



LEGACY SALMON CREEK MEDICAL STAFF RULES AND REGULATIONS

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Medical Staff Rules & Regulations

The Medical Staff is responsible to the Legacy Health Board of Directors for the professional medical care performed within Legacy Health facilities and the quality of medical care rendered. In accordance with the Bylaws of the Medical Staff, the following Rules and Regulations pertaining to professional care are hereby adopted. Individual Clinical Services may adopt service-specific rules governing both practice in the service and the professional medical care to be rendered by members of the Service. These documents are complementary.

I. Patient Types and Admissions of Patients

A. Description

The Hospital is a general acute care hospital that responds to the medical needs of patients who present for care. The Hospital provides care patients suffering from all types of disease dependent upon available facilities, personnel, and licensure.

B. Definitions

Patient encounters at Legacy fall into three general categories: inpatient, emergency, and outpatient. These are based on the service provided as well as on specific regulatory requirements such as the Medicare Conditions of Participation.

1. Inpatient:

A person who has been admitted to the hospital for bed occupancy for the purposes of receiving care. A person is considered an inpatient if formally admitted to a licensed inpatient bed with an admit to inpatient order.

2. Emergency:

The provision of emergency medical care in specifically designated areas of the hospital which is staffed and equipped at all times to provide prompt care for any patient presenting urgent medical conditions.

Practitioners admitting emergency cases may be required to justify to the Chairman of the department or President of the Medical Staff and the President of the Hospital that said emergency was a bona fide emergency.

3. Outpatient:

A person who has not been admitted to the hospital as an inpatient and who is not receiving emergency services but is registered on the hospital records as an outpatient and receives services from the hospital.

a) Hospitalized Episodes for Outpatients

(1) Ambulatory Procedure:

Outpatient procedures that are generally invasive, including same-day surgeries, invasive diagnostic imaging and therapeutic procedures, bronchoscopies and endoscopies.

(2) Observation:
Those services furnished on the hospital's premises, including the use of a bed and periodic monitoring by nursing or other staff, which are reasonable and necessary to evaluate a patient's condition in order to make a decision whether the patient will require further treatment as an inpatient or if able to be discharged.

b) Other Outpatient Episodes/Services

(1) Diagnostic and Treatment Services:
Services such as laboratory and radiologic studies, chemotherapy, radiation therapy, and physical therapy, which are performed based on the order of a qualified practitioner who is also responsible for providing the patient's diagnosis and other clinical justification for the test or therapy.

(2) Referred Specimen Services:
Services rendered when a specimen is sent by an external provider's office, hospital or other institution for evaluation or consultation when the patient does not present to Legacy for service.

C. Admission Criteria

Patients may be admitted to the Hospital as inpatients, accepted for outpatient hospital registration or accepted for observation services or ambulatory care procedures only by a qualified member of the Medical Staff who has been granted the privilege to admit patients to the hospital or order procedures in accordance with state law and criteria for standards of medical care established by the Medical Staff. All patients must be under the direct care or supervision of a member of the Medical Staff.

Only those practitioners authorized in accordance with the bylaws of the Medical Staff may admit patients to the Hospital. The patient's attending practitioner will execute, or cause to be executed, all physician responsibilities related to the admission and discharge of patients as expressed in the Hospital's Policies and Procedures governing admitting and discharging patients from the Hospital.

The admit order must specify the admission type (a) observation, (b) outpatient surgery, or (c) inpatient.

Except in emergencies, no patient may be admitted to the Hospital without a recorded provisional diagnosis. In the case of an emergency, a diagnosis must be recorded as soon as possible.

II. Medical Records

A. Definitions

A medical record consists of medical information that is specific to the patient, that is pertinent to the patient's care and treatment, and that is in the custody of the Hospital's Health Information Management Department. The information contained in the medical record and any other patient-specific information, must be treated in accordance with all

applicable legal and ethical rules related to the confidentiality of patient medical information.

B. Access

Access to confidential materials by members of the Medical and other staffs of the Hospital, Hospital employees, and other is only permissible when the person seeking access is involved in the care of the patient or is engaged in peer review, risk management, Medical Staff credentialing, approved research, educational pursuit, or which confidential materials are maintained or stored and applies equally to information stored in hard copy or electronically.

C. Electronic Health Record Use and Responsibilities

Legacy's electronic health record (EHR) system has the potential to offer many advantages over paper records, including improving the quality of care for patients, reducing medical errors, promoting best practices, and decreasing the cost of care. Like all new technology, however, the EHR, if used improperly, could potentially result in medical errors and patient harm. The purpose of these rules is to set forth the expectations of the Medical Staff for the proper use of the EHR to ensure patient safety and high-quality health care.

