

APPENDIX TO THE BYLAWS OF THE MEDICAL STAFF



**MEDICAL STAFF
RULES AND REGULATIONS**

**GUAM MEMORIAL HOSPITAL AUTHORITY
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GUAM MEMORIAL HOSPITAL AUTHORITY

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SECTION I: GENERAL

1.1 ADMISSION AND DISCHARGE OF PATIENTS

- 1.1-1 The hospital shall accept patients for care from all disease categories.
- 1.1-2 A patient may be admitted to the hospital only by a member of the Medical Staff.
- 1.1-3 A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical record, for necessary special instruction, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered in the progress notes of the medical record.
- 1.1-4 except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
- 1.1-5 in any emergency case in which it appears the patient will have to be admitted to a hospital, the practitioner shall, when possible, notify the hospital of the impending admission.
- 1.1-6 When a patient to be admitted on an emergency or urgent basis does not have a private practitioner and is unable to identify a physician willing to accept the case, the physician on call for the Emergency Room is responsible to see that treatment is provided for this patient.
- 1.1-7 Each member of the Staff who does not reside in the immediate vicinity or who will be "off-island" shall name a member of the Medical Staff who is resident in the area who may be called to attend his/her patients in an emergency, or until he/she arrives. This information will shall be reported to the Medical Staff Office and will be transmitted to the Emergency Room. In case of failure to name such associate, the Hospital Administrator, President of the Medical Staff, or chairperson of the department concerned, shall have authority to call any member of the Medical Staff in such an event. Failure to provide appropriate coverage may result in referral to Credentials Committee for possible adverse action.
- 1.1-8 The Admitting Office will admit patients on the basis of the following order of priorities:
- A. Emergency Admissions
The attending physician may be required to furnish sufficiently complete documentation of need for the admission to the Utilization Management Committee or its designee to prevent misuse of this classification.
 - B. Urgent Admissions
This category includes those so designated by the attending practitioner and may be reviewed as necessary by the Utilization Management Committee or its designee to determine priority.
 - C. Routine Admissions
This category includes elective admissions involving all services. If it is not possible to handle all such admissions, the time of scheduling will be reviewed. Admissions will be made on a first-scheduled basis.
 - D. 23 Hour Admissions
This category includes patients admitted for observation who will be released before 24 hours or who will be admitted as inpatients. ICU/CCU, Medical-Telemetry, and NICU will not accept 23-hour admissions.
- 1.1-9 The Admissions Office will be provided with the following information:
- A. Name of the patient;

- B. Patient's Date of Birth;
 - C. Admitting Diagnosis;
 - D. Condition of the patient;
 - E. Expected time of arrival; and
 - F. Method of transportation ambulance or private vehicle.
- 1.1-10 The attending physician shall provide the patient with all necessary orders or call the appropriate nursing unit to give the orders to the individual approved to receive orders over the telephone.
- 1.1-11 The admitting physician will see the patient within a reasonable period of time after admission to the unit. The receiving unit shall inform the attending physician of his/her patient's arrival and of any other information regarding the patient's condition (stable, unstable, critical, etc.).
- 1.1-12 The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatsoever.
- 1.1-13 For the protection of patients, the medical and nursing staffs in the hospital, certain principles are to be met in the care of patients.
- A. Any patient who has given evidence of an overt act and/or apparently attempted suicide and/or any violent act shall be admitted to a room with extra precautions for patient and staff safety. Special nursing and/or security companionship may be provided.
 - B. Any patient who has given evidence of an overt act and/or apparently has attempted suicide and/or any violent act should have, as prescribed by the attending physician, a consultation or referral to a Mental Health Professional.
- 1.1-14 If any question as to the validity of admission to or discharge from the Intensive Care Unit should arise, that decision is to be made through consultation with the Physician Director of the ICU or his/her designee.
- 1.1-15 The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as required by the Utilization Management Committee and GMHA policy. This documentation must contain:
- A. An adequate written record of the reason for continued hospitalization; the simple reconfirmation of the patient's diagnosis is not sufficient.
 - B. The estimated period of time the patient will need to remain in the hospital; and
 - C. Plans for post-hospital care.
- 1.1-16 Patients shall be discharged only on an order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
- 1.1-17 In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff. Policies with respect to release of dead bodies shall conform to local laws.

1.2 ON-CALL PHYSICIANS

- 1.2-1 **Call Schedule:**
 The Hospital is required to maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition. Each Medical Staff Department Head, or his/her designee, shall provide the Emergency Department and the Medical Staff Office with a list of physicians who are scheduled to take emergency call on a rotating basis. Emergency call shall be defined by the service. It is

the responsibility of the physician or his/her designee to keep the Medical Staff Office updated on contact information. The determination as to whether an on-call physician must physically assess the individual in the Emergency Department is the decision of the treating Emergency Department Physician.

- 1.2-2 **Response Time:** It is the responsibility of the on-call physician to respond in an appropriate time frame. The on-call physician or his/her designee should telephonically respond to calls from the Emergency Department within 15 minutes. If requested by the Emergency Department Physician to come in to assess the individual, on call physicians will respond in person to emergency consultation requests within 15 minutes if in the hospital and within 45 minutes if outside the hospital. Longer response times are acceptable if agreeable to the Emergency Department Physician. In specialties (e.g., radiology, pathology) where direct examination of the patient is often not clinically indicated, the physician must view the relevant images, specimens or other clinical materials within the specified time limits.

If the on-call physician does not respond to being called or paged, from the original page, the physician's Department Chairperson shall be contacted. Failure to respond in a timely manner may result in the initiation of disciplinary action.

- A. **Substitute Coverage:** It is the on-call physician's responsibility to arrange for coverage and notify the Emergency Department if he/she is unavailable to take call when assigned. Failure to notify the Emergency Department and the Communications Center of an alternate may result in the initiation of disciplinary action.
- B. **Call Schedules:** All call schedules will be maintained through the Medical Staff Office and changes to call schedule reported through the Communications Center.
- C. **Primary Residence:** All physicians providing call coverage or his/her alternate must maintain a primary residence within thirty (30) minutes of the hospital.
- D. Emergency Department Physicians are expected to document a bedside consult request with time and date.
- E. **Responsibilities of the on call physician include:**
 - 1. responding to the call from the ED or referring physician in a timely manner as described above
 - 2. participating in the evaluation and stabilization of the patient's condition in as it applies to the call service involved
 - 3. treating the patient for the condition for which the call service is involved
 - 4. in the instance the physician does not possess the skills or credentials to provide definitive treatment, the physician will still come in to evaluate/stabilize the patient and will work with the ED provider to identify an alternative treating physician, preferably internally, or transfer to an alternative facility.
 - 5. On-call physicians must refer to EMTALA Rules §489.24(j) for guidance.

