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Department	Section	Department/Section Rules and Regulations
Medicine		I. Emergency Room Call Schedule A. Medicine ER Call for follow-up care will be limited to physicians who have Active staff privileges and shall consist of a rotation among those physicians participating in the call schedule. B. Trades - Once an individual has been assigned a call date, that person must take the call assigned. Equal trades between physicians on the call schedule are permitted with one-week notice to the Medical Staff Office. C. Response time---pages from the ER must be returned within 30 minutes. D. Members of the department may choose to participate in the Outpatient Referral Call Roster. Those members are required to provide an initial follow-up visit to all patients that are referred to them through the Emergency Room.
Medicine	**Cardiology**	I. Emergency Room Call Schedule Members of the Section will decide on the desirability of an ER On-Call Schedule and will determine criteria for inclusion in such a roster.
Medicine	**Hospitalist**	I. Emergency Room Call Schedule Members of the Section may elect to participate in the Specialty Call Roster published by the Department of Medicine/Family Medicine. Eligible Section members (Active and Provisional Staff) may participate on a voluntary basis. Members wishing to participate in this Specialty Call Roster should submit their requests in writing to the Chair of the Department of Medicine/Family Medicine care of the Medical Staff Office. The Roster is published quarterly, and requests for inclusion or exclusion in the Roster should be submitted to the Department Chair no later than November 30, February 28, May 31, and August 31 for each respective quarter. Members will take call for one-week blocks, beginning 7 AM Monday through 7 AM the following Monday. Members may exchange their on-call weeks by notifying the Medical Staff Office no later than one week prior to the start of the rotation in question. Members taking Specialty Call are expected to return phone calls from the ED, the Hospitalist Service, or other requesting physician within 30 minutes.
Medicine	Pulmonary/Critical Care	I. Emergency Room Call Schedule

		Members of the Section may elect to participate in the Specialty Call Roster published by the Department of Medicine for Pulmonary Medicine. Eligible Section members (Active and Provisional Staff) may participate on a voluntary basis. Members wishing to participate in this Specialty Call Roster should submit their requests in writing to the Chair of the Department of Medicine care of the Medical Staff Office. The Roster is published quarterly, and requests for inclusion or exclusion in the Roster should be submitted to the Department Chair no later than November 30, February 28, May 31, and August 31 for each respective quarter. Members will take call for one-week blocks, beginning 7 AM Monday through 7 AM the following Monday. Members may exchange their on-call weeks by notifying the Medical Staff Office no later than one week prior to the start of the rotation in question. Members taking Specialty Call are expected to return phone calls from the ED, the Hospitalist Service, or other requesting physician within 30 minutes.
Medicine	**Gastroenterology**	I. Current Clinical Competence Policy and guidelines are being actively developed by the Subsection to establish ongoing assessment of continued clinical competence. Criteria will be established by the Subsection by majority vote. These criteria will reflect fair and unbiased methods of analysis which are intended to maintain high quality of care in the GI Subsection. The monitoring process will be performed by the GI Subsection. The hospital is expected to continue to provide protection for proctoring physicians so long as the proctor does not directly participate in the patient care, has no physician/patient relationship with the patient being treated and does not receive a fee from the patient. II. Guidelines and Protocols The subsection shall, from time to time, establish guidelines and protocols relevant to the practice and policy of Gastroenterology at Shady Grove Medical Center. These shall be passed and approved by a 2/3 vote of active and associate staff present. Gastroenterologist shall continue to manage sedation of their patients during GI procedures in compliance with the following outline (see separate addendum).

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Medicine	**Hematology**	N/A
Medicine	**Nephrology**	N/A
Surgery		I. ONBOARDING OPERATING ROOM ORIENTATION Operating Room orientation is mandatory for all new members of the Department of Surgery. Surgical cases cannot be scheduled prior to completion of this Orientation. II. EMERGENCY ROOM CALL SCHEDULE The Emergency Room On-Call Schedule regulations will be determined by the individual section of the department.
Surgery	**Neurosurgery**	I. EMERGENCY DEPARTMENT COVERAGE A. If needed Emergency Department will be covered by all staff members who perform elective cases without exception. B. Partners in the same practice group may cover for the scheduled physician on the ED call.
Surgery	**Ophthalmology**	A.-One must attend 50% of the Ophthalmology Section Meetings per annum as well as 50% of the aggregate regular departmental meetings, committee meetings to which he/she is assigned and the Semiannual Staff meetings.
Surgery	**Orthopedics**	N/A
Surgery	**Otolaryngology**	I. Emergency Room Call Schedule The Emergency Department will be covered by members of the Otolaryngology Section on a voluntary basis: A. Call hours will start at 7:00 a.m. on the specific start date of the call and end at 7:00 a.m. on the day after the specific call end schedule date. B. Physicians requiring a change to their call assignment must contact another person on the schedule and trade weeks. The physician requiring the change must notify the Chair and Medical Staff Office of the change/trade. C. Physician response time to call must be within 30 minutes. D. The Section Chair will be responsible for and have the final decision making authority when making the ED call schedule which is scheduled submitted to the Medical Staff Office on a timely basis.

