Rules and Regulations
COMMUNITY HOSPITALS AND WELLNESS CENTERS

A Medical Staff Document
I. Definitions

The definitions set forth in the Medical Staff Bylaws shall apply to these Medical Staff Rules & Regulations unless a different definition is otherwise specified herein.

II. Admission of Patients.

A. Patients may be admitted to the Hospital by Practitioners or Advanced Practice Providers (APP) (subject to the conditions set forth below) with admitting Privileges.

1. Certified Nurse Practitioners (CNP), Clinical Nurse Specialists (CNS), Certified Nurse Midwives (CNM) and Physician Assistants (PA) may admit patients to the Hospital if all of the following conditions are met:

   a. The CNP, CNS, or CNM has a Standard Care Arrangement (SCA) entered into, in accordance with applicable Ohio law, with a collaborating Physician or Podiatrist who is a member of the Medical Staff with Clinical Privileges including the ability to admit patients.

   b. The PA is listed on a Supervision Agreement, approved in accordance with applicable Ohio law, for a Physician or Podiatrist who is a member of the Hospital’s Medical Staff with Clinical Privileges including the ability to admit patients.

   c. The patient is under the medical supervision of the collaborating or supervising Physician or Podiatrist.

   d. The CNP, CNS, CNM, or PA has been granted the privilege of admitting patients to the Hospital.

   e. Prior to admitting a patient to the Hospital, the CNP, CNS, CNM, or PA must notify his/her collaborating or supervising Physician or Podiatrist of the planned admission.

2. For purposes of these Rules & Regulations, in the event an APP has been granted admitting Privileges, then references to the admitting/attending/responsible Practitioner shall include the admitting APP to the extent permitted by law, the APP’s Privileges, and as applicable to the admitting APP’s responsibilities toward his/her patient.

B. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been documented. In case of an emergency, the provisional diagnosis shall be documented as soon after admission as possible.

C. Practitioners or APPs admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other
patients from those who the Practitioner or APP has reason to believe may be a source of danger from any cause whatever, or to assure protection of the patient from self-harm.

D. Patients shall be attended by their own private Practitioner/APP or the covering hospitalist/Practitioner. Patients admitted through the Emergency Room who have no attending Practitioner/APP shall be assigned a Practitioner on duty.

E. All patients admitted to the Hospital must be under the care of an appropriate Practitioner(s)/APP with Privileges consistent with applicable law.

III. History & Physical Exam ("H&P").

A. Elements of an H&P:

1. Inpatients, Observation Patients, and Swing Bed (Skilled) Patients:
   a. H&Ps for inpatients, observation patients, and swing bed (skilled) patients must include, at a minimum, the following:
      i. History of present illness
      ii. Past medical history
      iii. Allergies
      iv. Current medications
      v. Review of systems
      vi. Physical exam
      vii. Heart and lung assessment
      viii. Neurological assessment
      ix. Target organ assessment for reason for hospitalization
      x. Diagnosis
      xi. Plan of care

2. Non-Inpatients: (Bryan and Archbold Only)
   a. H&Ps for outpatients undergoing invasive procedures with local anesthesia in the OR must include, at a minimum, the following:
      i. History of present illness
ii. Past medical history,

iii. Allergies,

iv. Current medications,

v. Target assessment of organ, body part of planned procedure

vi. Diagnosis

vii. Plan of care

b. H&Ps for outpatients undergoing invasive procedures with Moderate Sedation, Monitored Anesthesia Care (MAC/Deep Sedation), regional, or general anesthesia in the OR, Catheterization Lab, or Radiology must include, at a minimum, the following:

i. History of present illness

ii. Past medical history

iii. Allergies

iv. Current medications

v. Review of systems

vi. Physical exam

vii. Heart and lung assessment

viii. Neurological assessment

ix. Target organ assessment for reason for hospitalization,

x. Mallampati assessment for cardiac procedures (specific form)

xi. Diagnosis

xii. Plan of care

B. Requirements of H&P:

1. An H&P shall be completed, documented, and made a part of the patient's medical record within twenty-four (24) hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. If the H&P was completed within thirty (30) days prior to
admission or registration, an update documenting any changes in the patient’s condition shall be completed, documented, and made a part of the patient’s medical record within twenty-four (24) hours after admission or registration but prior to surgery or a procedure requiring anesthesia services. The update shall be based on an appropriate reassessment of the patient which should include a physical examination of the patient sufficient to update those components of the patient's current medical status that may have changed and to address any areas where more current data is needed since the H&P was completed. Additional information regarding H&Ps is set forth in the Medical Staff Bylaws.