1.3 **PATIENT TRANSFERS**

- 1.3-1 In house patient transfer priorities shall be as follows:
- A. From Emergency Room to appropriate patient bed.
 - B. From Obstetric patient care area to general care area, where medically indicated.
 - C. From ICU/CCU to general care area of a telemetry-monitored ward.
 - D. From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.
- 1.3-2 No patient should be transferred without such transfer being approved by the responsible practitioner.

1.4 HISTORY AND PHYSICAL

1.4-1 All history and physical examinations shall be completed no more than **30 days prior** to or **24 hours after** a patient's admission to the Hospital. If a complete history has been recorded and a physical examination performed prior to the patient's Admission to the hospital, a legible copy of these reports may be used in the patient's hospital medical records in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded. All outside records must be in a form approved by the hospital and must be compatible with its current medical records policies and procedures.

1.4-2 H&P's must be recorded within 24 hours of admission and present on the chart before any inpatient or outpatient elective invasive procedure is performed, regardless of location, otherwise the procedure will be canceled unless the attending surgeon states in writing that such delay would constitute a hazard to the patient. In all circumstances, when an H&P has been conducted, but is not present on the chart prior to surgery, a brief admission note on the chart is necessary. The note should include, at minimum, critical information about the patient's condition including pulmonary status, cardiovascular status, BP, Vital signs, etc. Every obstetrical patient must have an H&P. The physician's office prenatal record may serve as the H&P.

Legible copies of the H&Ps performed within 30 days prior to the hospital admission may be used in the medical record if an appropriate assessment performed by a qualified practitioner is completed within 24 hours of admission. All history and physical reports completed prior to the patient's admission must be updated within 24 hours of the patient's admission and prior to surgery to include any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, and confirming that the necessity for the procedure or care is still present. The update note must be attached to the H&P.

Contents of the H&P- For all inpatients, observation patients, and for those outpatients having procedures requiring general, spinal or epidural anesthesia the H&P must include the following documentation as appropriate:

- A. Medical History:
 - 1. Chief complaint
 - 2. History of current illness, including, when appropriate; assessment of emotional, behavioral and social status.
 - 3. Relevant part medical, family and/or social history appropriate to the patient's age.
 - 4. Review of body systems.
 - 5. A list of current medications and dosages.
 - 6. Any known allergies including past medication reactions and biological allergies
 - 7. Existing co-morbid conditions
- B. Physical examination: current physical assessment
- C. Provisional diagnosis: statement of the conclusions or impressions drawn from the medical history and physical examination.
- D. Initial Plan: statement of the course of action planned for the patient while in the hospital

1.4-3 For other outpatient (ambulatory) surgical patients, as necessary for treatment:

- 1. Indications/symptoms for the procedure
- 2. A list of current medications and dosages
- 3. Any known allergies including past medication reactions
- 4. Existing co-morbid conditions
- 5. Assessment of mental status
- 6. Exam specific to the procedures performed

- 1.4-4 For patients receiving procedural sedation, all of the above elements, plus the following:
1. Examination of heart and lungs by auscultation
 2. American Society of Anesthesia (ASA) status
 3. Documentation that patient is an appropriate candidate for procedural sedation.
- 1.4-5 Emergency Department Reports - A report is required for all Emergency Department visits. The following physician protocol should be followed:
1. Adequate patient identification
 2. A list of current medications ;dosages; and known allergies
 3. Information concerning time and means of arrival
 4. Pertinent history of the injury or illness;
 5. Significant clinical, laboratory, and radiologic findings
 6. Diagnosis and treatment given;
 7. Condition of patient on discharge or transfer;
 8. Final disposition, including instructions given to patient and/or his/her family, relative to necessary follow-up care.
 9. The record shall be signed/timed /dated by the physician in attendance, who is responsible for its clinical accuracy.
- 1.4-6 Responsibility for H&P - The attending medical staff member is responsible for the H&P, unless it was already performed by the admitting medical staff member. Dentist and podiatrist are responsible for the part of their patients H&P that relates to dentistry or podiatry.
- 1.4-7 Admission within 30 days of discharge for the same diagnosis, the previous history and physical examination is acceptable provided an interval admission note is included in the recording.
- 1.4-8 In the latter instance, the Admission Note should include a record of the status of the Cardiovascular respiratory system and other such data that are relevant to the problem of the patient. All history and physical examinations must be done no more than 30 days before or 24 hours after admission of the patient.
- 1.4-9 When such history and physical examination and the routine laboratory examination reports are not recorded before the time stated for a scheduled operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled by the operating room supervisor, unless the attending surgeon or physician states in writing that such a delay would constitute a hazard to the patient.
- 1.4-10 In all cases where history and physical have been dictated but are not on the chart, the Medical Records Department will place on the chart as soon as possible.
- 1.4-11 In the interim and in emergencies when transcriptionist is not on duty, the surgeon should document the following in the patient's record:
- A. existence of a dictated history and physical examination;
 - B. known allergies;
 - C. previous experience with any anesthesia; and
 - D. the indications for the surgery or procedure to be performed.
- 1.4-12 A podiatric patient shall have a history and physical examination by a Medical Staff physician, whose name shall appear on the front sheet together with the name of the Podiatrist, and a podiatric history and physical shall be recorded prior to surgery.

- 1.4-13 Pelvic examinations are recommended for female patients over the age of 18 years, including a pap smear, unless a negative result was received on this patient in the last one year.
- 1.4-14 Rectal examinations are recommended for patients unless contraindicated.
- 1.4-15 Funduscopic examinations are recommended as part of the physical examination on patients with conditions which may involve the eye grounds.

