CHARLESTON AREA MEDICAL CENTER

MEDICAL STAFF
ORGANIZATION AND FUNCTIONS MANUAL

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ARTICLE 1

GENERAL

1.A: DEFINITIONS

The following definitions shall apply to terms used in this Manual, the Bylaws and related policies and manuals:

(1) "ALLIED HEALTH PROFESSIONALS" means individuals other than staff appointees who are authorized by law to provide patient care services, whose scope of practice is defined in the Policy on Allied Health Professionals.

(2) "BOARD" means the Board of Trustees of the Hospital or its designated committee which has the overall responsibility for the Hospital.

(3) "BOARD CERTIFICATION" is the designation conferred by one of the affiliated specialties of the American Board of Medical Specialties ("ABMS"), the American Osteopathic Association ("AOA"), the American Board of Oral and Maxillofacial Surgery, or the American Board of Podiatric Surgery ("ABPS"), as applicable, upon a physician, dentist or podiatrist who has successfully completed an approved educational training program and an evaluation process, including passing an examination, in the applicant's area of clinical practice.

(4) "PRESIDENT" means the individual appointed by the Board to act on its behalf in the overall management of the Hospital.

(5) "CLINICAL PRIVILEGES" means the authorization granted by the Board to render specific patient care services.

(6) "CREDENTIALS POLICY" means the Hospital's Medical Staff Credentials Policy.

(7) "DAYS" means calendar days.
(8) "DENTIST" means a doctor of dental surgery ("D.D.S.") or doctor of dental medicine ("D.M.D.").

(9) "MEDICAL STAFF EXECUTIVE COMMITTEE" means the Executive Committee of the Medical Staff.

(10) "HOSPITAL" or "CAMC" means Charleston Area Medical Center.

(11) "HOUSE STAFF" means all physicians who are assigned for graduate medical education and will ordinarily carry the title of resident or fellow.

(12) "MEDICAL STAFF" means all physicians, dentists and oral surgeons who have been appointed to the Medical Staff by the Board.

(13) "APPOINTEE" means any physician, dentist, or oral surgeon who has been granted medical staff appointment and clinical privileges by the Board to practice at the Hospital.

(14) "NOTICE" means written communication by regular U.S. mail, e-mail, facsimile or Hospital mail, or hand delivery.

(15) "PATIENT CONTACTS" includes any admission, consultation, procedure, response to emergency call, evaluation, treatment or service performed in any facility operated by the Hospital or affiliate, including outpatient facilities.

(16) "PHYSICIAN" includes both doctors of medicine ("M.D.s") and doctors of osteopathy ("D.O.s").

(17) "SPECIAL NOTICE" means hand delivery, certified mail, return receipt requested or overnight delivery service providing receipt.

1.B: TIME LIMITS

Time limits referred to in this Manual are advisory only and are not mandatory, unless it is expressly stated that a particular right is waived by failing to take action within a specified period.
1.C: DELEGATION OF FUNCTIONS

When a function is to be carried out by a person or committee, the person, or the committee through its chairperson, may delegate performance of the function to one or more qualified designees.

1.D: MEDICAL STAFF BYLAWS AND POLICIES AND RULES AND REGULATIONS

In addition to the Medical Staff Bylaws, there shall be policies, procedures, and rules and regulations that shall be applicable to all members of the Medical Staff and other individuals who have been granted clinical privileges or a scope of practice. All Medical Staff policies, procedures, and rules and regulations shall be considered an integral part of the Medical Staff Bylaws, subject to the amendment and adoption provisions contained in each document.
ARTICLE 2
DEPARTMENTS AND SECTIONS

2.A: LIST OF DEPARTMENTS

The following departments are established:

(1) Anesthesiology;
(2) Cardiovascular Medicine
(3) Emergency Medicine;
(4) Family Practice;
(5) Medicine;
(6) Neurosciences,
(7) Obstetrics and Gynecology;
(8) Orthopedics and Rehabilitation;
(9) Otolaryngology - Head and Neck Surgery;
(10) Pathology;
(11) Pediatrics;
(12) Medical Imaging and Radiation Oncology;
(13) Surgery; and
(14) Urology.

2.B: FUNCTIONS AND RESPONSIBILITIES OF DEPARTMENTS AND SECTIONS

The functions and responsibilities of departments, department chiefs, sections and section heads are set forth in the Medical Staff Bylaws.
2.C: CREATION AND DISSOLUTION OF DEPARTMENTS AND SECTIONS

(1) Departments shall be created and may be consolidated or dissolved by the Medical Staff Executive Committee upon approval by the Board as set forth below.

(2) The following factors shall be considered in determining whether a department should be created:

(a) there exists a number of members of the Medical Staff who are available for appointment to, and are reasonably expected to actively participate in, the proposed new department (this number must be sufficiently large to enable the department to accomplish its functions as set forth in the Bylaws);

(b) the level of clinical activity that will be affected by the new department is substantial enough to warrant imposing the responsibility to accomplish departmental functions on a routine basis;

(c) a majority of the voting members of the proposed department vote in favor of the creation of a new department;

(d) the relevant Medical Staff members support that there is a clinical and administrative need for a new department; and

(e) the relevant Medical Staff members offer a reasonable proposal for how the new department will fulfill all of the designated responsibilities and functions including, where applicable, meeting requirements.

(3) The following factors shall be considered in determining whether the dissolution of a department is warranted:

(a) there is no longer an adequate number of members of the Medical Staff in the department to enable it to accomplish the functions set forth in the Bylaws;
(b) there is an insubstantial number of patients or an insignificant amount of clinical activity to warrant the imposition of the designated duties on the appointees in the department;

(c) the department fails to fulfill all designated responsibilities and functions including, where applicable, its meeting requirements;

(d) no qualified individual is willing to serve as chairperson of the department; or

(e) a majority of the voting members of the department vote for its dissolution.

(4) A group of physicians who practice in the same or similar areas and who wish to have a forum for discussion of those clinical areas may request to function as a department or section. The request must be signed by a majority of Active Staff members in the clinical specialty and shall be submitted to the appropriate department chairperson for review and recommendation. The request will be forwarded to the Medical Staff Executive Committee for recommendation and to the Board for approval.
ARTICLE 3
STANDING MEDICAL STAFF COMMITTEES

3.A: MEDICAL STAFF COMMITTEES

(1) Committee chairpersons and Medical Staff members of the committees shall be appointed by the Chief of Staff in accordance with the Medical Staff Bylaws.

(2) Unless otherwise provided, all Hospital and administrative representatives on the committees shall be appointed by the President or designee. All such representatives shall serve on the committees without vote.

3.B: MEETINGS, REPORTS AND RECOMMENDATIONS

Unless otherwise indicated, each committee described in this Manual shall meet at least quarterly, or at the discretion of the chairperson, and shall maintain a permanent record of its findings, proceedings, and actions. Each committee shall make a timely written report after each meeting to the Medical Staff Executive Committee and to other committees and individuals as may be indicated in this Manual.

3.C: CANCER COMMITTEE

3.C.1. Composition:
The Cancer Committee shall be composed of representatives as required by the American College of Surgeons model to maintain certification of the Cancer Program and other ad hoc appointees as deemed appropriate by the chairperson of the Cancer Committee. The Vice President for Operations, or designee; the Administrator of Professional Nursing, or designee; and a representative of the Department of Patient/Family Services, the Department of Pharmacy, the Tumor Registry, the
3.C.2. Duties:

The Cancer Committee shall:

(a) review the care of cancer patients admitted to the Hospital, including diagnosis, treatment, rehabilitation, regular follow-up and end results, as well as the review of any clinical or basic research in this area;

(b) be responsible for the operation and accreditation of any accredited cancer registry, operating under the regulations of the American College of Surgeons, in place at the Hospital.

