Salem Hospital
A part of Salem Health

SALEM HOSPITAL

MEDICAL STAFF RULES AND REGULATIONS

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- Amendment approved by Board of Trustees / /16

ARTICLE I: DEFINITIONS

The following definitions shall apply to terms used in these Rules and Regulations: Words used in these Rules and Regulations shall be read as the masculine, femine or neuter gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Rules and Regulations.

(a) **"Board"** means the Board of Trustees of Salem Hospital, who has the overall responsibility for the operation of the hospital;

(b) **"Chief Executive Officer"** means the President of the hospital or ~~his~~ their designee;

(c) **"Dental Staff"** means all dentists, including oral and maxillofacial surgeons, who are privileged to attend patients in the hospital;

(d) **"Emergency"** means a condition which could result in serious or permanent harm to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that harm or danger;

(e) **"Medical Executive Committee"** means the Executive Committee of the Medical Staff ~~unless specifically written "Executive Committee of the Board";~~

(f) **"Medical Staff"** means all physicians, dentists and podiatrists who are given privileges to treat patients in the hospital;

(g) **"Oral and maxillofacial surgeon"** means a dentist qualified by training or experience to practice oral and maxillofacial surgery;

(h) **"Patient"** or **"Patients"** means inpatients or out-patients;

(i) **"Physicians"** shall be interpreted to include both doctors of medicine and doctors of osteopathy;

(j) **"Podiatrists"** shall be interpreted to include doctors of podiatric medicine;

(k) ~~Words used in these Rules and Regulations shall be read as the masculine, feminine or neuter gender, and as the singular or plural, as the content requires. The captions or headings are for convenience only and are not intended to limit or define the scope or effect of any provisions of these Rules and Regulations.~~

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(l) **"Invasive Procedure"** means a procedure involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including but not limited to, percutaneous aspirations, biopsies, cardiac and vascular

catheterizations, endoscopies, angioplasties, and implantations, and excluding venipuncture and intravenous therapy.

(m) **"Licensed Independent Practitioner (LIP)"** means doctors of medicine (MD) and doctors of osteopathy (DO), podiatrists (DPM), dentists (DMD or DDS), and oral surgeons (DMD or DDS) who are currently licensed in the State of Oregon;

(n) **"~~Mid Level Provider~~Advanced Practice Clinician"** means a licensed or certified healthcare practitioner, other than a ~~member of the Medical Staff~~ LIPs, who is permitted to exercise limited clinical privileges and practices within the scope of their license with physician supervision, or on an independent basis without direct physician supervision if the practitioner has demonstrated experience and training in inpatient care and is permitted to do so by license and privileging. The following are deemed ~~Mid Level Providers~~ Advanced Practice Clinicians: certified nurse practitioners, certified nurse midwives, clinical psychologists, physician assistants, radiology practitioner assistants, registered nurse first assistants, clinical nurse specialist, certified surgical technician first assistant and others identified by the Board.

(o) **"Credentialed Provider"** means ~~an LIP or Mid Level~~ any Provider who has been credentialed and privileged to exercise clinical privileges, hereinafter referred to as a Provider~~.~~

ARTICLE II: TREATMENT OF PATIENTS

Patients may be treated by ~~Medical Staff (hereinafter called Staff) members and Mid Level~~ Credentialed Providers who have submitted proper credentials and have been duly appointed to membership and/or granted privileges.

Self-Treatment or Treatment of Immediate Family Members: Consistent with the American Medical Association Code of Ethics, Opinion 8.19,"Self-Treatment or Treatment of Immediate Family Members," physicians at Salem Hospital generally should not treat themselves, members of their household, or any other first-degree relative of a household member.

First-degree relatives are defined as spouse, parents, brothers, sisters or children of the individual.

It would not always be inappropriate to undertake self-treatment or treatment of members of their household or first-degree relatives of a household member. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances (schedule II, III, IV) for themselves, members of their household or any other first-degree relative of a household member.

If a physician is rendering care to a person with whom they have a significant social relationship, the situation will be referred for review by two members of the Medical Executive Committee (MEC). If the two MEC members find that, upon reviewing the medical record, it appears the care provider's relationship with the patient is in some way adversely affecting said care, the care provider may be required to step down and refer this case to another physician.

ARTICLE ~~IV~~III: ~~TENDING~~ATTENDING, CONSULTING AND REFERRING ~~PHYSICIANS~~ PROVIDERS

ARTICLE ~~IV –~~III – PART A: ATTENDING PHYSICIAN

At Salem Hospital, every patient shall have a ~~physician~~ Licensed Independent Provider who will be designated as the "Attending ~~Physician~~ Provider" for that hospital admission. Providers manage the treatment team in the Salem Health EMR. The attending ~~physician~~ provider ~~has~~ the final authority on any matters of patient care and will be charged with the responsibility for release of the patient. Any other ~~physicians~~ providers who are involved in patient care will be so designated through requests for consultation or referral.

ARTICLE ~~IV –~~III – PART B: CONSULTING PHYSICIAN AND CONSULTATION REQUIREMENTS~~:~~

Section 1. Consulting Physician and Consultation:

It is the duty of the Staff, through its Sections, Departments, and Medical Executive Committee, to make certain that members of the Staff do not fail in the matter of calling consultants or responding to consultation requests as needed. A consultant must be qualified to give an opinion in the field in which his/her opinion is sought. See Article VII Consultations for documentation requirements.

(a) Once contacted for a consultation, the consulting physician may direct a Physician Assistant or Nurse Practitioner as his or her representative to provide further assessment and stabilizing treatment.