1.5 CONSENTS

- 1.5-1 Consents for treatment and/or surgical operations shall be obtained from the patient or his/her legal representative except where such consent may result in delaying the administration of treatment or the performance of the necessary surgical operations, i.e., emergency cases.
- 1.5-2 The attending physician or surgeon is responsible for informing the patient of the nature of and risks and alternatives inherent in any surgical procedure, invasive diagnostic procedure, or other procedure as defined by specific policies regarding informed consent.

1.6 SCHEDULING

- 1.6-1 Except in cases where patients are to be hospitalized for operations, scheduling shall be accomplished in accordance with current admitting procedures.
- 1.6-2 All surgical procedures to be performed in the operating room shall be scheduled with the Ward Clerk in Surgery.
- 1.6-3 The surgeon, when scheduling a surgical case, must provide sufficient information to permit a realistic estimate of the operating time, surgical set-up, and hospital personnel to be provided. The basic information needed to assist the patient and surgeon includes:
 - A. Preoperative diagnosis;
 - B. All contemplated operative procedures;
 - C. Presence of infection or contamination, if any;
 - D. Request for additional hospital personnel; and requests for any special surgical prep orders or equipment if needed.
- 1.6-4 Those cases involving life-endangering or life-threatening situations shall automatically take precedence over scheduled and/or elective surgeries.

1.7 GENERAL CONDUCT OF CARE

- 1.7-1 Every inpatient at the acute level of care of the hospital shall be visited by his or her attending physician at least once a day; and more frequently if necessary. Each acute inpatient record except for the SNU level of care patient requires a written daily Progress Note by the attending physician.
- 1.7-2 Inpatients at the SNU level of care and resident in the Skilled Nursing Unit should be visited by their physician as frequently as medically necessary; and additionally when so requested by an SNU nurse or the SNU Medical Director .

Every SNU patient shall require an attending physician visit and written Progress Note within each 30 day period; without exception. This is a CMS requirement.

- 1.7-3 Any qualified practitioner with clinical privileges in this hospital may be called foR consultation within his/her area of expertise.
- 1.7-4 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant.

- 1.7-5 After attempting to contact and discuss with the attending practitioner, a nurse who has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the Supervisor who in turn may refer the matter to the Administrator of Nursing. The Administrator of Nursing will notify the Associate Administrator of Medical Services or the Hospital Administrator of the situation. If warranted, the Associate Administrator of Medical Services or the Hospital Administrator will bring the matter to the attention of the chairperson of the department wherein the practitioner has clinical privileges. The chairperson of the department will contact the attending physician to review the situation. When circumstances are such as to justify such action, the chairperson of the department may request a consultation.

1.8 ORDERS

1.8-1 General Requirements

- A. All orders for treatment or diagnostic tests shall be written in ink and shall be clear, legible, complete, and signed, dated and timed by the practitioner.
- B. Orders which are illegible or improperly written will not be carried out and the attending physician will be so notified. It is the responsibility of nursing to consult with the attending physician concerning any questionable orders.
- C. Orders for diagnostic tests which necessitate the administration of test substances or medications shall include the order to give those substances or medications.
- D. All patients for discharge shall have a written order by the attending physician.
- E. Orders may be written or reprinted and signed by the attending physician.
- F. All requisitions for radiologic or nuclear medicine examinations shall contain the reason(s) for the examination.
- G. Specific orders shall be written when the attending physician desires continuous ventilation therapy or oxygen therapy for a patient. The order shall contain the mode, respiratory rate, volume, pressure limits and Fraction of Inspired Oxygen.

1.8-2 Telephone and Verbal Orders

- A. Telephone and verbal orders shall be countersigned within 48 hours by the physician who gave the order, or by the physician alternate.
- B. Telephone and verbal orders may be given to:
 - 1. Licensed nurses
 - 2. Allied Health Professionals employed by members of the Medical Staff.
- C. Telephone and verbal orders should be minimized; and must include the "TORB" and "VORB" procedures required by Joint Commission. Telephone orders to SNU may be more often required since the SNU unit is off the GMHA main campus.

1.8-3 Standing Orders and Range Orders

- A. Standing orders and Range Orders for any department may be proposed by the Department chairman or the Physician Director of that unit.
- B. These orders shall be formulated in consultation with the appropriate medical staff department. and approved by the MEC.
- C. All standing orders and Range Orders shall be listed on the Physician's Order sheet that must be included in the patient's medical record.
- D. All standing orders and Range Orders shall be signed and dated and timed by the attending physician.
- E. Standing orders and Range Orders shall be considered as a specific order by the attending physician for that patient. These orders shall be followed in the absence of other specific orders by the attending physician, insofar as the proper treatment of the patient will allow.

- F. All standing orders and Range Orders shall be reviewed at least biannually and revised as necessary

1.8-4 **Corrections**

- A. Should a practitioner dispute the contents of a written verbal order, he shall leave the order as written and explain in the progress notes why he did not countersign.
- B. Correction of Orders
Errors shall be corrected as follows (as per American Health Information Management Association):
 1. A single line in ink should be drawn through the incorrect entry with "error" at the top of the entry with the legal signature or initials, date and time.
 2. Errors must never be obliterated.
 3. The existing entry shall be left intact with corrections being entered in chronological order.
 4. Late entries should be labeled as such.

1.8-5 Infections

- A. In cases where appropriate isolation orders are required, isolation procedures should be initiated by the nursing staff and Infection Control Officer and attending physician should be notified as soon as possible.
- B. In all cases where infection is suspected, and particularly with all draining wounds, the attending physician shall be notified and permission requested to order a culture. Infection Control Nurse or any other charge nurse assigned to the case shall have authority to culture all draining wounds except when attending physician orders otherwise.
- C. Patients with diagnosed infection that need telemetry must be transferred to Medical-Telemetry at the request of the attending physician.
- D. If a patient is thought to be a threat to other patients in the ICU/CCU area, he or she should be moved out of the ICU/CCU area. If there is a dispute about the need for such transfer, the Infection Control officer will reach an appropriate decision with the ICU/CCU Director, the department chair, and the attending physician.
- E. In transporting patients from the ICU/CCU area, the guidelines in the Infection Control Manual should be used for reference.
- F. All members of the medical staff and allied health professionals shall adhere to the hospital-approved policies regarding universal precautions. Additionally, the provisions of the "Blood-borne Pathogens Exposure Control Plan" require knowledge of personal protective equipment, work practice controls, engineering controls, and reporting requirements for exposure to blood-borne pathogens in order to minimize the risk of exposure to HIV and HBV.