2. The H&P shall be completed and documented by a Physician, an Oral & Maxillofacial Surgeon, or other qualified licensed individual who is granted the Privileges to do so in accordance with State law and Hospital policy.

C. Countersignature (Montpelier Hospital only).

H&Ps completed and documented by APPs granted Privileges to do so must be countersigned by the APP’s supervising or collaborating Physician who assumes full responsibility for the H&P.

IV. Orders.

A. Orders. All orders shall be in writing or electronically entered and authenticated, dated, and timed by the ordering Practitioner or APP. The Practitioner's or APP’s orders must be written clearly, legibly, and completely.

1. Practitioners shall have the authority to issue orders as permitted by their Privileges.

2. The ability of an APP to issue orders, if any, shall be as defined in the applicable APP Privilege set. All APP orders must be (i) within the APP’s defined scope of authority; (ii) within the APP’s delineated Privileges; (iii) consistent with the APP’s certificate to prescribe and standard care arrangement or supervision agreement; and (iv) in accordance with all applicable laws and Hospital and Medical Staff polices.

B. Verbal Orders. Verbal and telephone orders are permitted but must be used infrequently and must not be common practice. Verbal and telephone orders should be used only to meet the care needs of a patient when it is impossible or impractical for the ordering Practitioner or APP to write or enter the order without delaying treatment. Verbal and telephone orders shall be signed, dated, and timed by the person to whom dictated with the name of the ordering Practitioner or APP.

1. Authentication of Verbal Orders. Verbal and telephone orders must be authenticated, dated, and timed promptly by the ordering Practitioner/APP
or another Practitioner who is covering for the ordering Practitioner/APP and responsible for the care of the patient.

2. **Receipt and Documentation.** Only designated licensed personnel as specified in applicable Hospital policy, as such policy may be amended from time to time, are authorized to receive and document verbal and telephone orders within their scope of practice.

3. **Read Back.** All verbal and telephone orders require verification (write down and read back) of the complete order.

C. **Orders Cancelled Prior to Surgery.** All previous orders are canceled when patients go to surgery except those that are exempt under Hospital policy. At the end of surgery, the Practitioner or APP must issue new orders, as applicable, and may not write “resume previous orders.”

D. **Outpatient Orders.** Hospital outpatient services may be ordered (and patients may be referred for Hospital outpatient services) by a Practitioner or APP who is (i) responsible for the care of the patient; (ii) licensed in, or holds a license recognized in, the jurisdiction where he/she sees the patient; (iii) acting within his/her scope of practice under State law; and (iv) authorized by the Medical Staff to order the applicable outpatient services under these Rules & Regulations and/or applicable Hospital policy as approved by the Board.

V. **Medical Records.**

A. **Authentication of Medical Record Entries**

1. “Authentication” means to establish authorship by written signature, identifiable initials, electronic signature/computer key, or other code.

2. For authentication, in written or electronic form, a method must be established to identify the author.

3. Authorized users of electronic authorizations shall sign a statement assuring that they alone will use the electronic signature/computer key or code.

B. **Content of Medical Record**

1. The medical record contains the following demographic information as applicable:
   a. The patient’s name, address, and date of birth, and the name of any legally authorized representative
   b. The patient’s sex
c. The legal status of any patient receiving behavioral health care services

d. The patient’s communication needs, including preferred language for discussing health care

2. The medical record contains the following clinical information as applicable:

a. The reason(s) for admission for care, treatment, and services

b. The patient’s initial diagnosis, diagnostic impression(s), or condition(s)

c. Any findings of assessments and reassessments

d. Any allergies to food

e. Any allergies to medications

f. Any conclusions or impressions drawn from the patient’s medical history and physical examination

g. Any diagnoses or conditions established during the patient’s course of care, treatment, and services (including complications and hospital-acquired infections)

h. Any consultation reports

i. Any observations relevant to care, treatment, and services

j. The patient’s response to care, treatment, and services

k. Any emergency care, treatment, and services provided to the patient before his or her arrival

l. Any progress notes

m. All orders

n. Any medications ordered or prescribed

o. Any medications administered, including the strength, dose, and route

p. Any access site for medication, administration devices used, and rate of administration

q. Any adverse drug reactions
r. Treatment goals, plan of care, and revisions to the plan of care
s. Results of diagnostic and therapeutic tests and procedures
t. Any medications dispensed or prescribed on discharge
u. Discharge diagnosis
v. Discharge plan and discharge planning evaluation