(b) This determination should be based on the patient's medical needs.

(c) Although a Physician Assistant or Nurse Practitioner may respond to the consultation request, the physician retains responsibility for providing the necessary services to the patient.

(d) If the physician who requests the consultation disagrees with the decision to send a representative, he or she retains the right to request the actual appearance of the consulted physician.

Section 2. Definitions of Types of Consultation:

In the consultation process, it is important for both the physician requesting consultation and the physician providing consultation to have a mutual understanding of the nature of the request. The types of consultation are listed below.

(a) Collegial discussion regarding the care of a condition or patient is encouraged. Such discussion is not considered a consultation unless the consultant makes a written entry into the patient record.

(b) CONSULTATION for Opinion Only: a consultant's opinion on a specific problem is requested. There is no expectation that the consultant will provide continued care of the patient.

(c) CONSULTATION for Co-Management of Patient: The consultant is requested to provide co-management of the patient for a defined period of time or until resolution of the particular problem.

(d) CONSULTATION for Transfer of Care: A request is made to transfer care of the patient to the consultant on this issue.

Section 3. Required Consultations:

Except in an emergency, consultation with another qualified physician is required in cases in which the attending practitioner does not have clinical expertise or possess specific clinical privileges required for the patient's condition or problem.

Section 4. Rapid Response Team Consultations:

When deemed to be necessary based on the clinical needs of the patient, a non-physician representative of the Rapid Response Team may initiate a consultation with a physician on the behalf of the attending physician.

~~ARTICLE IV III PART C: REFERRAL PHYSICIAN~~

ARTICLE ~~V~~IV: STANDING ORDERS

The use of pre-printed and electronic standing orders, order sets, and protocols for patient orders are permitted and can be initiated by nurses or other clinicians without a specific order from the ~~physician/practitioner~~ provider only if the Hospital Representatives (including, as applicable, Nursing and Pharmacy Leadership) and Medical Staff:

(~~1~~a) Establish that such orders and protocols have been reviewed and approved by the Medical Staff and Hospital's Nursing and Pharmacy leadership;

(~~2~~b) Demonstrate that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

(~~3~~c) ~~Ensure that the periodic and regular~~Periodically and regularly review ~~of~~(at least annually) such orders and protocols~~ is conducted by the Medical Staff and the Hospital's Nursing and Pharmacy leadership~~ to determine the continuing usefulness and safety of the orders and protocols; and

(~~4~~d) ~~Ensure~~Require that such orders and protocols ~~are~~be dated, timed and authenticated as permitted by these Rules & Regulations, and by Hospital policies.

~~(5)~~ ~~Physicians/practitioners~~ Providers retain the right to modify, cancel, void or refuse to authenticate standing orders ~~that the responsible physician/practitioner determined were not medically necessary (76 FR 65896, October 24, 2011)~~as appropriate, considering medical necessity.

ARTICLE ~~VI~~ V: TREATMENT ORDERS

Patient Orders shall be electronic using the Salem Health EMR. Verbal and telephone orders shall be electronically signed by the ordering ~~practitioner~~ provider or another ~~practitioner~~ provider who is responsible for the care of the patient. ~~It is recommended that v~~Verbal telephone orders are co-signed or authenticated within 48 hours of transcription~~; such orders must be co-signed or authenticated within 7 days (168 hours).~~ Verbal and telephone orders are entered into the EMR by the person receiving the order.

(~~1~~a) All verbal or telephone orders are accepted by licensed personnel only or other individuals authorized by law or their scope of practice to accept verbal orders, e.g., RNs, Physical Therapists, Occupational Therapists, Speech and Language Therapists, Respiratory Therapists, Dieticians, Pharmacists, and Radiological Technologists. ~~The orders accepted must be within the scope of practice of the individual accepting the order.~~

(~~2~~b) ~~RNs may accept telephone orders from the physician's authorized representative. Respiratory Therapy, Physical Therapy, Occupational Therapy, or other licensed professionals may accept therapeutic orders which fall within the scope of their practice directly from the physician.~~

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(~~3~~be) The physician must be called on admission of patient if no orders were given pre-admission.

(~~4~~cd) ~~Certified Nurse Midwives and Nurse Practitioners may write orders within the~~

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(~~5~~de) ~~Physician Assistants may write orders within the scope of their practice, as approved by the Board of Trustees. History & physical examinations, admission~~

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~~orders and discharge summaries must be co-signed by supervising physician or~~

(~~6~~c~~f~~) Medical student orders must be verified by the designated preceptor prior to implementation.

(d~~g~~) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order.

ARTICLE ~~VII~~ VI: MEDICAL RECORDS

~~**ARTICLE VII VI – PART A: MEDICAL RECORD**~~
ARTICLE ~~VII~~VI – PART ~~A~~B: CONTENT OF MEDICAL RECORD

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All medical record entries must be legible and complete, and must be authenticated, and dated and timed promptly by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service furnished.

While it is acceptable to copy and paste from a source document into the Salem Health EMR, the provider must adhere to the following:

A provider may not copy another provider's document verbatim and use it as if it were their own work. If a document is copied and pasted, it must be stated as such and credit given to the author of the document. It cannot replace the provider's own documentation for that encounter.

A provider may not copy forward or clone their own document unless the document is updated/edited to reflect the unique patient encounter for that given day.

If a copied and pasted or cloned document is unchanged/unedited so that it cannot be used for billing purposes, the document will be considered "~~"~~incomplete"~~"~~ by the provider and a deficiency will be created in the medical record for that encounter.