1.8-6 Orders by Allied Health Professionals (AHP)

- A. An AHP may write orders only to the extent, if any, specified in the position description developed for that category of AHP's and consistent with the scope of services individually defined for him or her.
- B. Any authorized order by an AHP must be countersigned by the responsible supervising practitioner within the time frame required by Guam law

1.8-7 Automatic Cancellation of Orders

- A. All previous orders are automatically discontinued, unless a specific order is written otherwise, when:
 1. the patient goes to surgery; or

2. is transferred to another level of service;
- B. The medical record shall be flagged to indicate this has occurred and a listing of the discontinued orders will be attached thereto.

1.8-8 Stop Orders

- A. When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing physician is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified.
- B. Drugs: (Please refer to appropriate section of the Pharmacy Department Policies and Procedures Manual for further information.)
 1. There will be a "stop order" on antibiotics after five (5) days and anticoagulants after seven (7) days for adults and twenty four (24) hours for pediatric cases requiring the use of anticoagulants except where the number of doses or the number of days is specified.
 2. Orders requiring a narcotic license, i.e., narcotics, hypnotics shall be discontinued after forty eight (48) hours. A new order for these drugs will be written for any period in excess of the forty eight (48) hours' time limit.
The other medications which are not narcotics, hypnotics, antibiotics or anticoagulants will expire in 30 days.
 3. All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, the National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations.
 4. Each member of the medical staff and the various departments and services shall have access to a copy of the Guam Memorial Hospital Formulary.

1.8-9 Blood Transfusions and Intravenous Infusions

- A. Blood transfusions and intravenous infusions shall be started by the attending physician or registered nurse who has the requisite training and has been credentialed to do so in the hospital.
- B. The order shall specifically state the rate of infusion.

1.8-10 Special Orders

- A. Drugs brought into the hospital by a patient may not be administered unless the drugs have been identified by a registered Pharmacist and there is a written order from the attending physician to administer the drug.
- B. Self-administration of medication by a patient is permitted on specific written order by the attending physician and in accordance with established hospital policy.

1.8-11 Investigational Medications

- A. The use of investigational medications and medications in clinical trials must be in full accordance with the regulations of the Food and Drug Administration and must be approved by the appropriate department, Institutional Review Board and the Medical Executive Committee.
- B. Investigational medications and medications in clinical trial, based on applicable law, regulation and statutes shall be used only under the direct supervision of the principal investigator in accordance with an approved protocol for administering.
- C. The principal investigator shall be responsible for receiving all requirements for informed consent, completing all necessary forms and shall prepare and clarify directions for the administration of investigational drugs as to:
 1. untoward symptoms;

2. special precautions in administration;
3. proper labeling of container;
4. proper storage of drug;
5. administration of investigational medications and medications in clinical trials by those approved by the principal investigator to do so, and only after they have been given and demonstrated an understanding of pharmacological action, possible adverse effects and appropriate response;
6. method of documentation of doses dispensed, administered and destroyed when indicated; and
7. method of collection and recording specimens of urine and/or other specimens

1.9 CONSULTATION

- 1.9-1 The attending physician is charged with the responsibility of securing consultations when indicated. It is the duty of the Medical Staff through its chairpersons of departments and services and the Medical Executive Committee to make certain that members of the Staff do not fail in the matter of requesting consultations as needed.
- 1.9-2 Consultation shall not be requested prior to notification of the attending physician responsible for the case, and it shall remain the responsibility of the attending physician to notify the consultant.
- 1.9-3 The "Request for Consultation" should be properly completed with the reason for consultation, opinion and diagnosis, and current management of the case.
- 1.9-4 The Consultant shall examine the patient and the record at the earliest possible time, unless specified otherwise and complete a written report and sign it. The date and time of the consultation shall be part of the record.
- 1.9-5 If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of his/her supervisor, who may either refer the matter to the chairperson of the appropriate medical department or to the Assistant Administrator of Nursing Services for appropriate action, if warranted.
- 1.9-6 Except in an emergency, consultations with another qualified physician are recommended in the following instances:
- A. When the patient is not a good risk for operation or treatment;
 - B. Where there is doubt as to the choice of therapeutic measures to be utilized;
 - C. In unusually complicated situations where specific skills of other practitioners may be needed;
 - D. In instances in which the patient exhibits severe psychiatric symptoms;
 - E. When requested by the patient or his/her family.
- 1.9-7 Consultants must be members of the Medical Staff and must have full privileges in the field in which their opinion is sought.

When patient care services are performed outside the Hospital by another service provider, the service provider is approved by the Medical Staff through its designated mechanism; and a written agreement requires that the service provider meet applicable Joint Commission standards.

In extraordinary situations when no suitable consultant is available on the Medical Staff; and no written agreement exist with a community based consultant meeting Joint Commission

Standards; the consultation and /or procedure outside the Hospital may be permitted if informed consent is obtained between patient and attending physician.

- 1.9-8 The consultant may write orders if requested to do so. In all situations, the consultant will follow the standard ethics of the consultation process.
- 1.9-9 It is understood the patient's physician shall be responsible for advising the patient or the next of kin of the advisability of consultation. The patient or next of kin shall be informed when a consultant is requested.
- 1.9-10 The attending physician has the ultimate responsibility for the adherence to or variance from the consultant's opinions and recommendations.

1.10 ADMISSION TO SKILLED NURSING UNIT

Each member of the Medical Staff who admits a patient to the SNU must complete and shall comply with Medicare documentation requirements.

SECTION II: MEDICAL RECORDS

2.1 OWNERSHIP

All patient records, including radiologic films, tissue slides, and tissue(s) removed from a patient are the property of the hospital and may be removed from the hospital's jurisdiction and safe-keeping only in accordance with a court order, subpoena or statute. Unauthorized removal of medical records and tissue from the hospital may constitute grounds for disciplinary action GMHA.

2.2 RELEASE OF RECORD

2.2-1 Written consent of the patient or his or her legally qualified representative is required for release of medical information to persons not otherwise authorized to receive this information. This shall not be construed to require written consent for use of the medical record for automated data processing of designated information; for use in patient care evaluation studies, and for monitoring of quality improvement indicators for use in peer review; for official surveys for hospital compliance with accreditation, regulatory, and licensing standards; or for educational purposes and research programs consistent with preserving the confidentiality of personal information concerning the individual patients.

