ALAMEDA HEALTH SYSTEM

MEDICAL STAFF

RULES AND REGULATIONS

11/2024

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ARTICLE 1 - PREAMBLE

All terms used in these Rules and Regulations shall have the same meaning as used in the Medical Staff Bylaws, unless otherwise herein defined.

ARTICLE 2 - ADMISSION AND DISCHARGE OF PATIENTS

2.1 General

Members of the Medical Staff who have been granted clinical privileges and those physicians who have been granted temporary privileges for a specific case or period of time, in accordance with the Medical Staff Bylaws, may admit patients to the hospital.

2.3 Psychiatric Admissions

Any patient known or suspected to be suicidal shall be offered a psychiatric consultation by a member of the Psychiatry staff. In any case where consultation is not obtained, the reason, such as patient refusal, must be documented in the patient's medical record. Patients suspected to be suicidal in intent, who meet the criteria for involuntary detention and psychiatric evaluation as authorized in Section 5150 of the Welfare and Institutions Code, shall be placed on a 5150 hold by a provider duly authorized to order such holds.

2.4 Emergency Admissions

Any member of the Medical Staff with appropriate clinical privileges may admit a patient with an emergency or urgent condition if the physician has determined such admission is indicated.

ARTICLE 3 - ORDERS

3.1 Medication Orders

Orders for drugs shall be written by a person lawfully authorized and credentialed to prescribe and shall conform with the United States Pharmacopeia or National Formulary, with the exception of drugs used in bona fide approved clinical investigations or newly approved medications that are not listed but have been approved by an appropriate Health System Committee. Exceptions shall be approved by the Medical Executive Committee in accordance with all current applicable regulations.

3.2 Verbal Orders

a. Orders verbally dictated by a provider either face to face or by telephone to a licensed person are known as verbal orders.

b. Verbal Orders may not be given in situations whereby the prescriber is physically present on the unit except in emergency medical situations or during moderate sedation.

c. All verbal orders must be clearly communicated with drug, dose, route and frequency in the non-abbreviated format.

d. . The licensed person receiving the order must transcribe the order (in writing or typed) and then read the order back to the provider for confirmation.

e. All verbal orders are repeated back to the provider who verifies correctness of information before the conversation ends.

f. The person receiving the verbal order information must record the verbal order immediately in the patient's medical record.

g. Verbal orders for medications must be countersigned by a physician within forty-eight (48) hours.

h. Secure messaging and texting are not allowable methods of order transmission in the electronic health record.

i. Verbal orders for chemotherapy/biotherapy medications are prohibited.

ARTICLE 4 - COVERAGE

Chairs of the Department and Division Chiefs shall be responsible to ensure that physician coverage is provided as required.

ARTICLE 5 - EMERGENCY MANAGEMENT AND DISASTER ACTION RESPONSE

5.1 Emergency Management/Disaster Plan

All physicians shall be assigned posts either in the Health System or defined auxiliary areas during a disaster. It is their responsibility to report to their assigned stations. The Chair of the Department of Emergency Medicine and the Chief Executive Officer will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Health System to another or evacuation from the Health System premises, the Chair of the Department of Emergency Medicine or the Emergency Department physician on duty will authorize the movement of patients in consultation with the Chief Executive Officer or A.O.D. (Administrator of the Day) of the Health System during the disaster.

5.2 Credentialing in a Disaster

Licensed Independent Practitioners who are not members of the medical staff of AHS and who do not possess clinical privileges at the Health System, may be granted temporary or emergency privileges during a disaster pursuant to the **Medical Staff Bylaws.**

5.3 Plan for Mass Casualties

The plan for the care of mass casualties shall be updated at least annually and rehearsed at least twice a year by appropriate Health System personnel.

5.4 Fire and Internal Disaster Drills

Fire and internal disaster drills shall be held at least quarterly for each shift and under

varied conditions.

5.5 In-House Medical Emergency (Non-Patients)

5.5-1 Inpatient patient care areas

Medical personnel will react as appropriate to the person's needs and, as necessary, bring him/her to the Emergency Department.

5.5-2 Non-patient care areas inside the Health System buildings

The house code blue team will be contacted.

ARTICLE 6 - PERFORMANCE IMPROVEMENT

6.1 Performance Improvement Program

The Medical Executive Committee shall, in conjunction with Health System Administration, develop a Performance Improvement Program for patient care. The plan shall be reviewed annually and shall be subject to the approval of the Board of Trustees.

ARTICLE 7 – ON-CALL RESPONSIBILITIES TO THE EMERGENCY DEPARTMENT

Duties of practitioners on call to the Emergency Department are described in the AHS Emergency Medical Treatment and Active Labor Act (EMTALA).

ARTICLE 8 DISTRIBUTION OF THE RULES AND REGULATIONS

8.1 Each Medical Staff member and clinical privilege holder shall be provided access to these Medical Staff Rules and Regulations. Medical Staff members and clinical privilege holders agree, by being granted Medical Staff membership or clinical privileges in any capacity, to abide by these Rules and Regulations.

Approved	**Date**
Bylaws Committee	6/2024
Medical Executive Committee	11/2024
QPSC	
Board of Trustees	