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		E. As per the Medical Staff Clinical Practice Expectations which is signed by each applicant/member during new appointment and reappointment, all medical staff members must participate in the on- call ER schedule as determined by their department and/or section rules and regulations.
Surgery	**Plastic**	I. EMERGENCY ROOM CALL SCHEDULE Emergency Department will be covered by active staff members unless excused by the chairman of the Plastic Section. Emergency Department coverage is voluntary. If additional plastic surgeons are needed to cover the on call schedule, the chairman of the Plastic Section, at his discretion, may appoint members of the provisional or courtesy staff.
Surgery	**Podiatry**	N/A
Surgery	**General**	N/A
Surgery	**Pediatric Dentistry**	N/A
Surgery	**Oral**	I. EMERGENCY ROOM CALL SCHEDULE-The members of the Oral and Maxillofacial don't participate on the ER calls
Surgery	**Bariatric**	I. EMERGENCY ROOM CALL SCHEDULE The bariatric surgeon will be willing to respond to his/her calls within 30 minutes on the telephone and be physically present in urgent matters within one hour. The Section Chair will be responsible for coordinating the on-call schedule. Emeritus status physicians over 60 years of age have the choice whether to take ER Call.
Surgery	**Thoracic**	N/A

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Surgery	**Urology**	I. To be promoted to active, one must attend 50% of the aggregate regular departmental meetings, committee meetings to which he/she is assigned and the Semiannual Staff meetings as defined in the Bylaws. II. Emergency Room on Call Schedule A. Emergency Department will be covered by active and associate staff members, unless excused by the Chair of the Urology Section. B. If additional urologists are needed to cover the on call schedule, the Chair of the Urology Section, at his discretion, may appoint members of the provisional or courtesy staff. C. The urologist will be willing to respond to his/her calls within 20 minutes on the telephone and by physically present in urgent matters within one hour. D. For proper referral of patients of the community by the Emergency Department to the urologists on call, it would be expected that the surgeon should have an office within 20 miles or 30 minutes driving time maximum for SGAH. Failure of a surgeon to respond properly to the call in the E.D. with repeated complaints may result in removal from the on call list.
Surgery	**Vascular**	N/A
Anesthesia		N/A
Anesthesia	**Pain Medicine**	N/A
Emergency Medicine **Emergency Medicine Cont.**		I. REFFERAL OF PATIENTS Except in critically ill or unstable patients every effort will be made to identify a patient's PCP and/or subspecialty physicians and these physicians will be consulted to determine most appropriate disposition of a patient. Unassigned Patients: patient have no PCP or subspecialist on staff are considered to be unassigned The following rules will be followed for these patients.

Emergency Medicine Cont.		II. Consultation in ED or for admission to hospital: A. Medical: refer to Hospitalist service. If a medical subspecialist is needed that is not listed separately on the call board, eg cardiology, GI, infectious disease, then the hospitalist's rotation schedule should be used B. Non medical: refer to physician on the on call board C. Pediatric patients (18yo and under):: pediatric hospitalist D. Chest Pain Center: unassigned patients admitted to the chest pain center will be referred to the contracted physician group. The On Call list is the official list kept by the MSO and posted in the ED. III. BOARDER PATIENTS Patients that have been admitted to the hospital and are waiting in the ED for an inpatient bed are the primary responsibility of the admitting physician. IV. ED Review Chair The ED Review Chair shall be responsible for overall review of quality issues and direction of ED Review Committee. V. Quality Improvement A. Peer reviews and monthly audits of the following areas are conducted every month: 1. Mortality/morbidity 2. Patients who leave against medical advice 3. Transfers 4. Random Chart Review 5. Thrombolytic Therapy (periodic) 6. Special Reviews (as necessary) 7. Return visits within 72 hours requiring admission VI. ORIENTATION A. Each new physician and physician extenders must receive and review our orientation packet and sign