Members will access the EHR to review patient information in a HIPAA compliant fashion; such as when directly serving patient care needs, reviewing results and outcomes after having served as part of a treatment team, in the context of medical education, or as component of formal peer review and quality improvement activities.

Practitioners will actively and meaningfully use the EHR for all patients for whom they care for in the Hospital. Practitioners document all patient encounters in the EHR in a prompt and timely manner, and in all cases within the time frames as required by law and set forth in these Rules & Regulations. Practitioners must complete EHR documentation within the times frames required by law and these Rules & Regulations.

Demonstration of Competency

A Practitioner will be granted access to the EHR once the Practitioner demonstrates that they can utilize the system in the Hospital in a competent, safe and effective manner. Basic competence is defined as the role-specific ability of any Practitioner to perform their usual workflows in the care of the patient, including the specific components below. The Hospital will provide appropriate basic competence training for all Practitioners.

Periodic upgrades in EHR technology, structure or process may necessitate that Practitioners complete additional training to remain competent in use of the EHR. EHR training deemed necessary by Legacy Heath for the safe and efficient operation of the EHR system shall be reviewed and approved by the MEC. EHR training approved by the MEC shall be mandatory for designated practitioners.

Documenting in the EHR

Members will accurately document electronically in the EHR. Each note will be electronically reviewed and signed in the EHR with attention paid to ensuring the accuracy and temporal relevance of automated documentation tools (such as copy/paste and template text).

Computer Practitioner Order Management

All clinicians will use Computer Practitioner Order Entry (CPOE) for entering orders into the EHR. Verbal orders (including telephone orders) will only be given in urgent situations, when immediate access to CPOE is not feasible and orders are needed promptly to address changes in the patient's condition. All verbal orders must be dated, timed, and authenticated as required by law and these Rules & Regulations.

Problem List Maintenance

Practitioners will update the active Problem List, within the scope of their clinical expertise, at each clinical encounter. The Problem List is for the acute and/or chronic active problems of the patient. An accurate and up to date Problem List in the EHR is essential for ensuring safe and high-quality patient care.

Medication Management

Practitioners will update the Discrete Medication List at each clinical encounter. All medications, including PRN medications available for current use, chronic OTC medications, vitamins, supplements, homeopathic remedies, medications prescribed for chronic use by non-Legacy practitioners, should be on the Discrete Medication List. Duplicate medications should be removed from the Discrete Medication List.

Online Results Retrieval

Inpatient practitioners will utilize the online results retrieval in the EHR and communicate results to patients in a timely manner.

Failure to Properly Use the EHR

A Medical Staff appointee must properly use the EHR as set forth in these Rules. After notice from the Medical Staff for failure to properly use the EHR and an opportunity to come into compliance, a Medical Staff appointee's admitting and clinical privileges (elective and emergency) shall be automatically relinquished, for failure to comply. Clinical privileges shall be formally reinstated once the appointee (1) meets the requirements established by Legacy Information Services for EHR training and demonstration of competency and (2) agrees in writing to properly use the EHR as set forth in these Rules. Failure to complete training demonstrate competency and agree to properly use the EHR within sixty (60) days from the date privileges were relinquished shall constitute an automatic relinquishment of all admitting and clinical privileges and voluntary resignation from the Medical Staff.

D. Required Medical Record Elements

Elements required in a medical record include identification data, appropriate comprehensive history and physical examination; reports and consultations; clinical laboratory; radiology and other special reports; provisional diagnosis; medical or surgical treatments; operative reports; anesthesiology records; pathological findings; progress

notes; final diagnosis; discharge notes; clinical summary; autopsy report; and other pertinent information such as Patient Advanced Directives and Consent Forms.

E. Documentation Rules

1. Unless otherwise stated in these Rules and Regulations, the consent, form, nomenclature, permitted abbreviations, and timeliness requirements of all portions of and entries in the patient's medical record must be as stated in the Hospital's Policies and Procedures governing medical records.
2. Entries will accurately document electronically in the EHR and will be authenticated by the individual making the entry. Authentication is defined as written or electronic signature, timed and dated.
3. The attending practitioner is responsible for the timely preparation and completion of the patient Medical Record. Medical Record entries must be authenticated within two weeks following the patient's discharge.
4. Allied Health Professionals or other individuals acting within the scope of their professional licenses who have been authorized to do so, shall complete those portions of records which pertain to their care of patients.
5. All entries must be dated and timed. Entries that are time sensitive in the delivery or documentation of care should be timed. The following entries must be timed:
 - a) Orders
 - b) Post-operative note immediately following surgery
 - c) Forms that specify a time documentation requirement (i.e. consents)
 - d) Administration of medications
 - e) Restraint and/or seclusion application and removal
 - f) Emergency Room log or patient arrival, discharge
 - g) Anesthesia note immediately prior to induction
6. Symbols and abbreviations may not be used on the face sheet or in the final diagnosis but may be used within the medical staff record when approved by the Medical Staff.
7. A list of approved symbols and abbreviations has been approved by the Medical Staff under Legacy Policy 900.3900 *Approved Abbreviations and Do Not Use List*. Use of unapproved symbols and abbreviations has the potential to negatively impact patient care. No order for medications will be completed if the order contains a symbol or abbreviation with an unapproved symbol or abbreviation until the provider has been contacted for order clarification. Health Information Management will monitor compliance with these requirements.
8. A focused medical assessment must be documented prior to or at the time of an invasive procedure or moderate sedation, and should include:
 - a) Presenting diagnosis/condition
 - b) Description of symptoms
 - c) Significant past medical history
 - d) Current medications
 - e) Any drug allergies
 - f) Indications for the procedure
 - g) Focused physical exam as indicated
 - h) Proposed treatment or procedures

