



River Park Hospital

Medical Staff Rules and Regulations

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RIVER PARK HOSPITAL RULES AND REGULATIONS OF MEDICAL STAFF

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RULES AND REGULATIONS

INTRODUCTION

These Rules and Regulations are incorporated by reference into the Medical Staff Bylaws. They are intended to clarify standards of professional practice and the conditions of appointment to the Medical Staff.

Changes in these Rules and Regulations may be initiated by any committee of the Medical Staff or by the Medical Executive Committee (“MEC”) and any committee delegated with the responsibility of reviewing and recommending revisions. Before they may become effective, any suggested revisions must be adopted by the Medical Staff and approved by the Hospital’s Governing Board (“Board”) in accordance with the Medical Staff Bylaws and the Board Bylaws.

No rules or regulations or professional staff policies which conflict with the Medical Staff Bylaws, Board Bylaws, or any known law or regulation may be approved.

1. CRITERIA FOR ADMISSION

- 1.1 Each attending member of the Medical Staff (“Member”) must abide by the criteria for admitting patients to the Facility and to each program as approved by the Medical Staff and the Board. These criteria are identified in the Facility’s Utilization Review Plan and in each program narrative. Waiver of any of these criteria must be approved by the Medical Director.
- 1.2 Attending Members 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 Facility.
- 1.3 The Facility, through the Medical Director or the Facility CEO, reserves the right to refuse admission or to recommend to the attending 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. In no case will refusal be for reasons of race, color, creed, national origin, or payor source.

2. ADMISSION

- 2.1 Patients may be admitted to the Facility only by Members with Clinical Privileges to do so. All admissions to the Facility must meet the Facility’s admission criteria as defined for each program.
- 2.2 If a patient does not meet these criteria but circumstances exist such that the admission is deemed appropriate, the admitting Member may request that a final decision as to the appropriateness for the admission be made by the Facility’s Chief Executive Officer (“CEO”) or designee and/or the Medical Director.
- 2.3 Patients whose illness cannot be treated within the capability of the Facility shall not be admitted to the Facility. If such a patient presents with an “emergency medical condition” as defined in the Facility’s EMTALA policy, such patient will be stabilized to the extent

possible and, transferred to a facility equipped to treat their condition, in accordance with the Facility's policies with respect to EMTALA.

- 2.4 Except in an emergency, defined herein, no patient shall be admitted to the Facility until a provisional diagnosis has been made and documented by the admitting Member. In the case of an emergency, as defined herein, the provisional diagnosis shall be stated as soon after admission as possible, not to exceed 24 hours. Provisional diagnoses should include both psychiatric diagnosis(es) and intercurrent diseases, if any. Diagnoses are to be consistent with the Diagnostic and Statistical Manual of Mental Disorders (current edition).

"Emergency" in this context means a condition in which serious or permanent harm could result to an individual or an unborn child or in which the life of an individual or unborn child is in imminent danger.

- 2.5 Each patient admitted to the Facility shall undergo an admitting evaluation, a mental status examination and a complete physical examination according to approved medical records guidelines. Labs provided as ordered.

2.6 **[Reserved]**

- 2.7 Within 24 hours of admission, the complete physical examination shall be performed according to medical record guidelines and approved clinical privilege guidelines either by a designated staff P.A., nurse practitioner, internist, family physician/practitioner, psychiatrist with clinical privilege, or by another physician/practitioner only if that physician/practitioner can assume continuous medical responsibility for the patient.

2.7.1 The following should be included in the History and Physical ("H&P"):

- a. Chief complaint
- b. History of present illness
- c. Past medical history
- d. Current medications
- e. Allergies
- f. Review of systems
- g. Cranial nerves for adults only
- h. Exam of body cavities, as appropriate
- i. Identification of potential problems needing further assessment
- j. Impression of Medical Status
- k. Plan of Care Recommendation

2.7.2 For children and adolescents an H&P should include, in addition to the requirements of Section 2.7.1:

- a. Evaluation of sexual development (i.e. secondary sexual characteristics, onset of menarche)
- b. Motor development and functioning
- c. Sensorimotor functioning
- d. Speech, hearing, and language functioning
- e. Visual functioning
- f. Immunization status
- g. Oral health and oral hygiene