		off as having done so. This orientation packet addresses the following areas: 1. Orientation to physical site plan of Emergency Department *and hospital* 2. Chart documentation 3. X-ray request forms and proper documentation 4. Referral patterns 5. On-call roster 6. EmSTAT 7. Dress code 8. Attitudes 9. Duties and responsibilities of mid level practitioners, nurses, techs and EMS personnel 10. Schedules—shifts 11. Informed Consent Forms 12. Voluntary and Involuntary Commitment 13. Thrombolytic Therapy 14. ED Review Committee VII. DISCIPLINARY ACTION/DISMISSAL Reasons for disciplinary action or dismissal are as follows: 1. Dereliction of duty 2. Signs of substance abuse while on duty
Family Medicine		A. Emergency Room Call Schedule The Department of Family Medicine does not have nor does it require an Emergency Room Call Schedule. However, members of the department may chose to participate in the Outpatient Referral Call Roster. Those members are required to provide an initial follow-up visit to all patients that are referred to them through the Emergency Room.
OB/GYN		N/A
OB/GYN	**Maternal Fetal Medicine**	I. Unassigned Patient Call Schedule The roster order will be determined by the Maternal Fetal Medicine Section Chairman or designee. Each shift will be 24 hours beginning at 7 a.m. and continuing until 6:59 a.m. the following morning. A physician will be

		responsible for a given patient in the E.D. from the time when the call is initiated from the E.D. There will be a first and second call.
Pathology		N/A
Pediatrics		I. Emergency Room Call Schedule The on-call service for the Emergency Department will be shared by members of the active and provisional staff who are general pediatricians practicing in the community. Subspecialists and in-house physicians shall not be part of the on-call schedule.
Pediatrics	**Neonatology**	I. Emergency Room Call Schedule Members of the Section will decide on the desirability of an ER On-Call Schedule and will determine criteria for inclusion in such a roster.
Pediatrics	**Cardiology**	I. Emergency Room Call Schedule Members of the Section will decide on the desirability of an ER On-Call Schedule and will determine criteria for inclusion in such a roster.
Radiology		N/A
Psychiatry		I. Eligibility for membership in the Department of Psychiatry will be as stated in the Medical Staff Bylaws. Psychiatrists shall be either board certified by the American Board of Psychiatry and Neurology in psychiatry or neuropsychiatry or they shall be eligible to take the exam for the American Board of Psychiatry and Neurology. The members should obtain their board certification within Five years of joining the staff. All new psychiatry applicants will have completed an accredited psychiatric residency to PGY-4; except for physicians who were granted board eligibility status by the ABPN (American Board of Psychology & Neurology) after PGY-3. (This usually applies to physicians trained from 1970 to 1976 when the ABPN only required PGY-3 training.) Allied Health Practitioners - shall be Psychologists with Ph.D. or PsyD in clinical psychology or Psychiatric Nurse Practitioner They must have an agreement between them and an active member of the Department of Psychiatry who will supervise their actions. This agreement must be on file with the Medical Staff Office. The above delineations are in consonance with the Bylaws. Article IV, Sections 1 through 6. They are to be superseded by any future amendments to The Bylaws. Attendance requirements are as specified in The Bylaws, Article XII, Section 5. Emergency Room Call Schedule

Psychiatry Cont.		II. Emergency psychiatric evaluations will be as per the contract with **Adventist Medical Group** and Shady Grove Medical Center. III. CRITERIA FOR ADMISSION A. Each practitioner must accept the criteria for admission to the hospital and to each program as approved by the medical staff and the Board of Trustees. These criteria are identified in the hospital's Utilization Review Plan and in each program narrative. Waiver of any of these criteria must be approved by the Medical Director. B. Physicians are responsible for giving such information prior to admission as may be necessary to establish that the patient meets all admission criteria and to promote the safety of the patient and that of other patients in the hospital. C. The hospital, through the Medical Director, Administrator of Operations or designated Administrator on Call, reserves the right to refuse admission or to recommend to the Medical Staff member that a patient be referred to another facility because his/her needs cannot be met and/or because treatment cannot be adequately provided by this facility. VI. ADMISSION A. Patients may be admitted to the hospital only by physicians with Medical Staff privileges to do so. All admissions to the hospital must meet the hospital's admission criteria as defined in the hospital's Utilization Review Plan. B. No patient shall be admitted to the hospital until a provisional diagnosis has been made by the admitting Medical Staff member. The diagnosis may be established by the source of the referral or by the clinician performing the pre-admission assessment. Primary diagnoses are to be consistent with the Diagnostic and Statistical Manual of Mental Disorders (DSM - current edition) and should refer to an Axis I Psychiatric Condition C. Each patient admitted to the hospital or to the adolescent Partial Hospitalization Program (PHP) shall have a psychiatric and physical examination current within 30 days of admission. Admitting physician will review