9. Orders

Orders for ancillary and diagnostic services must include the diagnosis (ICD code) and, as necessary, other appropriate information about the patient's diagnosis, or the sign(s) or symptom(s) providing the justification for the service/treatment.

An order for medication must comply with the Medical Staff's approved Policies and Procedures which govern the content of, and nomenclature and abbreviations permitted and not permitted in medication orders, both generally and for specific types of medications.

- a) For treatment orders, an explanation must be provided as appropriate.
- b) Documentation of phone consultations must be included in the medical record.
- c) The summary lists will be revised when the medical condition/diagnosis changes, medications are discontinued or changed, the patient has undergone additional surgical procedures and/or when there is a change in allergy status.

F. Record Completion

A patient's medical record should be completed at the time of discharge. The attending practitioner shall be responsible for the completion of the medical record for each patient. No record shall be filed until it is complete or unless it is on order of the Medical Staff President.

Practitioners will be notified of incomplete records by the HIM Department. This notice will list records that are incomplete. Practitioners not completing records within 30 days of discharge will be placed on the No Admit list. Placement on the No Admit list will result in automatic suspension in the form of withdrawal of admitting (except emergencies), or other related privileges, including scheduling, assisting in surgery, and administering anesthesia. Practitioners staffing the ED are not excluded from suspension of privileges due to delinquent charts. Automatic suspension will remain in effect until the delinquent medical records are completed and the suspension has been officially lifted. In the event the practitioner is unable to complete their medical records, it is permissible for a partner or associate to assume this task so long as this practitioner has participated in the care of the patient and has sufficient information as to allow the record to be meaningful, factual and current. No Admit Lists will be generated bi-monthly for the Hospital. Notification of placement on the No Admit List shall be done in accordance with established Health Information Services policy.

G. Authentication of Records

All entries in the record are timed, dated, author identified and authenticated. Authentication of an entry may include written signatures, initials, or computer signatures.

III. Consent and Disclosure

A. Informed Consent

Unless an emergency exists, no care or treatment may be rendered to any patient in the Hospital, Emergency Department or Clinics without a written consent signed by the patient or their properly designated representative. In an emergency situation, when immediate services are required to alleviate or prevent severe pain, disability, or death, recommending treatment to the patient must follow Hospital policies and procedures regarding obtaining consent from a properly designated representative, such as a surrogate, or providing treatment pursuant to the emergency exception if applicable.

Except in an emergency situation as defined above, proper informed consent is a prerequisite to any procedure or treatment that is considered complex based on medical judgement, and includes, but is not limited to the following situations:

1. Operative procedures which involves an entry into the body through an incision or through one of the natural body openings, excluding vaginal childbirth
2. Invasive procedures involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspiration, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, but excluding venipuncture and intravenous therapy.
3. Blood transfusions or other use of blood products
4. Planned use of moderate sedation
5. When determined to be appropriate by the Licensed Independent Practitioner

In emergencies involving a minor as defined by the statute for medical treatment or involving an unconscious patient for whom consent cannot be immediately obtained from parents, guardians, or next of kin, the circumstances should be noted on the patient's medical record.

The informed consent document should include at least information about the specific procedure and treatment, the reasonably foreseeable risks and benefits of the treatment and the reasonable alternatives for care and treatment. Further information on what is required in the discussion and what must be documented is found in the Legacy Policy # 900.4058 regarding Informed Consent.

In all surgical procedures, the physician in whose name the permission for the operation is obtained must participate in person or as a member of the operating team and must be present during the critical portion(s) of the procedure. Such participation may not be delegated without the informed consent of the patient or the patient's properly designed representative.

IV. Research

A. Research Projects

Any research project conducted in the Hospital or Clinics involving human subjects must be approved by the Legacy Investigational Review Board. The Medical Staff Member who is participating as a Principal Investigator in a research protocol involving human subjects is responsible for submitting the research protocol for approval to the IRB and complying with all IRB requirements relating to the provision of care and treatment of a

patient under an approved research protocol. All research projects must be conducted in accordance with Legacy Research policies.

