the Medical Staff or his designee, who will consider the request based upon the nature and acuity of the immediate need for patient care and the practitioner’s prior good faith efforts to regularly complete his records. Alternative corrective actions may be implemented.

SECTION 7. GENERAL CONDUCT OF CARE

7.1. A general consent form, signed by or on behalf of every patient admitted to the Hospital will be obtained at the time of admission. Informed consent documents will be consistent with Hospital policy. The attending practitioner will be notified whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner’s obligation to obtain proper consent, consistent with Hospital policy, before the patient is treated in the Hospital.

7.2. Guidelines for scheduling of surgical cases and equipment, and surgical start times are defined in Hospital Policy.

7.3. Any patient who is to have an anesthetic shall have appropriate pre-admission testing in accordance with established guidelines. The physician may vary from these guidelines and document his reasons in the medical record. Laboratory studies done by an outside laboratory recognized by the hospitals will be accepted to fulfill these requirements and such laboratory studies shall be posted on the medical record at the time of admission to the Hospital and prior to surgery.

7.4. On-call anesthesiologist shall remain sufficiently close to the Hospital so that they are able to start a case within 30 minutes after receiving a call for services.

7.5. All tissue and hardware removed during surgical procedure, other than those excluded below, will be sent to Pathology for gross description and histological evaluation:

7.5.1. Lens (for cataract removal);
7.5.2. Orthopedic appliances;
7.5.3. Nasal cartilage not including soft tissue;
7.5.4. Foreskin (prepubertal);
7.5.5. Scars;
7.5.6. Placentas (from normal deliveries);
7.5.7. Bones for hammertoes;
7.5.8. Skin, fat, cartilage removed for cosmetic procedures (includes breast tissue removed by liposuction);
7.5.9. Teeth;
7.5.10. Nail tissue;
7.5.11. Bunions and corns;
7.5.12. Kidney stones, bladder stones, gallstones;
7.5.13. Meniscus;
7.5.14. Dental appliances;
7.5.15. Foreign bodies such as bullets or other medicolegal evidence given directly to law enforcement;
7.5.16. Intrauterine contraceptive devices without attached soft tissue;
7.5.17. Medical devices such as catheters, gastrostomy tubes, Myringotomy tubes;
7.5.18. Stents, and sutures that have not contributed to patient illness, injury or death;
7.5.19. Middle ear ossicles;
7.5.20. Orthopedic hardware and other radio-opaque mechanical devices;
7.5.21. Rib segments or other tissues removed only for purposes of gaining surgical access, provided the patient has no history of malignancy;
7.5.22. Saphenous vein segments harvested for coronary artery bypass;
7.5.23. Therapeutic radioactive sources.
7.5.24. **Note:** If disc or lamina is emulsified it is discarded, otherwise it will be sent to Pathology (MEC 5/2009)

7.6. Formulary: The development and maintenance of the hospital's medication formulary is the responsibility of the pharmacy in conjunction with the Pharmacy & Therapeutics Committee and in accordance with pharmacy policies.

7.7. Time limited medication orders**:** All antibiotic orders will stop after 30 (thirty) days. All controlled substances (schedule II-V) will automatically stop after 10 (ten) days. (MEC 8/2007, 01/2015,3/2015).

7.8. Care and Management of ICU Patients: (MEC 2/2012)
Intensivists will assume responsibility for and manage the care of all patients admitted to the ICU, unless the patient's primary attending physician continues to assume responsibility for the patient in the ICU, in which case the intensivist shall co-manage the care of the patient with the attending physician. In cases where the care of a patient is co-managed by the intensivist and the attending physician, the intensivist shall cooperate with the attending physician and nursing staff to develop

clear roles of each physician, open lines of communication with nursing and assure that care of the patient is provided appropriately. The intensivist shall provide all physician services within the scope of the intensivist physician's qualifications and privileges to such patients during their ICU admission. The intensivist shall coordinate its services with the patient's primary care physicians and shall consult with such primary care physicians as necessary to assure continuity of care during admission and upon discharge.

7.8.1. Rounding

An intensivist will round daily during on-site hours on all patients in both ICU's with nursing, support staff and the primary attending physician whenever possible.

7.9. CONSULTATIONS (MEC 8/2011)

7.9.1. An order for a consultation shall be placed in the EHR and include the reason for the consultation (12/2013). An order for a consultation should be considered in the following situations:

a. When the patient is a high risk for operation or treatment;
b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
c. Where there is doubt as to the choice of the therapeutic measures to be utilized;
d. In unusually complicated situations where specific skills of other practitioners may be needed;
e. In instances in which the patient exhibits severe psychiatric symptoms, has attempted suicide, is a danger to himself or others because of mental impairment requiring acute inpatient admission. The need for admission to the unit should be documented in the patient's medical record;
f. When requested by the patient or his family;
g. In those cases where each individual department indicates that a consultation is required (i.e. chemical dependency patients refer to BHS chemical dependency policy).

7.9.2. A satisfactory consultation includes examination of the patient and the patient's record. A dictated or written opinion signed legibly by the consultant must be included in the medical record following each consultation visit. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation except in situations when the procedure is an integral part of the consultation.