2.2-2 When certain portions of the medical record are so confidential that extraordinary means are considered necessary to preserve their privacy, such as in the treatment of some psychiatric disorders, these portions may be sorted separately, provided the complete record is readily available when required for current medical care of follow-up, for review functions, or for use in patient care evaluation studies. The medical record should indicate that a portion has been filed elsewhere, in order to alert authorized reviewing personnel of its existence.

2.2-3 When a patient is readmitted, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or another.

2.2-4 Subject to the discretion of the Hospital Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

2.3 CONTENT OF THE RECORD

2.3-1 ASSESSMENT OF PATIENT

The medical record for each patient shall contain the following which are legible and complete. This record shall include the following:

- A. Identification data (patient's name, address, date of birth, and the name of any legally authorized representative;
- B. Legal status, for patients receiving mental health services;
- C. Emergency care provided to the patient prior to arrival; if any;
- D. Assessment of Patient: Record and findings of the assessment of the patient's physical, psychological (including cognitive and communication skills or developmental) and social status.

When indicated and as appropriate, functional assessment for each patient referred for biopsychological rehabilitation services; Nutritional assessment by qualified dietitian on patients assessed at moderate and high nutritional risk; and education needs.

Nursing care assessment.

For outpatient Labor and Delivery Patients, the Medical Staff permits a qualified Labor and Delivery Registered Nurse to perform the medical screening exam of a patient to certify false labor by the utilization of a nursing assessment, including vaginal examination, and may discharge the patient from the facility provided that:

1. the procedure is approved and documented in hospital/facility bylaws.
 2. the RN functions under the protocols/algorithms that re approved by an interdisciplinary practice committee.
 3. the registered nurse has a post assessment consultation with a licensed obstetrical provider and receives a discharge order from that provider.
 4. the registered nurse has the documented knowledge, skills and abilities to complete the assessment and competency is appropriately documented.
- E. Statement of the conclusions or impressions drawn from the medical history and examination;
- F. Diagnosis or diagnostic impression;
- G. Reason(s) for admission or treatment;
- H. Goals of treatment and the treatment plan;
- I. Evidence of known advance directives;
- J. Evidence of informed consent for procedures and treatments for which informed consent is required by the Hospital;
- K. Diagnostic and therapeutic orders, if any;
- L. All diagnostic and therapeutic procedures and tests performed and the results;
- M. All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate;
- N. Progress notes by the medical staff and other authorized individuals;
- O. All reassessments, when necessary;
- P. Clinical observations;
- Q. Response to the care provided;
- R. Consultation reports;
- S. Every medication ordered or prescribed for an inpatient;
- T. Every dose of medication administered and any adverse drug reaction;
- U. Each medication dispensed to or prescribed for an ambulatory patient or an inpatient on discharge;
- V. All relevant diagnoses established during the course of care (based on terms specified in the Standard Nomenclature of Diseases and Operations [SNOP], International Classification of Disease--9th Revision--Clinical Modification [ICD-9-CM], Current Procedural Terminology [CPT], and Uniformed Healthcare Discharge Data Set [UHDDS]);
- W. Any referrals or communications made to external or internal care providers;
- X. Condition on discharge;
- Y. Discharge summary or note;
- Z. Follow-up and autopsy when performed.
- 2.3-2 No medical record shall be filed until it is complete, except by order of the appropriate department chairperson and the GMHA CEO.
- 2.3-3 A complete admission history, physical examination and nursing care assessment shall be recorded within 24 hours of admission in accordance with Section 1.3. This time frame applies for weekdays, weekend, and holiday admissions.
- 2.3-4 Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability.
- A. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

- B. All patients at the acute level of care must be assessed daily by the attending practitioner or designee and this assessment must be documented on the patient's chart.
- C. Pertinent progress notes should also be made by others so authorized by the Medical Staff and individuals who have been granted clinical privileges.

2.3-5 The medical record of patients undergoing operative or other invasive procedures and/or anesthesia includes the additional following information:

- A. An operative progress note is entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.
- B. Preoperative diagnosis prior to surgery by the licensed physician who is responsible for the patient records;
- C. An Operative Report for Inpatients and Outpatients must be written or dictated immediately following surgery describing techniques, findings, tissues removed or altered, any implants, postoperative diagnosis and name of the primary surgeon and any assistants, and to be signed by the surgeon and filed into the patients chart.
- D. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible following surgery.

2.3-6 Postoperative documentation includes at least a record of the following:

- A. Vital signs and level of consciousness;
- B. Medications (including intravenous fluids) and blood and blood components;
- C. Any unusual events or postoperative complications, including blood transfusion reactions, and the management of those events;
- D. Identification of who provided direct patient care nursing services and who supervised that care if it was provided by someone other than qualified registered nurses;
- E. The patient's discharge from the post anesthesia care area by the responsible licensed independent practitioner or by the use of relevant discharge criteria; and
- F. The name of the licensed independent practitioner responsible for the discharge.

2.3-7 Consultations shall show evidence of a review of the patient's record by a qualified specialist, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

2.3-8 The current obstetrical record shall include a complete prenatal record. In lieu of a history and physical, the prenatal record, which may be a legible copy of the attending practitioner's office record, may be transferred to the hospital before admission. In addition to the prenatal record, an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

2.3-9 All clinical entries in the patient's medical record shall be accurately signed, dated and timed, and a method is established to identify the authors of entries.

- A. Authentication means to establish authorship by written signature or identifiable initials, rubber-stamp signatures, or computer key.
- B. When rubber-stamp signatures or computer key are authorized, the individual whose signature the stamp represents or whose computer key is authorized signs a statement that s/he alone will use the stamp or the code for the computer key. This statement is filed in the practitioner's credentials file with copies sent to Pharmacy and Medical Records Department.