Psychiatry Cont.		H&P for any changes; amend if necessary, then sign/date/time. Laboratory work shall be ordered according to the patient and medication protocol needs. D. The psychiatric evaluation shall be performed by the admitting or by the attending psychiatrist. E. The physical examination may be performed either by the hospital's designated staff internist/pediatrician, nurse practitioner or by another physician only if the latter can assume continuous medical responsibility for the patient and is a member of the Medical Staff. F. The complete history and psychiatric evaluation shall, in all cases, be completed within 60 hours after admission of the patient. If the patient requires a psychiatric evaluation must be completed within 60 hours of admission. Complete medical history and physical examination in all cases will be completed and recorded in the medical record within 24 hours. The attending psychiatrist shall review the admission history and physical examination within 24 hours of its completion. G. Patients admitted must be seen by the admitting psychiatrist at the time of admission or within 24 hours of admission. VII. CARE AND TREATMENT OF PATIENTS A. The attending physician has the ultimate responsibility for providing each patient's diagnosis and treatment and for supervising the care of the patient in the hospital. The physician has the responsibility for prescribing medication. Nurse Practitioners (NP) employed by Shady Grove Medical Center and other clinically privileged Medical Staff appointees may write orders for medication and treatment within their scope of practice, as specified in section 12 of these rules and regulations. However, such action by the Nurse Practitioner or other clinically privileged Medical Staff appointee should not be construed as a transfer of clinical responsibility of any aspect of a patient's care. Similarly, after the initial admission history and physical exam has been completed, the attending physician remains directly and ultimately responsible for ongoing somatic (physical symptoms, lab results) assessment and treatment. B. Each attending physician agrees to adhere to the design of the hospital's treatment programs and agrees to practice in accordance with the program model. Each physician will adhere to all written hospital policies, procedures, protocols, and guidelines.

Psychiatry Cont.		C. All patients must be seen within 24 hours of admission by the attending psychiatrist. The admission history and physical, including the psychiatric evaluation and mental status examination, as well as the initial plan of treatment and anticipated length of stay, are to be completed within 24 hours of admission. D. The attending physician is responsible for all treatment activities related to patient treatment. The physician is legally responsible for the patient throughout the course of hospitalization and is responsible for all final decisions. E. Discharge criteria and discharge planning is to begin at time of admission. Updates and changes in discharge criteria and planning are recorded as appropriate. F. The attending physician or designee will see each of his/her patients no less than six (6) days per week if the patients are admitted to acute hospital services. Residential patients will be seen weekly. G. The attending physician is expected to be present at treatment planning meetings on all of his/her patients. The physician shall document relevant interventions, review, and approve by signature all treatment plans. H. Within 24 hours of the patient's admission, the attending physician is expected to have a verbal or face to face meeting with the adolescent patient's legal guardian(s) and, with consent, the adult patient's family members. I. Special provisions with respect to treatment/coverage of child psychiatry patients: 1. A member of the Medical Staff holding adult psychiatry privileges may provide night, weekend, and holiday coverage for child psychiatry patients for no more than 72 consecutive hours. However, in such cases a member of the medical staff who holds child psychiatry privileges must be available for telephonic consultation. 2. Only members of the medical staff with privileges in child psychiatry may act as attending physician for child psychiatry patients. However, when necessary, member of the medical staff holding adult psychiatry

Psychiatry Cont.		privileges may only provide follow-up care to such patients under supervision of a credentialed child psychiatrist. 3. Adult Psychiatrists may not admit Child and Adolescent psychiatry patients. VIII. MEDICAL RECORDS A. Confidentiality/Release of Information Information, written and/or verbal, is released under the direction of the Medical Records Department with written consent by the patient, or court order, or subpoena, or by statute. Release of mental health records and information contained therein are governed by the Maryland State Mental Health Code. The release of alcohol and drug records and information is governed by the Code of Federal Regulations Confidentiality of Alcohol and Drug Abuse Records, 42 CFR Part 2. 1. All medical records are the property of the hospital. Records may be removed from the hospital in accordance with a court order, a subpoena duces tecum (or subpoena for production of evidence), or pursuant to statutory authority. Written consent of the patient is required for the release of records to those not otherwise authorized to receive these records. 2. The release of a medical record that contains any reference to treatment for substance or alcohol abuse shall be in accordance with the stipulations of 42 CFR Part 2. 3. In the case of readmission of the patient, all previous records shall be available for the use of the attending physician or staff under his/her direction. 4. Access to medical record of patients shall be afforded to appointees to the Medical Staff in good standing for study and research under policies and procedures established by the hospital. 5. Patients may request to read their medical records. The specific guidelines for this procedure as defined by state law and hospital policy and procedure should be obtained from the Medical Records Department. IX. PHYSICIAN RESPONSIBILITY FOR MEDICAL RECORDS

