MEDICAL STAFF OF WASHINGTON ADVENTIST HOSPITAL
RULES AND REGULATIONS

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1) **Mandatory Interview:**
All initial applicants for medical staff membership and clinical privileges must be interviewed (preferably in person) by their respective section and/or department chairperson. In the event the appropriate section or department chair is unavailable, a member of the Credentials Committee will interview the applicant. A record of this interview will be kept in the applicant's credentials file.

2) **Orientation:**
All new members of the medical staff will participate in an orientation process in which they will be informed of the hospital and medical staff policies and procedures regarding:

Code Alerts	Patient Admission/Registration
HIPAA	Procedure Scheduling
Infection Control	Patient Rights/Responsibilities
Fire Safety	Informed Consents
Sexual Harassment	Advance Directives
Clinical Practice Expectations	Electronic Access to Patient Clinical Data
Medical Records Compliance	EMTALA & Patient Transfers
Use of Restraints	Autopsy Criteria
Pre-Op Requirements	Badges/Parking & Access
Pain and Pain Management	Patient Safety
Prescribing/Medication Orders	Contacting the Joint Commission

3) **Applicability of Bylaws and Rules & Regulations**: All provisions of the Medical Staff Bylaws apply to all units within the Hospital. Accordingly, the granting of clinical privileges for specific procedures will apply to all units within the Hospital unless otherwise specified in particular cases, and the termination of clinical privileges shall automatically apply to all units within the Hospital.

4) **Applicability of Hospital Policies and Procedures:** Medical staff is required to adhere to all hospital policies and procedures.

5) **Autopsies/Transplant Organs**: Every member of the Active Medical Staff is expected to be actively interested in securing autopsies in accordance with the criteria and procedures described in Hospital Policy #5955. No autopsy shall be performed without prior written consent or as permitted by law. All autopsies shall be performed by the hospital pathologist or by a physician to whom he may delegate the duty, when the autopsy meets the autopsy criteria. The pathologist shall notify the attending physician when an autopsy on his/her patient is being performed. The judgment of the attending physician shall determine notification of additional interested members of the medical staff.

Transplant organ procurement shall be performed by accredited qualified members of a recognized transplant team, who will be granted privileges for the specific purpose of harvesting organs.

6) **Policies on Diagnostic and Therapeutic Orders**: (For purposes of this rule, "attending physician" shall mean the physician with primary responsibility for the care and management of the patient, together with any physician consulting for or authorized to cover such physician upon his/her unavailability and "authorized provider" shall mean an

appropriately privileged nurse practitioner, certified registered nurse anesthetist, nurse mid-wife, or physician's assistant.)

a. **Who Can Order**: Diagnostic and therapeutic orders will be issued only by practitioners with appropriate clinical privileges.

b. **Requirements of a Written Order**: All orders for treatment shall be in writing, signed, dated, timed, include the hospital-issued medical staff member number, and issued in accordance with this rule. An order shall be considered to be in writing when (a) dictated to licensed registered nurses for medication and treatment and signed by the attending physician or authorized provider, or (b) dictated to registered or certified respiratory therapists for respiratory medications and treatments and signed by the attending physician or authorized provider, or (c) dictated to registered pharmacists for medication orders and signed by the attending physician or authorized provider; or (d) dictated to physical, occupational, and speech therapists for treatment within their various disciplines and signed by the attending physician or authorized provider; (e) dictated to registered dieticians regarding dietary orders and signed by the attending physician or authorized provider. (f) dictated over the telephone, as described below; or (g) given verbally, as described below. Every page of a multi-page order must be signed, dated and timed.

c. **Orders for Medication**: Attending physicians or authorized providers ordering or reordering medications including those that require the use of medication-related devices (e.g., nebulizers, catheters) must specify the following: name of the drug (generic name preferred), dose (including volume, concentration, type of fluid, and rate for IV administration), route/mode of administration, frequency of administration. Concentrations and formulations are to be included when multiple selections are available. All medication orders are to have a related diagnosis, condition or indication for use documented in the patient's medical chart. Orders for multiple medications with similar indication (e.g. pain) must include a basis for selection. Attending physicians or authorized providers ordering or reordering treatments must specify the treatment modality by name and frequency.

d. **Reinstatement of Previous Orders**: Blanket orders (a summary order to resume all previous orders) for medications will not be allowed. Blanket orders that affect unspecified medications (such as orders written as "Continue Previous Medications" or "Resume Preoperative Medications) will not be accepted as legitimate orders.

e. **Verbal Orders**: For patient safety purposes, verbal orders will only be allowed during emergent situations, when patient safety would be jeopardized by delays in treatment resulting from the initiator writing the order or when it is physically impossible for the initiator to write the order.

f. **Telephone Orders:** Orders dictated by telephone shall be dated, timed, and signed by the person who received the order, noting the name of the attending physician or authorized provider who issued the order. The attending physician or authorized provider providing a verbal or telephone order will participate in the read-back and confirm process.

g. **Faxed Orders:** Faxed orders must contain the practitioner's full name, address and telephone number, pre-printed or legibly handwritten, and be signed by the practitioner.

h. **Authentication of Orders:** All telephone and verbal orders shall be authenticated by the person who issued them (or another provider involved in the patient's care) within 48 hours. Either the attending or the covering physician may authenticate the verbal or telephone orders of the other, but the physician authenticating these orders shall have participated in the care or management of the patient.

7) **Policies on Admission and Discharge of Patients:**

a. **Unassigned Patients**: Patients being admitted without an attending physician shall be assigned to members of the Medical Staff on duty in the department or section to which the illness of the patient indicates assignment.

b. **Diagnosis is Mandatory**: Except in emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

c. **Potentially Dangerous Patients**: Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatsoever, or to assure protection of the patient from self-harm.

d. **Transferring Care:** A physician transferring a patient to another physician shall indicate the name of the physician on the order sheet of the patient's chart.

e. **Discharge Requirements**: Patients shall be discharged only on order of the attending physician. The physician is responsible for reconciling all medications and providing the patient or his representative with a written list of these medications with instructions for home administration. In addition, written instructions are to be provided addressing diet, activity follow up care, and any condition or disease-specific instructions. The attending physician shall see that the record is complete, state the final diagnosis, and sign the record.