- 2.7.3 For patients with Chemical Dependency or Addictive Behavior an H&P should include, in addition to the requirements of Section 2.7.1:
- a. History and physical/medical problems associated with dependencies or addictive behavior; and
- 2.8 The Psychiatric Evaluation and Mental Status Examination shall, in all cases, be completed and dictated within 24 hours after admission of the patient and the admission note will be entered in the progress notes at the time of evaluation. The admission note will include a **DSM- IV-TR** five axis diagnosis and initial plan of treatment. The complete medical history and physical examination in all cases will be completed and recorded in the chart within 24 hours after admission of the patient, unless one has been performed within 30 days prior to admission, in which case a durable, legible copy of the report may be used in the patient's medical record provided that the physician/practitioner reviews such copy, indicates any changes on the report copy in the chart, and signs and dates his review. If the H&P is dictated, a progress note shall be entered at the time of examination documenting any relevant medical conditions and recommendations. When the patient is readmitted within 30 days for the same or related problem, an "interval" physical exam reflecting any changes may be used, provided that the original physical exam is readily available.
- 2.8.1 The Psychiatric Evaluation should include:
- a. Chief complaint
 - b. Mental status evaluation, including description of attitudes and behavior and estimate of intellectual functioning, memory functioning, and orientation
 - c. History of present illness
 - d. Current and prior psychiatric disorders
 - e. Medical history
 - f. Social history
 - g. Family history
 - h. Developmental history
 - i. Education/vocational history
 - j. Admission diagnoses and axis
 - k. Determination of the degree of danger patient presents to self or others
 - l. Plan and recommendation for treatment or future assessments
 - m. Patient strengths and liabilities
 - n. Expected length of stay
 - o. Discharge Criteria/Preliminary discharge plan
 - p. Current medications.
- 2.8.2 For chemical dependency or addictive behavior patients, a Psychiatric Evaluation should include, in addition to the requirements of Section 2.8.1:
- a. History of use of alcohol and other drugs or Addictive Behavior
 - b. Age of onset
 - c. Duration of use
 - d. Pattern of use
 - e. Last time used
 - f. Consequences of use
 - g. Use of alcohol and/or other drugs by family members or Addictive Behavior by family members

- h. Types of previous treatment
 - i. Responses to previous treatment.
- 2.9 Persons who present to the Facility with an “emergency medical condition,” as set forth in the Facility’s EMTALA policy, shall be seen immediately by a Qualified Medical Person (“QMP”), as defined in the Facility’s Medical Staff Bylaws. If the QMP giving the medical screening exam is not a physician/practitioner, the QMP shall contact the physician/practitioner on call, to request that the physician/practitioner come to the hospital to see the person if necessary, or authorize immediate admission of the person to the Facility, or initiate a transfer of the patient to another facility if the facility does not have capability to treat the person.
- 2.10 Any variation from these admission rules must be approved in advance by the Medical Director or his designee.
- 2.11 Residential Treatment Program for Children and Adolescents (“RTPCA”).
 - 2.11.1 Before a patient may be admitted to the RTPCA, the admitting physician/practitioner must provide admitting orders.
 - 2.11.2 A dictated psychiatric admission evaluation by the attending physician/practitioner must be completed within 24 hours of admission of the patient to the RTPCA program.
 - 2.11.3 A complete physical examination must be completed and dictated within 60 hours of admission to the RTPCA program. If the patient is transferred to the RTPCA program from inpatient treatment, a copy of the patient's inpatient physical examination may be used, if it was performed within the last 30 days. If the patient has not undergone a physical examination within the last 30 days, a new physical examination must be performed when the patient is transferred from patient status to the RTPCA program.
 - 2.11.4 While a patient is in the RTPCA treatment, a physical examination will be performed once every 12 months unless there is an identified need to complete one at an earlier time.
 - 2.11.5 The attending physician/practitioner will document at least one progress note per week in the patient's chart during the patient's stay in the RTPCA program.
 - 2.11.6 In the event the treatment team has weekly meetings, the attending physician/practitioner will attend weekly meetings with the treatment team during the patient's stay in the RTPCA program. Otherwise, the attending physician/practitioner will attend monthly meetings with the treatment team during the patients stay in the RTPCA program.
 - 2.11.7 The attending physician/practitioner will complete a dictated discharge summary within 15 days of the patient's discharge from the RTPCA program.

3. CARE AND TREATMENT OF PATIENTS

- 3.1 The attending physician/practitioner has the ultimate responsibility for providing each patient's diagnosis and for supervising the care of the patient in the Facility.
- 3.2 Each attending Member agrees to adhere to the design of the Facility's treatment programs and agrees to practice in accordance with the program model. Each Member will adhere to all Facility Policies and Procedures, protocols, and guidelines.
- 3.3 Discharge criteria should be specified as soon as possible after admission, and discharge planning should begin at that time. Updates and changes in discharge criteria and discharge planning should be recorded as appropriate.
- 3.4 The attending physician/practitioner shall be present at treatment team meetings on all of his patients and shall participate in, review, and approve all treatment plans formulated by the treatment team.
- 3.5 The attending physician/practitioner is responsible for the patient's treatment through the course of hospitalization and is responsible for all treatment decisions.
- 3.6 The admitting Member shall be held responsible for giving such information as may be necessary to prevent harm to the patient and others. Admission orders will be given for the appropriate level of observation. Only a physician/practitioner or the attending Member may lower the level of observation.
- 3.7 When patients elope from the Facility, the appropriate Member(s) and the Program Director will be immediately contacted. The Facility and/or the Member(s) will contact the patient's family in regard to the elopement.
- 3.8 If the patient is either a danger to himself or to others, the CEO, Medical Director, or a Member shall notify the authorities and any person believed by the treatment team to be a potential victim. If time allows, legal consultation should be sought to determine the scope of disclosure.
- 3.9 A physician/practitioner shall visit each acute or residential care patient within 24 hours following admission, and an admission note shall be documented. A qualified practitioner shall complete and document a medical history/physical examination within 24 hours following admission for acute patients and within 60 hours following admission for residential care patients. The initial treatment plan for the patient shall be completed within 24 hours following admission. The master treatment plan shall be completed within 3 days of admission for acute care patients and 7 days for residential care patients. Treatment plans shall be based on an inventory of the patient/resident's strengths and liabilities and shall include the following elements: (a) a substantiated diagnosis; (b) short and long range goals; (c) specific treatment modalities used; (d) responsibilities of each member of the treatment team; (e) adequate documentation to justify the diagnosis, treatment, and rehabilitation activities carried out for the patient. Further, the treatment plan shall be modified, as necessary, to address restraint and seclusion of the patient.
- 3.10 The attending physician/practitioner or his designee shall visit each of his patients not less than 6 (six) times per week for acute care patients, 2 (two) times a week for sub-acute