Psychiatry Cont.		The attending psychiatrist is responsible for providing a complete medical record on each patient and shall be responsible for dating, timing, and documenting legibly and in chronological order admission information, orders for consultations, procedures, progress notes reflecting patient progress according to his/her signed treatment plan, responses to abnormal laboratory results, rationale and outcome of therapeutic passes and diagnosis at the time of discharge summary within 30 days of discharge. All attending psychiatrists are to follow the guidelines for medical records documentation distributed by the hospital's Medical Records Department. X. PHYSICIAN ORDERS A. Standing and range orders shall not be utilized. PRN Orders that indicate the route can be either PO or IM must specifically state the criteria/rationale under which either route should be used. B. The admitting psychiatrist will issue all initial orders; all succeeding orders, which must be in accordance with established general medical standards and in compliance with hospital regulations, will be issued by the attending psychiatrist. In certain circumstances, nurse practitioners or on-call psychiatrists may write orders for an attending psychiatrist's patient; in such case, the orders shall be reviewed and initialed by the attending psychiatrist. The attending psychiatrist may write an order authorizing the hospital internist/pediatrician or certified nurse practitioner in consultation with the attending, to write medical orders as necessary according to the recommendations of their History and Physical Examination and/or consultation. C. All orders shall be in writing. If the physician is absent from the hospital, an order shall be considered to be in writing if dictated over the phone by the individual to a licensed Registered Nurse or Pharmacist for clarification of medication order. The physician issuing the order should require that the Registered Nurse 'Read Back and Verify' that the correct order is noted. Orders dictated over the phone shall be signed by the person whom dictated, dated and timed within 48 hours, with the exception of seclusion and restraint orders which shall be signed within 24 hours. D. In some instances, the ordering physician may not be able to authenticate the verbal order. In such cases, it is acceptable for a covering physician to co-sign the verbal order of the ordering physician. The signature

Psychiatry Cont.		indicates that the covering physician assumes responsibility for his/her colleague's order as being complete, accurate and final. E. A physician's order shall be written clearly and legibly and shall be complete. Orders that are illegibly or improperly written will not be carried out until rewritten by the duly authorized person. The use of "renew", "resume", and "continue" will not be acceptable. It is necessary to fully discontinue a previous medication order and write an updated one. F. Orders are required for seclusion, restraint, medications, and restrictions of patient rights and shall be time limited pursuant to code and regulation. G. Orders are required to restrict patient rights to unimpeded, private, and uncensored communication by mail, telephone and visitation. These orders must document that the restriction is for therapeutic purposes, to protect the recipient or others from harm, harassment or intimidation. XI. SYMBOLS AND ABBREVIATIONS Only symbols and abbreviations approved by the hospital and Medical Staff can be used in the medical record. Information is available in the Medical Records Department and on the units. Symbols and abbreviations may not be used in recording diagnosis. XII. ADMISSION DOCUMENTATION A. An admission psychiatric history should include the following elements: 1. Chief Complaint 2. History of Present Illness a. Precipitating event b. Circumstances leading to admission c. Recent symptoms as well as pertinent negatives 3. Justification for inpatient level of care 4. Past Psychiatric History a. Hospitalizations and other episodes of treatment

Psychiatry Cont.		b. Longitudinal course of symptoms 5. Past Medical History 6. Current Medications 7. History of medications taken and clinical response 8. Mental Status Exam 9. Strengths/Weaknesses 10. Formulation 11. Summary of positive findings 12. DSM (current version) Diagnoses 13. Initial Treatment Plan 14. Estimated Length of Stay 15. Criteria for Discharge B. The history and physical examination should include history of somatic illness, review of systems, and physical exam of organ systems according to established standards. The admission psychiatric evaluation should be attempted within 24 hours of admission and in the record within 60 hours of admission. Both The evaluation and history and physical examination should be completed and in the record within 24 hours after the patient's admission. C. It is recognized that given the patient population, often history is difficult to obtain. In this case, any attempt to obtain history and the reason for the failure to do so should be noted. D. The Medical Executive Committee will periodically review data on Admission for Documentation quality and adherence to required elements. XIII. PROGRESS NOTES A. Pertinent progress notes related to diagnosis and to treatment plan goals and objectives, sufficient to permit continuity of care shall be recorded at the time of observation. Wherever possible, each of the patient's clinical problems/goals should be clearly identified in the progress note and correlated with specific orders, as well as results of tests and treatments. B. Physicians shall document:

Psychiatry Cont.		1. Abnormal laboratory values and their response to such; 2. Therapeutic pass goals and patient's response to passes. C. Consultants must make dated and timed recorded entries whenever they see a patient. XIV. THERAPEUTIC PASSES A. Therapeutic passes are defined as times away from the hospital in order to provide an opportunity to work toward therapeutic objectives critically necessary to patient recovery and leading to discharge. They may be used during hospitalization to permit orderly transition from the hospital to a less restrictive level of care. Passes may also be subject to approval from 3rd party payers. B. Therapeutic passes shall be integrated into the patient's written treatment plan. C. The psychiatrist shall write an order specifying the date and length of the pass, therapeutic goals and the identity of any person to accompany the patient. The order will indicate any medication to be taken by the patient during the pass by a specific order. D. The order shall include whether search procedures and/or toxicology screens are clinically indicated upon a patient's return from pass. The psychiatrist shall document the therapeutic outcome of each pass in the medical record. XV. DISCHARGE DOCUMENTATION A. Patients shall be discharged only on written order of the attending psychiatrist. AMA discharges must be written by the attending psychiatrist or covering psychiatrist if the AMA occurs on the weekend or when the attending psychiatrist is on extended leave. The attending psychiatrist shall complete the discharge summary according to the approved guidelines, state final DSM5 diagnosis and sign and date the record.

Psychiatry Cont.		B. All discharge summaries and signatures not specified in 5.4.3 of this section will be completed within 30 days following the patient's discharge. Incomplete records as defined above will be considered delinquent. The following disciplinary measures may be instituted against the psychiatrist who fails to complete medical records within the specified time frame: 1. Fines as outlined in the medical staff delinquent records policy as approved by the MEC. XVI. MEDICATION USAGE A. The prescribing of medication is limited to physicians, dentists, and podiatrists with appropriate qualifications, licenses and clinical privileges and to nurse practitioners credentialed by Shady Grove Medical Center. B. Licensed Nurses/Pharmacist are the only individuals allowed to accept telephone medication orders from a physician or nurse practitioner. C. In conservative medical practice, medications are be used only for standard indications as published in the United States Pharmacopeia, DI, of the Physician's Desk Reference, current edition. However, it is recognized that in psychiatry medications are often used for other than the approved indication. Use of medications in this manner must be consistent with established psychiatric practice. In doubtful situations, it is recommended that the use of medications in this manner be supported by such measures as (1) consultation of another member of the medical staff or (2) appending to the clinical record peer reviewed articles or letters (or established secondary sources referencing such) describing the successful , outcomes associated with this intervention. D. Medications prescribed will specify dosage, frequency, route of administration, and rationale. Medication prescribed for PRN administration will indicate a maximum dosage over a stated period of time and will identify the symptoms for which the medication should be administered. You must have an indication for PRN use. E. Stop Orders: For the following classes of medications, the physician will order medications for a specified number of days or for a specified number of dosages: Narcotics, Antibiotics, Hypnotics, Steroids, and Anticoagulants. If this is not done, reorders will be necessary as follows: Narcotics = 3 days, Anticoagulants

Psychiatry Cont.		(Heparin and Coumadin) = 5 days, Antibiotics = 10 days, Sleep medications (Dalmane, Restoril, Chloral Hydrate) = 7 days, Steroids = 10 days. F. The maximum duration of any medication order is 30 days. The medication orders will not be continued without being reviewed and rewritten at least every 30. G. The attending physician must be notified before any medication is discontinued. H. When drugs are prescribed that are known to involve a substantial risk or to be associated with undesirable side effects, the appropriate protocols or guidelines must be observed. These include guidelines for the use of Schedule II drugs for maintenance use, Lithium Carbonate, Antabuse, MAO Inhibitors, Neuroleptics, Droperidol, and Schedule II and Schedule IV drugs used in polypharmacy. This list of drugs is for illustrated purposed only, and is not intended to be all inclusive. I. Physicians shall discuss fully with patients and appropriate relatives the indications and side effects of prescribed medications with documentation as established by hospital policy and procedure. J. When prescribing Schedule II drugs for maintenance use, the physician should inform the patient (and guardian if appropriate) of the risks and benefits of the medication. The patient/guardian must be provided with sufficient information to make an informed decision regarding the proposed medication. A progress note detailing the benefits, risks and any alternate treatment(s) will be entered into the medical record by the physician. XVII. SECLUSION AND/OR RESTRAINT A. **Definitions:** 1. Restraint is used to limit or restrict the movement of the whole, or a portion of, patient's body for the purpose of preventing intentional harm to self or others. Mechanical restraints shall not be utilized. 2. Seclusion is the involuntary confinement of a patient alone in a room in which a patient is physically prevented from leaving. This activity may only be initiated by the order of a physician