8) **Coverage Requirements**

a. **Alternate Coverage:** Each member of the Medical Staff shall name a member of the Medical Staff who is a resident in the city or immediate vicinity, who may be called to attend a patient in an emergency. In case of failure to name such an associate, the administrator of the hospital shall have the authority to call any member of the staff should it be considered necessary. In the absence from the city of any attending physician by reason of vacation, meetings, etc., a physician shall be named who has comparable qualifications and privileges at Washington Adventist Hospital to care for his patients. The physician so designated shall be informed as to the patient's condition. The name of the physician's replacement

shall be documented on the order sheet of the patient's medical record.

b. **Emergency Department "On-Call" Rosters:** All patients presenting at the Emergency Department without an attending physician shall be assigned to an appropriate physician, when necessary, by the Emergency Department physician pursuant to on-call roster protocols. Physicians on-call for the Emergency Department are obligated to perform, upon request, in-house consultations in their specialty on patients whose admission required assignment of an attending physician from the Emergency Department on-call roster. Each Department and Section is authorized to, and shall include in its Rules and Regulations provisions for, the establishment and functioning of an on-call roster for Emergency Department referrals, including the designation of who is responsible for preparing the roster, the frequency, preparation and rotation of the roster, the eligibility for service on the roster and any other relevant matters. The Executive Committee or each Department or Section may require all members or members of a designated category of Medical Staff Membership to accept Emergency Department roster referrals. The roster shall be devised so that Medical Staff participation rotates fairly and provides equal access to the roster among those who are deemed qualified and eligible by the Department or Section. For administrative efficiency, the various rosters maintained by each Department or Section shall be the exclusive source of referrals to physicians from the Emergency Department. There shall be no appeal from or due process rights related to the preparation and administration of rosters for Emergency Department coverage. The Executive Committee shall supervise the Emergency Department roster system as necessary to assure conformity with this Rule.

c. **Emergency Preparedness**: The medical staff will participate in the Emergency Preparedness Program and Plan for the hospital.

9) **Consultation Requirements**

a. **Duty to Provide Consultation:** As a condition of membership on the Medical Staff, each eligiblemember shall be obligated to provide consultations upon the request of a chairman of a clinical department or specialty section when necessary for a patient of an attending physician. Failure or refusal to provide such consultations shall be a basis for corrective action under the Bylaws.

b. **Responsibility to Request Consultation**: The patient's attending physician is responsible for requesting consultations when indicated. It is the duty of the medical staff through its department chairperson and Executive Committee to make certain that members of the medical staff do not fail in the matter of calling consultations as needed.

c. **Cases Requiring Consultation**: Except in emergency, consultation with another qualified physician is required in:

1. Procedures by which a known or suspected pregnancy may be interrupted.

2. Cases in which according to the judgment of the physician:

a. The patient is not a good risk for operation or treatment.
b. The diagnosis is obscure.
c. There is doubt about the best therapeutic measures to be utilized.

d. **Definition of a Consultant**: Must be a member of the Medical Staff and well qualified to give an opinion in the field in which his opinion is sought. The status of the consultant is determined by the Medical Staff on the basis of the individual's training, experience, and competence.

e. **Essentials of a Consultation**: A satisfactory consultation includes examination of the patient and the record. A complete consultative note signed by the consultant must be included in the medical record. When operative procedures are involved, the consultation note, except in emergency, shall be recorded prior to operation.

f. **Unresponsive/Unavailable Consultants**: In the event the attending physician is unable to obtain the services of a consultant in a given specialty, he/she shall contact the departmental chairperson of that specialty, Medical Staff President, or Chief Medical Officer for a resolution.

10) **Policies on Medical Records:**

a. **Responsibility**: The attending physician is responsible for the preparation of a complete medical record for each patient.

b. **Elements of a Complete Record**: The medical record shall include identification data, complaint, personal history, family history, history of present illness, physical examination, pain assessment and reassessment special reports such as consultations, clinical laboratory, x-ray, and others, provisional diagnosis, medical or surgical treatment, operative report, pathological findings, progress notes, final diagnosis, condition on discharge, summary or discharge note, follow-up and autopsy when available. No medical record shall be filed until it is complete, except on order of the Medical Records Committee. All entries must be signed, dated, timed, legible and free of unapproved abbreviations.

c. **Authentication**: All portions of the medical record created by privileged Practitioners and Advanced Practice Practitioners should be signed, dated, and timed (either electronically, or by hand if using a paper form), and countersigned as specified in Sections 7, 18, and 31..

d. **Custodian of Records**: All records are the property of the hospital and shall not leave the safe-keeping and jurisdiction of the hospital without a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be made available for the use of the attending physician upon request and by notifying the Medical Records Department.

e. **Privacy of Patient Information:** Practitioners are entitled to only access

patient information in the Hospital which is necessary and relevant to the medical care and treatment to be rendered by the practitioner to his/her particular patient or one for whom the practitioner is providing consultation. Accordingly, except as permitted by Hospital policies,Medical Staff Bylaws and/or law, a practitioner shall not review nor make use of any Hospital department, personnel, property or equipment to discover or review patient information which is not germane to his or her care of such patient, or which has not been authorized by the patient or his legal representative.

f. **Delinquent Medical Records**:

It is the policy of Washington Adventist Hospital that discharge summaries must be dictated within 15 days of discharge. The dictated report must be signed, dated and timed by the 30th day following discharge. Failure to complete a medical record within 30 days of the patient's discharge may result in disciplinary action against the practitioner.

Practitioners may be suspended from the medical staff in the event they have delinquent medical records that fall into one of the following categories:

- Any charts that remain incomplete greater than 90 days post-discharge (provided the charts are available)

Notwithstanding the criteria described above, the decision to suspend may be modified based on the degree to which suspension will disrupt normal hospital operations.

Should the physician choose to resign his/her privileges rather than pay the fine, the practitioner is still responsible for the completion of the medical records. Therefore: The resignation will be classified as voluntary so long as outstanding medical records are completed by the 60th day. If the medical records are not completed by the 60th day, the resignation shall be classified as a revocation of medical staff privileges "*for cause"* and be reported to both the Maryland Board of Physicians and the National Practitioner Databank.

Notwithstanding the above, exceptions may be made for practitioners who can document extreme circumstances (such as disability) impeding their ability to complete delinquent medical records and have made good faith efforts to arrange for their completion through some other means.

If the practitioner completes the delinquent medical records and pays any accrued fines before the 60th day of delinquency, the practitioner's membership and clinical privileges will be restored. If the practitioner is recommended for revocation of privileges, the practitioner will be sent a certified letter informing him or her of the recommendation and of the due process rights in accordance with the Medical Staff Bylaws. If the practitioner fails to exercise his or her due process rights in accordance with the Medical Staff Bylaws, the revocation shall become effective as of the 90th day of delinquency.
When a chart remains incomplete and the Medical Record Department cannot deduce the diagnosis, the chart shall be submitted to the appropriate

departmental chairperson for determination of probable diagnosis.

