



# Rules and Regulations

## Department of Medicine and Family Practice

Medical Staff Services Department  
September 2010

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# Pacific Hospital of Long Beach

## DEPARTMENT OF MEDICINE/FAMILY PRACTICE

### Rules and Regulations

#### I. ORGANIZATION

1. Name:  
The name of this organization shall be the Department of Medicine/Family Practice of the Medical Staff of Pacific Hospital of Long Beach. The Department is established as provided in the Medical Staff Bylaws.

2. Composition:  
The Department of Medicine/Family Practice shall be composed of the section or shall include specialties of:

Cardiology	Hematology/Oncology
Critical Care	Infectious Disease
Endocrinology	Nephrology
Family Practice	Physical Med & Rehab
Emergency Medicine	Psychiatry
Gastroenterology	Pulmonary Med
General Practice	Rheumatology

3. Membership:

**A. Qualifications:**

Physicians (MD, DO) and psychologists may be members of the Department of Medicine/Family Practice. Other sub-specialties may become members as determined by the Department, the Medical Executive Committee and the Board of Directors. Physician Assistants Nurse Practitioners, CRNA, CNIM, LPT and other individuals may be appointed to the Allied Health Professional category of the Medical Staff and hold privileges in the Department of Medicine/Family Practice. Other non-physician/psychologist providers may be permitted to request membership in the Allied Health Professional category of the Medical Staff with privileges when deemed appropriate by the Department, Medical Executive Committee and Board of Directors.

All members must meet qualifications for membership and for privileges as defined in Article II of the Bylaws of the Medical Staff of Pacific Hospital of Long Beach.

**B. Appointments:**

New members recommended for provisional category by the Department of Medicine must also have the approval of the Medical Executive Committee and Board of Directors pursuant to the Medical Staff Bylaws. The initial term of appointment shall be provisional in nature and in accordance with the Medical Staff Bylaws.

#### II. CONDUCT

1. Ethics:  
The professional ethics of the members of the Department of Medicine/ Family Practice shall be governed by the Bylaws, Rules and Regulation and Policies of the Medical Staff.

2. Discipline:

Evaluation of the care rendered patients by members of the Department of Medicine/Family Practice shall be the concern of the Department of Medicine/Family Practice. Matters involving discipline not satisfactorily resolved by the Department of Medicine/ Family Practice shall be as prescribed in the Medical Staff Bylaws.

3. Consultations:  
Consultation requirements will be as outlined in the Medical Staff Rules and Regulations.

### III. DEPARTMENT MEETINGS

The Department of Medicine/Family Practice will meet quarterly.

### III. PRIVILEGES

1. Privileges:  
Privileges will be granted by the Medicine/Family Practice Department, in accordance with Article V of the Medical Staff Bylaws.

General/Family Practice privileges in Obstetrics shall be governed by the Rules and Regulations of the Department of OB/Gyn/Neonatal. Any and all complications must have a consultant by a qualified obstetrician.

### IV. OBSERVATION REQUIREMENTS

1. Proctoring:  
Following accepted practice, the Medicine/Family Practice Department shall appoint a proctor for each physician/psychologist on provisional status, temporary privileges and those seeking a modification of their current clinical privileges. The applicant is responsible for arranging for his/her proctor to be available to observe the procedure/s when necessary. Proctoring guidelines are as follows:
  - (a) Proctoring shall be accomplished by direct concurrent observation if at all possible. Retrospective review may also be conducted. Cases that are peer reviewed by the department may also be considered as a proctored case.
  - (b) A minimum of three (3) major representative cases must be observed. An additional number of cases may be required if the proctor feels that additional proctoring is required.
  - (c) The proctor shall observe a variety of cases, based upon the privileges requested by the physician/psychologist.
  - (d) The proctor shall complete proctor/evaluation forms which include the type of case, as well as an evaluation of the performance of the individual being proctored and submit the evaluation forms to the Medical Staff Office
  - (e) Proctors must have sufficient training and expertise and must be of the same specialty to judge the quality of work being performed by the Proctoree.
  - (f) State or County medical societies should be consulted for guidance in obtaining a proctor if there are no members qualified to proctor the Proctoree.
  - (g) The utilization of more than one proctor shall be encouraged. Except in extraordinary circumstances, associates shall not proctor each other.