inpatients, and 1 (one) time per week for residential care patients, or more frequently as necessitated by either the patient's condition or binding contractual or licensure requirements. In minimal coverage, it is imperative that acute inpatients not go 2 (two) consecutive days without being seen and evaluated by a physician/practitioner or designated licensed independent contractor. The attending physician/practitioner or his designee shall complete progress notes for each visit.

The forensics program is a specialized program designed to meet the needs of this population, while establishing standards of care that are consistent with the State Hospital(s) from which the patients shall be transferred. All forensic patients will have been admitted to the State Hospital for a minimum of 90 days and will have demonstrated a measure of psychiatric stability. Forensic patients will be considered to be sub-acute admissions and will be seen a minimum of twice weekly by the attending/covering physician/practitioner. **A physical examination will be performed on forensic patients once every 12 months unless there is an identified need to complete one at an earlier time.**

Irrespective of the frequency of physician/practitioner visits per week for either acute, **sub-acute** or residential inpatients, the attending/covering physician/practitioner must, in accordance with accepted clinical and legal standards of care, attend to the emergent clinical needs of all for whose care he/she is clinically responsible for. This would include appropriate face to face assessment of the patient, consultation, liaison, decisions about transfer patients to other facilities, as well as record keeping. The attending physician/practitioner or his designee shall complete progress notes of each visit. Allied Health Professionals shall complete a progress note of each visit with the patient.

- 3.11 The attending physician/practitioner is responsible for requesting consultation when indicated. A consultant must be qualified to give an opinion in the field in which his opinion is sought. If, in the opinion of the Medical Director, a patient requires consultation, such consultation shall be obtained with or without approval from the attending Physician/practitioner.
- 3.12 No patient should be discharged or sign out against medical advice without first being evaluated by a physician/practitioner or the attending Member.

4. ADMINISTRATIVE DISCHARGE

- 4.1 Administrative discharges may occur when, in the best interest of the patient/resident, it is determined that treatment is no longer appropriate. A recommendation or request for administrative discharge may originate from any Member associated with the care and treatment of the patient, other Members, or family members. Upon receipt of a recommendation or request for administrative discharge, the CEO/or designee shall notify Members involved in the care of the individual.
- 4.2 After an investigation, the CEO/or designee, the Medical Director, and other Members involved in the individual's treatment shall recommend or overrule the recommendation or request for discharge. In the event administrative discharge is recommended contrary to the wishes of the attending physician/practitioner or the treating therapist, the Medical Director shall write the order for discharge, allowing 24 hours for disposition. In no case shall a patient be administratively discharged without appropriate discharge plans being prearranged. All administrative discharges shall be reviewed by the MEC and reported to the Board.

5. MEDICAL RECORDS

5.1 Confidentiality and Release of Information

Information, written and/or verbal, may be released only in accordance with HIPAA Guidelines, applicable State law, and the Facility's Policies and Procedures.

5.2 Medical Record Access

- 5.2.1 All medical records are the property of the Facility. Records may be removed from the Facility only in accordance with the Facility's written privacy policies.
- 5.2.2 The release of a medical record that contains any reference to treatment for substance or alcohol abuse shall be only in accordance with the Facility's written privacy policies.
- 5.2.3 In the case of readmission of the patient, all previous records shall be available for the use of the attending Member and staff under his direction.
- 5.2.4 If allowed by the Facility's written privacy policies, and if approved by the Medical Director, former Members of the Medical Staff may be permitted access to information included in the medical records of their patients for those periods of time during which they attended such patients in this Facility.
- 5.2.5 Patients may request to read their medical records. The specific guidelines for this procedure, as defined by state law and Facility policy and procedure, must be obtained from the Medical Records Department or the Facility's privacy officer.

5.3 Member Responsibility for Medical Record

- 5.3.1 Attending Members are responsible for ensuring that the medical record contains all such information as may be necessary to prevent harm to patients in the Facility or to others.
- 5.3.2 Members are responsible for ensuring that the following are dated and timed, documented legibly, and in chronological order in each patient's medical record: admission information, orders for consultations, medications, procedures, progress notes reflecting patient progress according to the signed treatment plan, responses to abnormal laboratory results, rationale and outcome of therapeutic passes, and diagnoses at the time of discharge. Members must complete the discharge summary within 30 days of discharge. Members are to follow the guidelines for medical record documentation distributed by the Facility's Medical Records Department.
- 5.3.3 If a patient is discharged within 24 hours of admission, the attending Member may, in lieu of preparing a separate psychiatric evaluation and separate discharge summary, prepare a psychiatric evaluation and discharge summary in combined form. In such a case the combined form must contain the reason for admission, mental status, course in Facility, summary of treatment and prognosis.