Medical Staff and Advanced Practice Practitioners will be notified of impending actions before they occur. If the provider is going on vacation when a patient is discharged, and so notifies the Medical Record Department, then the vacation period would be added to the 30 days before placing a physician on the delinquent list.

11) **Requirements for History and Physicals (H&Ps)**

a. **H&Ps and H&P Updates:** A complete history and physical examination and any required updates shall in all cases be completed, entered into the patient's medical record, and signed, dated and timed (or if completed by an Advance Practice Practitioner, countersigned, dated and timed by the supervising Practitioner) within 24 hours after admission or registration of the patient, but prior to surgery or a procedure requiring anesthesia services. An H&P completed up to 30 days prior to admission is acceptable as long as an H&P update note is added to the medical record within 24 hours after admission or registration. The update note must document an examination for any changes in the patient's condition since the patient's H&P was performed that might be significant for the planned course of treatment. If, upon examination, the licensed practitioner finds no change in the patient's condition since the H&P was completed, he/she shall indicate in the patient's medical record that: the H&P was reviewed, the patient was examined, and that "no change" has occurred in the patient's condition since the H&P was completed. Any changes in the patient's condition must be documented by the practitioner in the update note and placed in the patient's medical record within 24 hours of admission or registration, but prior to surgery or a procedure requirement anesthesia services. If components are found to be missing (see section d below), they should also be added at that time. The H&P update should be signed, dated and timed by the Practitioner (or, if completed by the Advance Practice Practitioner, countersigned, dated and timed by the supervising Practitioner) within 24 hours after admission or registration of the patient, but prior to surgery or a procedure requiring anesthesia services.
b. **Acceptance of, and Updates to H&Ps from Community Physicians:** H&Ps may be accepted from any community-based LIP. However an appropriately privileged LIP must update the H&P as described above, within 24 hours after admission or registration of the patient, but prior to surgery or a procedure requiring anesthesia services.
c. **H&P's and H&P Updates Prior to Surgery/ Procedure:** If the surgery or procedure requiring anesthesia services was not included as part of the plan in the most recent H&P, an updated H&P shall be required as described under (12.a) above. When a history and physical examination or any required updates are not recorded before the time stated for surgical procedure or diagnostic procedure, the surgical procedure or diagnostic procedure shall be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient.

d. **Standard Components of a Complete Inpatient H&P**

- Date of admission
- Chief complaint/reason for admission
- History of present illness/condition
- Past medical/surgical history/past treatment
- Current medications
- Allergies
- Psychosocial/social history
- Family history
- Review of Systems
- Physical Examination, which will include an exam of:
    - heart and lungs

  And any system correlated to:
    - the patient's chief complaint
    - the reason for admission
    - the reason for operative procedure
    - the reason for diagnostic procedure requiring anesthesia services
- Diagnostic and therapeutic results
- Assessment/Impression/working diagnosis
- Plan

e. **Standard Components of a Complete Outpatient H&P**

- Chief complaint
- History of present illness/condition
- Pertinent past medical/surgical history/past treatment
- Current medications
- Allergies
- Review of Systems
- Physical Examination, which will include an exam of:
    - heart and lungs

  And any system correlated to:
    - the patient's chief complaint
    - the reason for operative procedure
    - the reason for diagnostic procedure requiring anesthesia services
- Diagnostic and therapeutic results
- Assessment/Impression/working diagnosis
- Plan

f. **Minimal Requirements for H&Ps Based on Setting, Level of Care, Treatment and Services**

1. *Obstetrical Patients*: The entire prenatal record should be included in the record, together with an updated H&P as defined under (12.a) and (12.d). These shall be completed prior to delivery, but prior to surgery or a procedure requiring anesthesia services (except under emergency conditions).
2. *Same-Day or Outpatient Pre-op (Procedure) Patients*: If a patient is a same day admit or outpatient surgery patient, they must have an updated H&P as described under (12.a) and (12.e), once the patient is physically present in the facility, but prior to surgery or a procedure requiring anesthesia services. This is required even if the H&P is performed the day of surgery but outside the facility.

3. *Outpatients*: Patients in the Catheter and Electrophysiology Labs, Endoscopy, and those receiving sedation for special radiologic procedures must have an updated H&P as described under (12.a) and (12.e) prior to moderate or deep sedation. For outpatients not receiving moderate or deep sedation, an H&P is not required.
4. *Outpatient Behavioral Health Patients*: An updated H&P is only required when indicated by the initial health assessment triggers per departmental policy. Otherwise, COMAR regulations should be followed.

12) **Requirements for Operative Reports**: Operative Reports shall be dictated or documented and authenticated in the medical record within 24 hours after surgery or a high-risk procedure. The required elements of this note are: the name of the procedure/s performed, a description of the procedure, the indications for surgery, a description of the findings, the specimen removed, the pre and postoperative diagnosis, estimated blood loss, and the name of the primary surgeon and any assistants. An operative progress note shall be documented in the medical record immediately after the procedure if the full operative report cannot be entered into the record upon completion of the procedure but before the patient is transferred to the next level of care.

13) **Requirements for Discharge Summaries**:

All patients (inpatients and outpatients) will have a discharge summary covering the following components:

- Reason for hospitalization/procedure
- Procedure/s performed, care, treatment, services provided
- Significant findings
- Final diagnosis
- Condition at discharge/outcome
- Disposition
- Provisions for follow up care, including
    - Follow up appointment
    - Medications
    - Diet
    - Activity

A final progress note in lieu of a dictated summary covering all of the above components is acceptable for outpatients, for inpatients with hospital stays under 24 hours, and normal vaginal deliveries with a hospital stay less than 48 hours.

14) **Professional Practice Evaluation**:

a. **Cases Subject to Review:** All outpatient and short stay surgical cases performed in the hospital are subject to the same review processes as all in-patient care activities.

b. **Duty to Respond**: Every member of the Medical Staff is required to respond to inquiries from case management or Quality and professional peer review activites in accordance with Hospital policy.. Failure to do so within 14 days shall require notifying the physician by certified mail, return receipt requested, that

he/she may be suspended within 30 days of the initial inquiry and the facilities of the hospital will not be available to him/her for admission of new patients, consultations, special procedures or surgical procedures. The department chairman will be notified that the physician has failed to respond within 14 days. If the physician has not responded within 30 days, the Medical Staff Office is to be notified and the physician automatically suspended. Failure to respond in a timely manner may lead to further disciplinary actions.