3. As needed to provide care, treatment, and services, the medical record contains the following additional information:
   a. Any advance directives
   b. Any informed consent, when required by Hospital policy
c. Any records of communication with the patient, such as telephone calls or email
d. Any patient-generated information

4. The medical record of a patient who receives urgent or immediate care, treatment, and services contains all of the following:
   a. The time and means of arrival
   b. Indication that the patient left against medical advice, when applicable
c. Conclusions reached at the termination of care, treatment, and services, including the patient’s final disposition, condition, and instructions given for follow-up care, treatment, and services
d. A copy of any information made available to the Practitioner or medical organization providing follow-up care, treatment, or services

5. The medical record contains the patient’s race and ethnicity.

6. Other information as required by applicable law and/or accreditation standards.

C. Operative/Other High-Risk Procedure Reports (Bryan and Archbold Facilities only). A full operative or other high-risk procedure report must be dictated within twenty-four (24) hours after the completion of the operation. The operative or other high-risk procedure report includes the following information:

1. Name and Hospital identification number of the patient.
2. Dates and times of the surgery.

3. The name(s) of the surgeon(s)/Practitioner(s) who performed the procedure and his/her assistant(s) or others who performed surgical tasks even when performing those tasks under supervision.

4. Description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/Practitioner including opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, or altering tissues.

5. Preoperative diagnosis.

6. The name of the procedure performed.

7. Type of anesthesia administered.

8. A description of the procedure/techniques.


10. Complications, if any.

11. Any estimated blood loss.

12. Any specimen(s)/tissues removed or altered.

13. Prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

14. The postoperative diagnosis.

D. Post-Operative/Procedure Progress Notes (Bryan and Archbold Facilities only). When a full operative or other high-risk procedure report cannot be entered immediately into the patient’s medical record after the operation or procedure, the Practitioner must enter an immediate post-operative/procedure progress note in the medical record following the operation or other high-risk procedure and before the patient is transferred to the next level of care in order to ensure uninterrupted and continuous care of the patient. This progress note includes:

1. The name(s) of the primary surgeon(s) or Practitioner(s) performing the procedure and other assistant(s).

2. Procedure performed.

3. Description of each procedure finding.

4. Estimated blood loss.

5. Specimens removed.

E. Discharge Summary. The medical record shall contain a discharge summary or final progress note in accordance with the requirements set forth in Section XII of these Medical Staff Rules & Regulations.

F. Progress Notes. Progress notes shall be recorded at the time of examination to facilitate continuity of care. Each of the patient’s clinical problems should be clearly defined in the progress notes and correlated with specific orders as well as the results of tests and treatments. Progress notes shall be entered into the medical record at least daily.

G. Timely Completion of Medical Records.

1. Practitioners and APPs shall be notified of any medical records that are incomplete within ten (10) days after the date of completion of service, and the Practitioner or APP shall have until thirty (30) days after the completion of service to complete such medical records. A follow up phone call will be made to the Practitioner or APP no later than twenty-five (25) days after completion of service to set up a time for the Practitioner or APP to complete medical records that remain incomplete. Medical records that are incomplete beyond thirty (30) days of service are delinquent. Upon the thirty-first (31st) day of any medical record not being completed, the Practitioner’s or APP’s Privileges will be automatically suspended. The automatic suspension will be communicated to the Practitioner or APP in writing and will take effect immediately.

2. A Practitioner or APP whose Privileges are automatically suspended may not, as applicable, exercise any Privileges at the Hospital, participate in Emergency Room Call, schedule surgery, or otherwise provide professional services within the Hospital for patients with the exception that such Practitioners or APPs may:

   a. Conclude the management of any patient under his or her care in the Hospital at the time of the effective date of the automatic suspension of Privileges.

   b. Attend an obstetrical patient who has been under his or her active care and management and who comes to term and is admitted to the Hospital in labor.

   c. Attend to the management of any patient under his or her care whose admission or outpatient procedure was scheduled prior to the effective date of the automatic suspension.

   d. Attend to the management of any patient requiring emergency care and intervention.
3. An automatic suspension will continue until such time as all of the Practitioner’s or APP’s delinquent medical records are completed. If a Practitioner's or APP’s Privileges are suspended three (3) or more times in one (1) Medical Staff Year for delinquent medical records, the Practitioner or APP will be referred to the Credentials Committee for review and appropriate follow up action.