(c) supervise the Cancer Registry for quality control of abstracting, staging, and reporting and serve as Cancer Registry physician advisor(s);

(d) organize, publicize, conduct, and evaluate regular educational and consultative cancer conferences that are multidisciplinary, institution-wide, and patient oriented and make certain cancer conferences include major cancer sites yearly and are primarily patient oriented and prospective;

(e) ensure that consultative services from all major disciplines are available to all patients;

(f) evaluate the quality of care of patients with cancer;

(g) plan, complete, and evaluate a minimum of two patient care evaluation studies annually, one to include survival data and, if available, comparison data; and

(h) publish and distribute an annual report.
3.D: CLINICAL DOCUMENTATION QUALITY COMMITTEE

3.D.1. Composition:
The Clinical Documentation Quality Committee shall be composed of one representative from each of the Medical Staff departments and the Hospital's Utilization Management physician advisor. The Corporate Director of Medical Affairs; Manager of Health Information Management; Vice President for Professional Nursing or designee; Directors of Patient/Family Services; Clinical Quality Specialist; Director of Care Management; Director of Material Management; and External Review Coordinator shall all be non-voting members of the Committee.

3.D.2. Duties:
The Clinical Documentation Quality Committee shall:

(a) oversee and review monthly Health Information Systems reports of the systematic review of a representative sample of patient records to assure physicians, residents, PAs, ANPs or other professionals approved to document, as physician designees, are completing records legibly, and in a manner pertinent to patient condition and consistent with standards, rules and regulations, policy and procedures, and patient safety.

(b) review and act on periodic reports concerning all related medical records, hospital and HIM support services that affect physicians and patient care to include but not limited to transcription turn around time, timeliness of record and results report availability to physicians.

(c) review at least quarterly, utilization management statistics as prepared by the physician advisor on utilization management.
(d) oversee physician development of content for clinical pertinence review screens to be performed by non-physicians and review reported data for trends useful in performance improvement.

(e) create and maintain the hospital list of approved and non-approved abbreviations; review at least annually.

(f) determine the format for a complete medical record, receive recommendations on and approve forms used in the medical record.

(g) develop policies and procedures related to retention of records, archiving, and other issues related to Health Information Management; and

(h) oversee development of performance improvement projects, data measurement and analysis, implementation of improvement plans, and maintenance of improvement.

[Section 3.D and its subsections amended 03/23/2005]

3.E: CREDENTIALS COMMITTEE

3.E.1. Composition:
The Credentials Committee shall be composed of one representative from each of the Medical Staff departments and two non-physician members of the Board who shall serve as ex officio, non-voting members. Medical Staff members shall serve three-year terms with staggered appointment on a yearly basis to provide for continuity of the Committee.
3.E.2. Duties:

The Credentials Committee shall:

(a) investigate the character, professional competence and qualifications of physicians, dentists and allied health professionals who have completed applications for appointment or reappointment to the Medical Staff and of appointees who have requested changes in clinical privileges and make recommendations on the same;

(b) investigate the character, professional competence and qualifications of allied health professionals who have requested permission to practice at the Medical Center and make recommendations on clinical privileges or scopes of practice requested;

(c) coordinate the standardization of minimal criteria for evaluating the credentials of persons who desire to perform procedures which involve more than one discipline, specialty or department;

(d) require applicants to the Medical Staff to resolve any doubts concerning competence, ethics, training, ability to fulfill the obligations of appointment, or any other matter bearing upon suitability for appointment or privileges;

(e) actively seek the information that the Committee requires in the execution of its duties and insist that applicants provide all necessary information for processing an application; and

(f) make its recommendations to the Medical Staff Executive Committee and, when requested, to the Board.
3.F: PHARMACY AND THERAPEUTICS COMMITTEE

3.F.1. Composition:
The Pharmacy and Therapeutics Committee will be composed of a Chair and nine additional voting members chosen from the clinical departments of Medicine, Surgery, Family Medicine, Cardiovascular Medicine, Pediatrics, Obstetrics and Gynecology, Neurosciences, Emergency Medicine, Anesthesiology. The Director of Clinical Nutrition, Safety Officer, JCAHO Coordinator, Health System Director of Pharmacy, Director of Nursing Quality, and Vice President overseeing Pharmacy shall be non-voting members of the Committee. Representatives so chosen should have demonstrated an interest in medication related issues, especially including safety. The members of the committee commit to working with the Chair and the hospital to maintain the Formulary and to promote safe medication practices at CAMC.

3.F.2. Functions Of The Pharmacy And Therapeutics Committee:
(a) Consult with Pharmacies. Consult as required with Hospital pharmacies regarding the acquisition, storage, inventory, preparation, distribution and ordering of drugs and other diagnostic testing materials under the control of the pharmacies;

(b) Evaluate Drug Usage. Set criteria and standards for medication evaluation and use within the Hospital. Medication use and benefit studies performed by the Medical Staff must be approved by the Medical Staff Executive Committee.

(c) Develop Professional Policies and the Formulary. Assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures and all other matters relating to medication and the medication Formulary in the Hospital;
(d) Review Adverse Drug Events. Define, monitor and review adverse drug events, including adverse drug reactions and medication errors, and may participate in processes of continuously improving medication safety throughout the Hospital.

(e) Make Periodic Reports Concerning Nutrition Support; Obtain Approvals. The Nutrition Support Committee will submit periodic reports to the Pharmacy and Therapeutics Committee regarding issues related to the nutritional care of patients at CAMC as well as its other activities, including the maintenance of an enteral feeding products formulary. The Pharmacy and Therapeutics Committee will report these activities to each Department of the Medical Staff, and obtain approval for any changes to the enteral feeding products formulary from the Medical Staff Executive Committee.

(f) Maintain the following medication definitions and processes:

Acceptable Medications: The only medications (including traditional and biological) provided to patients shall be those approved by the Food and Drug Administration (FDA) and the Medical Executive Committee. Medications for bona fide clinical investigations may be excepted from this requirement provided they are used in full accordance with the Statement Of Principals Involved In The Use Of Investigational Drugs In Hospitals and all regulations of the Federal Drug Administration, and their use is approved by the Institutional Review Board.

Formulary. By accepting appointment to the Medical Staff, each Medical Staff appointee gives assent to the use of the CAMC Formulary. The Medical Staff, through the Pharmacy and Therapeutics and the Medical Executive
Committees have established processes to make sure that clinically appropriate alternatives will be available for the treatment of patients at CAMC.

**Discontinuation Of Medication And Other Treatment Orders.** A process is established by the P&T Committee to identify drugs, which will be monitored for length of treatment. A system to remind the physicians will be established, with the policy being housed in the Pharmacy Policy and Procedure Manual. Medications and other treatment shall not be discontinued without notifying the practitioner.

[Sections 3.F through 3.F.2.(f) amended 01/26/2005]

3.G: TISSUE, TRANSFUSION AND PROCEDURES COMMITTEE

3.G.1. Composition:
The Tissue, Transfusion and Procedures Committee shall be composed of one representative from each department of the Medical Staff designated by the Chief of Staff. The Department of Pathology shall have two (2) representatives, one (1) of whom shall be the Medical Director of the Blood Bank. The Administrator of Professional Nursing or designee; the Blood Bank Supervisor; a Clinical Quality Specialist and other hospital representatives as deemed appropriate by the committee chairperson shall all be non-voting members of the Committee.