15) **Restraints and Seclusion:**

LIPs ordering restraints or seclusion must be familiar with and adhere to the hospital policy.

16) **Medication and Narcotics Policies**:

a. **Duty to Use Formulary**: Each member of the Medical Staff, in agreeing to abide by the Bylaws, Rules and Regulations, gives his assent to the use of the hospital Formulary, unless otherwise specified in writing on the patient's order sheet.

b. **Drug Standards**: Drugs used shall meet the standards of the United States Pharmacopoeia, National Formulary, New and Non-Official Drugs with the exception of drugs for bona fide clinical investigations. Exceptions to the rule shall be well justified.

c. **Medication Errors**: All medications errors of commission and/or omission and all adverse drug reactions will be reported to the Hospital incident reporting system or the Pharmacy & Therapeutics Committee in accordance with the written policy of that committee.

d. **Medications will Auto-Stop**: In accordance with hospital policy,

17) **Practice Parameters for Various Medical Staff Categories**

a. **Oral Surgeons performing History and Physicals**: Oral Surgeons who have graduated from a training program which included experience in performing history and physical examinations, and which complies with the standards for Advanced Specialty Education Programs in Oral and Maxillofacial Surgery and which is accredited by the American Dental Association's Commission on Dental Accreditation, may complete histories and physicals on their own patients who lack significant medical problems (i.e. ASA Class I anesthesia risks).

b. **Limits on the Advanced Practice Professional (APP) Staff:** The Advanced Practice Professional Staff may not admit patients to the hospital. The APP Staff may only treat a patient under the supervision of - or in collaboration with - the patient's attending physician. In the event of disagreement between a patient's attending physician and a member of the APP Staff as to treatment of a patient, the attending physician's decision shall prevail.

c. **Physician Assistants:**

The following types of documentation, if created by a Physician's Assistant, must be countersigned by a Physician:

- History and Physicals, within 24 hours of admission or registration, but prior to surgery or procedure requiring anesthesia services.
- Operative Notes, prior to transfer to the next level of care
- Consultations within 48 hours of consultation
- Discharge Summaries within 48 hours of discharge

Other types of notes and documentation (such as orders and prescriptions) do not require countersignature by a Physician provided the Physician's Assistant has been granted privileges to make such documentation by the medical staff and by the Board of Physicians in the Delegation Agreement.

d. **Advanced Practice Nurses (APRNs)**

APRNs will require countersignature by a physician for the following:

- History and Physicals within 24 hours of admission or registration, but prior to surgery or procedure requiring anesthesia services
- Discharge Summaries within 48 hours of discharge
- Procedural notes for procedures not performed by the APRN, prior to transfer to the next level of care

Unless precluded by their job description or not in possession of proper credentialing, Advanced Practice Nurses shall not require the countersignature of a physician for the following:

- Consultations and verbal and telephone orders
- Procedures performed wholly by the APRN
- Prescriptions,medication orders, verbal and telephone orders

e. **Expectation to Seek Higher Staff Status**: Physicians who admit 12 or more patients to the hospital per year should seek higher membership status at the appropriate opportunities provided for in the Bylaws.

18) **Delegation of designated medical services to Qualified Medical Personnel**

When an emergency medical condition exists, the medical staff may delegate conducting medical screening examinations to "Qualified Medical Personnel"

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"Emergency medical condition" refers to a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in:

a. Placing the health of the individual (or, with respect to a pregnant woman, the health of a woman or her unborn child) in serious jeopardy
b. Serious impairment to any bodily functions

c. Serious dysfunction of any bodily organ or part
d. With respect to a pregnant woman who is having contractions: that there is inadequate time to effect a safe transfer to another hospital before delivery, or that the transfer may pose a threat to the health or safety of the woman or the unborn child.

"Qualified Medical Personnel" are those professionals who have been identified by the Hospital's governing body as qualified to administer a medical screening examination as set forth in the Hospital's Medical Staff Bylaws or Rules and Regulations. In all cases, Qualified Medical Personnel will include medical and osteopathic physicians, and may include non-physicians such as nurse practitioners, registered nurses, and physician assistants operating within their scope of practice and, where required by law, in accordance with standardized procedures. Under these guidelines, for maternity patients, Qualified Medical Personnel may include registered nurses assigned to the Labor and Delivery Department pursuant to an approved standardized procedure.

19) **Intensive Care Units and Intensivists**:

a. Except for patients with a cardiac diagnosis and who are under the care of a cardiologist, any patient admitted to the intensive care units will receive a mandatory consultation with the in-house intensivists group and will be followed by that group on a daily basis.

b. All mechanically ventilated patients managed in the intensive care unit will receive a mandatory consultation with the in-house intensivists group and will be followed by that group on a daily basis.

c. Attending physicians may co-manage patients in the intensive care units; however, in the event of disagreement on clinical management, the opinion of the in-house intensivist shall prevail.

d. In-house Intensivists have the authority to ask the attending physician to obtain consultation with a qualified specialist on patients in the intensive care unit. Should the attending physician refuse to obtain such consultation, the intensivist may call the consultation. The chairman of the attending physician's department will be contacted and a report filed with the Executive Committee.

e. Post-operative cardiac critical care patients needing the services of an intensivist for continuing management purposes must be under the care of the in-house intensivists group as the sole critical care consultant.

20) **Protocol for Isolation of Infectious Diseases Patients**:

The physician directly responsible for the care of the patient is expected to order proper isolation or precautions as necessary. The nurse or infection control practitioner also has the authority to initiate the proper isolation precautions when a patient is suspected to be infectious. The infection control practitioner serves as a resource to recommend appropriate culture orders when indicated. If there is disagreement on isolation status, the final authority rests with the chairperson of the Infection Prevention Committee to write culture orders and to institute/maintain the appropriate isolation procedures.

All personnel are responsible for reporting improper techniques in carrying out isolation in the hospital's occurrence reporting system as well as to the Infection Prevention nurse and/or chairperson of the Infection Prevention Committee.

In the absence of the chairperson of the Infection Prevention Committee, authority shall be delegated to the Infectious Disease practitioner on call.