V. Patient Assessment

A. H & P Requirements

The history and physical examination is completed by a physician member of the medical staff, or a licensed independent practitioner (LIP) who has been granted privileges, or a by individuals who are not LIPs who have been authorized to do so, under the supervision of, or through appropriate delegation by, a specific qualified physician who is accountable for the patient's medical history and physical examination.

For patients admitted to the hospital by a medical staff member such as a dentist, oral surgeon or podiatrist, the admitting provider may rely on or seek a prompt medical evaluation by another practitioner who has such privileges.

A history and physical examination (H&P) must be completed no more than 30 days before or 24 hours after an inpatient or outpatient admission. If the H&P was completed within 30 days before the admission, an updated examination, also known as an H&P Interval, must be completed and documented within 24 hours after admission and prior to an invasive procedure requiring sedation.

If the procedure requires only a local anesthetic and no sedation, then an H&P does not need to be completed. Sedation is defined as ANY medication given for anti-anxiety or sedation via ANY route. This includes po, IV, IM, IN, PR, SQ. A patient may take their own prior to the procedure; however, if a medication is ordered and removed from the Pyxis for the purpose of sedation or anti-anxiety, then an H&P is required.

The H&P must be completed for every patient prior to surgery, or an invasive procedure requiring sedation, except in emergencies. In all cases, except for emergencies, the H&P and/or H&P Interval must be completed and documented before the surgery or procedure takes place, even if that surgery occurs less than 24 hours after admission or registration.

The History and Physical will include, at minimum, the following components and any other information deemed to be relevant by the examining provider:

1. Chief Complaint
2. History of Present Illness
3. Medications and Medication Allergies
4. Review of Symptoms
5. Physical Examination
6. Assessment including Provisional Diagnosis
7. Treatment Plan

The H&P Interval will indicate that the H&P was reviewed, the patient was examined, any changes that have occurred, or that "no changes" have occurred in the patient's condition.

In addition to the H&P requirements above, patients undergoing sedation or anesthesia care must also have a Pre-Anesthesia Assessment. The assessment is performed and

documented prior to the induction of sedation/anesthesia in accordance with Legacy Policy 900.3311 *Procedural Moderate and Deep Sedation* and considers data from other assessments.

The H&P requirement does not apply for Emergency Surgery; however, an H&P must be documented as soon as possible after surgery.

VI. Planning Care, Treatment and Services

A. Orders

All orders for treatment must be in writing or entered into the electronic medical record, dated and timed. Orders written by an individual who is not a medical staff member, housestaff member or allied health authorized to enter orders, must be cosigned by the supervising physician prior to implementation.

B. Verbal/Telephone Orders

Verbal/telephone orders may be issued by members of the medical staff, housestaff, or allied health authorized to write orders to licensed nursing personnel (RN's) and registered pharmacists. Verbal/telephone orders appropriate to their discipline may be given to any licensed physical therapist, occupational therapist, speech-language pathologist, registered laboratory technologist, registered MRI technologist, registered nuclear medicine technologist, registered sonographer, registered x-ray technologist, or dietician.

Verbal/telephone orders may be issued only if the circumstances are such that an immediate order is required, and it would be impractical for the prescriber issuing the order to do so in writing or to directly enter the order into the electronic medical record.

1. Verbal/telephone orders are appropriate in the following situations:
 - Emergency
 - If the person placing the order is physically unavailable and does not have access to the Electronic Medical Record system
 - If the physician/clinician is performing a procedure
2. The ordering provider must identify themselves, and the person receiving the verbal order will read back this identifier as part of the process.
3. For the Electronic Medical Record, the provider must remain on the phone if asked by the person receiving the verbal order while the order is entered to ensure that the desired order is available in the system and that any alerts are addressed.
4. Verbal/telephone orders must be signed within 48 hours by the prescribing practitioner or by the attending or covering physician. The physician to whom the verbal order is attributed, should cosign it, authenticating authorship and confirming the accuracy, content, and patient identifiers. Members of a Physician Team may cosign verbal orders for any other member of that team if they are sufficiently familiar with the clinical circumstances and appropriateness of the order.

VII. Medications

An order for medication must comply with the Medical Staff approved Medication Policies and Procedures which govern the content of abbreviations and nomenclature permitted in medication orders, both generally and for specific types of medications. Complete medication orders must include the name of the drug, dosage, frequency of administration, route of administration, date, time, and signature of the prescriber. There should be a documented diagnosis, condition, or indication for each medication ordered.

Medication ordering and administration must comply with all Legacy Medication Administration Procedures such as using patient specific information, monitoring the effects of the medications, not using unapproved abbreviations, etc.