H. **Property of Records.** All records are the property of the Hospital and shall not be removed from the Hospital without the Hospital's approval or as otherwise required by law. In cases where the Hospital consents to a release of records, or a court order or law requires such a release, certified copies of the records shall be released. The original records should never be released from the Hospital.

I. **Access to Medical Records.** Access to medical records of all patients shall be afforded to Practitioners in Good Standing and APPs, to the extent applicable, for bona fide study and research, consistent with preserving the confidentiality of personal information concerning the individual patients and subject to MEC approval of the research and all applicable federal and state laws governing the confidentiality of medical records. Subject to the discretion of the Chief of Staff and CEO and all applicable federal and state laws governing the confidentiality of medical records, former Practitioners and APPs shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

VI. **Drugs.**

A. All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopeia-National Formulary with the exception of drugs for *bona fide* clinical investigations or other justified exceptions as determined on a case-by-case basis by the Pharmacy and Therapeutics Committee and MEC.

B. A Practitioner or, if applicable, an APP requesting an investigational drug be obtained for treatment of a specific inpatient must agree to the following criteria:

1. The drugs must be used in accordance with regulations governing the use of investigational drugs issued by the FDA.

2. Obtain consultation and approval from the Pharmacy and Therapeutics Committee chair and the IRB of the Hospital.

3. Obtain approval from the Hospital's CEO.

4. Obtain informed consent from patient or the patient’s legal guardian(s) or authorized representative(s).

C. Practitioners and APPs will receive a computer printout listing drug orders that are scheduled to expire within twenty-four (24) hours for the Practitioner’s/APP’s
patients. If not renewed, the drugs will be automatically discontinued. Pharmacy will monitor and contact those Practitioners and APPs who miss their renewals. Orders for controlled substances, antibiotics, antifungals, anticoagulants, thrombolytics, and chemotherapy will automatically expire in five (5) days unless a different length of time is specifically stated in the Practitioner’s or, if applicable, APP’s order. All other drug orders expire in ten (10) days unless a different length of time is specifically stated in the Practitioner’s or APP’s order.

VII. Consent. A general consent form must be signed by or on behalf of every patient treated at the Hospital. Except in cases of emergency, an appropriate informed consent must be obtained from the patient or his/her legal representative by the treating Practitioner prior to performance of designated treatments or procedures. Additional requirements with respect to informed consent are set forth in applicable Hospital policy as such policy may be amended from time to time (The name/number of the applicable policy can be specified as desired).

VIII. Sterilization (Bryan and Archbold Facilities only). Requirements for consent for sterilization shall be in accordance with applicable Ohio law (including ORC 5123.86) and Hospital policy.

IX. Induction of Labor (Bryan Facility only). The Physician or Certified Nurse Midwife who induces labor on a patient shall be readily available at all times while the induction is in progress. A Physician with Privileges to perform cesarean sections must also be readily available.

X. Coverage. Practitioners must be available to provide continuous care to their patients or make arrangements for appropriate coverage in the Practitioner’s absence in accordance with the requirement set forth in the Medical Staff Bylaws. In the event that both the Practitioner and covering Practitioner are not available, the CEO or designee shall have the authority to call any Appointee with appropriate Privileges to provide care, treatment, and/or services.

XI. Call Coverage. It is the policy of the Hospital to assure the emergency department is adequately covered by an on-call Practitioner according to a schedule for such coverage.

A. On-call Practitioners are expected to be available to respond by telephone within ten (10) minutes of being called by the Hospital. On Call practitioner’s are expected to arrive at the Hospital within thirty (30) minutes after having been contacted or such other longer time as is medically appropriate as dictated by the patient’s condition.

B. On call practitioners responding to a Cesarean Section are to respond by telephone within ten (10) minutes of being called and to respond in person within thirty (30) minutes of being called.