3.G.2. Duties:
The Tissue, Transfusion and Procedures Committee shall measure, assess and improve the:

(a) Evaluation of tissue.
i. The committee shall review reports on autopsy outcomes including but not limited to agreement/disagreements, rates, and timeliness.

ii. The committee shall review reports on outcome of tissue examination including but not limited to agreement/disagreements, pre-pathology or post-pathology processes.

iii. Physician members of the committee will be involved in study design, evaluation of the findings and recommendations for improvement.

(b) Use of blood and blood components.

i. Blood and blood products administered will be monitored and reported on an ongoing basis.

ii. Focus of review may include but is not limited to appropriateness of transfusion, cross match to transfusion ratios, the processing and administration of blood and/or blood components, and adverse outcomes of transfusion.

iii. Physician members of the committee will be involved in study design, evaluation of the findings and recommendations for improvement.

iv. Provide appropriate update to the Medical Staff regarding current practice standards and risks of transfusions.

(c) Use of operative and other procedures.

i. The committee will select two or more procedures of interest (high volume, high risk, and/or problem prone) to investigate each year.

ii. Focus of review may include but is not limited to appropriateness of candidate for procedure, the procedure itself, pre- or post-procedure care or procedure outcomes.

iii. Physician members of the committee will be involved in study design, evaluation of the findings and recommendations for improvement.
(d) Provide annual summary of findings, interventions, education and improvements made.

[Section 3.G and its subsections amended 03/23/2005]

3.H: PHYSICIAN INTEGRITY TEAM

3.H1. Composition:
The Physician Integrity Team shall be composed of the past five Chiefs of Staff and will handle "behavioral" issues for physicians who are not candidates of the Wellness Group.

3.H2. Duties:
(Language is being developed)

3.I: PHYSICIAN WELLNESS CONSULTANT GROUP

3.I1. Composition:
The Physician Wellness Consultant Group shall consist of at least four members, including an appointed chair, and members appointed by the Chief of Staff for a term of membership, and ad hoc members required for assistance with individual cases.

3.I2. Duties:
The intent of the Physician Wellness Consultant Group is to provide a mechanism for early identification, intervention, assistance and monitoring of impaired or behaviorally disordered, yet willing staff members in order to allow them to regain optimal functioning and provide quality patient care while protecting the
confidentiality of the staff member in question; and to protect patients by ensuring that their treating physicians are free of impairments.

[Sections 3.1 through 3.1.2 added 03/23/2005; Section 3.1.3 moved to 4.G.2 on 10/24/07]
ARTICLE 4

CLINICAL FUNCTIONS

4.A: ADMISSION, DISCHARGE AND TRANSFER OF PATIENTS

(1) Admissions.

(a) Eligibility. Only persons eligible to do so under the Medical Staff Bylaws shall admit, discharge and order transfers of patients at CAMC.

(b) Responsibility for Care. The practitioner who admits a patient to CAMC shall be responsible for the patient's continuing medical care and treatment, for prompt completion and accuracy of the medical record, for providing all necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and to appropriate relatives of the patient. If any of these responsibilities are transferred to another practitioner, a note documenting the transfer of responsibility shall be entered on the order sheet of the medical records, with date and time.

(i) Role of Attending Physician. The attending physician is responsible to provide admitting orders upon admission in conjunction with the Emergency Physician following an initial screening examination and must see the patient in a time frame consistent with the status of the patient, but in no event, longer than 24 hours. The attending physician is responsible for managing the patient's care from admission through discharge. An admission plan of care must be documented and be communicated to the patient/or family within 24 hours. The
attending is the primary coordinator and communicator of care for the patient.

When an attending will be unavailable to manage the patient's care, he/she is responsible to identify a covering physician. The attending is responsible to report to the covering physician the plan of care for all patients to ensure continuity of care. The attending must write on the patient's chart on the order sheet the name of the covering physician and for what time period.

(ii) Role of Covering Physician. The covering physician assumes all of the duties of the attending physician during the period of coverage and is responsible for managing the patient's care until the return of the attending. This includes discussing the plan of care with the patient and family, transferring the patient and discharging the patient when appropriate.

(iii) Discharge Planning. The attending physician is expected to participate in the discharge planning process by communicating discharge needs, as identified by the attending and consulting physicians, with the appropriate ancillary staff (nurses, case coordinators, respiratory therapists, social workers, etc.). The attending physician is also responsible for discussing the discharge plans with the patient/or family.

(c) Reason for Admission. No patient shall be admitted to CAMC until a provisional diagnosis or valid reason for admission has been stated. In the case of both elective and emergency admissions, such statements shall be recorded within 24 hours, and the record shall contain, at a minimum, all documentation currently required by law and adequate
justification for admission to fulfill utilization review criteria currently approved.

(d) Emergency Admissions. A practitioner who admits an emergency case shall be prepared to justify to the Clinical Documentation Quality Committee of the Medical Staff that the admission was a bona fide emergency. Justification for the emergency admission shall be made in a written note placed in the medical record at the time of admission. A history and physical examination shall be recorded within 24 hours of admission.

(e) Admission of Unassigned Patients. A patient who is admitted on an emergency basis who is not under the care of a private practitioner may request any Medical Staff appointee in the applicable department or service to attend him. Where no such request is made or the requested practitioner is not available, the patient shall be assigned to the applicable specialty service.

(f) Admission of Surgical Patients. A practitioner who admits a patient to CAMC for surgery where the services of the Department of Anesthesia are required shall order a minimum "surgical/anesthesia screen" which shall consist of, at a minimum, hemoglobin and hematocrit.

(g) Admitting Priorities. Patients will be assigned beds by the admitting office staff according to the following priorities:

(i) Emergency Admissions. Emergency Admissions are admissions required when the patient needs immediate medical intervention as the result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the Emergency Department.
(ii) **Urgent Admissions.** Urgent admissions are admissions where the patient needs immediate attention for the care or treatment of a physical or mental disorder.

(iii) **Operative Admissions.** Operative admissions are admissions where the patient is already scheduled for elective surgery. If it is not possible to accept all such admissions on any one day, the divisional Vice President for Operations, the Admitting Supervisor, and the Chief of the Department of Surgery will establish priorities for admission until specific criteria are developed by the divisional surgical committee.

(iv) **Elective Admissions.** This category includes all admissions not covered in the categories above and involves all services.

(h) **Priority Bed Assignment.** The admitting office staff will give priority in bed assignment to patients of practitioners appointed to the Active and Associate Staff, except for emergencies.

(i) **Admission to Intensive and Cardiac Care Units.** If any question arises as to the validity of admission to or discharge from a Special Care Unit, a decision on the question is to be made through consultation with the appropriate Physician in charge of the particular unit.

(2) **Transfers.**

(a) **Patient Transfer Priorities.** Transfer priorities shall be as follows:

(i) from emergency department to appropriate patient bed;

(ii) from intensive care unit to general care area;

(iii) from cardiac care unit to general care area;

(iv) from obstetric unit to general care area, when medically indicated; and
(v) from temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient. No patient will be transferred unless the transfer has been approved by the attending practitioner or his designee except in situations defined by CCU and ICU policy.

(3) Discharge.

(a) Patient Discharge. A patient shall be discharged only upon order of the attending practitioner or his designee. If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record by the attending practitioner or his designee, and the patient will be asked to sign a "Discharge Against Medical Advice" form. Chronically ill patients, or patients whose condition cannot be further improved by hospitalization, should be discharged to a nursing home, convalescent facility, or to their homes.