- C. The medical practitioner authenticates the parts of the medical record that are his/her responsibility.
- 2.3-10 Symbols and abbreviations may be used only if approved by the Joint Commission. An official record of approved abbreviations should be kept on file in the Medical Records Department.
- 2.3-11 Final diagnosis should be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.
- 2.3-12 A discharge summary shall be written or dictated on all medical records of patients hospitalized (greater than 48 hours) when death or transfer to another facility has occurred.
- 2.3-12.1 A discharge summary shall include the following factors:
- A. Reason for hospitalization;
 - B. Significant findings;
 - C. Procedures performed and treatment rendered;
 - D. Patient's condition on discharge; and
 - E. Specific instructions given to the patient and/or family, as pertinent.
- 2.3-12.2 A transfer summary may be substituted for the discharge summary in the case of the transfer of the patient to a different level of hospitalization or Skill Nursing Facility within the Hospital organization.
- 2.3-12.3 A final progress note may be substituted for the discharge summary only for those patients with problems and interventions of a minor nature (as defined by the Medical Staff) who require less than 48 hours period of hospitalization, and in the case of normal infants, and uncomplicated obstetrics deliveries.
- A. The final progress note shall document the following:
 - 1) Condition of patient on discharge;
 - 2) Special instructions to the patient and/or family;
 - 3) Final Diagnosis;
 - 4) Procedures performed.
 - B. The physician's record of newborn infant report may be used for normal newborn discharges. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.
 - C. All summaries shall be authenticated by the responsible practitioner.
- 2.3-13 When authorized by the patient or his or her legally authorized representative, a copy of the emergency services provided is available to the practitioner or medical organization responsible for follow-up care;
- Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- 2.3-14 Free access to the data contained in the medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee before records can be studied.
- 2.3-15 When Allied Health Professionals are involved in patient care, sufficient evidence should be documented in the medical records to substantiate the active participation in, and supervision of, the patient's care by the responsible attending physician.

2.4 INCOMPLETE AND DELINQUENT MEDICAL RECORDS

- 2.4-1 Medical records must be completed within thirty (30) calendar days after the patient is discharged. To enforce this ruling, a suspension policy has been established and will be enforced as prescribed.
- A. Within nine (9) calendar days after discharge date, the Medical Records Department shall send the physician a First Notice to complete the chart.
 - B. If not completed within eighteen (18) calendar days after discharge date, the Medical Records Department shall transmit a second notice to the physician and a copy to the Chairperson of the Department of which the physician is a member.
 - C. If not completed within twenty-seven (27) calendar days after the Discharge date, the Medical Records Department shall prepare a third notice to be sent by the Office of the President of the Medical Staff to the physician and a copy of the Chairperson of the Department of which the physician is a member.
 - D. This third notice shall inform the physician that he or she has forty-eight (48) hours to complete the delinquent charts.
 - E. If the physician fails to comply with this, the Chief of Staff or designee shall issue a notice to the physician that hospital privileges are suspended until all delinquent charts are completed.
 - F. If the physician has filed the proper off-island notification and is off-island when a third notice is given, then the third notice will be reissued to that physician upon his/return and shall inform the physician that he or she has forty-eight (48) hours to complete the delinquent charts.
 - G. Members of the Professional Staff are required to complete medical records within such reasonable time as may be prescribed by the Medical Executive Committee. A limited suspension in the form of withdrawal of admitting and other related privileges until medical records are completed, shall be imposed by the Chief of Staff or designee, after notice of delinquency for failure to complete medical records within such period. For the purpose of this Section, "related privileges" means scheduling surgery, assisting in surgery, consulting on hospital cases, and providing those professional services specific to each physician. Bona fide vacation or illness may constitute an excuse subject to approval by the Medical Executive Committee. Members whose privileges have been suspended for delinquent records may admit patients only in life-threatening situations when an alternative admitting physician is not available or while on emergency department call; and shall not be exempt from such call, or from caring for patients already admitted. The suspension shall continue until lifted by the Chief of Staff or his/her designee, or by the Medical Executive Committee (MEC). If the member resigns while on the suspension list or does not complete his/her medical records within 30 additional calendar days following the Automatic Suspension, he/she is considered resigned not in good standing; and will be so notified by the Chief of Staff with the concurrence of the MEC and the Medical Director. Bona fide illness may constitute an excuse subject to approval by the Medical Executive Committee.

2.6 AUTOPSIES

- 2.6-1 Every member of the medical staff shall attempt to secure autopsies in cases of potential medical and educational interest including:
- A. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
 - B. Deaths in which the cause is not known with certainty on clinical grounds.
 - C. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death.

- D. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
 - E. Deaths occurring in patients who have participated in clinical trials (protocols) approved by the institutional review board.
 - F. Sudden, unexpected, or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.
 - G. Natural deaths that are subject to but waived by a forensic jurisdiction such as the following:
 - 1) Deaths occurring in GMHA within 24 hours of admission; and
 - 2) Deaths in which the patient sustained or apparently sustained an injury while hospitalized.
 - H. Deaths resulting from high-risk infectious and contagious disease.
 - I. All obstetric deaths.
 - J. All neonatal and pediatric deaths except when the cause of death is clear to both the physician(s) and parents with the concurrence of a staff pathologist or Chief Medical Examiner.
 - K. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness, which may also have a bearing on survivors or recipients of transplant organs.
 - L. Deaths known or suspected to have resulted from environmental or occupational hazards.
- 2.6-2 Proper written consent for an autopsy by the appropriate relative or authorized agent shall be in accordance with hospital policy on informed consents.
- 2.6-3 All autopsies shall be performed by a hospital pathologist, by his or her qualified designee, or by the Chief Medical Examiner according to Guam law.

2.7 REPORTS OF PROCEDURES, TESTS, AND THE RESULTS

- 2.7-1 Reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures shall be completed promptly, authenticated, and filed in the record, within twenty-four (24) hours of completion, if possible. Facilities outside the hospital from which reports are received shall be identified on the report.
- 2.7-2 On pre-operative chest X-rays ordered by the physician; either a wet reading or a typed report should be in the patient's chart prior to the surgery.
- 2.7-3 The radiologist reserves the right to return x ray request slips if they are not completed properly.
- 2.7-4 Each apparent transfusion reaction shall be reported immediately to the laboratory blood bank, and to the patient's physician, and a reaction report form should be completed. The laboratory immediately shall perform necessary tests to determine whether a hemolytic reaction has occurred and, if so, attempt to find the cause. The results of all such tests shall become a permanent part of the patient's record.
- 2.7-5 Pathology reports will be available, dictated and in the patient's chart within ninety six (96) hours after the surgery is performed.
- 2.7-6 The pathologist reserves the right to return request slips if they are not completed properly.

