COUNTY OF LOS ANGELES　　DEPARTMENT OF HEALTH SERVICES

HARBOR-UCLA MEDICAL CENTER

SUBJECT: INPATIENT / EMERGENCY DEPARTMENT CONSULTATION　　**POLICY NO. 360A**

PURPOSE:
To delineate criteria for and describe the process of consultation for Emergency Department (ED) patients and hospital inpatients. Requests for, and responses to outpatient consultations are not covered by this policy.

POLICY:
At Harbor-UCLA Medical Center an appropriate consultation will be obtained for any hospitalized or ED patient with a condition, symptom, diagnosis, or who is in need of a procedure, diagnosis or treatment plan, that arises and is outside of the area of expertise and/or granted privileges of the physician responsible for the care of the patient. All consultations performed at Harbor-UCLA Medical Center reflect the medical opinion of the Specialty or Subspecialty attending assigned to the call panel at the time the consultation is performed.

Consultation is available 24 hours a day. Consultations shall be performed in a timeliness that is commensurate to the patient's condition, (by qualified practitioners). Communications regarding consultation are practitioner-to-practitioner, and the consultant's recommendations must be documented in the medical record.

Consultations are encouraged and expected where clinically indicated and are required under the following circumstances:
A. Need for specialized expertise in providing a procedure, diagnosis or therapy;
B. Patient exhibits severe symptoms of mental illness or psychosis (e.g., consultation by member in Department of Psychiatry);
C. Patient has attempted suicide or has taken a chemical overdose (e.g., consultation by member in Department of Psychiatry);

In addition, consultations by an individual with critical care and/or appropriate subspecialty expertise should be considered under the following circumstances:
A. Patient has experienced an unexpected major complication;
B. Patient has an acute life-threatening condition or one that requires organ system support (see Policy 360B).

EFFECTIVE DATE: 3/99　　**SUPERSEDES: 360**
REVISED: 1/09, 12/11, 9/16
REVIEWED: 2/02, 2/05, 1/09, 12/11, 9/16, 12/19
REVIEWED COMMITTEE: Medical Staff / PSARC

APPROVED BY:

Kim McKenzie, RN, MSN, CPHQ
Chief Executive Officer

Anish Mahajan, MD
Chief Medical Officer

Nancy Blake, PhD, RN, NEA-BC, FAAN
Chief Nursing Officer

PROCEDURE:

1. The mechanism for requesting a consultation will be via direct communication including paging, telephoning or via an in-person conversation with the consultant or the consulting service. An attending physician from the treating service shall assure that in all instances in which consultations are requested, they are communicated to the consulting service in a timely manner.
2. The requesting practitioner must provide the consultant with adequate information regarding the issues for which the consultation is deemed necessary and indicate whether the consultation request is for consultation only, consultation and management of a problem, and/or change of the patient's clinical service.
3. The urgency with which a consultation response is required must be defined by the service requesting the Consultation, and should be commensurate to the patient's condition.
   In general, the categories of consultation response are defined as follows:
   Routine: The consulting service will provide their initial recommendations within 24 hours of the request.
   Urgent: The consulting service will provide their initial recommendations within 12 hours of the request.
   Emergent: The consulting service will provide their initial recommendations within 2 hour of the request.
   Following a consultation request, the consulting service will acknowledge receipt of the consultation request (e.g., return the page), see the patient, and provide initial recommendations in the timeframe outlined as appropriate for the level of consultation above.
4. For emergent-urgent consultations, the requesting physician shall notify the clinical service directly of the need for the consultation.
5. The consultant must be qualified by training and experience to give an opinion in the field in which this advice is sought. Residents with specific practice prerogatives permitting consultation and allied health staff whose standardized procedures permit it may perform consultations. The attending physician from the consulting service shall assure that the assessment of the patient is accurate, that any recommendations are appropriate, and that the consultation is conducted in a timely manner. The attending physician must electronically co-sign the consultation within 24 hours seven days a week. (The twenty-four hour clock begins at the time the consultation note is placed in the electronic medical record.) Although the consultation may be provided by residents or allied health staff, the ultimate responsibility for patient care and supervision of residents rests with the attending physician.
6. The consultation shall include a review of the medical record and examination of the patient. The consultant's findings and recommendations must be included in the medical record. Recommendations should include diagnostic testing, medications, and subsequent management, as appropriate.
7. If the initial consultant is a resident or allied health staff member, he/she will discuss the patient consultation and recommendations with the appropriate supervisory resident, fellow, or attending physician and then document that this discussion occurred in the consult note. The resident or allied health staff member will forward the consult note to the responsible attending physician for signature.
8. Both initial and final recommendations by the consultant should be documented in written format unless this is expected to delay care of the patient (in which case it will be documented as soon as possible).
9. The consultant must contact the treating practitioner directly if the recommendations are deemed urgent or emergent.

10. The consultant should stipulate his/her plan of continued involvement and sign off the case when the patient no longer requires the consultant's care – a decision agreed to by the treating service.
11. Orders arising from the consultation are written only by the treating practitioner unless the treating team requests the consultant to do so.
12. Recommendations made by the consultant should be acknowledged in the chart whether or not they are followed.
13. If additional input from a consultant is needed during the same hospital admission, then the primary service will re-contact the consultant service.

Reference: Policy 622A: Supervision of Residents