Psychiatry Cont.		as specified in the seclusion and restraint policy subject to the exception specified in paragraph 7.4 below. XVIII. TREATMENT UNDER THE LEAST RESTRICTIVE CONDITIONS A. Each patient shall be treated under the least restrictive conditions consistent with his/her condition and shall not be subjected to unnecessary restraint and seclusion. In no event shall seclusion and/or restraint be utilized to punish or discipline a patient or for the convenience of the staff. B. Seclusion and/or restraint may be ordered as a therapeutic measure to prevent a patient from causing physical harm to him/herself. C. Documentation in the progress notes for seclusion/restraint shall be in accordance with approved hospital policy and procedures. XIX. ORDERS FOR SECLUSION AND/OR RESTRAINT WILL: A. be time limited and include the date and time of order; B. include the emergency safety intervention ordered, including the length of time for which the physician ordered it; C. not exceed the approved time limits per age-specific populations; D. be STAT orders only; E. specify the reason for utilization; F. be signed by the physician within 24 hours of initiation; G. indicate whether restraint or seclusion is being used;

Psychiatry Cont.		H. identify special precautions, if any, to safeguard the patient; and, I. indicate criteria for release of restraint or discontinuation of seclusion. J. Each patient placed in seclusion or restraint shall have his/her physical condition and psychiatric condition monitored by qualified personnel as per hospital policy. K. The attending physician performs a face to face assessment of the patient within one hour of the seclusion or restraint order and documents, signs, times and dates said assessment in the medical record. Alternatively, in the absence of the attending physician, a qualified nurse shall perform a face to face assessment of the patient within one hour of seclusion or restraint order and shall document, sign, date and time findings of his/her face to face assessment. L. The physician will review and sign seclusion/restraint progress note written by nursing within 24 hours. M. In case of an emergency, a Registered Nurse, specifically trained, upon the assessment of the need for seclusion and restraint may initiate seclusion and/or restraint. Physician's order must be obtained within one hour and the order must be countersigned by the physician within 24 hours. A face to face assessment of the patient must still be made by a physician within one hour of the initiation of the emergency seclusion or restraint. N. The Medical Director or his/her designee will review cases of multiple seclusion and restraint cases daily. On the weekends or in the absence of the Medical Director, an on-call member of the medical staff will review cases of multiple seclusion and restraint. Unusual or unwarranted patterns or utilization will be investigated by the Risk Manager and reported to the Safety, Performance Improvement and Medical Executive Committees. O. Repetitious use of restraint and/or seclusion, as defined by hospital policy and procedure, must be justified by the physician in the progress notes and must be integrated into the patient's treatment plan.

Psychiatry Cont.		XX. RESTRICTIONS A patient placed on a behavior modification program as part of his/her treatment plan may be restricted but not physically confined to a given area or room for a reasonable period of time and such restriction shall not constitute seclusion. The approved hospital guidelines must be followed in the use of this procedure and/or any other restrictions. XXI. MEDICAL ALTERNATE A. When the attending physician is not at the hospital, he/she will notify the hospital of an alternate member of the medical staff who has agreed to provide care of his patients during his absence. The information should be transmitted to the Medical Director through the Medical Staff executive assistant who will disseminate notice by email. B. In an emergency when the attending physician or his /her designee is unavailable, the Medical Director must be contacted and shall have the authority to make provisions for caring for the patients. XXII. PATIENT HAND-OFF A. Hand-off between physicians refers to an event in which clinical responsibility for a patient is transferred from one physician to another. This includes coverage for weekends, vacations, illness or absence from the hospital. Any time nursing staff is instructed, by order, memo, or call schedule, to consider a different doctor responsible for a patient's care, a hand-off has occurred. B. When a patient-hand off, as defined above, has occurred. The transferring physician will communicate to the receiving physician clinical information relevant to the immediate management of the patient. Such communication can take place verbal-- in person or by telephone-- or as a written sign-out report. If a written sign-out report is used, the transferring physician will be available until an agreed upon time by phone to allow for questions or a discussion to take place