The attending physician shall be responsible for the ~~preparation~~ completion of the medical record~~. (chart) for the Hospital files.~~

All records are the property of the Hospital and may not be removed except pursuant to a court order, subpoena or statute.

~~In case of readmission to the Hospital, all previous electronic encounters and charts shall be available for the use of the attending physician.~~

~~ARTICLE VII – PART C: HISTORY AND PHYSICAL EXAMINATION~~HISTORY AND PHYSICAL EXAMINATION

(See Bylaws, Part 1, Appendix A, as required by the Joint Commission and CMS.)

Section 1. History and Physical Examination:

The History and Physical Examination (H&P) serves several purposes:

- It is an important reference document that gives concise information about a patient's history and exam findings at the time of admission. It addition, it outlines a plan for addressing the issues which prompted the hospitalization/visit. This information should be presented in a logical fashion that prominently features all data immediately relevant to the patient's condition.

- It is a means of communicating information to all providers who are involved in the care of a particular patient.

- It allows students and house staff an opportunity to demonstrate their ability to accumulate historical and examination based information, make use of their medical fund of knowledge, and derive a treatment plan.

- It is an important medical-legal document.

Except for emergencies, patients who do not have an H&P for an operative or high-risk procedure shall not be taken to the operating/procedure room, and the operation/procedure shall be deferred until an H&P is documented in the medical record.

The H&P must be performed and recorded by a Licensed Independent Practitioner (LIP) who has been granted privileges to do so. The admitting LIP is responsible for the H&P, unless otherwise directed by an order.

More than one privileged practitioner can participate in performing, documenting, and authenticating an H&P for a single patient. When performance, documentation, and authentication are split among qualified practitioners, the practitioner who authenticates the H&P will be held responsible for its contents.

A complete history and results of a physical examination shall be entered into the electronic medical record or dictated no later than 24 hours after admission of the patient, and will become a permanent portion of the chart. The H&P documentation requirements by patient type are listed in the algorithm below:

Full H&P must contain the following required elements:

- Chief complaint
- Details of the present illness (reason for hospitalization)
- Presence of significant allergies or documentation of none
- Current medications which are pertinent to the reason for admission or procedure
- Physical examination including vital signs
- Impression, Differential Diagnoses, Conclusion

- ~~Treatment~~
- ~~Plan~~

~~H&P Update must contain the following required elements:~~

- ~~H&P reviewed~~
- ~~Patient examined~~
- ~~Document if there are no changes or changes noted~~

~~If changes have occurred since the H&P was documented, the provider should address what changed in the physical examination and how those change the plan of care.~~

~~**Immediate Admission Progress Note**: must contain the following required elements:~~

- ~~Impression~~
- ~~Problem list~~
- ~~Plan of care for the first 24 hours~~

~~Section 2. History and Physical Examinations for Podiatric Patients:~~

~~(a) In addition to the History and Physical Examination, as outlined in Article VII, Part B, Section 1, the charts of podiatric patients shall set forth the history and pertinent physical aspects of the pathology of each case preoperatively. Should these conditions not be met, the surgery will be postponed.~~

~~(b) Podiatrists may be granted clinical privileges to perform admission history and physical examinations on ASA Class I or II outpatients~~

~~**(See Bylaws, Part 1, Appendix A, as required by the Joint Commission and CMS.)**~~
ARTICLE ~~VII~~ VI – PART ~~D~~C B: PROTOCOL FOR OUTPATIENT INVASIVE PROCEDURES

A ~~physician's~~ provider's legible note indicating significant history and physical findings must be present on the chart prior to the procedure. This note must be written by the practitioner performing the procedure and must meet the standards required in ~~Article VII, Part C: History and Physical Examination~~ Bylaws Part 1, Appendix A. The physician ordering the procedure will provide the H&P, and the practitioner performing the procedure will complete the Focused H&P.

(~~a~~1) If the patient is kept only for the invasive procedure and then post-procedure for observation in the outpatient areas, the physician performing the procedure (i.e., radiologist or anesthesiologist) will remain the attending physician.

(~~b~~2) If the patient is admitted to Salem Hospital for an overnight stay, the attending physician shall be the physician performing the procedure regardless of the indication for the admission. If the physician performing the procedure does not

have admitting privileges, it is the responsibility of the physician performing the procedure to find an accepting admitting physician. The physician performing the procedure shall remain involved in the case as a consultant to deal with complications directly related to the procedure. ~~Completion of the brief history and physical form will suffice for the medical record.~~

(~~c~~3) In the event a patient referred by a non-Staff member requires admission, the physician performing the invasive procedure will make arrangements for an attending Staff physician to care for the patient as described in (2~~b~~) above.

(~~d~~4) If the outpatient invasive procedure does not require use of moderate or deep sedation or general anesthesia, an assessment, as recommended by the Section Chief and Department Chair, and approved by the Medical Staff Executive Committee, is sufficient. (NOTE: The "assessment" noted above is a pre-procedure assessment consisting of vital signs, allergies, assessment of site, and pertinent history of contraindications for those procedures that require only local anesthesia, or minimal sedation/anxiolysis.)

ARTICLE ~~VII~~ VI – PART C ~~E~~D: POST INVASIVE PROCEDURE REPORTS

All invasive procedures performed shall be fully described by the practitioner performing the procedure, and an operative report shall be dictated, or self entered into the electronic medical record upon completion of surgery, before the patient is transferred to the next level of care.