7.9.3. The referring physician is responsible for directly contacting the consulting physician or his/her designee[1], when a consultation is needed. The only exceptions to this will be routine tests and routine radiological procedures (invasive radiologic procedures would require physician to physician consults). Referring physicians actively participating in invasive procedures may relay information to consulting physicians using intermediaries in these clinical scenarios. *Voice mail, pager messages and emails do not constitute a consult.* A referring practitioner may use these forms of communication but, the

[1] Physician Assistant or Nurse Practitioner under the direct supervision of the Physician, and who have been identified in writing to the Hospital by the Physician as the Physician's designee for the purposes of accepting consultation requests.

consulting practitioner's responsibility begins only after direct communication from the referring practitioner or his/her designee.

7.9.4. If a specific physician is requested for a consultation but is unavailable, the physician on-call for that physician is responsible for assuring the consultation is completed.

7.9.5. Consultations not designated as urgent/emergent by the requesting physician will be seen within 24 hours of the request for consultation.

7.9.6. Consultations designated as 'trauma" may be initiated by a PA/NP within 12 hours of notification. The NP/PA who then may dictate the H&P and plan of care. The consulting physician then must provide consultation in-person within 24 hours from the time of notification or prior to discharge, whichever comes first. The physician will then provide a focused exam, review the plan of care, and document both at the time of the consult. This may be in the form of an addendum to the PA/NP provider dictation (7/2015).

7.9.6.1 In the event a consultation physician transfers care to another physician, either within or outside of the consulting physician group, such transfer shall be via direct physician–to-physician contact, and the receiving physician shall accept the transfer and perform the focused examination within the initial 24-hour period, or it f not practical, no later than 24-hour of the transfer. (5.2019)

7.9.7. The urgency of a response must be communicated during the physician to physician contact based on the patient's acuity. In the event of a disagreement regarding appropriate response time, the referring physician's opinion will prevail. (12/2013)

7.9.8. Problems obtaining a consultation should be directed to the attention of the Department Chairman or Medical Staff President. (12/2013)

7.9.9. When consultation has been requested, or when two or more physicians are involved in the care of patients while in the hospital, the admitting physician shall be primarily responsible for the care of that patient. However, should consultations disclose a condition or illness whose management is likely to exceed the privileges of the attending physician, the consultant shall, upon written request of the attending physician, accept responsibility on a referral basis.

7.9.10. Psychiatric consultations. For acute care medical admissions (including those to the Behavioral Health Unit), which have need for psychiatric consultation, the primary care physician assumes care and treatment of the medical condition and may delegate continued psychiatric care and treatment to the psychiatric consultant. It is the responsibility of the primary care physician to document the acceptance of responsibility by the psychiatric consultant.

7.9.11. For Behavioral Health Unit admissions that need medical consultation the psychiatrist assumes the care for treatment of the psychiatric condition and may delegate continued medical care and treatment to the medical consultant. It is the responsibility of the psychiatrist to document the acceptance of responsibility by the medical consultant.

7.10. Members of the Medical Staff are required to follow Hospital policies and procedures.

7.11. Members of the Medical Staff are encouraged to wear a name badge in order to promote a safe and professional environment at BCH.

7.12. Every member of the Medical Staff absent from his/her practice must make satisfactory arrangements with another member of the BCH Medical Staff for the care of hospitalized patients and patients presenting to the hospital for treatment. If coverage arrangements have not been made, the patient will be assigned to the Medical Staff member currently taking applicable specialty call to assume charge of the absent member's patient(s) for the duration of their admission.

SECTION 8. ELECTRONIC MAIL COMMUNICATIONS

(7/2011)

8.1 To ensure a reliable, timely and cost-efficient mode of communication with members of the hospital staff, all Medical Staff members and all Allied Health Professional members with delineated privileges, with the exclusion of the members of the Honorary staff, shall be required to maintain and provide a personal, active and unique electronic mail address to the Medical Staff Department. In addition, these members will be responsible for the following:

- 8.1.1 Regularly checking the preferred email account for official medical staff communication;
- 8.1.2 Providing immediate notification to the Medical Staff Department of any change in preferred email address;
- 8.1.3 Maintaining confidentiality of all Hospital electronic communications;
- 8.1.4 Maintaining sole access to the preferred email account provide to the Hospital for communications.

8.2 Accepting sole responsibility and authorship for any communication to the Hospital from the preferred email account. All applicants will be notified of this requirement during the credentialing process and privileges/membership will not be activated until a qualified electronic address has been provided

8.3 Hospital and Medical Staff shall use email addresses of Medical Staff members strictly in accordance with M.1005: Electronic Communication Use and IM.1010: Information Security Program Policy. (5/2019)

SECTION 9. RESTRAINTS and SECLUSION

(MEC 7/2012)

Each patient will be treated under the least restrictive conditions consistent with his or her condition. Seclusion or restraints should be prescribed only when needed to protect the patient or others from harm, or to maintain the therapeutic environment. Restraints or seclusion may not be used to punish or discipline a patient or for the convenience of the staff. Restraints for non-violent patient management must be authorized/ordered by a physician with clinical privileges and in accordance with hospital policy P.C.2061.ORG. Restraints and seclusion for violent patient management must be authorized/ordered by physicians with privileges in emergency medicine, psychiatry, intensive/critical care, or hospital medicine, In accordance with hospital policy P.C.2060.ORG (5/2019)