Psychiatry Cont.		C. The hand-off communication may consist of the following elements: 1. Patient's name 2. Psychiatric and medical diagnoses 3. Current clinical status, including active psychiatric and medical problems 4. Medications 5. Pending lab tests or values of immediate clinical relevance 6. Assessment of state and current needs 7. Recommendation for management during the coverage time. D. In the case of an on-call physician transferring newly admitted patients according to the redistribution procedure, the required hand-off communication would be expected to be brief and to include such information as the patient's name, diagnoses, medical concerns, and any medications that have been ordered. XXII. ON-CALL A. The Administrator of Operations and the Medical Director shall be administratively responsible for maintaining the hospital's on-call roster. B. Each attending physician is responsible for arranging adequate medical /psychiatric coverage in his/her absence. C. Physicians routinely attending acute hospital patients are expected to participate in the Doctor of the Day rotation for admissions. Guidelines for this rotation system are to be addressed by the Department of Psychiatry. D. Physicians are expected to be fully compliant with COBRA regulations; patients who meet commitment criteria, as defined by COMAR regulations, are expected to be admitted and attended by physicians regardless of the patient's financial resources. XXIII. CONSULTATIONS

Psychiatry Cont.		A. Consultations must be requested by the attending psychiatrist or nurse practitioner. B. Progress notes must indicate the reason for the consultation and requests are by written order, specifying reasons for consultation request. C. Emergency consultation requests must be requested by the attending psychiatrist directly to the consulting clinician. A verbal order may be dictated in the case of an emergency. D. Initiation of a request for consultation by the patient or, if the patient is incompetent, by next of kin, must be accompanied by an order. The Medical Director may initiate a requested consultation in the absence of the attending psychiatrist or designee. F. Psychiatric consultations are required in cases in which: 1. The patient's diagnosis is obscure; 1. There is a doubt as to the best therapeutic measures to be utilized; 2. There are unusual treatment risks for the patient; 3. The case has been determined by Utilization Review to require consultation. Requests for consultation may be made by the attending psychiatrist, or the Medical Director. XXIV. UTILIZATION REVIEW The attending physician is required to document the need for admission and for continued hospitalization. Utilization reviews are scheduled on a systematic basis according to the Utilization Review Plan of the Hospital as approved by the Medical Staff and the Board of Trustees. Willful or continued failure to furnish such required documentation is

Psychiatry Cont.		cause for a request to the Medical Executive Committee for corrective action and can be initiated by the Utilization Review Department. XXV. PATIENT REQUEST TO CHANGE PHYSICIAN A patient may request to change attending physician. In the event of controversy, the Medical Director should be contacted to investigate and, if appropriate, to facilitate the change. XXVI. HOSPITAL DISASTER AND EXPOSURE CONTROL PLAN A. All members of the medical staff of the hospital agree to follow the outlined hospital's Infection Control policies and procedures as approved by the medical staff. B. Medical Staff Participation during Disaster Plan Implementation Physicians are expected to understand their role in the hospital's disaster plan and will perform their duties as assigned. The Chief of Psychiatry and the AVP of Operations will work as a team to coordinate activities and directions. In cases of evacuation of patients from the hospital to another, or evacuation from the hospital premises, the Medical Director will authorize the movement of patients. All policies concerning patient care will be a joint responsibility of the Medical Director and the President/Chief Operating Officer. XXVII. MEDICAL SERVICES PAYMENT Each attending physician shall communicate to his/her patient (and family where appropriate) the financial terms of the treatment relationship including the applicable compensatory services provided by all professionals under the attending physician's supervision. XXVIII. PATIENT DEATH AND AUTOPSY

		In the event of a patient's death, The attending physician or his designee shall notify the family. Completion of death pronunciations and certificates shall be governed by the applicable state regulations and reporting requirements. It shall be the duty of the attending physician to secure an autopsy, whenever appropriate. A provisional anatomic diagnosis shall be requested from the coroner and recorded in the medical record within 72 hours. All autopsies shall be performed by a licensed Pathologist or his designee, and with written consent signed in accordance with State law. In all cases, the guidelines established in the hospital's autopsy policy and procedures shall be followed. Please refer to Death of a Patient Policy and Autopsy Policy.

Approved- 8/25/2021