An ~~operative progress~~ immediate post invasive note is to be entered into the medical record immediately after the procedure to provide pertinent information for any individual required to attend to the patient. This is not required if self entered complete operative note is entered into the Salem Health EMR. The operative progress note is to be dated and timed.

Fulfillment of the requirements of a post-invasive procedure note can be accomplished by the following methods:

(~~a~~1) Place an immediate post-invasive procedure note into the electronic medical record using the following required elements:

- Name of the specific procedure(s) performed;
- Pre-op diagnosis ~~(RECOMMENDED ONLY);~~
- Post-op diagnosis;
- Name of the surgeon(s) and assistants or other practitioners who performed surgical tasks (defined as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Complications, if any;
- Estimated blood loss;

AND

(~~b~~2) Dictate a post-invasive procedure report including the following required elements:

- Name of the specific procedure(s) performed;
- Brief history/indications for surgery ~~(RECOMMENDED ONLY);~~
- Pre-operative diagnosis ~~(RECOMMENDED ONLY);~~
- Post-operative diagnosis;
- Name of the surgeon(s) and assistants or other practitioners who performed surgical tasks(defined as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Description of techniques, findings, and tissues removed or altered;
- Prosthetic devices, grafts, transplants, or devices implanted, if any;
- Condition after surgery;
- Estimated blood loss;

OR

(~~c~~3) Self-enter a post-invasive procedure report into the electronic medical record including the following required elements:

- Name of the specific procedure(s) performed;
- Brief history/indications for surgery ~~(RECOMMENDED ONLY);~~
- Post-operative diagnosis;
- Name of the surgeon(s) and assistants or other practitioners who performed surgical tasks (defined as opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues);
- Description of techniques, findings, and tissues removed or altered;
- Prosthetic devices, grafts, transplants, or devices implanted, if any;
- Condition after surgery;
- Estimated blood loss.

ARTICLE ~~VII~~ VI – PART ~~F~~ED: FOREIGN MATERIAL AND TISSUES REMOVED

Specimens removed during a surgical procedure shall be routinely sent for Pathological review ~~to the Hospital Pathologist~~, except those specimens defined in the ~~Operating Room~~ Care and Handling of Surgical/Procedural Specimens policy which has been approved by the Executive Committee.

ARTICLE ~~VII~~ VI – PART ~~G~~F E : PROGRESS NOTES

The attending ~~practitioner~~ provider of record or the covering ~~practitioner~~ provider shall be required to make daily face-to-face rounds on their hospitalized patients, followed by the documentation of their observation in a progress note.

Progress notes must be documented no less than daily, and must be documented on the day of the encounter ~~rounds~~. The only exception to daily progress notes are patients who meet discharge criteria, who remain in the hospital other than due to medical necessity, when progress notes and face-to-face visits must be documented at least every other day. An additional progress note is required for any immediate change in patient status, defined as:

(~~a~~1) Any change in condition of the patient that requires the provider to perform a bedside evaluation,

(~~b~~2) ICU-to-floor transfer, or if there is a change in provider,

(~~c~~3) Floor-to-ICU transfer.

Daily Progress notes shall be self entered into the EMR and give a pertinent ~~chronological~~ report of the patient's course in the hospital over the past 24 hours and, reflect any changes in the patient's condition, the results of treatment, and any changes in plan of care. ~~Final progress notes should include instructions to the patient and/or family if used in lieu of a discharge summary.~~

~~Self entry into the Salem Health EMR is the only approved medium for a progress note. Paper progress notes are acceptable if the EMR is unavailable during downtime.~~

~~**ARTICLE VII VI PART HG F: EMERGENCY DEPARTMENT (ED) HOLDING NOTE**~~

ARTICLE ~~VII~~ VI – PART ~~H G~~ F: CONSULTATION

A consultation shall include appropriate examination of the patient and the record. A written opinion authenticated by the consultant will be made a part of the record. The following elements are strongly recommended for inclusion:

- Chief complaint;
- Details of the present illness ;
- A medical history which includes information from the patient and/or family, prior medical testing, and results of prior medical treatment;
- Detailed past, psychosocial/social, and family history;
- Presence of significant allergies or documentation of none;
- Current medications which are pertinent to the reason for admission or procedure;
- Review of systems;
- Vital signs;
- Physical examination ;
- Mental status exam if indicated or pertinent to the admission or procedure;
- Impression, Differential Diagnoses, Conclusion ;
- Treatment; and
- Plan.

Fulfillment of this requirement is accomplished by:

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(~~a~~1) Dictation plus brief consultation note in electronic medical record~~,~~; or

(~~b~~2) Self-entry of full consultation in electronic medical record.

ARTICLE ~~VII~~ –VI – PART ~~J~~~~I H~~ G: DISCHARGE DIAGNOSES/SUMMARIES

Commented [A7]: The below recommendations in Article VI were made in collaboration with Debra Harris, Director of HIM based on current CMS requirements.

The discharge summary will be assigned to the credentialed provider who is identified in the discharge order. If no designation exists, the attending physician will be responsible for the discharge summary. The discharge summary shall be dictated or documented no later than 7 days following patient's discharge.

A discharge summary contains the following elements, some of which are required as noted below:

REQUIRED:

- Final diagnoses, including principal and all secondary diagnoses.
- Treatment rendered.
- Disposition: Discharge to home, discharge to skilled nursing facility, expired, etc.
- Any instruction given to the patient or family relating to physical activity, medication, diet, and follow-up care.

RECOMMENDED:

- Reason for hospitalization.
- Significant findings.
- Principal and secondary procedures performed.
- The condition of the patient on discharge.