- 5.3.4 Members shall be held responsible for all required documentation in the medical record unless an official transfer of the patient to the care of another Member has taken place and has been documented in the medical record.
- 5.3.5 The final diagnosis shall be provided by the attending Member on or before the time of the patient discharge. The final diagnosis shall be recorded in DSM IV five axis format without the use of symbols or abbreviations. Discharge diagnoses are to be written in the medical records prior to discharge, and no patient will be discharged without a DSM IV five axis diagnosis.
- 5.3.6 All entries must be dated and signed by the person making the entry and must include his/her discipline at the time the services are rendered.

5.4 Member Orders

- 5.4.1 All orders for medication and/or treatment for patients admitted to the Facility shall be in writing. Orders must be written clearly and legibly and must be complete, including the date, time and justification for the order. A verbal order or telephone order shall be considered to be written if accepted by a nurse or licensed pharmacist and signed, dated, and timed. All orders, including verbal orders, must be dated, timed, and authenticated promptly (within twenty-four (24) hours for acute and seven days for residential) by the ordering practitioner or by another practitioner who is responsible for the care of the patient. Non-professional nursing personnel or clerical staff are not authorized to take medication or treatment orders. The nurse or pharmacist accepting the verbal or telephone order shall write the order then read back the order to the Member for clarification purposes. Orders dictated over the telephone shall also be signed, dated, and timed by the person who took the order and shall include the name of the Member giving the order. A verbal order for medication, not otherwise considered written as provided in this paragraph, may only be given in the case of an emergency, as defined in Section 2.4. Verbal orders should be discouraged except in emergency cases.
- 5.4.2 Routine admitting orders and detoxification orders may be formulated and utilized by individual Members only after approval by the Medical Executive Committee. Such orders must be consistent with policies and procedures established by the Facility and will be applicable to the individual patient and program of treatment to which the patient is admitted as determined by the attending physician/practitioner or his Member designee.
- 5.4.3 Only Physician/practitioners/Licensed Independent Practitioners with appropriate privileges may write orders for:
- a. Laboratory examinations;
 - b. Medical consultation other than initial history and physical;
 - c. Medication; and
 - d. Medical treatments (e.g. physical therapy).

Dieticians may write therapeutic diet orders which have been approved by the MEC.

- 5.4.4 All orders shall be dated and timed. In addition, all Facility personnel shall record the date and time when the order has been transcribed.

- 5.4.5 A physician/practitioner's signed, dated and timed order shall be written clearly and legibly and shall be complete. Orders which are illegibly or improperly written will not be carried out until rewritten and understood by the duly authorized person. The use of "renew," "resume," or "continue" without identification of medication, dosage, frequency, and route of administration will not be accepted.
- 5.4.6 Physician/practitioner orders are required for admission, discharge, medications, treatments, therapeutic passes, and restrictions of patient rights.
- 5.4.7 Physician/practitioner orders are required to restrict patient rights to unimpeded, private, and uncensored communication by mail, telephone and visitation, other than programmatic restrictions explained to patients and/or their legal guardian prior to admission. These orders must document that the restriction is for therapeutic purposes or to protect the patient or others from harm, harassment or intimidation. Physician/practitioner's order must be given to reinstate these limitations.

5.5 Symbols and Abbreviations

Only symbols and abbreviations approved by the Facility may be used in the patient's record. Lists are available in the Medical Records Department and on patient units. Symbols and abbreviations may not be used in recorded diagnoses. "Do not use" symbols and abbreviations must not be used by any staff member according to hospital policy.

5.6 Progress Notes

- 5.6.1 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. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress note and correlated with specific orders, as well as results of tests and treatments.
- 5.6.2 Progress notes involving subjective interpretation of the patient's progress should be supplemented with a description of the actual behavior observed.
- 5.6.3 A progress note shall be recorded at each visit by the Member making the visit and dated.
- 5.6.4 Attending Members shall document:
 - a. abnormal lab values and their responses to such;
 - b. therapeutic pass goals and patient's response to passes;
 - c. reason for requested consultations;
 - d. seclusion/restraint;
 - e. medical evaluation and results of evaluation;
 - f. reason for continued hospitalization;
 - g. discharge plan;
 - h. response to Medication and Treatment Interventions; and
 - i. justification for changes to the patient's medication.
- 5.6.5 Progress notes of acute and residential patients shall contain the following information as applicable:

- a. treatment rendered;
- b. response to treatment;
- c. outcome of treatment;
- d. response of family/significant others to important events;
- e. changes in condition of the patient;
- f. complications;
- g. accidents/injuries/physical status;
- h. morbidity;
- i. mortality;
- j. procedures that place the individual at risk or cause unusual pain;
- k. correspondence concerning individual treatment;
- l. signed and dated notations of telephone calls concerning patient treatment;
- m. implementation of treatment plan; and
- n. response to medication.

- 5.6.6 Consultants must make record entries, dated, signed and timed, whenever they see a patient.
- 5.6.7 Unless required more frequently due to the patient's condition or program requirements, progress notes must be recorded as required by applicable law. They must contain recommendations for revisions in the treatment plan as indicated, as well as a precise assessment of the patient's progress in accordance with the original or revised treatment plan.