The Licensed Independent Practitioner or Allied Health Practitioner is responsible for ensuring that an indication or diagnosis is present in the medical record for every medication prescribed.

VIII. Providing Care, Treatment and Services

A. Availability of Practitioner

Each member of the Medical Staff shall make prior arrangements with another appropriate practitioner to provide appropriate professional care for any patient in the hospital or patient who may be admitted to the hospital for whom they are the attending practitioner when the practitioner is otherwise unable to attend to their patients.

B. Daily Care of Patients

A hospitalized patient must be seen by the attending practitioner or a member of the housestaff, allied health practitioner or appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented for each patient daily in sufficient detail to allow formulation of a reasonable picture of the patient's clinical status at the time of observation.

Progress notes written by practitioners requiring physician supervision, for example, Physician Assistants, should be reviewed in accordance with the state's medical board supervision requirements. Resident notes should be reviewed in accordance with residency program supervision requirements.

C. Consultations

Consultations must show evidence in the Medical Record of the consultant's review of the patient's record, their pertinent findings on the examination of the patient, and the consultant's opinion and recommendations. When the needs of the patient exceed the privileges of the medical practitioner, a consult must be obtained.

Requests for consultation should include a note delineating the intended expectations of the needed consult or that note a collegial conversation with consultant has occurred.

D. Sedation and Anesthesia

1. Prior to sedation and anesthesia, a pre-anesthesia evaluation must be completed, including a focused H&P with attention to:
 - a) Any history of adverse or allergic drug reactions with anesthesia or sedation
 - b) NPO status
 - c) Level of consciousness
 - d) Airway assessment
 - e) Brief description of the planned procedure(s)
 - f) Planned anesthesia type, including risks, benefits, and alternatives
 - g) Determination of ASA classification
2. At the time of sedation and anesthesia:
 - a) Prior to induction of anesthesia or sedation, vital signs and oxygen saturation must be updated.
 - b) Immediately prior to the use of moderate or deep sedation or the induction of anesthesia, re-evaluation of the focused H&P must be done.
 - c) Physiological parameters including (but not limited to) vital signs and oxygen saturation must be measured and assessed throughout anesthesia and documented on the anesthesia record or procedure form record.
3. A post anesthesia follow-up report by the individual who administered the sedation or anesthesia must be documented within 48 hours after the procedure that necessitated sedation or anesthesia and should
 - a) Be records on the Anesthesia Assessment Form
 - b) Specifically document any intro-operative or postoperative anesthesia complications

E. Operative Care of Patients

Either a full operative or procedure report, or a brief operative or procedure note must be documented within 60 minutes after a patient leaves the operating room (inpatient or outpatient) that requires anesthesia, or deep or moderate sedation before the patient is transferred from the operating room or procedure room to the next level of care. If a brief operative or procedure note is written prior to transfer of the patient to the next level of care, a full operative or procedure report must be documented or dictated within 24 hours after the procedure.

If the practitioner performing the operation or procedure accompanies the patient from the operating room to the next area of care, the note or report can be written in the next area of care. Documentation may be performed by any member of the housestaff or an allied health practitioner who was present and directly participated during the entire procedure. Documentation must include the following:

1. The brief immediate operative or procedure note must include all the following elements without omission or reference to a record not yet available at time of documenting the note
 - a) The name(s) of the practitioner(s) who performed the procedure and their assistant(s)
 - b) The name of the procedure(s) performed
 - c) Complications/findings of the procedure, or indicate “none”, if there were no complications/findings
 - d) Any estimated blood loss, or indicate “none”, if there was no blood loss
 - e) Any specimen(s) removed, or indicate “none”, if there were no specimens removed.
 - f) The postoperative diagnosis
2. The full operative or procedure report must include all of the elements of the brief operative or procedure note, plus the following:
 - a) Pre-op diagnosis
 - b) Type of anesthesia or sedation
 - c) Description of the procedure
 - d) Date and time of procedure
3. The documentation of reports required by this section may be delegated to a member of the housestaff or an allied health practitioner who was present and directly participated during the entire surgery or procedure. The level of involvement of the attending practitioner (e.g. “was present and directly participated during the entire procedure”) must be clearly documented by either the housestaff or by the attending practitioner. If the housestaff provides the documentation, the attending practitioner must document an attestation statement confirming their level of involvement.

F. **Statement of Nursing Responsibility**

If a nurse believes that proper care is not being provided or observes an undesirable situation which might have a deleterious effect on the physical and mental well-being of the patient, it is the responsibility of the nurse to notify the practitioner of these observations and concerns. If the practitioner does not or cannot respond within a reasonable length of time, the nurse should follow-up with the proper authority as described in Hospital Policy Legacy Policy 100.34 to ensure that prompt and adequate measures are taken to safeguard the patient. Administration should be advised through appropriate nursing authority when it is believed that such measures are not forthcoming.