~~All deaths require a dictated or self entered into the Salem Health EMR discharge summary.~~

~~Patient Type~~	~~Discharge Summary~~	~~Fulfilled by~~
~~Any Admission, Inpatient, Outpatient or Observation Patient~~	~~Required~~	~~Dictated with required elements~~ ~~OR~~ ~~Self-entered into the Salem Health EMR with required elements~~ ~~See NOTE below~~

~~NOTE:~~

All patients regardless of type, request a discharge summary with the following exceptions.

Final progress note may be substituted for a discharge summary if:

- The patient was hospitalized less than 48 hours for a minor problem (does not include deaths), must contain the same required elements listed above, **OR**
- The patient had an uncomplicated obstetrical stay, **OR**
- The patient was a normal newborn infant

ARTICLE ~~VII~~VI – PART ~~K~~J I H: PROBLEM LIST

(~~a~~1) Purpose of the Problem List: The purpose of the problem list is to communicate to other members of the health care team the relevant problem(s) the patient is experiencing for the current episode of care, specifically rationale for why treatment is chosen and may be used for the purpose of coding. ~~Sometimes this will be a new problem(s), a reactivation of an old problem(s) or "no identifiable" problem(s)." Specifically the problem list is NOT intended to be used for coding of the encounter for reimbursement. It is acceptable to enter "No problem identified."~~

(~~b~~2) Management of the Problem List: The management of the problem list falls to all credentialed provider(s) taking care of the patient, each provider managing their problem(s) on the list. All credentialed providers will manage the problem list, specicifically any credentialed provider may edit, remove or make inactive any other provider's problem(s). ~~Specifically~~, N~~n~~on-credentialed providers (nursing staff, certified nurse assistants, medical assistants, unit clerks, pharmacists, ancillary staff – RT, PT, OT) will not be expected or allowed to manage the problem list. The exception to this is for nursing and ancillary staff that have patient encounters without credentialed providers present (i.e., Infusion and Wound Care). ~~In this instance the nurses will be allowed to enter the most salient problem, enter no new problems or enter no problems in the electronic medical record. All credentialed providers will manage the problem list, specifically any credentialed provider may edit, remove or make inactive any other provider's problem(s).~~

(~~c~~3) ~~Core Measures: Core Measures (CHF, AMI, CAP, SCIP) are to be identified as soon as the diagnosis reaches reasonable certainty. By entering the Core Measure, the healthcare team can mobilize to assist the credentialed provider in achieving Core Measure compliance.~~

(~~d~~34) Entering the Problems: ~~The expectation is that each provider who sees the patient will enter why the patient is being seen on the problem list. Ideally this entry would occur when the provider initially sees the patient for the encounter~~. The problem list should continue all problems actively managed or monitored during that hospital stay. ~~also be reviewed and managed on a daily basis for inpatients.~~ If ~~there is~~ no problem is entered, a deficiency will be created for the attending provider. ~~it will be considered a deficiency and will be handled by the HIM Department as such for inpatients. Ambulatory encounters will not be closed without at least one problem identified.~~

ARTICLE ~~VII~~VI – PART ~~LK J~~ I: REQUIREMENTS FOR PRE-SEDATION/PRE-ANESTHESIA

A pre-sedation/anesthesia examination assessing those aspects of the patient's physical condition that might affect decisions regarding intra-procedure risk and management ~~is~~ will be completed by the appropriately credentialed practitioner. This includes:

(1) ASA Classification System;

(2) Previous history of adverse reactions to sedatives/anesthesia;

(3) Heart, lungs, airway and ~~part to be invaded~~ treatment site;;

(4) Plan for sedation/anesthesia.

Procedure, Alternatives, Risks and Questions (PARQ) discussion for both planned procedure and sedation/anesthesia ~~is~~ will be documented.

ARTICLE ~~VII~~ VI – PART ~~ML K~~ J: PROCEDURE FOR DELINQUENT RECORDS

Section 1. Delinquent Charts:

(~~a~~) Hospital charts will become delinquent seven (7) days after allocation date (date deficiency is assigned for completion by the HIM Department) if these charts do not include all items that must be completed by the Medical Staff member. Completed charts will include all required documentation ~~appropriate dictation~~ and signatures.

(b) ~~Medical Staff members are to check in with an HIM Clerk upon arrival in the Health Information Management (HIM) Department. If a record is not available at the time the Staff member is in the department and the Staff member checked in with an HIM Clerk, the allocation date will be changed to the current date, giving the Staff member an additional seven (7) days to complete the record.~~

Section 2. Health Information Management Department (~~Medical Records~~) Procedure for Impending Administrative Suspension:

(a) The Health Information Management Department shall send a notification to each Staff Member having such delinquent charts, approximately five (5) working days before privileges are automatically suspended. The effective date of suspension will be included ~~show~~ on the notification.

(b) If all delinquent records are not completed (including all required documentation ~~dictations~~ and signatures) by noon on the effective date of suspension, the Staff member will be ~~sanctioned based on~~ subject to the penalties outlined in Section ~~4~~ 3 below.