- (h) Proctor/evaluation reports shall be reviewed by the Chief of the Department who, in turn, will make a recommendation to the Credentials Committee and Medical Executive Committee to either discontinue or continue proctoring.
- (i) Proctoring evaluation reports are confidential and are maintained in the practitioner's credential file.

## VII. DUTIES AND RESPONSIBILITIES

1. General rules:  
All members of the Department of Medicine/Family Practice shall comply with the Bylaws, Rules and Regulations and policies of the Medical Staff of Pacific Hospital of Long Beach.

## VIII. SCOPE OF CARE AND SERVICE

1. Critical Care Unit:  
Medical direction is provided through the Department of Medicine/Family Practice. The medical staff includes a Medical Director of Critical Care Unit. The unit ordinarily accepts any patient 13 years or older as the primary population with current or potential life-threatening medical-surgical or cardiac conditions. The Critical Care Unit exists to provide 24 hour high-quality care to adult patients who are critically ill. These patients may be acutely ill in unstable or stable conditions, in need of skilled technological monitoring, or in need of a life-saving procedure that requires a high degree of monitoring.

The primary patient population for the Critical Care Unit may include, but is not limited to patients with: acute or impending respiratory failure, shock, acute cardiac disease, gastrointestinal disease, endocrine/metabolic crisis, ingestion/inhalation, neurologic disorders, other medical conditions such as pulmonary embolus, uncontrolled bleeding, pulmonary edema, surgical problems, and monitoring or technical concerns.

2. Emergency Department:  
Emergency patients are of all ages with diagnoses of varying complexity.

The Emergency Department scope of care involves the assessment, diagnosis, treatment, and evaluation of perceived, actual, or potential, sudden or urgent, physical or psychosocial problems that are primarily episodic or acute and occur in a variety of settings.

3. Medical/Surgical:  
The medical staff includes approved physicians under the direction of the Department of Medicine and Department of Surgery.

The department offers skilled, specialized nursing care to adult and geriatric inpatients with medical or surgical problems.

## IX. PSYCHIATRY SECTION

1. Behavioral Health:  
The medical staff includes psychiatrists, psychologists, and other medical physicians who provide specialized care to the mentally ill patient. The unit accepts patients on Legal Holds applied to individuals who are a danger to self, danger to others, or who are gravely disturbed as well as voluntary admits. The mental health unit is a locked unit designed to offer comfort and promote a sense of well being for all patients, provide quality care, maintain patients' rights, and endeavor to maintain dignity of the patient.

2. Admission of patients
  - (a) Physicians shall admit only those patients suffering from psychiatric disorders.
  - (b) Admissions may be voluntary or involuntary.
  - (c) Refer to Hospital Policies and Procedures for a detailed description of the treatment planning process.
  
3. Admissions criteria
  - (a) All physicians admitting patients shall be held responsible for giving such information to the nursing staff as may be necessary to assure the protection of the patient from the self harm and to assure the protection of other patients from those who are a source of danger.
  - (b) All medically compromised psychiatric patients that are to be admitted to the psychiatric unit via the Emergency Room (ER) should be discussed between the ER physician and the admitting medical physician prior to admission.
  - (c) The medical status of psychiatric patients, new to the psychiatric unit or the physician admitting the patient, should conduct an assessment for medical clearance by the ER physician before admission. Also, the status of patients, known to the physician/hospital, with possible medical problems at time of admission should be evaluated for clearance by the ER physician before admission. Exception to the above maybe referrals from another facility that has already evaluated the medical status of the patient and has cleared him/her. Regardless of the above, ER clearance should be provided to a patient if the admitting psychiatrist or primary care physician (PCP) requests it.
  - (d) The ER work up should include the following tests, unless specified otherwise by his physician or ER physician, CBC, metabolic panel, blood levels of seizure medicine, lithium and valproic acide, UDS and EKG.
  - (e) ER nurse should communicate the findings of their assessments and any other pertinent findings including x-ray, EKG and laboratory results to the psychiatric unit charge nurse.
  - (f) Patients that have blood alcohol levels of greater than 200mg/dl (0.20%) shall be held in the ER or a medical unit until their alcohol level is below 200mg/dl (0.20%) and are physically stable.
  - (g) Patients with seizure disorders should be properly medicated prior to admission to the psychiatric units to prevent from having a break through seizure. Those whose seizure medication blood levels are low but are considered stable should also be admitted to 1 South or 1 West.
  - (h) Psychiatric patient who are medically compromised yet are considered manageable on the psychiatric units should be admitted to 1 South or 1 West. This includes patients who have major organ problems or multiple organ problems that need close observation by nursing staff and/or physicians or might require the resources found in the main hospital e.g. breathing treatments, IV medications, dialysis and frequent wound care.
  - (i) Regarding patients already on the psychiatric unit, who develop a medical emergency, the staff should inform immediately their PCP and treating psychiatrist about their status. Additionally, for patients on 1 South or 1