(b) Patient Death. In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner 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 Medical Staff appointee. The attending practitioner or his designee shall notify the medical examiner of the death in cases where such notification is required by Section 4.C(11)(a) of these Medical Staff Rules & Regulations and by CAMC Administrative Policy & Procedure 6040.00 (Reporting Deaths to the Medical Examiner).
4.B: MEDICAL RECORDS

(1) General Contents. The attending practitioner is 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, at a minimum identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultation, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; anesthesia record, if anesthesia given; pathological findings; progress notes; final diagnosis; condition on discharge; clinical summary or discharge note; and autopsy report if autopsy is performed. Results of history and physical examinations shall be made a physical part of the patient's medical record for every admission and shall not be included merely by reference to the medical record of a prior admission. This requirement may be satisfied through inclusion of a copy of the history and physical from a prior record, if appropriate.

(2) Continued Hospitalization. The attending practitioner shall document the need for continued hospitalization after specific periods of stay. The documentation shall be adequate to justify extension of continuing hospitalization according to approved criteria. The reasons for extended stay shall be documented in the medical record not later than twenty-four hours prior to the date of review.

(3) Admission History and Physical. A complete history and physical examination must be on the chart within twenty-four (24) hours of admission to the hospital. The following elements must be included: patient identification, chief complaint, history of present illness, family history, psychosocial history, review of systems, physical exam, impression/diagnosis, and treatment plan. A written note must be made on the chart including date of dictation and sufficient pertinent information to justify the admission. The
comprehensive Emergency Department history and physical may be considered as the admission history and physical. However, an admission note that includes pertinent specialty-specific assessments, impression/diagnosis and treatment plan sufficient to update the emergency physician's history and physical and justify admission, must be documented by the attending physician within twenty-four (24) hours.

A history and physical performed within thirty (30) days prior to admission or readmission is acceptable, provided an addendum of an appropriate physical assessment to update the patient's medical status since the prior history and physical, is completed within twenty-four (24) hours of admission. Histories and physicals performed by non-physicians authorized by the Medical Staff, including advanced practice nurses, certified nurse midwives, physician assistants, medical students and registered nurse first assistants, must be completed and countersigned by a Physician within twenty-four hours of admission or prior to the procedure, whichever is earlier. Except in emergencies, the history and physical must be completed, signed, and the results available before an operation; if not, the operation will not be performed. [Section 4.B(3) amended 03/23/05 & 08/22/07]

(4) **Invasive Diagnostic Or Operative Procedures And Anesthesia, Moderate, Or Deep Sedation.** A history and physical examination shall be placed in the medical record before any elective invasive diagnostic or operative procedures may be performed, and for all short term therapeutic diagnostic or surgical procedures requiring anesthesia, moderate, or deep sedation. History and physical examinations for outpatients may be documented on the approved short forms, or written in the outpatient record and shall include at a minimum the following information: chief complaint, relevant past medical and family
history, findings of physical examination and reason for surgery. A history and physical performed within thirty (30) days prior to the procedure is acceptable, provided an addendum of an appropriate physical assessment, to update the patient's medical status since the prior history and physical, is completed within twenty-four (24) hours prior to the procedure. The original history and physical and the updated addendum must be present in the patient's medical record prior to the procedure. In the case of anesthesia, moderate, or deep sedation a pertinent pre-anesthesia assessment shall be completed prior to induction. [Section 4.B(4) amended 03/23/05]

(5) **Progress Notes.** Pertinent progress notes shall be recorded at the time of observation and contain enough substance and detail to facilitate continuity of care, especially in cases of impending transfer. Except for the days of admission and discharge, a progress note shall be entered at least daily by the attending practitioner or his designee.

(6) **Operative Reports and Operative Progress Notes.**

(a) **Dictated Operative Reports.** Except as provided in Subsections (b) and (c) below, the practitioner must dictate/write/generate an operative or procedure report as soon as possible, but less than 12 hours after each surgery/procedure. Operative reports shall include the preoperative and postoperative diagnoses, a description of the procedure performed, the names of the primary surgeon and assistants, type of anesthesia, a detailed account of the findings at surgery, details of the surgical technique, notation of any specimen removed, packs and drains inserted, estimated blood loss, and the condition of the patient.

(b) **Written Operative Progress Notes.** The practitioner must write an operative progress note in the medical record immediately to provide pertinent information for others required to care for the patient. The
written operative progress note shall include at least the following elements: the preoperative and postoperative diagnoses; procedure performed; surgeon and assistants; type of anesthesia; specimen removed; packs and drains inserted; estimated blood loss, pertinent clinical findings not identified in the postoperative diagnosis; and condition of the patient.

(c) **Operative Reports of Minor Surgical Procedures.** A written operative report will be deemed to fulfill the dictated operative report requirement of Subsection (a) for minor surgical procedures that meet all three of the following criteria: (1) the minor surgical procedure does not require the attendance of either a certified registered nurse anesthetist or an anesthesiologist; (2) the minor surgical procedure is completed without an intraoperative complication; and (3) the patient does not require admission from outpatient to inpatient status after the minor procedure. When used in lieu of a dictated operative report for minor surgical procedure, the written operative report must be entered into the medical record immediately after the procedure and must include at least the following elements: preoperative and postoperative diagnoses; type of anesthesia; procedure performed; surgeon and assistants; pertinent clinical findings; notation of any specimen removed; packs or drains inserted; and condition of the patient.

(7) **Standing Orders.** A practitioner's standing 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 practitioner. [§4.B(7) amended 03/26/08]

(8) **Abbreviations.** Symbols and abbreviations may be used in CAMC medical records only after they have been approved by the Medical Staff. An official record of approved abbreviations will be kept on file in the record room.
(9) **Consultations.** Dated consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. The consultant's report shall be made a part of the patient's record and noted in the discharge summary. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations verified on the record, be recorded prior to the operation.

(10) **Obstetrical Records.** The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending practitioner's office record transferred to the Hospital before admission, but an interval admission note shall be written that includes pertinent additions to the history and any subsequent changes in the physical findings since the last office visit.

(11) **Emergency Department Records.** Each patient's medical record in the Emergency Department shall be signed by the practitioner in attendance who shall be responsible for its clinical accuracy. The medical record of each Emergency Department patient who is not admitted to the Hospital as an inpatient shall include, at a minimum, the patient's relevant medical history, if obtainable; report of the physical examination; report of any diagnostic studies performed; statement of diagnosis and treatment plan; adequate information to support the diagnosis and treatment plan; progress notes to describe the patient's condition and the patient's response to treatment. If an Emergency Department patient is admitted to the Hospital as an inpatient, the Emergency Department record need not duplicate information which appears on the patient's inpatient record.
(12) **Anesthesia Records.** The Department of Anesthesiology shall maintain a complete anesthesia record including evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

(13) **Authentication.**

(a) All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. Authentication means to establish authorship by any of the following methods:

(i) recognizable, written signature;

(ii) electronic signature; or

(iii) such other procedure which meets federal and state requirements.

(b) The use of rubber stamp signatures is acceptable under the following conditions which shall be strictly applied:

(i) The practitioner whose signature the rubber stamp represents is the only one who has possession of the stamp and is the only one who will use it.

(ii) The practitioner places in the administrative offices of the Hospital a signed statement to the effect that he is the only one who will have possession of the stamp and is the only one who will use it.

(c) **Passwords and Electronic Signatures.** Use of the hospital's electronic clinical information systems is required to properly care for patients and complete medical records. Due to the nature of electronic clinical information systems, the following rules shall be strictly applied:

(i) Practitioners are required to safeguard their electronic passwords and to assure that no other person uses or knows their passwords. Administrators in charge of electronic clinical
information systems will suspend or revoke the password of any practitioner who allows another person to use his or her password for any reason. Suspension or revocation of a practitioner's password is an administrative action and not a professional review action; accordingly, the action shall not imply a judgment about the practitioner's professional competence or professional conduct.