~~Section 3. Notification of Suspension:~~

Section 34. Penalties for Non-Completion of Delinquent Medical Records by Noon on the Effective Date of Suspension:

Penalties will be imposed for non-completion of delinquent medical records by the noon deadline on the effective date of suspension that occur within a rolling 24-month period as follows. Any practitioner fines imposed are expected to be paid immediately, but must be paid within 2 weeks or prior to privileges being reinstated if privileges have been administratively suspended:

(a) First Non-Completion of Delinquent Medical Records:

i.(1) Privileges will not be suspended, however, a A disciplinary fine of $250 will be imposed, to be paid within 2 weeks of notification of the missed noon deadline for completion of delinquent medical records.
ii.(2) A personal telephone call to the practitioner from the Section Chief or Department Chair.
iii.(3) All outstanding medical records must be completed.
iv.(4) Fines not paid within 2 weeks will result in an administrative suspension of privileges until the fine is paid and all records are completed.

(b) Second Non-Completion of Delinquent Medical Records:

i.(1) Administrative Suspension of Privileges will be invoked.
ii.(2) Disciplinary fine of $250, to be collected prior to privileges being reinstated.
iii.(3) All outstanding medical records must be completed.

(c) Third Non-Completion of Delinquent Medical Records:

i.(1) Administrative Suspension of Privileges will be invoked.
ii.(2) Disciplinary fine of $500, to be collected prior to privileges being reinstated.
iii.(3) All outstanding medical records must be completed.
iv.(4) Mandatory one-week disciplinary suspension.

(d) Fourth Non-Completion of Delinquent Medical Records:

i.(1) Administrative Suspension of Privileges will be invoked.
ii.(2) Disciplinary fine of $1,000, to be collected prior to privileges being reinstated.
iii.(3) Mandatory two-week disciplinary suspension.
iv.(4) Mandatory meeting with the MEC to provide an explanation for repeated non-compliance.

(e) Fifth Non-Completion of Delinquent Medical Records:

i.(1) Voluntary resignation from the Medical Staff.

Section ~~43~~. Notification of Suspension:

On the effective date of administrative suspension from the Medical Staff for delinquent medical records, the Medical Staff ~~Services~~ Office Department will notify the Staff member of the suspension by telephone and by letter. In addition, ~~various~~ relevant ~~areas~~ of the Hospital ~~will~~ notified. These areas will include the Admitting Office, Bed Control, House Supervisor, Main Operating Room, COM Operating Room, Surgery Scheduling Office, Medical Staff Office, Surgery Director, Angiography, Labor and Delivery, OB Department, Psychiatry, and the Emergency Department.

Section ~~5.~~4 5. Completion of Delinquent Charts:

So long as the staff member is not subject to Section ~~3~~4(e) above, then upon completion of all charts, payment of any disciplinary fine and completion of any other requirements, Staff members will be reinstated upon notification by the ~~Health Information Management Department~~ Medical Staff Office and approval of ~~Administration~~ the Medical Executive Committee, Medical Staff President or Medical Staff President Elect. The ~~HIM~~ Medical Staff Office staff shall also immediately notify all of the above departments as listed in Section ~~4~~3.

Section ~~6.~~ 5 6. Notification of Unavailability:

Any Staff member notifying the Health Information Management Department or the Medical Staff Office of absence from the city or unavailability for one week or longer will not be considered delinquent for that period of time. Unavailability means that the Staff member will not be performing other functions in the hospital. It is expected that the Staff member will complete all available records before ~~leaving for vacation~~ planned absence. The Staff member will have seven (7) days beginning the Monday following the Staff member's return to complete records prior to receiving suspension notification.

Section ~~7.~~ 6 7. Suspension Process:

The Medical Staff Executive Committee may modify the suspension process to impose some lesser penalty on a uniform basis to be applied to all members of the Medical Staff. In the situation of an urgent patient care need and a practitioner that is administratively suspended for delinquent medical records, the Administrator on Call, together with the Medical Executive Committee (MEC) Member on Call, can reinstate privileges for no greater than a 24-hour period. All such reinstatements will be subsequently reviewed by the MEC at the next meeting.

ARTICLE ~~VIII~~VII: AVAILABILITY TO SEE HOSPITAL PATIENTS

All Active Staff members shall be available to see their hospital patients every day or to make arrangements with a member of the Active Staff who has comparable ~~admitting~~ privileges to see their hospital patients in case of their unavailability. Hospital patients shall be defined as both inpatients and outpatients.

In case of failure of the Staff member to make such arrangements, the Staff President or his delegate, shall select a Staff member to take the necessary action. A Staff member called by the Staff President shall give appropriate treatment and shall leave a report for inclusion in the record.

Timely response to phone, beeper and/or answering service is expected of all Staff members, defined as within 15 minutes of the initial contact. If there is no response within 15 minutes, a second attempt at contacting the Staff member will be made. If there is no response within 15 minutes of the second attempt, the Section Chief (or Department Chair if no Section) will be contacted to handle the patient care issue.

ARTICLE ~~IX~~VIII: EDUCATION OF HOSPITAL PERSONNEL

Medical Staff members shall cooperate with Administration in education of Hospital personnel by giving such personal supervision and lectures as required.

ARTICLE ~~X~~IX: EMERGENCY DEPARTMENT

ARTICLE ~~X~~ IX – PART A: DEFINITIONS

~~1.~~(1) UNASSIGNED PATIENT: Patients who have no assigned Primary Care Physician.

~~2.~~(2) PRIMARY CARE ~~PHYISICAN~~PHYSICIAN: A physician from the Salem Hospital Medical Staff whom the patient has an ongoing relationship with and provides primary care services.

~~3.~~(3) EMERGENCY DEPARTMENT: The Salem Hospital department that provides initial treatment to patients with a broad spectrum of illnesses and injuries, some of which may be life threatening, requiring immediate attention.