West, the staff should refer the patient to the Rapid Response Team (RRT). If it is not appropriate or not feasible to refer to the RRT, then they should be referred to the ER. The referral to ER may be done by the PCP, treating psychiatrist (or designee). For emergencies at South Campus, the staff has to call 911 for assistance in addition to notifying the PCP and treating psychiatrist. The PCP may by-pass the referral to ER and admit a patient directly to a medical floor.

- (j) PCP will follow-up with patients with medical problems for a minimum of two days a week or more frequently depending on the acuity/complexity of the patient's medical condition.
- (k) PCP should follow-up with their orders including lab tests, EKG, contrast studies, etc.

4. Treatment Plans:

- (a) The attending physician shall be responsible to insure that comprehensive inter-disciplinary treatment plans are developed, reviewed, updated and are appropriate for each patient under his care.
- (b) The attending physician shall participate in the development of treatment plans for each patient under his care.
- (c) The attending physician shall authenticate each treatment plan for patients under his care demonstrating involvement and approval.
- (d) The attending physician's signature shall permit Allied Health Care Professionals to carry out their identified therapeutic assignments under supervision and within the scope of their licensure.
- (e) Refer to Policies and Procedures for a detailed description of the treatment planning process.

4. Special Treatment Procedures:

- (a) See hospital Seclusion & Restraint Policy
- (b) Electroconvulsive Therapy:  
Hospital does not offer Electroconvulsive Therapy
- (c) Psychosurgery:  
The hospital does not perform psychosurgery on adults, adolescents, or children or other surgical procedures for the intervention in or alteration of a mental, emotional, or behavior disorder.
- (d) Behavior Modification:  
The Hospital does not perform behavior modification procedures that use painful stimuli to adults, adolescents or children.

5. Within 24 hours after admission or immediately before, every patient shall have a complete history and physical examination and psychiatric evaluation performed.

6. Psychiatric Evaluation:

The Psychiatric Evaluation will be completed within twenty-four(24) hours after the patient's admission and will include the following:

- (a) Patient's name, age, sex, and date of evaluation
- (b) Medical record number
- (c) Date of admission

- (d) Chief complaint and/or reaction to hospitalization in patient's words, if possible
- (e) History of present illness
- (f) Past psychiatric history
- (g) Medical history
- (h) Substance abuse
- (i) Medications
- (j) Allergies
- (k) Strengths/weaknesses
- (l) Family and social history, educational, vocational, and occupational history
- (m) Mental Status Exam – estimated intellectual functioning, and memory functioning:
  - 1) Orientation
  - 2) Cognitive functioning including ability to calculate, memory, vocabulary
  - 3) Thought content, pattern, and perception
  - 4) Mood and affect
  - 5) Insight
  - 6) Judgment
- (n) Legal status
- (o) Complete DMSIV diagnosis – all 5 axes
- (p) Initial plan of care

Revised and approved:

Board of Directors: 12/20/00

Board of Directors: 9/17/03

Board of Directors: 11/03

Board of Directors: 10/25/2005

Board of Directors: 11/28/06

Board of Directors: 11/26/08

Board of Directors: 9/29/10

Board of Directors: 11/28/11