5.7 Therapeutic Passes

- 5.7.1 Therapeutic passes or leaves of absence are defined as times away from the Facility ordered by the Member to provide an opportunity to work toward therapeutic objectives critically necessary to patient recovery and leading to discharge.
- 5.7.2 Therapeutic passes shall, where appropriate, be integrated into the patient's written treatment plan.
- 5.7.3 The attending Member 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 attending physician/practitioner will indicate through a specific order any medication to be taken by the patient during the pass.
- 5.7.4 The attending Member shall document the therapeutic outcome of each pass in the medical record.

5.8 Discharge Documentation

- 5.8.1 Except in cases of administrative discharge, patients shall be discharged only on a written order of the attending Member.
- 5.8.2 Should a patient leave the Facility against the advice of the attending Member, or without proper discharge, a notation of the incident shall be made in the patient's

medical record. The patient should sign the appropriate release. If the release is not obtainable, the circumstances shall be documented in the medical record.

- 5.8.3 At the time of discharge, the attending Member shall complete the discharge according to the approved guidelines, state final diagnoses on all five DSM-IV-TR Axis, and sign the record.
- 5.8.4 The record of each discharged patient must include a discharge summary of the patient's hospitalization and recommendations concerning follow-up or aftercare, as well as a brief summary of the patient's condition on discharge.

5.9 Completion of Medical Records

- 5.9.1 The attending physician/practitioner will complete a dictated discharge summary within 5 business days of the patient's discharge date. All discharge summaries and other medical record documentation shall be fully complete (signature, date, and time) within 30 days following the patient's discharge. Incomplete records exceeding 30 days following discharge will be considered delinquent.
- 5.9.2 The Facility CEO in consultation with the Medical Director shall be authorized to temporarily suspend the admitting privileges of Members when:
 - a. The Member does not complete medical records within the time frame prescribed by these Rules and Regulations;
 - b. The Member does not comply with requests for additional documentation for justification of the patient's stay to meet the requirements of third-party payers or social and other agencies responsible for payment of Facility bills; or
 - c. The Member does not adequately participate in treatment planning.
- 5.9.3 The Facility CEO shall comply with any statutorily-imposed mandatory reporting requirements that apply to the suspensions under these circumstances.

6. MEDICATION USAGE

- 6.1 The Facility formulary shall be reviewed annually by the professional staff. Items not listed in the formulary may be obtained by physician/practitioner request. All drugs listed in the formulary shall be approved by the Food and Drug Administration. Drugs shall meet standards of the United States Pharmacopoeia and National Formulary, New and Unofficial Drugs. Exceptions to this rule shall be well justified and approved by the Medical Executive Committee.
- 6.2 Only physician/practitioners/licensed independent practitioners with appropriate qualifications, licenses, and clinical privileges may prescribe medication.
- 6.3 Medications prescribed will specify dosage, frequency, route of administration and date. Medication prescribed for as needed ("PRN") administration will indicate a maximum dosage over a stated time period and will identify the symptoms for which the medication should be administered.

- 6.4 Patients may not self-administer personal medications that they bring to the Facility unless approved in writing by the attending physician/practitioner. Only nursing or other appropriately trained staff may administer such medications and only if the attending physician/practitioner has approved through a written order the administration of such medications. Only personal medications that are properly labeled (showing the name of the medication, issuing pharmacy, and prescription number) and verified by a Facility pharmacist or the attending physician/practitioner may be administered. If personal medications will not be administered, they must be packaged, sealed, and stored in an area accessible only by approved nursing and pharmacy staff. If approved by the attending physician/practitioner, they may be returned to the patient or his family at discharge.
- 6.5 Medications are not allowed to be stored and/or kept in the patient's room.
- 6.6 No drugs supplied by the Facility shall be taken from the Facility unless a prescription has been written for the medication and the medication has been properly labeled and prepared by the Pharmacist in accordance with state and federal laws for use outside the Facility.
- 6.7 For the following classes of medications, the physician/practitioner will order medications for a specified number of days or for a specified number of dosages: Narcotics, Antibiotics, Hypnotics, and Anticoagulants. If the number of days or dosages is not specified in the order, reorders must be obtained as follows: Schedule II drugs, 10 days; Antibiotics, 10 days; Anticoagulates, 10 days; Hypnotics, 10 days; all other drugs, 30 days. If the laws of the state in which the Facility is located mandate a shorter time frame for re-orders, the state requirements must be followed.
- 6.8 The maximum duration of any medication order is 30 days. The medication orders will not be continued without being reviewed by the attending physician/practitioner at least every 30 days and the review noted in the medical record.
- 6.9 The attending physician/practitioner must be notified before any medication is discontinued. If the order is to expire during the night, the pharmacy staff shall notify the Member by, at the latest, the evening prior to the night that the order is to expire. An order to discontinue medication shall include the date and time to discontinue, medication name, dose and frequency.
- 6.10 The appropriate protocols or guidelines must be observed for the prescription and use of medications that are known to involve a substantial risk or to be associated with undesirable side affects, including, but not limited to Schedule II drugs for maintenance use, Lithium Carbonate, Antabuse, MAO Inhibitors, Neuroleptics, and Schedule II, III, and Schedule IV drugs.
- 6.11 Physician/practitioners shall discuss fully with patients and appropriate relatives the indications of risks, benefits, alternative treatments, and side affects of prescribed medications with documentation as established by the Facility and accepted medical practice.
- 6.12 When prescribing Schedule II drugs for maintenance use, the attending physician/practitioner should inform the patient (and the parent or guardian, if the patient is a minor) of the risks and benefits of the medication. The patient (or parent or guardian) must be provided with sufficient information to make an informed decision regarding the proposed medication.