(ii) A practitioner whose password is suspended or revoked shall automatically be deemed to have voluntarily relinquished his or her clinical privileges for the duration of the suspension or revocation. Such relinquishment is administrative in nature because the practitioner cannot adequately care for patients without access to the electronic clinical information systems; accordingly, the relinquishment shall not imply a judgment about the practitioner's professional competence or professional conduct. The appropriate department chief or, in his absence, the Chief of Staff shall assign to another individual with appropriate Clinical Privileges responsibility for care of the practitioner's patients still in the Hospital at the time of such relinquishment until such time as they are discharged. The wishes of the patient shall be considered by the department chief in the selection of a substitute.

(iii) Any person who suspends or revokes a practitioner's password shall immediately report the action to the Chief of Staff pursuant to Section 6.B.1 of the Credentials Policy and shall act accordingly.
(14) **Signature File.** At the time of application for appointment and reappointment to the Medical Staff, each practitioner shall supply the Office of Medical Affairs with a sample of the signature he intends to use on medical records. The Office of Medical Affairs shall keep a file of such signatures for verification purposes.

(15) **Final Diagnoses.** The final diagnosis shall be documented by the responsible practitioner in the discharge summary. The diagnosis shall be entered in full without the use of symbols or abbreviations and signed by the responsible practitioner. A practitioner need not sign the face sheet unless the practitioner has recorded a diagnosis on it.

(16) **Discharge Summary.** A discharge summary should provide information about the admission to other care providers and facilitate the continuity of care into the outpatient setting. The discharge summary should include, but not be limited to:

(a) Reason for admission;
(b) Significant findings;
(c) Procedures performed and treatment rendered;
(d) The patient's condition on discharge; and
(e) Instructions given to the patient or family, if any.

For newborns with uncomplicated deliveries, or for patient's hospitalized less than 48 hours with only minor problems, a progress note may be substituted for the discharge summary. This progress note should at least document the patient's condition at discharge, discharge instructions and required follow up care.

It is recommended that all discharge summaries be dictated within 36 hours of discharge, especially for referred patients. If not dictated within 36 hours, the
discharge summary must be dictated in sufficient time to allow the entire chart to be completed by 30 days post discharge.

(17) **Release of Information from Medical Records.** Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. The attending practitioner will be notified upon receipt of this request. The records may also be released by legal subpoena, statute, or court order and otherwise as required by law. Additional policies relating to the release of medical records may be found in the Administrative Policy and Procedure Manual.

(a) **Readmissions.** The medical records of a previously admitted patient shall be available for the use of the attending practitioner during a current admission. This availability shall apply whether or not the patient is attended by the same practitioner.

(b) **Access to Medical Records for Research, Quality Assurance and Peer Review.** Members of the Medical Staff shall have access to medical records of patients for bona fide study and research, quality assurance and peer review activities provided that the confidentiality of personal information concerning individual patients is preserved. Requests for such access in the case of research shall be made in writing to the director of medical records who shall release the requested records absent good cause for withholding them. Any member of the Medical Staff who is refused access by the director shall have the right to present his request to the chairman of the Clinical Documentation Quality Committee. Notice of requests and the action taken shall be given to the chairman of the Clinical Documentation Quality Committee.
(c) **Access to Medical Records by Former Members of the Medical Staff.**

Former members of the Medical Staff who desire to obtain information from the medical records of patients they attended at CAMC shall submit their requests for such records to the director of medical records who shall have the right to approve or deny such requests. Notice of the request and the action taken shall be made to the chairman of the Clinical Documentation Quality Committee.

(18) ** Permanent Filing; Incomplete Records.** A medical record shall not be permanently filed until either it is completed by the responsible practitioner or is ordered filed by the chairman of the Clinical Documentation Quality Committee. The attending practitioner is ultimately responsible for completing the medical record when a locum tenens is used. When a Medical Staff member is deceased or removed from the Medical Staff for any reason on a protracted basis, the chairman of the Clinical Documentation Quality Committee is authorized to direct that the medical records of that individual should be filed incomplete. In such cases, a notation shall be made in the medical record that the record is being filed incomplete. The chairman of the Clinical Documentation Quality Committee may also direct that medical records be filed incomplete in the case where a Medical Staff member is suspended temporarily for incomplete medical records, and the medical records are not completed within a period of three months.

(19) **Loss of Privileges for Incomplete Records.** The patient's medical records shall be made complete at the time of discharge and include progress notes, final diagnosis, and clinical summary, but regardless of any other circumstances medical records should be made complete within 30 days of discharge. Administrative suspensions for delinquent medical records will be imposed weekly. On Thursday night, a report will be generated of any physicians with
charts not complete 21 days after discharge. On Friday, a notice will go out to all physicians on the list to complete those records. Records on the list still not complete by the following Thursday at 12:00 noon shall result in the Chief of Staff or his designee notifying the practitioner by writing (delivered by e-mail facsimile, hand or Postal Service) that his clinical privileges to admit, consult, or care for new patients (including emergencies) will be considered voluntarily relinquished. If any record is still not complete by the next Thursday after the first suspension, then a second suspension will result and so forth. The practitioner is expected to continue care of his current in-house patients and his clinical privileges shall not be considered relinquished with regard to those patients. If the record is incomplete because the practitioner is seriously ill or necessarily absent from the city for more than seven days, an extension equal to the number of days absent will be granted providing the Medical Records Department has been notified prior to the absence. If Medical Records is not informed prior to the absence, the extension will not be granted. When a practitioner presents to the appropriate Medical Records Department to complete a chart, and the chart is not available for him, then an extension equal to 13 days will be granted. When a practitioner voluntarily relinquishes his clinical privileges pursuant to this rule, the Chief of Staff or his designee shall mail a notice to the practitioner confirming the loss.

(20) Habitual Delinquency.

(a) Any Physician who relinquishes his admitting privileges three (3) times within any consecutive six month period, by failing to complete medical records, shall be deemed habitually delinquent. When a Physician is deemed habitually delinquent in completing medical records, the Vice President of Medical Affairs shall arrange for the habitually delinquent Physician to attend the next regular meeting of
the Medical Staff Officers. The purpose shall be to determine the cause of the delinquencies, to find ways of alleviating the cause of the delinquencies and to counsel the delinquent Physician on this policy, the potential consequences and a corrective improvement plan. [Amended 01/26/2005]

(b) If an habitually delinquent Physician relinquishes his admitting privileges three times within the six (6) months immediately following the date of the third delinquency that caused him to be deemed habitually delinquent, the third (3rd) relinquishment shall constitute an automatic resignation from the Medical Staff effective at the end of the next regular meeting of the Medical Staff Executive Committee. The Medical Staff Executive Committee may then, for good cause shown, vote to rescind the habitually delinquent Physician's resignation contingent on his/her successful implementation of a corrective action plan as determined by the Medical Staff Executive Committee. [Amended 01/26/2005.]

4.C: GENERAL CONDUCT OF CARE

(1) Standards of Ethics and Conduct. A physician's adherence to the following standards shall be taken into account in decisions relating to his or her initial appointment and reappointment to the Medical Staff and shall be a requirement for continuing clinical privileges.

(a) A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.
(b) A physician shall deal honestly with patients and colleagues, and not tolerate those physicians deficient in character or competence, or who engage in fraud or deception.

(c) A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

(d) A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

(e) A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues, and the public, obtain consultation, and use the talents of other health professionals when indicated.

(f) A physician shall recognize a responsibility to participate in activities contributing to an improved community.

In judging whether the foregoing standards have been met in an individual case, CAMC, in its discretion, shall be guided by the most recent issue of the Code of Medical Ethics Current Opinions of the Council on Ethical and Judicial Affairs of the American Medical Association.