C. Providers on call for newborn care are to respond in by telephone within ten (10) minutes of being called and to respond in person to emergencies in the Newborn Nursery within thirty (30) minutes of being called.
D. The Hospital and Medical Staff recognize that certain specialists may not be available for emergency department call coverage 24 hours per day, 365 days per year, but will assure that Practitioners are assigned to a reasonable amount of emergency department call coverage. For periods of time during which the Hospital does not have call coverage, the Hospital will make alternative arrangements to secure coverage by *locum tenens* or to transfer patients to other appropriate facilities.

E. Practitioners who treat patients while on-call shall be responsible for treating the patient through the acute emergency phase of their treatment and for any necessary office follow-up care related to the emergency visit. Such treatment shall not be based on or limited by the patient's ability to pay.

F. Qualified personnel for purposes of conducting a medical screening examination of a patient who presents to the Emergency Department shall be defined to mean a Physician, physician’s assistant, or advanced practice registered nurse except in the case of obstetrical patients who may be screened by an appropriately trained registered nurse.

XII. Discharge and Discharge Summary.

A. Patients shall be discharged only on order of the attending Practitioner or APP.

B. A discharge summary shall be entered into the medical record within fifteen (15) days of discharge. A discharge summary shall address the:

1. Reason for hospitalization.
2. Procedures performed.
3. Care, treatment, and services provided.
4. Outcome of hospitalization; or, for outpatient records, the outcome of treatment, procedures, or surgery.
5. Patient’s condition and disposition at discharge.
6. Information provided to the patient and/or his/her legal guardian or authorized representative.

C. A discharge summary is not required when a patient is seen for minor problems or interventions as defined by the Medical Staff. In this instance a final progress note may be substituted for the discharge summary provided the note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care.

XIII. Patient Death.
A. Pronouncement of Death.

1. Only a Physician may declare a patient dead.

2. If a Physician is thoroughly familiar with the patient's medical history and if a "competent observer" recites to the Physician the fact of the deceased's present medical condition, the Physician, if satisfied by telephone that death has occurred, may make the pronouncement of death without personally examining the body of the deceased. For purposes of this paragraph, a "competent observer" means:

   a. Advanced practice registered nurse, registered nurse, or licensed practical nurse holding a current applicable Ohio license

   b. EMT-B, EMT-I, or paramedic holding a current applicable Ohio certificate

   c. Physician assistant holding a current Ohio certificate to practice

   d. Chiropractor holding a current applicable Ohio certificate

   e. Podiatrist holding a current Ohio certificate to practice podiatric medicine and surgery

   f. Physician with a current Ohio certificate to practice medicine and surgery or osteopathic medicine and surgery; or, holding a current Ohio visiting medical faculty certificate or special activities certificate

   g. Resident holding a current Ohio training certificate

   h. Coroner’s investigator

B. Autopsies.

1. The Medical Staff is expected to order autopsies when the immediate cause of death is questionable and does not meet coroner criteria.

2. The Medical Staff should attempt to secure autopsies in all cases of unusual deaths and of medical-legal and educational interest.

3. The Medical Staff, and specifically the attending Practitioner, is notified when an autopsy is being performed.

4. The mechanism for documenting permission to perform a Physician ordered autopsy shall be as set forth in applicable Hospital policy as such policy may be amended from time to time.
5. Autopsies shall be performed by a pathologist or at a contracted health care facility and transportation will be arranged.

6. The provisional and final diagnosis will be made part of the medical record.

XIV. Operations (Bryan and Archbold Facilities Only).

A. Requirements with respect to post-operative reports and progress notes are set forth in Section V (C) and Section V (D) of these Rules & Regulations.

B. Tissues removed during surgery shall be sent to the Hospital pathologist as directed by the surgeon. The Hospital pathologist shall conduct such examination as he/she may consider necessary to arrive at a pathological diagnosis and he/she shall authenticate, date, and time his/her report, which shall become a part of the patient's medical record.

C. Except in emergencies, the pre-operative diagnosis, H&P, ordered laboratory and diagnostic test results must be recorded on the patient's medical record prior to any surgical procedure. In an emergency the Practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and the start of the surgery procedure.

D. Anesthetists and surgeons must be in the operating room and ready to commence operation at the time scheduled and in no case will the operating room be held longer than fifteen (15) minutes after the time scheduled.

E. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation of systems and post-anesthesia follow-up of the patient's condition.