SECTION III: PHYSICIAN DIRECTORS

3.1 ACCOUNTABILITY

Each Physician Director is accountable to the Hospital Administrator or his designee.

3.2 EVALUATION

An ongoing evaluation of all patient care services shall be done by the Physician Directors with employees of each department/service.

3.3 ANNUAL REVIEW

A yearly review of services should be conducted by the Physician Directors and the Associate Administrator of Medical Services and submitted to the appropriate department and the Medical Executive Committee.

SECTION IV: ASSOCIATE ADMINISTRATOR OF MEDICAL SERVICES

Shall be appointed by the Hospital Administrator with the approval of the Board of Trustees; with recommendations from the Medical Executive Committee.

4.1 DUTIES

- 4.1-1 Act in coordination and cooperation with the President of the Medical Staff on all matters of mutual concern within the hospital.
- 4.1-2 serve as ex officio member of all medical staff committees.
- 4.1-3 work to improve the medical practices used in patient care.
- 4.1-4 deal with problems or differences between physicians; carry out the hospital policy on disruptive physicians.
- 4.1-4 recruit physicians for the hospital.
- 4.1-5 act in coordination and cooperation with the president of the medical staff in the enforcement of the medical staff bylaws, rules and regulation, for implementation of sanctions when these are indicated; and when corrective action has been requested against a practitioner.
- 4.1-6 act in coordination and cooperation with the president of the medical staff in representing the views, policies, needs, and grievances of the medical staff to the bot and to the hospital administrator.
- 4.1-7 act in coordination and cooperation with the president of the medical staff in receiving and interpreting the policies of the bot on the performance and maintenance of quality and safety with respect to the medical staff's delegated responsibility to provide medical care.
- 4.1-8 have the authority and responsibility to carry out the established policies of the performance improvement committee, utilization management committee, and all professional ancillary services when directly concerned with patient care.
- 4.1-9 be responsible for the overall direction of house physicians.
- 4.1-10 help to direct the continuing medical education program for the medical staff.
- 4.1-11 review and evaluate all physician directors at least bi-annually.
- 4.1-12 exercise authority to assign house cases.

SECTION V: AMBULATORY SURGERY

5.1 DEFINITION

Shall be done according to the Rules and Regulations of the Department of Surgery.

SECTION VI: RESTRAINTS AND SECLUSION

6.1 USE

The use of Restraints or Seclusion shall be in compliance with the established hospital policies consistent with CMS and Joint Commission Standards.

SECTION VII: DO NOT RESUSCITATE ORDERS

7.1 POLICY

All physicians shall comply with the hospital's approved DO NOT RESUSCITATE (DNR) policy.

SECTION VIII: ADVANCE DIRECTIVES

8.1 DEFINITION

All advance directives shall be honored in accordance with Federal and Guam laws

SECTION IX: PROCTORSHIP and FPPE; and OPPE

9.1 PROCTORSHIP/FPPE

All physicians and other Medical Staff members requesting privileges with Guam Memorial Hospital shall undergo a proctorship/FPPE (Focused Professional Practice Evaluation) within the Department he or she is requesting privileges. The proctorship/FPPE must be implemented immediately upon granting of privileges, including Temporary Privileges; so that patient safety is assured.

9.2 BASIS

This proctorship/FPPE program is the basis for granting initial or additional Medical Staff privileges. The details of this proctorship/FPPE shall be determined by the Department Chair for each applicable Medical Staff member; and approved by the Credentials Committee and the MEC; as required. Also, the OPPE (Ongoing Professional Practice Evaluation) program provides for continuous evaluation of all physicians beyond the Temporary and Provisional Staff period so that high quality care and patient safety is assured. See applicable Medical Staff Bylaws, Rules and Regulations; and specific Medical Staff Policies

SECTION X: PATIENT TRANSFERS

10.1 RESPONSIBILITY

- 10.1-1 The attending physician is responsible for the evaluation of the medical need for, determination of the type of, and the assessment of the fitness for patient transfer. The responsibility of the attending physician for patient transfer includes:
- A. Completing the history and physical examination;
 - B. Stabilizing the patient medically and summarizing this stabilization in the progress notes;
- 10.1-2 A patient may not be transferred without prior stabilization unless the following conditions apply:
- A. The patient or legal representative requests for the transfer; and
 - B. The medical risks of not being transferred outweigh the risks of the transfer itself; and
 - C. The risks associated with transfer are explained to the patient or legal representative and consent for transfer is obtained releasing the Hospital and its agents from any liability which is associated with the transfer.
- 10.1-3 The attending physician is responsible for discussing the need for transfer with the patient and/or the legal representative. If they concur, the attending physician determines a facility that has the services and skills needed for the patient.
- 10.1-4 The attending physician is responsible contacting a referral facility to make arrangements with a physician and facility who will accept the patient transfer and confirming with a representative of the Admissions Department of the accepting facility, that a bed will be available for the patient. The attending physician must record the name of the accepting facility, physician who has agreed to assume care for the patient, and the admissions staff contact person on the appropriate sections of the "Authorization for Patient Transfer" Form Sections I and III.
- 10.1.5 The attending physician is responsible to write an order for the specific type of transfer that will be required (emergency, medivac, non-emergency, or elective), when the transfer should take place, seating requirements (stretcher, fully reclining first class seat, incubator, or regular coach seat), the specific classification of the patient escort needed (physician, registered nurse, licensed practical nurse, respiratory therapist) along with any specific qualifications needed (adult, pediatric, neonatal critical care experience, ACLS, PALS), identification of all radiology, CT scans, pathology reports/slides, laboratory results, or drug profiles to be released with the patient, all equipment needed, and all medications needed for the duration of the transport.
- 10.1-6 The attending physician is responsible for informing the Associate Administrator of Medical Services of the plan to transfer the patient if a physician escort is required or Nursing is unable to provide a qualified Nurse Escort.
- 10.1-7 The attending physician is responsible Completing the air transportation "Fitness for Air Travel" form and completing the "Informed Consent: Patient Transfer" form.