21) **Director of the Medical Staff Services Department**

The director and/or designees in the Medical Staff Services Department shall keep accurate and complete minutes of all staff meetings, call meetings on order of the president, attend to all correspondence and perform such other duties as ordinarily pertain to his/her office.

22) **Physical and Verbal Abuse/Sexual Harassment Policy**

a. **Positive Work Environment**: The Washington Adventist Hospital Medical Staff is determined to maintain a working environment for everyone that is free of physical and verbal abuse and sexual harassment. As a result, the Medical Staff expressly prohibits physical and verbal abuse or sexual harassment of any member of the Medical taff, resident, medical student, technician, Hospital employee, patient, or visitor. It is expected that all levels of staff, patient and visitor, will be treated with respect.

b. **Abusive Behavior, Definition**: includes, but is not limited to: attacks leveled at other medical staff members which are personal, irrelevant, or go beyond the bounds of professional comment; impertinent and inappropriate comments impugning the quality of care in the hospital, or attacking physicians or nurses or other personnel; non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle, or to impute stupidity, or incompetence. All members of the Medical Staff are required to abide by the Policy,and any violation of the Policy may result in disciplinary action, up to and including revocation of membership and clinical privileges.

c. **Sexual Harassment, Definition**: Sexual Harassment includes, but is not limited to: sexual advances; requests for sexual favors; the taking of any action that may affect any facet of an individual's employment or work retention (such as promotion, assignments, or compensation) on the basis of the individual's appearance; the display of sexually suggestive pictures or objects; foul or obscene language, jokes, or gestures; and any other offensive conduct or suggestive statements having a sexual connotation.

d. **Physical and Verbal Abuse** Definition:Unreasonably interfering with an individual's work performance.Creating an intimidating, hostile or offensive working environment.

e. **Reporting of Abuse**: Any individual who believes that he/she has been the victim of physical and/or verbal abuse/sexual harassment or who has knowledge of any such

behavior should report such conduct immediately to the President of the Medical Staff or the Hospital CMO for investigation and appropriate action. Hospital employees should report any such conduct to their supervisor, and the Hospital CMO will notify the President of the Medical Staff. Once the President of the Medical Staff has determined the severity of the incident and a recommendation or action has been made, the Hospital President will be informed.

f. **Records of Abuse**: All incident reports and documentation regarding abusive behavior and/or sexual harassment shall be promptly forwarded to the Medical Staff and Risk Management Offices. Protocols as delineated in the Medical Staff Blyaws and Hospital policies shall be followed

23) **Policies on Physical/Mental Fitness to Practice:**

a. **Physical Examination**: At the time of biannual reappointment or sooner (if indicated by peer review activity), the Credentials Committee and/or Medical Executive Committee may require any member of the medical staff to demonstrate their physical capacity to perform the clinical privileges they have requested.
b. **Mental/Behavioral Health Evaluation**: At the time of reappointment or sooner (if indicated by peer review activity), the Credentials Committee and/or Medical Executive Committee may require any member of the medical staff to demonstrate their mental capacity to perform the clinical privileges they have requested.
c. **Tuberculosis:** All members of the medical staff are required to undergo evaluation annually. This in no way negates individual departmental policies that may require more frequent verification of a negative status.

24) **Collegial Intervention Policy:**

a. This policy encourages collegial and educational efforts by medical staff leaders and management to address questions relating to medical staff member(s) clinical practice and/or professional conduct. The goal of these efforts is to arrive at voluntary, responsive actions by the individual to resolve questions/concerns that have been raised.

b. Collegial efforts may include, but are not limited to, counseling, sharing of comparative data, monitoring, and additional training or education.

c. All collegial intervention efforts by medical staff leaders and management are part of the hospital's performance improvement and peer review activities.

d. The relevant medical staff leader shall determine whether it is appropriate to include documentation of collegial intervention efforts in an individual's confidential file. If documentation is included in an individual's file, the individual will have an opportunity to review it and respond in writing. The response shall be maintained in that individual's file along with the original documentation.

e. Collegial intervention efforts are encouraged, but are not mandatory, and shall be within the discretion of the appropriate medical staff leaders.

25) **Impaired Practitioners:**

It is the goal of the Medical Staff to help practitioners, where practicable, who may be impaired, so long as reasonable measures can be implemented without presenting a threat to patients or to the efficient administration of the Hospital. If it is known or suspected that a practitioner is impaired, the following procedures shall be followed.

a. The initial response to any concerns that a member of the Medical Staff is impaired and/or providing unsafe patient care or treatment shall be an oral or written report to the chair of the relevant Department or President of the Medical Staff or CMO. The identity of the informant shall remain confidential unless adverse action is taken.

b. Practitioners are encouraged to self-report their impairment orally or in writing to the chair of the relevant Department and President of the Medical Staff.

c. The Department chair, President of the Medical Staff or CMO shall seek further information to evaluate the credibility of a complaint, allegation, or concern. If the complaint, allegation or concern appears to be valid, the Department chair, President of the Medical Staff or CMO, shalldiscuss with the practitioner the concerns which were expressed regarding his/her behavior, as well as such other information as may be available. The source and specific nature of the concerns may, within the discretion of the Department chair, be kept confidential. The Department chair must immediately inform the President of the Medical Staff of all complaints, allegations and concerns that appear to be valid.

d. If the affected practitioner acknowledges that he/she is impaired, the Department chair, President of the Medical Staff or CMO may refer him/her to the MedChi Physician Health Program, or to other outside services for evaluation, diagnosis, counseling or treatment services as may be appropriate under the circumstances. Documentation of the facts available, and the practitioner's response,shall be documented in a memorandum to be placed in the practitioner's credentialing file.

e. If the affected member denies that he/she is impaired or fails to follow up appropriately on any recommended course of conduct, the Department chair, President of the Medical Staff or CMO shall document the facts available, and the practitioner's response, in a memorandum to be placed in the practitioner's credentialing file. The Medical Executive Committee (MEC) shall review the report of suspected impairment and the results of the informal fact finding conducted by the Department chair. Should the MEC determine that the complaint, allegation, or concern is sufficiently credible and may result in potential harm to a patient, fellow member of the medical staff, or hospital personnel or operations the MEC mayrefer the practitioner to the MedChi Physician Health Program or other outside services for evaluation, diagnosis, counseling or treatment services as may be appropriate under the

circumstances. All fees are at the provider's expense. Should the practitioner refuse to undergo such evaluation, diagnosis, counseling or treatment, the practitioner's clinical privileges may be summarily suspended in accordance with the provisions of the Medical Staff Bylaws.