The minimum standard of conduct at CAMC shall include contribution to a positive environment. Physicians shall not engage in conduct so disruptive to the operations of the hospital that the value of the physician's clinical work is outweighed by the negative impact of his or her behavior.

(2) Timely Care. An attending practitioner who anticipates being too far from the Hospital to allow him to provide continuous care to any of his hospitalized patients in a timely fashion shall notify appropriate nursing staff of and advise such staff to record on the chart the name of another practitioner with Clinical
Privileges who may be called to attend his patients in an emergency or until he arrives at the Hospital. If such notification is not made, the chief of the department concerned, the chief of staff, or the Vice President for Medical Affairs of CAMC (in order of availability) shall have authority to call upon any member of the active category of the Medical Staff to cover such an emergency. Each attending practitioner shall assure timely, adequate, professional care for his patients in the Hospital either by being available or having available through his office an eligible alternate practitioner with whom prior arrangements have been made and who has appropriate clinical privileges at the hospital. Failure of an attending practitioner to meet these requirements may result in loss of clinical privileges.

(3) Protection of Patients and Staff. The attending practitioner shall give such information to Hospital staff as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his patients might be a source of danger by reason of any cause whatever. The attending practitioner shall request an emergency behavioral medical consultation for any patient known or suspected to be suicidal. The consultation request will be timely answered by the psychiatrist on call as specified in the duty roster. The attending practitioner must document in the record any patient refusal of this consultation.

(4) Informed Consent. CAMC's general consent form will be signed by, or on behalf of, each patient admitted to the hospital at the time of admission. It is the responsibility of the attending practitioner to explain to the patient the nature, risks, and benefits of and alternatives for all procedures and treatments to be performed while the patient is hospitalized. Additional policies and information relating to proper informed consent and substituted informed consent may be found in the Administrative Policy and Procedure Manual.
(5) **Special Consents.** Admitting office personnel will notify the attending practitioner whenever the general consent form has not been properly executed. When so notified, the practitioner shall obtain proper consent before the patient is treated in the Hospital. In addition to obtaining the patient's general consent to treatment, a specific consent for any special treatment or surgical procedures shall be obtained. Forms for such consents are available at CAMC.

(6) **Legibility.** The practitioner's orders must be written clearly, legibly, and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.

(7) **New Orders After Surgery.** Any patient returning to any nursing unit after surgery in a major operating room suite under general anesthesia must have all orders rewritten by the surgeon or by the attending physician. Additionally, the nurse who is responsible for the patient shall compare the pre-op and post-op medications for questions. In the event there is an identified question, the nurse shall contact the physician writing the orders to obtain clarification to expedite quality patient care.

(8) **Drugs and Medications.**

(a) **Acceptable Drugs and Medications.** The only 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 excepted from this requirement provided they are 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, and their use is approved by the Institutional Review Board.

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(b) **Formulary.** By accepting appointment to the Medical Staff, each Medical Staff appointee gives assent to the use of the CAMC Formulary. Other drugs may be used if an appropriate alternative is not found in the CAMC Formulary upon completion of the proper order form supplied by the pharmacy.

(c) **Discontinuation of Drug and Other Treatment Orders.** A reminder for length of treatment will be given at ten days for all narcotics and antibiotics except intravenous quinolones and intravenous fluconazole which will have a five day reminder. Drugs and other treatment shall not be discontinued without notifying the practitioner. Orders for inhalation therapy, physiotherapy, laboratory (with the exception of Protime and International Ratio of the Protime) and radiologic examinations shall be discontinued after 72 hours.

(9) **Critical List.** The attending Physician shall notify the appropriate staff nurse of any patient in impending danger of death, and such person shall place the patient's name on the critical list to alert all appropriate staff. The critical list shall be revised daily.

(10) **Isolation.** Patients with contagious, infectious diseases shall be admitted and isolated according to the recommendations of the Pharmacy and Therapeutics Committee.

(11) **Autopsies and Reporting Death to the Medical Examiner.** The attending practitioner of a patient who dies in the Hospital or who is pronounced dead in the Hospital has a legal duty under certain circumstances to report the death to government authorities and has a duty imposed by these Rules and Regulations to attempt a meaningful autopsy under other circumstances.

(a) **Deaths Reportable to the Medical Examiner.** To aid law enforcement authorities' efforts to investigate deaths occurring in West Virginia, the
attending practitioner of a patient who dies in the Hospital or who is pronounced dead in the Hospital shall fully comply with CAMC Administrative Policy & Procedure 6040.00 (Reporting Deaths to the Medical Examiner.) If the Medical Examiner assumes jurisdiction for investigation of cause of death, the deceased patient's attending practitioner must so inform the family. If the Medical Examiner assumes jurisdiction and later releases jurisdiction without performing an autopsy, the deceased patient's attending practitioner should consider the conditions listed in Subsection (b) below as possible indications for autopsy.

(b) Autopsies When Death Is Not Reportable. Whenever a patient's death is not reportable to the medical examiner, the attending practitioner shall determine whether an autopsy is advisable in the interest of medical science after considering all of the circumstances of the death. The following types of deaths are generally considered appropriate for autopsy:

(i) Death under the age of 50 years;
(ii) Death within 48 hours after a surgical or invasive procedure, including radiologic procedures;
(iii) Death associated with drug reaction;
(iv) Death associated with an adverse patient occurrence;
(v) Death within 48 hours after admission (for patient receiving outpatient care);
(vi) Death in the Emergency Department;
(vii) Death in the Outpatient Clinics;
(viii) Death when the admission diagnosis suggests death was not expected;
(ix) Death when an autopsy might help explain unknown or unanticipated complications;

(x) Death when it is believed that an autopsy would disclose a known or suspected illness that may have a bearing on survivors or recipients of transplant organs;

(xi) Death known or suspected to have resulted from environmental or occupational hazards.

(c) Consent to Autopsy. The attending practitioner shall request consent to perform an autopsy if an autopsy is advisable. An autopsy may be performed only with written consent obtained in accordance with CAMC Administrative Policy & Procedure 4010.00. The attending practitioner must fully comply with CAMC Administrative Policy & Procedure 4010.00. The attending practitioner of each patient who dies at the Hospital must assure that the patient's medical record state whether an autopsy was recommended and whether consent was granted or refused.

(d) Procedure for Performing an Autopsy. All autopsies shall be performed by members of the Department of Pathology or the medical examiner. Provisional anatomic diagnoses shall be recorded on the medical record within 48 hours after completion of the autopsy, and the complete protocol shall be made a part of the record within two calendar months after the date of autopsy. The medical record of each patient who expires at CAMC shall show whether an autopsy was recommended. If autopsy was offered and consent for autopsy was refused, the medical record shall so reflect.
(12) **Consultations.**

(a) **Required Consultations.** Except in an emergency, the attending practitioner shall obtain a consultation with another qualified practitioner in the following situations:

(i) when patient is known or suspected to be suicidal or a danger to others, except where admitted to the behavioral medicine unit;

(ii) in complicated situations where the practitioner determines that specific skills of other practitioners are needed;

(iii) all other times when indicated by departmental rules; and

(iv) when an appropriate second opinion is requested by third parties.

The attending practitioner who requests a consult shall provide written authorization to permit the consultant to attend or examine his patient and shall specifically state the purpose of the consultation.

(b) **Consult Orders.** When ordering a consult, the attending is responsible for communicating directly to the consultant and specify the reason for the consult. It must be clarified in the consult order whether the plan is to assess and recommend only, recommend and treat or transfer the care. Before consultants can order another consult, there needs to be a discussion with the attending.