1. A pre-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within forty-eight (48) hours prior to any inpatient or outpatient surgery or a procedure requiring anesthesia services. The pre-anesthesia evaluation of the patient includes, at a minimum:

   a. Elements that must be performed within the 48-hour timeframe:

      i. Review of the medical history, including anesthesia, drug and allergy history

      ii. Interview, if possible given the patient’s condition, and examination of the patient.

   b. Elements that must be reviewed and updated as necessary within 48 hours, but which may also have been performed during or
within 30 days prior to the 48-hour time period, in preparation for the procedure:

i. Notation of anesthesia risk according to standards of practice (e.g. ASA classification of risk).

ii. Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g. difficult airway, ongoing infection, limited intravascular access).

iii. Additional pre-anesthesia data or information, if applicable and required in accordance with standard practice prior to administering anesthesia (e.g. stress tests, additional specialist consultation).

iv. Development of the plan for the patient’s anesthesia care, including the type of medications for induction, maintenance, and post-operative care and discussion with the patient or the patient’s legal guardian(s) or authorized representative of the risks and benefits of the delivery of anesthesia.

2. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia services. The post-anesthesia evaluation for anesthesia recovery must be completed in accordance with State law and with hospital policies and procedures that have been approved by the medical staff and that reflect current standards of anesthesia care. The elements of an adequate post-anesthesia evaluation should conform to current standards of anesthesia care, including:

a. Respiratory function including respiratory rate, airway patency, and oxygen saturation.

b. Cardiovascular function including pulse rate and blood pressure.

c. Mental status.

d. Temperature.

e. Pain

f. Nausea and vomiting.

g. Postoperative hydration.
Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

F. Major operations, as defined by the Surgical Services Committee, shall typically include a qualified First Assistant.

XV. **Prenatal Medical Records.** Prenatal medical records will be made a part of the mother’s inpatient medical record upon delivery of a newborn.

XVI. **Disaster Assignments.** At the time of any disaster, Practitioners and APPs will be governed by the applicable provisions of the Medical Staff Bylaws or APP Policy and the Hospital Disaster Plan as written and integrated with the Civil Defense of Williams County and Community Hospitals and Wellness Centers.

XVII. **Compliance.** It is the policy of the Medical Staff to comply with all federal and state laws, rules, and regulations pertaining to the delivery of health care in a hospital setting. Each Practitioner and APP is expected to maintain compliance with applicable state and federal laws and regulations including, but not limited to, the Medicare hospital and critical access hospital conditions of participation, and applicable accreditation standards governing the Hospital and the delivery of health care in the Hospital.

XVIII. **Consultations.**

A. Any Practitioner with Privileges can be called for consultation within the Practitioner’s area of expertise.

B. Consultations are recommended when, in the judgment of the attending Practitioner or APP:

1. The patient is not a good medical and/or surgical risk.
2. The patient's diagnosis is obscure.
3. There is doubt as to the best therapeutic measures to be utilized.
4. When requested by the patient or patient's legal representative.
5. To manage a medical condition outside the scope of the attending Practitioner's or APP’s scope of expertise.

C. A satisfactory consultation includes examination of the patient, review of the patient’s medical record, and documentation of the opinion of the consultant, which is made part of the medical record.

D. A consultation for an inpatient or observation patient is to be completed within twenty-four (24) hours of notification of the order.
E. When operative procedures are involved, the consultation note should be recorded prior to the operation, except in an emergency.

F. The patient's Practitioner or APP is responsible for requesting consultation and communicating the reasons for a consultation. Practitioner/APP to Practitioner communication to request a consultation is preferred.

G. Consultations for swing (skilled) patients may be completed in a time period mutually agreed upon by the ordering Practitioner/APP and the consulting Practitioner. These consultations may take place in the Montpelier Hospital or the patient may be sent to the consultant’s office.

XIX. Restraints. Restraints shall be used (1) only when all other interventions have been exhausted and (2) consistent with the Hospital's Restraint Policy as set forth in its Nursing Procedure Manual.

XX. Advanced Directives. The Hospital will, to the best of its ability, recognize legal documents pertaining to Living Wills, Durable Power of Attorney for Health Care, Do Not Resuscitate Comfort Care, Do Not Resuscitate Comfort Care-Arrest, and Declarations for Mental Health Treatment that are appropriately and properly executed as recognized under Ohio law. Additional information with respect to Advanced Directives and Do Not Resuscitate (DNR) Orders is set forth in applicable Hospital policy as such policy may be amended from time to time.

Medical Staff Approval: May 8, 2017
Board of Directors Approval: May 17, 2017