6.13 Investigational drugs shall be used only in accordance with the Facility's policies for investigational drugs and clinical research.

7. SECLUSION AND/OR RESTRAINT

7.1 Definitions:

- 7.1.1 "Restraint" means either (a) any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient's body that the individual cannot remove easily that restricts freedom of movement or normal access to the patient's body, or (b) a drug administered to the patient, used to control the behavior or to restrict the patient's freedom of movement and is not a standard treatment for the patient's medical or psychiatric condition. Drugs used as restraints are addressed in Section 13.
- 7.1.2 "Seclusion" means the involuntary confinement of a person in a room or area away from others where the person is physically prevented from leaving.

7.2 Treatment Under the Least Restrictive Conditions:

- 7.2.1 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.
- 7.2.2 Seclusion and/or restraint shall be ordered only in the case of an emergency, as defined herein. For purposes of this Section 7, "emergency" shall mean a situation in which the patient's behavior becomes aggressive or violent, presenting an immediate, serious danger to his/her safety or the safety of others. The ordering physician/practitioner shall document a clinical assessment of the patient.

7.3 Orders

7.3.1 Orders for seclusion and/or restraint shall:

- a. be time limited;
- b. be STAT orders only;
- c. specify the reason for utilization;
- d. be signed by the physician/practitioner within 24 hours of initiation for acute and seven days for residential, or as required by the laws and regulations of the state in which the facility is located;
- e. specify type of restraint or seclusion;
- f. indicate criteria for release of restraint or discontinuation of seclusion.

7.3.2 Seclusion and/or restraint shall not be based on routine orders or PRN orders.

7.3.3 Orders for seclusion and/or restraint should be given by a Licensed Independent Practitioner ("LIP") permitted by applicable state law. If a LIP is not immediately available, however, a Registered Nurse may, if specifically trained, initiate seclusion

and/or restraint, and shall contact a LIP within 1 hour to obtain an order and to consult about the patient's condition.

- 7.3.4 Written orders for seclusion or restraint are limited to for acute care: 4 hours for adults with primary behavioral health needs, 2 hours for children and adolescents age 9 through 17 with primary behavioral health needs, and 1 hour for children under 9 with primary behavioral health needs. For residential care orders for youth ages 9-17 shall not exceed 30 minutes in duration and for children less than 9 shall not exceed 15 minutes in duration. The acute care patient must be seen by a physician/practitioner or other LIP or qualified RN (specially trained) within 1 hour of initiation of the initiation of the restraint or seclusion. The RTPCA patient must be seen by an LIP or qualified RN within 1 hour of initiation of the restraint or seclusion.

7.4 Evaluation

- 7.4.1 The LIP/or designee (who must be an LIP with appropriate privileges at the facility) or qualified RN shall conduct an in-person evaluation of the patient within 1 hour of the initiation of the restraint or seclusion
- 7.4.2 If the patient remains in restraint or seclusion when the original order expires, the patient must be reevaluated in person. The reevaluation shall be conducted by a LIP or a Registered Nurse with specific training. Reevaluation shall take place within 4 hours for patients 18 or older, within 2 hours for patients 9 through 17, and within 1 hour for patients under 9.
- 7.4.3 If following 7.4.2, a restraint or seclusion is continued, a new written, verbal, or telephone order must be obtained from a LIP, and the LIP shall conduct an in-person reevaluation of the patient within 8 hours of the initiation of the restraint or seclusion for patients 18 or older or within 4 hours of the initiation of the restraint or seclusion for patients under 18.
- 7.4.4 Notwithstanding any evaluation requirements for LIPs or their designees to the contrary, as set forth in this Section 7.4, the condition of the patient who is in restraint or in seclusion must be continually assessed, monitored, and reevaluated by appropriately trained staff.

7.5 Monitoring

- 7.5.1 All patients placed in restraint or seclusion shall be monitored by qualified personnel by continuous one-to-one observation, and their observations shall be noted in the medical record.
- 7.5.2 Patients in restraint and seclusion shall be continually monitored face-to-face by an assigned staff member. After the first hour, patients in seclusion may be continually monitored by staff using both audio and video equipment, consistent with the patient's condition and wishes. Any video and audio monitoring equipment must be in close proximity to the patient.
- 7.5.3 Patients in physical holds shall also be monitored by a second staff person not involved in the physical hold assigned to monitor the patient.

7.6 Patient Health and Safety

- 7.6.1 Each patient placed in restraint or seclusion shall have his physical condition and psychiatric condition assessed by competent trained professional staff at the initiation of restraint or seclusion and reassessed every 15 minutes thereafter. The assessment shall include signs of injury, nutrition/hydration, circulation and range of motion in the extremities, vital signs, hygiene and elimination, physical and psychological status and comfort, and readiness for discontinuation of restraint or seclusion.
- 7.6.2 Each patient whose condition requires restraint or seclusion shall have an opportunity to be fed at least at the times that other patients or residents normally have their meals and shall be offered fluids at least every two hours or upon request .
- 7.6.3 The patient shall be assessed for bathroom needs and assistance provided upon request or every two hours.
- 7.6.4 In applying restraints or seclusion, careful consideration shall be given to the methods by which patients can be speedily removed in case of fire or other emergency, as defined in Section 2.4.
- 7.6.5 Upon admission, each patient shall be assessed to determine whether there are any physical, emotional, or psychological contraindications to restraint or seclusion. Any such contraindications shall be noted in the chart.