IX. Coordinating Care and Treatment

A. Discharge

It is the responsibility of the attending practitioner to plan the discharge in a timely and coordinated fashion. The responsible practitioner is obligated to communicate to a referring doctor all appropriate medical information and provide the same information to any institution or agency to which a patient is referred following discharge from the hospital. For patients who have been in the hospital for a period of more than 48 hours,

the patient's discharge summary should either be documented in the medical record or dictated within 48 hours of discharge. For patients with a stay less than 48 hours, the final progress note may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition, and any provisions for follow-up care. All inpatient deaths must have a death summary regardless of length of stay. The discharge summary must be completed by the discharging practitioner with fourteen (14) days of discharge.

If a patient leaves the hospital against medical advice, this must be documented in the patient's medical record and the patient should be asked to sign the appropriate release form.

1. Discharge Summary

- a) The Discharge Summary can be directly entered in the electronic health record or dictated.
- b) The content of the discharge summary should be consistent with the rest of the record and includes:
 - Admitting date and reason for hospitalization
 - Discharge date
 - Final diagnosis
 - Succinct summary of significant findings, treatment provided and patient outcome
 - Documentation of all procedures performed during current hospitalization and complications (if any)
 - Condition of patient upon discharge and to where the patient is discharged
 - Discharge medication, follow-up plan, and specific instructions given to the patient and/or family, particularly in relation to activity, diet, medication, and rehabilitation potential

B. Patient Death

In the event of death, it is the responsibility of the attending practitioner that the deceased be pronounced dead within a reasonable time period. The licensed independent practitioner pronouncing the death is responsible for determining whether the death is appropriate to report to the County Coroner's Office and must make such reports in accordance with applicable state law. The body may not be released from the hospital until an appropriate entry by a licensed practitioner has been made and signed in the patient's medical record. Policies with respect to the release of bodies must confirm to applicable state law.

Death Summary

- a) The Death Summary is entered in the electronic health record or dictated.
- b) The content of the death summary should be consistent with the rest of the record and includes:
 - Admitting date and reason for hospitalization
 - Date of Death
 - Final Diagnosis
 - Succinct summary of significant findings, treatment provided and patient outcome
 - Goals of Care- if patient was placed on DNR/palliative/comfort/hospice care status
 - Documentation of all procedures performed during current hospitalization and complications (if any)

X. Rules Pertaining to Specific Patient Situations

A. Autopsy

Unless otherwise required by the Coroner, an autopsy may be performed only with written consent, signed in accordance with applicable law, in the event of a patient death in the Hospital, the practitioner/service is expected to attempt to obtain permission to perform an autopsy from the appropriate legally authorized person.

When an autopsy is performed, a provisional anatomic diagnosis must be recorded in the medical record within 3 days and the complete post-mortem report should be made part of the medical record within 60 days unless the medical staff established exceptions for special studies. Refer to Legacy Policy 900-4367 on Postmortem Care, Adult, Pediatric Newborn.

Autopsies should be solicited in the following instances:

1. Deaths from unknown causes;
2. Deaths that are unexpected;
3. Deaths occurring during surgery or under anesthesia, or complications thereof
4. Iatrogenic or nosocomial deaths.

B. Restraints and Seclusion

A restraint or seclusion may only be used if needed to improve the patient's well-being or to protect the safety of other persons, and less restrictive interventions have been determined to be ineffective.

A member of the medical staff, housestaff, or an allied health practitioner with the appropriate privileges may order restraints.

The order for restraint or seclusion must comply with the medical staff approved hospital policy on restraints and seclusion. Standards for restraint and seclusion care exist in the Legacy policy for Restraint and Seclusion. Seclusion may only be used in the psychiatry unit and the Emergency Department.

The use of restraints for safety concerns in the delivery of the patient's medical-surgical care (i.e. for non-violent patients who are not self-destructive) requires a licensed independent practitioner or allied health practitioner order prior to application of restraints. If a licensed independent practitioner or allied health practitioner is unavailable, and an RN who has successfully demonstrated competence in assessment for restraint has applied restraints for patient protection, a verbal or written order must be placed within 12 hours of the application of the restraint. The patient must be examined by a licensed independent practitioner or allied health practitioner within 24 hours of the initiation of the restraint, and a written order entered into the medical record.

Hospital policy specifies the time within which an order must be obtained after each use of restraint or seclusion and the maximum time for the use of either information. PRN orders are not allowed. Restraints are time-limited to no more than one calendar day or 24 hours from the original order. The licensed independent practitioner or allied health practitioner must do a face-to-face examination of the patient and renew the order at least once each calendar day or 24-hour period from when the order was initiated that the restraint is required.