f. Practitioners undergoing rehabilitation for a physical, psychiatric, or emotional illness who fail to complete the required rehabilitation program may be summarily suspended in accordance with the provisions of the Medical Staff Bylaws.

g. Practitioners undergoing rehabilitation for a physical, psychiatric, or emotional illness who fail to complete the required rehabilitation program may be summarily suspended in accordance with the provisions of the Medical Staff Bylaws.

h. Practitioners undergoing rehabilitation for a physical, psychiatric, or emotional illness shall then consent to a period of close monitoring (beyond the period of their rehabilitation) of his/her professional activities in the hospital by his/her department chair, the results of which shall be reported to the Medical Executive Committee. Should the department chair and the MEC continue to suspect impairment and they deem, in their best judgment, that this impairment may negatively impact patient safety in the hospital, the member's clinical privileges may be summarily suspended in accordance with the provisions of the Medical Staff Bylaws.

i. If the practitioner is believed to have abused drugs (whether prescription or otherwise), the Department chair, President of the Medical Staff of CMO shall contact the Hospital's Risk Management
Department to determine if further action is necessary.

26) **Professional Liability Insurance Coverage:** All members of the medical staff must maintain professional liability insurance with limits of $1,000,000 per occurrence and $3,000,000 aggregate. Washington Adventist Hospital must be listed as the Certificate Holder.

Special Privileging and Credentialing Situations:

27) **Fast Track Credentialing Process Policy:** This policy is developed to facilitate a streamlined process for new applicants to the Medical staff who fall in the category below. Upon approval by their respective department chairman and section chairman (if applicable), the application will be forwarded directly to the Chairman of the Credentials Committee and at his discretion and approval, these applications may bypass presentation to the Credentials Committee and be sent to the Medical Executive Committee or the President of the Medical Staff for approval and submission to the Board of Directors if:

1. All materials are verified;

2. The applicant has requested privileges consistent with the privileges as defined for that specialty; and

3. There are no suggestions in the verified materials of potential problems.

28) **Urgent Patient Care Need Privileges**

When there is an urgent patient care need for a practitioner of a specialty that is significantly underrepresented or absent from the medical staff, the Hospital President may grant urgent patient need privileges to practitioners of that specialty under the following conditions:

- A Department Chair or Section Chair must make the request, in writing, citing the basis for the urgent patient need.
- Primary Source Verification of the practitioner's Maryland license, NPDB Report, Verification of Board Certification, Verification of Education and Training, SAM and OIG Report are obtained.
- Evidence of current liability insurance coverage within the required limits are obtained
- The Medical Staff Services Department Director, President of the Medical Staff (or his/her designee) and Hospital President (or his/her designee) signs the "Urgent Patient Need" privileges form
- Urgent Patient Need privileges expire after the urgent need is resolved or 30 days, whichever comes first.

29) **Emergency Privileges for Volunteer Practitioners During Disaster Response**

a. **Policy**: The Hospital President and the Medical Staff President or their designees may grant emergency privileges to licensed independent practitioners (LIP'S) when the emergency management plan has been activated and the organization is unable to meet immediate patient care needs.

b. **Requirements for Obtaining Emergency Privileges**:

In order for volunteers to be eligible to act as Licensed Independent Practitioners, the hospital must obtain a valid state or federal government-issued form of photo identification that clearly establishes the identity of the volunteer practitioner and at least one of the following:

- A current hospital or critical access hospital picture identification card that clearly identifies professional designation.
- A current license to practice medicine
- Primary source verification of licensure,
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT8), or MRC, ESAR-VHP, or other recognized state or federal organizations or groups.
- Identification indicating that the individual has been granted authority to render patient care, treatment, and services in disaster circumstances (such authority having been granted by a federal, state, or municipal entity).
- Identification by current organization member(s) who possesses personal knowledge regarding the volunteer practitioner's qualifications.

All healthcare provider volunteers must present to the Medical Staff Office for processing of their emergency privileges.

c. Once emergency privileges have been granted to any volunteer licensed independent practitioner, the volunteer LIP will be issued an IDbadge by the Medical Staff Services Department. This ID will be labeled to denote that the holder has Emergency Privileges.

d. Oversight of the care, treatment, and services provided will be done by a current medical staff member. The medical staff shall oversee the professional performance of volunteer practitioners who receive emergency **disaster privileges.**

e. Primary source verification of licensure begins as soon as practical, and is generally completed within 72 hours from the time the volunteer practitioner presents to the organization.

f. A decision (based on information obtained regarding the professional practice of the volunteer) related to the continuation of the initial privileges will be made within a maximum of 72 hours. Otherwise all emergency disaster privileges will expire once the disaster is deemed to have ended.

g. The Physician Leader of the Command Center may terminate emergency privileges at any time. No due process rights are applicable to the termination of emergency privileges.

30) **Residents and Fellows:**

a. **Limits on Activities**: Residents and Fellows who are assigned to the Hospital through their graduate education program may only render services to Hospital patients in accordance with the Hospital's policies and procedures, their Hospital job description, and Maryland and federal laws and regulations.

b. **Credentialing/Membership Status**: Residents and fellows will not be credentialed and/or privileged through the Medical Staff Services Department processes but will, instead, be registered with the Medical Staff Services Department as outlined below. Fellows working outside of the scope of their fellowship program shall be credentialed and privileged through the Medical Staff Services Department process. Residents and fellows shall not be considered members of the Medical Staff for any purpose; accordingly, they are not entitled to due process, voting, or any other rights under the Medical Staff Bylaws. Residents and fellows will participate in the same hospital orientation process as members of the medical staff.

c. **Supervision and Countersigning**: Residents and fellows may only provide services to Hospital patients under the supervision of a physician member of the Medical Staff. The degree of supervision is to be determined by the appropriate attending physician within the parameters of the Hospital job description.

Residents and fellows may write orders and progress notes, however, all such orders and notes must be countersigned by the attending physician within 48 hours. Residents and fellows may also write H&Ps, however the attending physician must countersign and/or add an H&P update to the medical record (as outlined in Section 12), within 24 hours of patient admission or registration, but prior to surgery or diagnostic procedure requiring anesthesia services.

d. **Requirements for Registration of Residents and Fellows**

Residents and fellows will register with the Medical Staff Services Department where a file will be maintained that includes the following items:

- Training program's recommendation of each trainee, in writing, to the hospital
- Trainee's Maryland "Unlicensed Medical Practitioner" number or Maryland State License.
- Evidence of professional liability insurance coverage in the amounts specified in these Rules and Regulations.