7.7 Notification and Review

- 7.7.1 The Medical Director or designee shall be notified immediately of any instance in which a patient: (i) remains in restraint or seclusion for more than 12 hours, or (ii) experiences 2 or more separate episodes of restraint and/or seclusion of any duration within 12 hours. Thereafter, the Medical or designee shall be notified every 24 hours if either of these conditions continue.
- 7.7.2 The Medical Director or designee shall review all seclusion and restraint cases monthly and shall investigate unusual or unwarranted patterns or utilization.
- 7.7.3 Both Medical Staff and Nursing Staff will review 100 percent of all restraints and seclusions. The results will be reported to the Performance Improvement Committee and to the Medical Staff.

7.8 Progress Notes

- 7.8.1 Repetitious use of restraint and/or seclusion, as defined by Facility policy and procedure, must be justified by the physician/practitioner in the progress notes.
- 7.8.2 Documentation in the progress notes for seclusion and/or restraint shall be in accordance with approved Facility policy and procedure.

7.9 Informing Patient and Family

Each patient must be informed of the reason for his/her seclusion and/or restraint. If appropriate, the patient's family will be promptly notified of the use of seclusion and/or restraint.

8. MEDICAL ALTERNATE

- 8.1 When the attending physician/practitioner is out of town, he shall give advance written notice to the Facility, CEO and Medical Director of an alternate member of the Medical Staff who has agreed to provide care for his patients and for how long. Failure to provide advance notification and alternate coverage is cause for disciplinary action.
- 8.2 In an emergency, as defined in Section 2.4, when the attending physician/practitioner or his designee is unavailable, the Medical Director or his designee must be contacted and shall have the authority to make provisions for care for the patient.

9. ON-CALL

- 9.1 There is a psychiatrist on-call to the Facility on a 24-hour basis to cover assessments, admissions, and emergencies. All psychiatrist members of the active staff must participate in the on-call roster unless exempted by Medical Director.
- 9.2 Each attending Member is responsible for arranging adequate medical coverage in his absence (see Section 8.1 above).
- 9.3 The Facility CEO and the Medical Director shall be administratively responsible for maintaining the Facility's on-call roster.
- 9.4 On-call Members are required to respond to calls/pages by the Facility within 10 minutes and, if necessary, to be physically present at the Facility within 30 minutes.

10. MEDICAL/PSYCHIATRIC CONSULTATIONS

- 10.1 Medical/Psychiatric consultations may be requested by the attending/covering physician/practitioner or licensed independent practitioner with approved clinical privileges, the Medical. In the rare event that a consultation must be performed by a physician/practitioner who is not an appointee of the Medical Staff, the consultant must obtain temporary consulting privileges from the Facility.
- 10.2 Progress notes must provide the reason for the consultation, a written opinion by the consultant, and recommendations for further care.
- 10.3 Emergency consultation requests must be requested by the attending/covering physician/practitioner or licensed independent practitioner directly to the consulting physician/practitioner. A verbal order or telephone order may be dictated in the case of an emergency, as defined in Section 2.4.
- 10.4 Initiation of a request for consultation by the patient or, if the patient is incompetent, by next of kin, must be accompanied by a physician/practitioner order.
- 10.5 Psychiatric consultations are required in cases in which:
 - 10.5.1 The problem, need, or service is beyond the expertise of the attending Member;
 - 10.5.2 The diagnosis is obscure;
 - 10.5.3 There is doubt as to the best therapeutic measures to be utilized;

- 10.5.4 The patient or patient's family has requested consultation;
 - 10.5.5 There are treatment risks for the patient;
 - 10.5.6 The case has been determined by the Utilization Review staff to require consultation; or
 - 10.5.7 There are unusual or complicating circumstances.
- 10.6 A satisfactory consultation includes examination of the patient and the medical record. A progress note and formal report, signed by the consultant, must be included in the medical records.

11. UTILIZATION REVIEW

The attending Member is required to document the need for admission and for continued stay. Utilization reviews are scheduled on a systematic basis according to the Utilization Review Plan of the Facility. Failure to furnish such required documentation may result in corrective action.

12. PATIENT REQUEST TO CHANGE PHYSICIAN/PRACTITIONER

A patient may request to be assigned to a different attending physician/practitioner. In the event of controversy, the Medical Director shall be contacted to investigate and, if appropriate, to facilitate the change.

13. SPECIAL TREATMENT PROCEDURES

The following are special treatment procedures that are not permitted to be used at the Facility except in accordance with Facility Policies and Procedures and with the prior approval of the Medical Executive Committee and Facility CEO:

- The use of behavior modification procedures that restrict any rights of the patient.
- The use of investigational or experimental drugs.
- The use of drugs as restraints (chemical restraints).