C. Therapeutic Abortion

Therapeutic abortion may be carried out by a physician member of the Medical Staff of the Hospital providing only that all conditions in accordance with state law and the Bylaws, Rules and Regulations of the Hospital Medical Staff. A signed request by the patient for therapeutic abortion and/or voluntary sterilization should be made part of the patient's record prior to the procedure of abortion being carried out. Administration and/or Medical Staff shall set up suitable mechanisms for the implementation of this section.

D. Reporting Contagious Diseases

When the attending practitioner or any member of the Hospital becomes aware of, or is reasonably suspicious of, the presence of an acute infectious or contagious disease within the Hospital, he shall immediately notify the Nursing Staff regarding such patient, in order that proper measures be instituted.

XI. Transfer of Patient

If the attending practitioner transfers the care of a patient to another Medical Staff Member, the transferring attending practitioner should clearly document the transfer of responsibility in the medical record to the accepting attending practitioner.

XII. Clinical Service Policies and Procedures

Each Clinical Service may develop policies and procedures to be administered routinely to all patients admitted to their Service. This does not preclude the Medical Executive Committee from adopting similar policies regarding procedures to be administered to all patients admitted to the Hospital. Where clinical service and medical staff rules appear to be inconsistent, medical staff rules will supersede service rules.

XIII. Emergency Services

The provision of emergency medical services occurs through the Emergency Department of the hospital, which is organized and directed by a member of the Medical Staff who is trained and experienced in Emergency Medicine. The Emergency Department may be staffed by housestaff and members of the Medical Staff.

A medical record must be kept for every patient and becomes part of the Legacy Health legal medical record.

A Medical Staff member, allied health practitioner or housestaff under the direct supervision of a Medical Staff member, may determine the need to transfer a patient to another medical facility. This must be done in accordance with EMTALA guidelines and the practitioner making the determination must complete and sign all forms related to the transfer, including a transfer statement.

A. Medical Screening Examination

Medical screening examination of emergency patients to rule out the presence of an emergent condition may be performed by a physician assistant who has demonstrated competency through training and skills verification, a nurse practitioner who has demonstrated competency through training and skills verification, or a physician. Medical screening examination of patients who present to OB Departments to determine whether the patient is in active labor may be performed by a registered nurse who has demonstrated competency through training and skills verification, a certified nurse midwife or physician.

B. Emergency Admission Call Responsibility

In the case of an emergency admission, patients who do not have a private practitioner may have a choice of any known practitioner in the department or service in which he is to be admitted, with concurrence of the practitioner, or be assigned in rotation a member of the Medical Staff on duty in the appropriate service or department. The Chairman of each department or section shall provide an assignment schedule for this purpose.

Medical Staff members have a general duty to serve in a rotational manner on the emergency room "Call" list and other rotational obligations if asked to do so by the Medical Executive Committee. The call list shall contain individual names, rather than group names, of those individuals assigned to provide emergency call coverage. Members must be available to respond by phone, and when clinically indicated in person, to the Hospital within a thirty (30) minutes when on the published emergency call schedule. The ED physician shall make the determination of whether it's clinically indicated that the on-call physician responds to a request to come in person to the Emergency Department.

If a physician self-limits their practice to a "sub-specialty", then they are obligated to obtain appropriate support when designated to be on-call. The medical staff department or section are responsible to establish an acceptable system of emergency call coverage and may require Active, Courtesy and even Affiliate members to take call as necessary and appropriate. Any exceptions to the call schedule will need to be approved by the appropriate department or section along with approval by the Medical Executive Committee.

On-call physicians may be on simultaneous call at another hospital or perform elective surgeries while on-call. The on-call physician shall attempt to identify another member of the Medical Staff (“Substitute Physician”) who can respond to emergencies if the on-call physician is unable to respond to an emergency call within thirty (30) minutes because he or she is taking simultaneous call or performing an elective surgery. If an on-call physician is unable to identify a Substitute Physician and a patient is in need of emergency services in the on-call physician’s specialty, the patient will be transferred according to Hospital’s policies. It is the responsibility of Departments to provide adequate call coverage of the emergency department.

If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the Hospital on the ED roster and notifies the on-call physician and the physician fails or refuses to appear within a reasonable period of time, and all other resources* have been exhausted, the physician will order the transfer of the individual when physician determines that without the services of the on-call physician, the benefits of transfer outweigh the risks of transfer. Documentation on the medical record will include name of physician called, time of call, time of response or lack of response and reason for transfer.

**The chain-of-command will be to call the Chair of the Department or Section and then the Medical Staff President.*

If clinically indicated, patients (a) seen in the Emergency Department by the on-call physician or (b) referred by the Emergency Department to the on-call physician will be scheduled for at least one follow up visit, regardless of the patient’s ability to pay, for the problem which precipitated the initial visit to the Emergency Department. This obligation ends if the patient does not contact the physician’s office within two (2) weeks of the Emergency Department visit to request an appointment. Further aftercare may be referred elsewhere at the discretion of the physician.