10.2 ADDITIONAL MEDICAL STAFF RESPONSIBILITIES FOR SPECIFIC TRANSFER SITUATIONS:

- 10.2-1 If the transfer is refused by the patient or legal representative the attending physician is responsible for:
- A. Completing Section IV of the "Authorization for Patient Transfer" form.
 - B. Documenting in the progress notes the information communicated to the patient or legal representative, the opposition expressed to the transfer, and any other interventions taken to change the patient's decision against transfer.

- C. Requesting that the patient or legal representative sign a "Refusal for Transfer against Medical Advice Form". If this is refused, the refusal must be indicated on the appropriate section of the form.

10.3 IF A TRANSFER IS NOT MEDICALLY NECESSARY BUT, THE PATIENT OR LEGAL REPRESENTATIVE INSISTS UPON ONE THE ATTENDING PHYSICIAN MAY:

- 10.3-1 Discharge the patient if his/her medical condition warrants it or obtain, as appropriate, "Release against Medical Advice" signature.
- 10.3-2 Assist in the arrangement for transfer as part of discharge planning.
- 10.3-3 Arrange for a second opinion or referral to another facility.
- 10.3-4 Provide orders and instructions for necessary care during transfer.

10.4 A PHYSICIAN WHO PERFORMS THE ROLE OF PATIENT ESCORT HAS THESE ADDITIONAL RESPONSIBILITIES:

- 10.4-1 Reports to the nursing unit where the patient is currently cared for prior to the scheduled time of departure from GMHA. Assures that he/she has a current passport/proof of citizenship and any required visa(s).
- 10.4-2 Reviews the patient's medical record.
- 10.4-3 Meets the patient if he/she has not already done so, and if possible a family member or the legal representative.
- 10.4-4 Verifies with the charge nurse that all of the needed medication, equipment, and supplies have been ordered by the attending physician, and that they have been packed for the transfer. Also verifies that the patient and any accompanying persons have a current passport and any required visa(s).
- 10.4-5 Reviews the Pre-Transfer Checklist to ensure all arrangements regarding the transfer have been or are being completed.
- 10.4-6 Assures that all necessary equipment has been or is being checked by the Bio-Medical Department for safety.
- 10.4-7 Obtains from nursing supervisor's office a Patient Escort Packet containing:
 - A. Copy of the Patient Transfer Policies and Procedure;
 - B. Listing of GMHA address, phone and FAX numbers. Ensure the U.S. Embassy phone number is listed for transfers to a foreign country;
 - C. Patient Transfer Record;
 - D. Patient/Family Questionnaire;
 - E. Concurrent Transport Review Form; and
 - F. Patient Transfer Expense Report Form;
- 10.4-8 During the transport the escort completes the "Patient Transfer Record". This record contains, at minimum, the following information:
 - A. Documentation of pulse, respiration, blood pressure and temperature prior to the transfer, following landing and as indicated;

- B. Documentation of any problems encountered enroute, the interventions that were implemented and the patient's response;
- C. Documentation of any medications and IV fluids administered;
- D. Summary of the patient's intake and output;
- E. In the event of transport by air documentation of time the flight departed, time the flight arrived, time the ground transport arrived, and the time the patient arrived at the receiving facility; and
- F. Summary of the condition of the patient enroute and upon arrival to the receiving facility.

10.4-9 Upon arrival at the receiving facility, the escort:

- A. Stays with the patient until care has been transferred to the receiving facility;
- B. Provides a patient report to a licensed nurse or a physician;
- C. Transfers all documents, and x-ray, tests, or specimens to the receiving facility;
- D. Completes the transfer of care section of the Patient Transfer Record;
- E. Provides receiving facility a copy of Patient Transfer Record and retains the original for submission to Medical Records upon return to GMHA;
- F. Secures all equipment for return to GMHA.

10.4-10 If the patient expires enroute the escort:

- A. In the event of transfer by air, instruct the airline's flight crew to contact the local office in Guam to contact GMHA with an emergency message for the on-call Social Services Department representative;
- B. Arranges transfer of the body to a health care facility;
- C. Completes documentation of the events that led to the patient's death in the Patient Transfer Record; and
- D. Coordinates the resolution of any problems either with the Social Services Department at the receiving hospital or with the Social Services Representative at GMHA. Additional resources to be considered are the local police department or the U.S. Embassy.

10.4-11 Upon completion of the patient's transfer to the receiving facility, the escort:

- A. Requests the patient and/or family to complete the Patient/Family Questionnaire; and
- B. Completes the Concurrent Transport Review form and retains for submission to the Risk Manager upon return to GMHA.

10.4-12 Upon return to GMHA, the escort:

- A. Submits the original copy of the completed Patient Transfer Record to Medical Records Department for inclusion in the patient's medical records;
- B. Returns all equipment to the appropriate departments;
- C. Returns all unused medications and supplies to the appropriate department for proper crediting to the patient;
- D. Submits the completed Concurrent Transport Review Form to the Risk Manager;
- E. Submits the completed Patient/Family Questionnaire and, if a hospital-employed physician; submits the completed Patient Transfer Expense Report to the Comptroller's Office for payment and billing purposes.

10.5 ROLE OF THE ASSOCIATE ADMINISTRATOR OF MEDICAL SERVICES

The Associate Administrator of Medical Services is responsible for the following:

- 10.5-1 Consulting the Nursing Supervisor and/or Nursing Administrator on-call when a qualified nurse escort cannot be found;

- 10.5-2 Collaborating with the attending physician in arranging for a qualified physician to escort the patient when the patient's needs require or in the situation that Nursing cannot provide a qualified escort;
- 10.5-3 Completing the appropriate section of the Clinical Competence Checklist for the designated hospital staff physician escort; and
- 10.5-4 Implementing appropriate corrective actions when quality of care problems have been identified which involve members of the medical staff.

SECTION XI: ADOPTION

These Medical Staff Rules and Regulations made effective upon approval of a majority vote of the Medical Staff of Guam Memorial Hospital Authority and approval by the Board (BOT), superseding and replacing any and all previous Medical Staff Rules and Regulations, and henceforth all activities and actions of the Medical Staff and of each individual exercising clinical privileges in the hospital shall be taken under and pursuant to the requirements of these Rules and Regulations. The Medical Executive Committee may recommend interim changes to these Medical Staff Rules and Regulations directly to the BOT when expedited changes are deemed important for Patient Safety and/ or Quality Improvement. In such cases the approval of the Medical Staff is required at the next Medical Staff meeting.