~~4.~~(4) EMERGENCY DEPARTMENT BACKUP: This is the process whereby the Salem Hospital back-up physician is requested to:

(a~~.~~) Come to the Emergency Department to provide care, as determined by the Emergency Department physician;

(b~~.~~) Admit and provide inpatient services, as determined by the Emergency Department physician, in collaboration with the back-up physician; and

(c~~.~~) Provide outpatient follow up of the patient's evaluation in the Emergency Department in cases where the patient is deemed to have an acute medical problem that requires follow up. This excludes Convenience Care.

ARTICLE ~~X~~IX – PART B: EMERGENCY DEPARTMENT BACKUP REQUIREMENTS

(1) Sections which include four or more Active staff members are responsible for providing continuos call coverage for their Emegency call roster.

~~1.~~(2~~1~~) The Active~~, Associate Staff and Refer & Follow~~ Staff shall be responsible for maintenance of ~~its own~~ their Emergency call roster. In the event of a schedule dispute, the Section Chief has the authority to resolve the dispute; if unable to do so, the dispute will be referred to the Department Chair. If the dispute cannot be resolved by the Section Chief and/or Department Chair, it shall be referred to the Medical Executive Committee (MEC).

~~2.~~(3~~2~~) Family Medicine Physicians shall participate on a backup list commensurate with their Hospital privileges.

~~3.~~(4~~3~~) Exceptions to the above requirements are as follows:

(a~~.~~) Those members who are 60 years of age or more, on approval of Section;
(b~~.~~) Those members who are hospital-based physicians in the following sections: Anesthesiology, Emergency, Imaging, Pathology, Physical Medicine & Rehabilitation, Radiation Oncology, Neonatology, Palliative Medicine, Urgent Care, and Psychiatry Unit physicians.

~~4.~~(5~~4~~) Upon written request, and upon the receipt of a recommendation by the Department Chair approving such request, the MEC may relieve any Staff member from duties under this section for such time and under such circumstances and conditions as the MEC shall consider appropriate and in the best interest of the hospital.

ARTICLE ~~X~~IX – PART C: ~~DUTIES OF EMERGENCY DEPARTMENT~~

~~1.~~(1) The duties of the backup member shall be:

(a~~.~~) To respond promptly to the Emergency ~~physician~~ Department Credentialed Provider, as listed in Sections 3, 4 and 5 below, and assume responsibility for Emergency Department emergencies referred by the Emergency physician for unassigned patients. ~~those patients who do not have a Primary Care Physician;b.~~
(b) Once contacted by the Emergency Department Credentialed Provider ~~physician~~, the backup or on-call physician may direct a Physician Assistant or Nurse practitioner as his or her representative to provide further assessment and stabilizing treatment.
(c~~.~~) This determination should be based on the patient's medical needs.
(d~~.~~) The backup or on-call physician retains responsibility for providing the necessary services to the patient.

(e.) If the Emergency Department physician disagrees with the decision to send a representative, he or she retains the right to request an in-persona consultation ~~the actual appearance~~ of the on-call physician.

(f.) If the patient is transferred to another acute care facility, the Credentialed Provider ~~the physician~~ must certify the risks and benefits discussion.

(g.) In the case of patients who have a Primary Care ~~Physician~~ Provider ~~Physician~~, it shall be the responsibility of that ~~physician~~ Credentialed Provider , or his/her designated substitute, to admit or to obtain consultation.

(h.) To provide subsequent outpatient follow-up care for a particular problem referred by the Emergency Department Credentialed Provider ~~physician~~, as listed in Section 6 below.

~~2.~~(2) ~~Associate Staff and Refer & Follow members shall participate in outpatient follow-up care on a rotational basis as determined by their section and department and approved by the Executive Committee.~~

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~~3.~~(3) TELEPHONE OR ARRIVAL: Timely response to the Emergency Department Credentialed Provider ~~physician~~ request is defined as responding by telephone or arrival in person within 15 minutes.

~~4.~~(4) ARRIVAL: Request by Emergency physician or other member of the Medical Staff to come to the Emergency Department~~s~~.

(a) ~~Physician~~ Credentialed Provider Request for Urgent Arrival: Medical Staff member shall arrive in person within 30 minutes.*

(b.) ~~Physician~~ Credentialed Provider Request for Non-Urgent Arrival: Medical Staff member shall arrive in person within 1 hour.*

~~5.~~(5) LEVEL II TRAUMA: Trauma Surgeon response time is within 15 minutes.

~~6.~~(6) OUTPATIENT FOLLOW-UP CARE OF ~~UNASSIGNED PATIENTS~~ED REFERRAL PATIENTS:

(a.) Patient Responsibilities:

~~i.~~(1) ~~If the patient does not~~ The patient must request follow-up care within a two-week period of time., Otherwise the ~~backup physician~~ Emergency Department Referred provider may refer the patient back to the Emergency Department or Convenient Care Center.

~~ii.~~(2) If the patient does not accept ~~keep~~ the offered appointment, the patient may be referred to the Emergency Department or Convenient Care Center.

(b.) Medical Staff Members Responsibilities:

~~i.~~(1) Active, Associate Staff and Refer & Follow members shall participate in outpatient follow-up care on a rotational basis as determined by their

section and department and approved by the Medical Executive Committee.

(2) The Medical Staff member must agree to see the patient within two weeks of the patient's initial follow-up call, or sooner at the discretion of the physicians involved and based on the nature of the medical condition, providing that the patient met the responsibilities outlined in 6.a. above. The Medical Staff member must provide one follow-up option in the two-week time frame. Medical Staff will care for patients who return to the Emergency Department for a similar problem within 48 hours of the original visit.