(c) **Role of the Consultant:** The primary responsibility of the consultant is to assess and recommend a plan of care to the attending. The attending should discuss the reason for the consult with the consultant physician, who should respond to the order in a time frame consistent with the status of the patient but in any event no longer than 24 hours. Consultants are expected to respond to an order for an unstable patient as soon as possible or assure that the care of the patient is assumed by
another physician. The consultant must confer with the attending to assure continuity in the plan of care.

(d) **Responses to Request for Consultations.** Physicians shall respond to requests for all elective and non-emergency consultations within 24 hours of notification of the request. Failures to respond within twenty-four hours may be reported to the Chief of the consultant's department by the person who requested the consultation. The Chief of the department shall then inform the offender of the complaint. If three complaints of violation are received by the Chief of the department against one Physician, the Chief shall bring the matter to the attention of the Chief of Staff for investigation and resolution in accordance with the provisions for rule violations contained in the Medical Staff Procedures Manual.

(13) **Physician Responsibility for Emergency Patients and Emergency Call.**

(a) **Definitions.**

(i) **Calling Physician** means (a) the emergency department physician, physician's assistant, or nurse practitioner on duty or (b) the patient's private attending physician present in the emergency department, or (c) the attending physician or resident physician of the appropriate clinical service, whichever is appropriate, or (d) the qualified medical personnel who has conducted the medical screening examination of the patient. [Amended 12/22/2004]

(ii) **Capacity** means the ability of an hospital to accommodate a patient who comes to the emergency department or to treat a transferred patient, and encompasses such things as numbers and availability of qualified staff, beds and equipment and
CAMC's past practice of accommodating additional patients in excess of its occupancy limits.

(iii) **Emergency Medical Condition** means a medical condition manifested by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances and/or symptoms of substance abuse) that the absence of immediate medical attention could be reasonably expected to place the patient's health in serious jeopardy, or cause impairment to bodily functions or serious dysfunction to an organ or part. With respect to a pregnant woman who is having contractions, Emergency Medical Condition means that there is inadequate time to effect a safe transfer to another medical facility before delivery or that the transfer may pose a serious threat to the safety of the woman or the unborn child.

(iv) **On-Call Physician** means the physician designated by his or her department rules to respond to emergency calls at any given time.

(b) **Acceptance, Screening and Treatment of Patients.**

(i) **Of Patients Transferred From Outside Emergency Departments.**

The emergency department physician shall accept the transfer from an outside medical facility's emergency department of any patient if (a) the transferring facility describes the patient as having an Emergency Medical Condition that the transferring facility does not have Capacity to treat and if (b) CAMC has Capacity to treat that patient.

(ii) **Of Inpatients Transferred From Outside Medical Facilities.** The attending physician of the appropriate CAMC clinical service
shall accept the transfer from an outside medical facility of any inpatient if (a) the transferring facility describes the patient as having an Emergency Medical Condition that the transferring facility does not have capacity to treat and if (b) CAMC has capacity to treat that patient.

(iii) Patients Coming to the Emergency Department. CAMC shall accept any patient who comes to the hospital with an emergency medical condition. The emergency department physician (or the patient's private attending physician present in the emergency department, whichever is appropriate) shall either treat the patient or contact the appropriate on-call Physician. The emergency department physician or the private attending physician may make an appropriate transfer if CAMC does not have capacity to treat that patient.

(iv) Medical Screening Examination. Any patient who is accepted for transfer or who comes to the emergency department for examination or treatment will be provided an appropriate medical screening examination by a qualified medical professional to determine whether the patient has an emergency medical condition. The medical screening examination will be performed by a licensed physician, resident physician or credentialed physician's assistant, nurse practitioner, advance practice nurse or certified registered nurse midwife. The medical screening examination may also be performed by a licensed registered nurse if said registered nurse has been deemed qualified to perform a medical screening examination and performs the screening examination according to written
protocols approved by the Medical Staff Executive Committee or its designee. [Amended 12/22/2004]

(c) Duties of On-Call Physicians. On-Call Physicians shall respond to the call within twenty minutes. The Calling Physician will communicate the patient's condition to the On-Call Physician. If requested by the calling physician, the on-call physician must make every effort to see any patient with an emergency medical condition within thirty minutes after the request. When called, the on-call physician is personally responsible for providing or assuring the care of the patient. Sometimes a patient will come to the hospital with an emergency medical condition that CAMC does not have capacity to treat. Such patients may be appropriately transferred to an outside facility. Upon request of the calling physician, the on-call physician must help attempt to stabilize the patient prior to transfer.

(d) Contingency Coverage If the On-Call Physician Fails to Respond or Appear. If the on-call physician fails for any reason to respond or appear as required by this Section 14, the calling physician may contact any of the following: the chief of the on-call Physician's department, the vice chief of the On-Call physician's department, the Chief of Staff and the Chief of Staff Elect. When contacted, each of these department officers and Medical Staff officers have authority to (a) assign an appropriate member of the Medical Staff to perform the duties of the on-call physician regarding the patient and to (b) invoke Medical Staff Procedures Manual Section 2.4 to summarily suspend the clinical privileges of any physician who unreasonably refuses the assignment.

(e) Violations of this Section. Any physician violating this Section 14 may be subject to the sanctions contained in the CAMC Medical Staff

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governing documents, up to and including loss of clinical privileges and Medical Staff appointment. The calling physician shall request an investigation of any suspected violation of this Section 14. The request for an investigation shall be delivered to the Chief of Staff in care of the Office of Medical Affairs as provided by the Medical Staff governing documents. If the on-call physician violated this Section 14, the Chief of Staff or his designee shall impose at least the following: (a) a first violation will result in a letter of counsel; (b) a second violation will result in a letter of reprimand and a seven-day suspension; (c) a third violation will result in a letter of reprimand and a 14-day suspension; and (d) a fourth violation will result in a termination of appointment and clinical privileges. However, a single violation or a pattern of violations may be so unacceptable that other immediate disciplinary action is required. [Amended 09/28/2005]

(f) Suspected Inappropriate Transfers to CAMC. Any physician who suspects that a patient has been inappropriately transferred to CAMC shall immediately notify CAMC's Vice President for Medical Affairs and CAMC's Vice President for Neuroscience, Orthopedic and Trauma Services who will jointly assure that the inappropriate transfer is reported as required by law.

4.D: GENERAL RULES REGARDING SURGICAL CARE

(1) Need for Scrubbed Assistants. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed.

(2) Removed Tissue. All significant tissues removed during any surgical procedure shall be sent to the Department of Pathology where they shall be
examined as necessary to arrive at a tissue diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

4.E: PEER REVIEW

(1) **Peer Review Letters.** If a quality of care issue or other questions arise regarding case management during review activities of a Medical Staff peer review committee (i.e., Tissue, Transfusion and Procedures Committee, Clinical Documentation Quality Committee, and departmental quality improvement committees), the involved physician and/or department shall be informed by letter.

(a) The committee after discussion of the case, shall direct the chairperson to inform the involved clinician(s) by letter of issues regarding case management. All letters shall be sent certified mail, return receipt requested.

(b) The involved clinician(s) shall have the option of attending the next scheduled meeting of the peer review committee to discuss the case with committee members or responding to the inquiry in writing within 30 days.

(c) A peer review committee is satisfied with the response, the clinician(s) shall be notified in writing, and the case shall be closed.

(d) A peer review committee may request more information from the involved clinician(s), or in rare instances when the response is inadequate, the case and response shall be referred to the chief of the involved department for review and action.