31) **Procedural Sedation**: Physicians must have current privileges to administer sedation, with or without analgesia. These privileges must be requested for renewal every two years. To obtain privileges, physicians must show evidence of having passed a written test (with a score of 80% or better) the Sedation/Analgesia Test, found in Appendix C of the Hospital's Sedation/Analgesia Policy. All LIPS must adhere to the hospital-wide policy for sedation and analgesia (available on the Intranet and in departments) which requires at a minimum, pre-procedural assessment and scoring of airway status and ASA classification, reassessment immediately prior to sedation, using only approved medications and dosage ranges, and providing the level of supervision specified in policy.

32) **Fluoroscopy:** Physicians must have current privileges to utilize or direct utilization of fluoroscopic equipment during diagnostic or therapeutic procedures. These privileges must be requested for renewal every two years. To obtain privileges, physicians must show evidence of having completed four hours of training in the use of a fluoroscopic system. Physicians may also satisfy the requirement by showing evidence they passed the test at another institution. All LIPS must adhere to the hospital-wide policy for fluoroscopy (available on the Intranet and in departments.)

33) **Telemedicine**

Physicians practicing from a remote location shall be credentialed and privileged through the same procedures as on-site practitioners but they shall not be granted any category of membership on the medical staff nor afforded rights to due process as described in the Medical Staff Bylaws.

In the event off-site physicians are subcontracted from a separate Joint Commission accredited facility, the hospital may defer credentialing and privileging to that entity provided the following procedures and documentation are maintained:

- Signed copy of the Agreement between the Joint Commission-accredited entity and the hospital or local physician/group on the medical staff
- Copy of the Joint Commission accreditation certificate of the entity
- A copy of off-site physician's Maryland license
- Evidence of liability insurance with the required coverage limits
- Delineation of privileges
- Evidence of Board Certification
- Aforementioned items must be updated at each reappointment
- Each applicant to be approved by the Chair of the appropriate department

34) **Chest Pain Patients**

All cardiologists, emergency physicians and other attending physicians who admit or place patients in observation status with an ACS diagnosis must be either board certified in their respective specialty or must be able to demonstrate completion of 10hrs of CME in the past 3 years related to the pathophysiology, diagnosis, and treatment of ACS (Acute Coronary Syndrome). Any physician not meeting these requirements must consult with a board-certified cardiologist.

35) **Progressive Policy on the Enforcement of Legibility Standards**

In an effort to improve the legibility of medical record documentation to prevent medical errors and improve patient care, the following progressive process will be enforced:

a. All members of the Medical Staff shall be informed of the importance of legible handwriting.

b. Members who have been regularly identified as having poor handwriting will receive a personalized letter from the President of the Medical Staff regarding the need and expectation for improvement in the legibility of their handwriting.

c. Members who are cited a second time for poor legibility, will receive a second personalized letter from the President of the Medical Staff requesting that the member meet with his/her respective Department Chairman to discuss the necessary improvement options. This letter shall be placed in the member's credentials file.

d. If the member is cited a third time, they will be required to complete a self-study course on handwriting legibility (such as the "Write Now", program manual). and submit the completed program to the appropriate peer review committee.

e. If the member is cited fourth time, he/she will be required to appear before the Medical Executive Committee to explain how he/she intends to improve the legibility of his/her handwriting.

f. Should the physician be cited a fifth time, they will be required to appear before the Medical Executive Committee to show cause as to why their medical staff privileges should not be terminated.

36) **Progressive Policy on the Enforcement of Medical Records Compliance**

Medical Staff and Advanced Practice Professionals who fail to maintain medical records in the manner mandated by the hospital and regulatory agencies are subject to the following progressive steps:

First Occurrence: A letter will be sent by the appropriate hospital department.

Second Occurrence: A letter will be sent by the appropriate hospital department and collegial intervention by the Department Chairperson, President of the Medical Staff, Chief Medical Officer or other appropriate physician leader.

Third Occurrence: Suspension of clnical privleges.

Notwithstanding the above, practitioners remain subject to the consequences for failure to maintain medical records described in other relevant sections throughout these Rules and Regulations, including suspension of clinical privileges.

37) **Policies on Practitioner's Access to Own Files**

I. General Principles

(1) A Medical Staff member may be notified and given an opportunity to review and respond in writing to any written communication concerning the individual that is prepared by a Medical Staff leader or a member of the Hospital's administration and included in the individual's Practitioner File. The Medical Staff member's response shall be maintained in the Practitioner File along with the original communication.

(2) In accordance with this Policy, each Medical Staff member shall also be afforded a reasonable opportunity to inspect his/her credentials file and make notes regarding it, in the presence of the Medical Staff Office Director, the CMO, an appropriate Medical Staff leader (e.g., President of the Medical Staff, department chairperson, Credentials Committee Chairperson), and/or the Hospital President in accordance with the terms of this Policy. In no case shall a Medical Staff member remove the credentials file or any portions thereof from the Medical Staff Office or make copies of it, without the express permission of the Hospital President.

(3) The CMO, the Medical Staff Services Director, or their authorized representatives shall correct or delete materials contained in a credentials file only after the individual has submitted a written request demonstrating good cause for the correction or deletion and that request has been approved by the Executive Committee and the Hospital President.

(4) Practitioners will be allowed to review and copy their full credentialing and quality assurance files if an adverse action is taken against their

privileges based on the recommendation of the MEC or action of the Hospital's Board of Directors.

II. Category 1 Access

A Medical Staff member shall routinely be permitted access to the following information, provided appropriate notice is given to the Medical Staff Office Director:

(1) applications for appointment, reappointment, and requested changes in staff status or clinical privileges, with all attachments;

(2) all information gathered in the course of verifying, evaluating, or otherwise investigating applications for appointment, reappointment, or changes in staff status or clinical privileges (except for confidential reference information obtained from third parties);

(3) any performance improvement trend sheets data, and reports concerning the individual's practice at the Hospital;

(4) any routine correspondence between the Hospital and the Medical Staff member; and

(5) information concerning the Medical Staff member's meeting attendance record and compliance with other citizenship requirements.

III. Category 2 Access

A Medical Staff member may review Category 2 documents while in the presence of an appropriate Medical Staff leader (e.g., President of the Medical Staff, department chairperson, Credentials Committee Chairperson), the CMO, and/or the Hospital President. At this meeting, the Medical Staff member shall be shown the document or an appropriate summary of it (but shall not be told the identity of any individual who provided the information unless, in the discretion of those involved in the meeting, revealing the individual's identity would be conducive to quality and performance improvement and would not result in adverse consequences to the individual(s) or willingness of other individuals to document incidents).