XIV. Conflict of Care Resolution

All members of the health care team have a duty to advocate for the patient through the organizational chain of command when they have concerns about a patient’s care. The chain of command involves administrative and clinical lines of authority, which are established to ensure effective conflict resolution in patient care situations. In all cases, the final authority in the chain of command on patient care decisions rests with the Medical Staff President or the Medical Staff President’s designee.

XV. Supervision of Housestaff

All members of the Housestaff are under the supervision of the Medical Staff. Members of the Medical Staff exercise that supervision under the guidelines established by the Graduate Medical Education Program. Medical Staff members who serve as housestaff supervisors must be licensed independent practitioners and must hold clinical privileges that reflect the patient care,

treatment, and service responsibilities given to the housestaff. Housestaff, who are approved to provide patient care, treatment, and services, may write orders unless otherwise specified in the Bylaws, Medical Staff Rules and Regulations, or Service requirements. However, supervising members of the Medical Staff are responsible for the patient care, treatment, services, safety, and quality, and documentation activities of the residents they supervise.

The attending physician must always be available to the resident via phone or pager. The attending physician must have the capability to be physically present in the hospital within thirty minutes of notification if their presence is required to care for their patient.

For procedures performed in the operating room, the attending physician should be in the operating room suite and scrubbed during key parts of the case. The cath lab is considered the operating room equivalent.

At no time may a resident's or clinical fellow's scope of practice exceed the scope of privileges of the attending practitioner. Each physician of record has the responsibility to make rounds on their patients and to communicate effectively with the residents or clinical fellows participating in the care of this patient at a frequency appropriate to the changing care needs of the patients. More detailed descriptions of the types of supervision which must be provided for residents and clinical fellows, the roles, responsibilities, and patient care activities of the participants are included in the GME Policy "Supervision of Residents and Clinical Fellows" which policy is approved by the MEC and the Board.

The Graduate Medical Education Committee must provide regular reports of the activities of the Graduate Medical Education Program to the Medical Executive Committee, which will communicate this report to the Legacy Health Medical Quality & Credentials Committee.

XVI. Confidentiality

All members of the Medical Staff and Allied Health Practitioners associated with the Medical Staff, and their respective employees and agents, must maintain confidentiality, privacy and security of all Protected Health Information in records maintained by Legacy Health or by business associated of Legacy Health, in accordance with any and all privacy and security policies and procedures adopted by Legacy Health to comply with current federal, state and local laws and regulations, including but not limited to, the HIPAA Privacy Regulations. Protected Health Information may not be requested, accessed, used, shared, removed, released, or disclosed except in accordance with Legacy Health's policy # 700.18, Use and Disclosure of Protected Health Information, and applicable law. Medical record information about a patient whom a Medical Staff member is treating can be furnished by the medical staff member to any health care provider within the facility who has responsibility for that patient's care.

The use of electronic signature or rubber stamp signature is acceptable only if the practitioner whose signature the electronic signature or rubber stamp represents is the only person who has possession of the electronic user ID and password combination and is the only one who uses it.

All electronic data pertaining to the medical care of individual patients is a part of the legal medical record and confidential to the same extent as other Legacy medical records. Passwords used by a member of the Medical Staff to access Legacy computers may be used only by such member, who may not disclose the password to any other individual (except to authorized security staff of the computer system). The user of a member's passwords is equivalent to the electronic signature of the member. The member may not permit any practitioner, resident, or

other person to use their passwords to access Legacy Health computers or computerized medical information. Any misuse may, in addition to any sanctions approved by the Medical Staff and/or the Legacy Health Board of Directors regarding security measures, be a violation of state and federal law and may result in denial of payment under Medicare and Medicaid.

XVII. Surgery

The operating room will function in accordance with rules established by the Surgery Committee, subject to the approval of the Medical Executive Committee.

Certain surgical procedures may require the presence of a qualified assistant. When such a surgery is being performed, there shall always be an appropriately credentialed assistant scrubbed and present throughout the procedure who is capable of protecting the patient in the event of incapacity of the surgeon until a qualified surgeon can be summoned to complete the case. The primary operating surgeon shall determine the level and number of assistants required (*e.g.*, qualified nurse or surgical technician/physician's assistant, qualified surgeon, other qualified physician) commensurate with the gravity and complexity of the procedure being undertaken, generally recognized professional standards of care for the performance of the procedure, particular medical conditions which the patient may have which require active care during surgery, and any other exceptional circumstances present.

Attending Supervision of Residents in the O.R.: The attending should be in the Operating Room Suite and scrubbed during key parts of the case and present in the Operating Room with scrubs on during the rest of the case.