14. CONSENTS

- 14.1 A condition of admission form, with applicable consent(s) signed by every voluntary patient, the patient's parents, or the patient's legal representative, must be obtained at the time of admission.
- 14.2 It shall be the attending Member's responsibility to obtain informed consent from the patient or his/her legal representative for any procedure or treatment requiring such consent. Evidence of the informed consent shall be documented in the medical record by the attending Member.
- 14.3 A written record of the patient's or legal representative's consent will be made part of the medical record. In the event of an emergency, as defined in Section 2.4, an informed consent does not have to be signed. The treatment and medications administered during such an emergency shall be only that which is necessary to address the emergency situation and be administered in a way that is least restrictive to the personal liberty of the patient. Once the emergency situation no longer exists, the attending physician/practitioner must obtain informed consent before treatment may be continued.

15. MEMBER INFORMATION/LICENSURE/MALPRACTICE INSURANCE

- 15.1 Each Member is responsible for informing the CEO within 10 days of any change in status of his:
- 15.1.1 Address;
 - 15.1.2 Telephone number;
 - 15.1.3 Other professionals supervised by the Member; or
 - 15.1.4 Discontinuance of supervision of other professionals.
- 15.2 Each Member is responsible for informing the CEO immediately of any change in status of his:
- 15.2.1 Licensure status;
 - 15.2.2 Professional liability insurance or settlement of a malpractice claim; or
 - 15.2.3 Change in status or eligibility regarding participation in Medicare, Medicaid, or any other federal or state reimbursement programs.

16. FACILITY DISASTER PLAN

- 16.1 Medical Staff Disaster Assignments:

In case of a disaster, Members shall be assigned to posts in the Facility and will perform duties specifically assigned. The Medical Director and the Facility CEO/Incident Commander will coordinate activities and assignments. In cases of transfer or evacuation of patients, the Medical Director, or designee, will direct and monitor the movement of patients.

- 16.2 All members of the Medical Staff of the Facility specifically agree to relinquish authority over the professional care of their patients to the Medical Director in cases of disaster.

17. EMERGENCY CARE

- 17.1 Persons presenting at the Facility potentially seeking treatment for an emergency medical condition (an “Emergency Patient”) shall be appropriately medically screened and treated in accordance with the Facility’s EMTALA policy, to the extent of the Facility’s capabilities.
- 17.2 Physician/practitioners who are on-call are responsible for returning to the Facility when requested by a Qualified Medical Person to provide necessary screening and stabilizing treatment to Emergency Patients. All transfers of Emergency Patients shall be in accordance with the Facility’s EMTALA policy. The decision to transfer a person who has presented to a Facility with an “emergency medical condition” (as such term is defined in the Facility’s EMTALA policy) that has not been stabilized shall in all cases remain with a physician/practitioner Member of the Medical Staff, and a written order will be obtained.
- 17.3 Following assessment and treatment to address an emergency medical condition, the physician/practitioner attending to the Emergency Patient shall complete an assessment of the patient’s diagnosis/recommendations and implement appropriate orders for follow-up treatment.

18. MEDICAL SERVICES PAYMENT

If the attending Member will be billing the patient separately from the Facility's bill, the Member shall communicate to his patient (and family where appropriate) the financial terms of the treatment relationship, including the applicable compensatory services provided by all professionals under the attending Member's supervision.

19. PATIENT DEATH AND AUTOPSY

- 19.1 In the event of a patient's death, the deceased shall be pronounced dead and the family notified by the attending Member or his designee. Death certificates shall comply with the applicable state regulations and reporting requirements. The attending Member shall secure an autopsy in all cases of unusual deaths or when required by a coroner or medical examiner. A provisional anatomic diagnosis shall be recorded in the medical record within 72 hours. All autopsies shall be performed by a licensed pathologist or his designee, and with written consent of the decedent's family, signed in accordance with state law. The attending Member will be notified of the time and place of the autopsy.
- 19.2 When a patient expires, a summation statement shall be entered in the medical record in the form of a discharge summary. The summation statement shall describe the circumstances leading to death and shall be signed by the attending physician/practitioner. The MEC shall review the summation statement.

20. STANDARDS OF PRACTICE

- 20.1 In general, the standards of the practice of psychiatry and clinical psychology in the Facility shall be governed by the standards of practice prevailing within the community. The Medical Director is accountable for the quality of practice within the Facility, and may ask a Member to alter temporarily aspects of the treatment to a patient when, in the judgment of the Medical Director, such a request is necessary. When such a request is made, the attending Member shall comply with the Medical Director's request. If the Member fails to comply with the request, the Member may transfer the patient to another facility, but if the patient is not transferred, the Medical Director shall assign responsibility for the care of the patient to a suitable Member until the dispute can be addressed by the MEC.
- 20.2 All Members on the active Medical Staff are required to participate in Monthly Peer Review Procedures or as otherwise mandated by the Medical Director.

21. DEFINITION OF QUALIFIED MEDICAL PERSON

In addition to physician/practitioners, the following classes of practitioners are granted authority, within the scope of the clinical privileges or prerogatives for which they have been approved, to conduct medical screening examinations as required under the facility's EMTALA policy as a "Qualified Medical Person" or "QMP": nurse practitioners and RNs with certain specified training.

22. REVIEW

These Bylaws, Rules and Regulations shall be reviewed at least **annually** and approved by the Medical Staff and Board.

Signatures

Medical Director

Date

President of the Governing Board

Date