Category 2 documents are the following:

(1) any and all incident reports concerning the Medical Staff member which are placed into the file, along with any written explanations submitted by the individual;

(2) any confidential correspondence and/or memos to the file, prepared pursuant to collegial intervention efforts or other progressive disciplinary steps with the individual, along with any responses from the individual;

(3) any periodic review and appraisal forms completed by the appropriate department chairperson, including those completed at the time of appointment or reappointment;

(4) any routine peer review evaluation forms completed;

(5) any evaluations or reports from proctors, monitors, and/or external clinical reviewers, and any written explanations submitted by the individual;

(6) confidential reports and/or minutes (redacted) of peer review committees pertaining to the Medical Staff member;

(7) any correspondence setting forth formal Executive Committee action, including, but not limited to, letters of guidance, warning, or reprimand, terms of probation, or consultation requirements, or final adverse actions following completion or waiver of a hearing and appeal, accompanied by any written explanation the individual submits; and

(8) any written explanation to any of the above submitted by the Medical Staff member.

IV. Category 3 Access

Because of the expectation of confidentiality on the part of individuals who submit Category 3 documents, a Medical Staff member may not have access to these documents, unless (i) the individual providing such information consents to the disclosure, or (ii) the information is the basis for an adverse professional review action that entitles the individual to a hearing pursuant to the Medical Staff Bylaws.

Notwithstanding this, a Medical Staff member may meet with an appropriate Medical Staff leader, the CMO, and/or the Hospital President to discuss any Category 3 information and may review a written summary of the information (provided the summary does not reveal the identity of any individual who submitted the information).

Category 3 documents are the following:

(1) any and all confidential correspondence from references and other third parties, including, but not limited to, letters of reference, confidential evaluation forms, and other documents concerning the Medical Staff member's training, clinical practice, professional competence, or conduct at any other health care facility or medical school; and

(2) notations of telephone conversations with references and other third parties concerning the Medical Staff member's qualifications.

V. Disputes

Should any dispute arise over access to information in a practitioner file, the dispute shall be resolved by the CMO and the President of the Medical Staff, after discussing the matter with the Medical Staff member involved, whose decision shall be final and not subject to appeal.

39) Any member of the medical staff with concerns about the safety or quality of care provided in the organization may report these concerns to the Joint Commission. The hospital will take no disciplinary or punitive action because a member of the medical staff reports safety or quality of care concerns to the Joint Commission.

Revised: 1.3.11 ; 3.1.16; 4.6.16; 5.4.16; 6.1.16
Approved by the Medical Executive Committee: June 6, 2016

ADDENDUM A
Medical Staff Clinical Practice Expectations

The goal of the Medical Staff of Washington Adventist Hospital is to provide the highest quality of care to our patients.

In an effort to accomplish this, the medical staff has articulated generally accepted criteria which govern the practice of medicine within this hospital. All members of the medical staff are expected to adhere to the following principles as members of a community of health care professionals engaged in the delivery of high quality medical care.

1. Abide by the Bylaws, Rules and Regulations and other policies & procedures of WAH.

2. Participate in the on-call ER schedule as determined by hospital policy.

3. Examine and develop a plan of care for patients promptly on their admission to the hospital.

4. Ensure continuous physician coverage (24hrs/day, 7days/week) for providers' in-house patients by the provider or a covering physician with privileges at WAH.

5. Maintain medical records consistent with medical staff bylaws and rules and regulations including:

    a. Completing a dictated or written H&P within 12 hours of patient admission and prior to transfer to the Operating Room or for any invasive procedure requiring sedation.

    b. Completing a brief operative note immediately after surgery and before transfer to the next level of care.

    c. Completing a fully dictated and signed operative report within 24 hours of procedure.

    d. Provide a daily progress note in the record for all inpatients that updates the patients condition and plan of care and addresses their need for continued stay in an acute care facility.

    e. Complete a dictated discharge summary within 2 weeks of discharge, and transfer summaries immediately when patient is to be transferred. Attending physicians who transfer care from one service to another must dictate a transfer summary that includes all pertinent details to enable the next provider to manage the patient's care.

    f. All written entries in the medical record are to be legible, signed, dated and timed.

6. Provide regular thoughtful communications with patients and their families regarding the patient's condition and the plan of care.

7. Maintain acceptable standards of quality care, utilizing, when appropriate, approved clinical pathways.

8. Participate fully in the Peer Review process by responding fully and promptly to Peer Review inquiries regarding quality of care issues.

9. Follow generally accepted medical practice in the ordering of medications and blood products.

10. Communicate effectively with other members of the health care team including nurses, therapists, other physicians, and anyone involved in the welfare of patients. This includes:

    a. Responding promptly to pages in no more than 30 minutes

    b. Keeping other members of the team informed of the plan of care.

    c. Communicating directly with consulting physicians regarding the specific reason for requesting consultation and the level of urgency of the consultation.

    d. Avoiding disruptive or threatening behavior or communication including the avoidance of impulsive, disrespectful or sexually harassing behavior directed at fellow physicians, WAH staff, patients or their families.

    e. When transferring complete responsibility for a patient (such as during vacation coverage), physicians will conduct a verbal hand-off to the covering physician. This hand-off will contain pertinent information about current treatment and condition as well as about any recent or anticipated changes. The information will be provided within a timeframe sufficient for the receiving physician to review the information and request any additional information needed. A similar verbal exchange will be provided by the covering physician on the return of the physician taking leave.

    f. When transferring on-call responsibility, physicians will verbally inform the oncoming on-call physician of any patient that is anticipated to require monitoring or intervention during the on-call period prior to the on-call coverage period. At the end of the call period, the covering on-call physician will verbally inform the receiving team or on-call physician of patients with urgent clinical issues.

    g. Physicians are required to provide their current cell phone number to the medical staff office for the reporting of critical results and urgent information about patients.

h. Physicians are required to maintain an active e-mail account for all non-urgent communications such as policy changes & meeting announcements. Spam filters must be set to permit messages from the hospital.

I agree to abide by these Clinical Practice Expectations.

Printed Name	Signature	Date

Revised: 1.3.11 ; 3.1.16; 4.6.16; 5.4.16; 6.1.16
Approved by the Medical Executive Committee: June 6, 2016