(e) If the involved clinician(s) do not respond within 30 days to the first letter, a second letter shall be sent. If the involved clinician(s) do not respond to the second letter, the chief of the department shall intervene.
through verbal or written communication with the involved clinician(s) to discuss why no response has been provided. The second letter shall indicate the case will be referred to the chief of the involved department if no answer is received within 30 days.

(f) If there is no response to the second letter and inquiries from the chief of the department, the matter will be referred to the next meeting of the Chief of Staff for review and action. This information shall be communicated to the clinician(s) in the third letter which is sent by the chief of the department.

(2) **Intensified Review.** Intensified review shall be initiated by a Medical Staff peer review committee (i.e., Tissue, Transfusion and Procedures Committee, Clinical Documentation Quality Committee, Surgical Case Review Committee, and departmental quality improvement committees) based upon evaluation of a serious occurrence in patient care delivery and/or from trend analysis which identifies problems in systems, procedures, and/or clinician(s) performance. Intensified review involves 100 percent review of all admissions, particular diagnosis, and/or invasive procedure(s). The type of review and time frame for review shall be determined by the committee initiating the review. The involved clinician shall be informed of the intensified review at the time the decision is made to institute the review process.

(a) After review of documentation which identifies a problem in clinician(s)' performance, the Medical Staff peer review committee may place the clinician(s) under intensified review.

(b) The peer committee shall decide whether all admissions, a particular diagnosis, and/or invasive procedure(s) shall be included in the review process.
(c) The peer review committee shall decide the time frame for the review process.

(d) The chairperson of the Medical Staff peer review committee shall meet with the chief of the involved Medical Staff department to discuss the rationale for the review and proposed time frame for the review.

(e) The chief of the department shall notify the clinician(s) by letter of the decision of the Medical Staff peer review committee to institute intensified review. The letter shall discuss the reason for review, type of review, and time frame for the review process. A copy of the letter shall be forwarded to the Medical Affairs Department so the review process can be initiated. All letters shall be sent certified mail, return receipt requested.

(f) The Medical Staff peer review committee shall be responsible for reviewing the cases needing review under the intensified review criteria [Section 4.E amended 03/26/08]
4.F: MISCELLANEOUS

(1) **Disaster Plan.** Each member of the Medical Staff is responsible for following an identified role in CAMC's disaster plan. This plan provides for the care of mass casualties at the time of any major disaster, external or internal, and is based upon the Hospital's capabilities, alone and in conjunction with the emergency facilities in the community. It shall be the responsibility of each department chief and section head to explain the practitioner's role in the disaster plan through department and section meetings. A copy of the plan is always available in the Office of Medical Affairs.

(2) **Medical Staff Relationship to Ancillary Services.** The Medical Staff acknowledges and values the importance of ancillary services in the delivery of comprehensive health care. These services include, but are not limited to, social services, dietary service, pharmacy service, pastoral care, etc. These services may be ordered by the attending practitioner or rendered at request of the patient, the patient's family, or the nurse with the approval of the attending practitioner. In all cases, an initial note will be made by the responding service in the chart stating who requested the service, for what reasons the service was requested, and, if possible, what the plan may be for the particular patient.

(3) **Enforcement of Duty to Pay Dues.** Failure to pay dues and assessments when due shall be deemed to be a voluntary resignation from the Medical Staff.

(4) **Continuing Medical Education.** The minimum hours of continuing medical education required for appointment and reappointment to the Medical Staff shall be 50 hours within the previous two years. For initial appointment,
(5) Evaluation of Independent Allied Health Professionals. Each applicant for appointment and reappointment as an Independent Allied Health professional shall be evaluated by the Credentials Committee and the department as follows:

(a) Podiatrists: Department of Family Practice
(b) Psychologists: Department of Neurological Medicine, Section of Psychiatry

(6) Limitation on Number of Clinical Assistants to be Supervised. The number of Clinical Assistants that one Physician may have under his sponsorship and supervision at any one time shall be limited in accordance with the rules and regulations developed by the departments of the Medical Staff to which the sponsoring Physician is assigned.

4.G: ORDERS FOR TREATMENT

Credentialed physicians, dentists and Independent Allied Health Professionals shall issue orders for treatment and medication by one of the following methods.

Advanced Practice Nurses and Physicians Assistants authorized to do so by the supervising physician may issue orders consistent with licensed scope of practice and privileges and CAMC policies.

(1) Inpatients.

(a) By writing the order directly on the order sheet in the patient's medical record and authenticating the order which shall be dated and timed; or
(b) When not present to write the order, by delivering the order verbally or by telephone to a person authorized by CAMC to receive such orders, including registered nurses employed by CAMC and/or privately employed registered nurses; registered pharmacists for medication orders and related laboratory orders; licensed respiratory therapists for respiratory therapy orders; licensed dieticians for medical nutrition therapy orders; licensed physical therapists for physical therapy orders; licensed occupational therapists for occupational therapy orders; licensed speech therapists for speech therapy orders; licensed and certified imaging technologists for imaging procedure orders.

4.G.1 Verbal/telephone orders: Verbal/telephone orders may be issued when necessary. The physician should write the order or utilize the services of a personal scribe to write the order when possible. In those situations where the physician is involved in patient care, and a verbal order is necessary, the order should be signed before the physician leaves the patient care area. All orders for inpatients delivered verbally or by telephone by the Physician, Dentist, or Independent Allied Health Professional or authorized Advanced Practice Nurse or Physician Assistant shall be authenticated consistent with applicable West Virginia law, licensing boards regulations and CAMC policies. (WV Law: Section 7.2r of 64 CSR 12 states: "Physicians shall countersign and date all verbal and telephone orders at the next hospital visit.").
Referred Outpatient Diagnostic Procedures: In the case of outpatient diagnostic procedures, by electronically transmitting or faxing the written order to include diagnosis and/or indication to the registrar or clerk designated by CAMC to receive such orders.

[4.G and 4.G.1 amended 04/27/05 and 10/24/07]

A Physician may order that his or her patient be restrained while hospitalized at CAMC if the order: (1) includes appropriate justification for use of restraint, (2) is time-limited (does not exceed four hours for adult behavioral medicine patients or one calendar day for acute medical and surgical patients), and (3) indicates the type and location of restraints to be applied. The physician shall review and document the patient's need for continued restraint near the expiration of each order and, if necessary based upon examination, may renew the order for up to four hours for behavioral medicine patients and one calendar day for other patients. [4.G.2 moved here from 3.1.3 on 10/24/07.]

4.G.3 Medication Orders
i. Complete medication orders include full medication name, dosage, route of administration, frequency or end point, and indications.

ii. Range orders for prn medications are not acceptable. A complete order should be written as above.

iii. Orders may not include unsafe abbreviations identified by the medical staff on the "Prohibited Abbreviation List."

[Section 4.G.3 added 10/24/07]
ARTICLE 5

AMENDMENTS

This Manual may be amended by a majority vote of the members of the Medical Staff Executive Committee present and voting, at any meeting of that committee where a quorum exists. The written recommendations of any committee whose composition or duties are proposed to be revised shall have first been received and reviewed by the Chief of Staff. The Chief of Staff shall assure that notice of all such proposed revisions or amendments is delivered to the Medical Staff Executive Committee with ample time to review and consider prior to the Medical Staff Executive Committee meeting at which the proposed revisions are to be considered. No amendment shall be effective unless and until it has been approved by the Board.
ARTICLE 6
ADOPTION

This Medical Staff Organization and Functions Manual is adopted and made effective upon approval of the Board, superseding and replacing any and all previous Medical Staff Bylaws and policies pertaining to the subject matter herein, and henceforth all section and committee activities of the Medical Staff and of each individual serving as a member of a section or staff committee shall be undertaken pursuant to the requirements of this Manual.