~~ii.~~(32) Outpatient follow-up care shall be limited to only the particular problem referred by the Emergency physician. It is not the responsibility of the back-up physician to accept the patient as a full-time patient to his/her practice; however they may do so at their discretion~~.~~

~~7.~~(7) VIOLATION OF MEDICAL STAFF REGULATIONS: Violations will be dealt with by the Section Chief, Department Chair or MEC.

*Unless the on-call credentialed provider ~~physician~~ is preoccupied in a procedure or care of an unstable patient. In this case, an estimate should be obtained from the on-call credentialed provider ~~physician~~ as to when they are likely to become available. If the patient's condition requires more prompt evaluation and treatment, then the patient should be stabilized and transferred to a facility with available resources. This is to be coordinated with the assistance of the house supervisor.

ARTICLE ~~X~~ IX – PART ~~C~~D: EMERGENCY MEDICAL SERVICES

(1) Emergency services and care shall be provided to any person in danger of loss of life or serious injury or illness whenever there are appropriate facilities and qualified personnel available to provide such services or care. Such emergency services and care shall be provided without regard to the patient's race, ethnicity, religion, national origin, citizenship, age, gender, gender identity, sexual orientation, ~~sex~~, pre-existing medical condition, physical or mental handicap, insurance status, economic status or ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

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(2) Medical Screening Examinations, within the capability of the Hospital, will be performed on all individuals who come to the hospital requesting examination or treatment to determine the presence of an emergent~~cy~~ medical condition. Qualified medical personnel who can perform Medical Screening Examinations within applicable Hospital policies and procedures are defined as:

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~~A.~~(a) Emergency Section:

(1) Physician members of the Medical Staff with clinical privileges in Emergency Medicine.

(2) Advanced Practice Clinicians ~~Nurse Practitioners and Physician Assistants~~ with clinical privileges in Emergency Medicine.

(3) Registered Nurses who have completed Sexual Assault Nurse Examiner (SANE) certification and maintain competency may perform medical screening examinations on adolescent and adult alleged sexual assault victims in accordance with Emergency Department policies and procedures.

~~B.~~(b) Labor and Delivery:

(1) Physician members of the Medical Staff with OB~~/GYN~~ privileges~~:~~.

(2) Certified Nurse Midwives with OB privileges.

(3) Registered Nurses who have completed a Labor and Delivery departmental orientation/competency program may perform the initial medical screening in accordance with Labor and Delivery Policies and Procedures.

~~C.(c) Licensed Non-Physician Practitioners~~

ARTICLE ~~XI~~ X: REPORTABLE DEATH ~~and~~AND AUTOPSIES

ARTICLE IX PART A: REPORTABLE DEATHS

(~~1~~a) When deaths occur in the following categories they are reportable to the Marion County Medical Examiner. The Medical Examiner must be notified in all cases in which death occurs in any of the below categories. In these cases the Medical Examiner must give consent prior to requesting organ donation.~~:~~

(~~a~~1) All cases "Dead on Arrival" not attended by a physician;

(~~b~~2) Deaths subsequent to violence (homicide, suicide or accident);

(~~c~~3) Death was assumed to be due to a communicable disease that might be hazardous to the public health;

(~~d~~4) Death occurred where the individual was not under the care of a physician;

(~~e~~5) Death was apparently the result of the individual's employment (including accidents);

(~~f~~6) Sudden unexplained death;

(~~g~~7) Death occurred in a public or private hospital less than 24 hours after admission;

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(~~h~~8) The death certificate had been signed but circumstances suggest that further investigation is indicated; and/or

(~~i~~9) Death occurred under suspicious circumstances.

~~NOTE: The Medical Examiner must be notified in all cases in which death occurs in any of the above categories. In these cases the Medical Examiner must give consent prior to requesting organ donation.~~

ARTICLE IX PART B: AUTOPSY

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(~~2~~b) An autopsy should be performed in all neonatal deaths, maternal deaths, pediatric (age <18) deaths, and deaths occurring intra-operatively or within 24 hours following surgery. The attending physician or designee will be responsible for requesting permission for the autopsy. If in the opinion of the attending physician the request for an autopsy would be uninformative ~~redundant~~ or would be unduly distressing to the family, or would likely be rejected by the family, the request may be deferred.

~~NOTE:~~ In cases falling under the jurisdiction of the Marion County Medical Examiner, the Medical Examiner determines if a Medical-Legal Autopsy is performed. (ORS 146.045)

If the Medical Examiner waives Medical-Legal Autopsy, permission for hospital autopsy may be requested from next-of-kin.

(~~3~~c) Use of autopsy in Quality Assessment and Improvement activities:

Autopsy reports are included in the review of death peer review indicators as part of the quality assessment and improvement activities by the Medical Staff.

~~**ARTICLE XII: AMENDMENTS**~~

~~(1) Particular rules and regulations may be adopted, amended, repealed or added by vote of the Executive Committee at any regular or special meeting provided that copies of the proposed amendments, additions or repeals are posted on the Medical Staff bulletin board and made available to all members of the Executive Committee 30 days before being voted on, and further provided that all written comments on the proposed changes by persons holding current appointments to the Medical Staff are brought to the attention of the Executive Committee before the change is voted upon. Changes in the rules and regulations shall become effective only when approved by the Board.~~

~~(2) Rules and regulations may also be adopted, amended, repealed or added by the Medical Staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the Medical Staff Bylaws is followed. All such changes shall become effective only when approved by the Board.~~

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