WEST VALLEY HOSPITAL

MEDICAL STAFF

RULES AND REGULATIONS

July, 2002

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INTRODUCTION

Rules and regulations shall be established to control the conduct of work of the medical staff and other practitioners functioning within the hospital as a whole. Authority for establishing and changing rules, regulations or any standing order is stated in the bylaws. This shall require approval of the Medical Executive Committee before final action by the Board of Directors.

Rules shall be established which refer to the medical administrative conduct of staff work in general as well as to specific areas of medical service on clinical activity. These may require approval by the Medical Executive Committee before approval by the Board of Directors.

No regulations, rules or orders, which in any way limit or conflict with anything in the hospital bylaws, rules and regulations or medical staff bylaws or which are in conflict with any known law or regulation thereof, may be approved.

ADMISSION OF PATIENTS:

1. No patient, include patients admitted for observation status, shall be admitted to West Valley Hospital except on the order of a practitioner to whom admitting privileges have been granted. The admitting practitioner must provide sufficient information at the time of admission to establish that care can be provided to meet the needs of the patient. Admission medical information shall include a statement concerning the admitting diagnosis and general condition of the patient. Other pertinent medical information, orders for medication, diet and treatments must also be provided, as well as a medical history and physical. All members shall be governed by the admitting policy of the hospital.

2. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting department should notify the attending physician whenever such consent has not been obtained, so that consent may be obtained as soon as possible.

3. All members of the Medical Staff must continuously demonstrate their ability to meet the terms of Medicare/Medicaid participation applicable to the Hospital, JCAHO accreditation standards and conditions for reimbursement of the Hospital for service initiated by the member.

4. Each patient shall be the responsibility of a member of the medical staff. Such practitioner is referred to herein as the "attending practitioner." The attending practitioner shall assess each patient's physical, psychological and social status, shall be responsible for the patient's medical care and treatment, for the prompt completion and accuracy of the medical records, and for transmitting reports of the condition of the patient to the referring medical staff member, if any. Whenever these responsibilities are transferred to another medical staff member, a note covering the transfer of responsibility shall be entered in EHR.

5. Psychiatric consultation and/or appropriate referral must be requested for and offered to all patients who have attempted suicide. That such services were at least offered must be documented in the patient's medical record.

6. All 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 Department Chair will be contacted to handle the patient care issue.

7. The admitting medical staff member shall be held responsible for setting forth known information necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient might be a source of danger in any way, whatever.

8. All patients admitted to the hospital are to be seen and orders confirmed within 12 hours.

9. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. Medical staff members admitting emergency cases shall be prepared to show the Medical Executive Committee and the administration of the hospital that the admission was a bona fide emergency. The history and physical must clearly justify the patient being admitted, on an emergency basis, and must be recorded on the patient's chart within 24 hours after admission. In the case of an emergency, such statement shall be recorded as soon as possible.

ANESTHESIA SERVICES

1. Admitting.
A.M. surgical and Day Surgery admissions shall be in the hospital a minimum of two (2) hours prior to elective anesthetic procedures. Any desired lab work will be completed prior to admission.

2. Responsibility of the Anesthesiologist or the Certified Registered Nurse Anesthetist (CRNA).
Before anesthetizing a patient, the anesthesiologist must determine that the patient is an appropriate candidate for the planned anesthesia. Pre-anesthetic and post anesthetic patient evaluation and care shall be the responsibility of the anesthesiologist or CRNA.

3. Post-Operative Recovery.
Following anesthesia, when the patient's status will allow transfer from the operating room, the patient shall be transferred to the recovery area prior to being returned to his assigned hospital bed. The decision to discharge the patient from the recovery area shall be the responsibility of the anesthesiologist, the CRNA, or the attending practitioner when an anesthesiologist or CRNA is not in attendance.

4. Complications in Recovery.
All complications developed while in the recovery area shall be directed to the anesthesiologist, the CRNA, or the attending practitioner when an anesthesiologist or CRNA is not in attendance. However, when a patient develops an immediate life-threatening complication, any capable practitioner may render the appropriate treatment until an anesthesiologist or CRNA can be present.

5. Safety Regulations.
Anesthesia safety regulations shall comply with the recommendations of the Joint Commission on Accreditation of Health Care Organizations and the National Fire Prevention Association. All personally-owned anesthesia equipment shall be maintained in compliance with the above requirement prior to use in the hospital.

6. Medical Records.
The patient's medical record shall contain the following:

A. Pre-anesthetic evaluation with findings recorded.

B. Reevaluation of patient immediately before anesthesia induction with time, date and findings recorded.

C. Records of anesthesia, analgesia, medications given in the course of the operation.

D. Handwritten or electronically recorded documentation of the patient's physiologic status during the procedure.

E. Timely post anesthetic recovery progress notes with time, date and findings recorded.

AUTOPSIES

1. When deaths occur in the following categories they are reportable to the Medical Examiner:

a. Apparently homicidal, suicidal or occurring under suspicious or unknown circumstances;
b. Resulting from the unlawful use of controlled substances or the use or abuse of chemicals or toxic agents;
c. Occurring while incarcerated in any jail, correction facility or in police custody;
d. Apparently accidental or following an injury;
e. By disease, injury or toxic agent during or arising from employment;
f. While not under the care of a physician during the period immediately previous to death;
g. Related to disease which might constitute a threat to the public health; or
h. In which a human body apparently has been disposed of in an offensive manner. ("Offensive manner" means a manner offensive to the generally accepted standards of the community).

(ORS146.090)

i. All deaths of persons admitted to a hospital or institution for less than 24 hours, although the medical examiner need not investigate nor certify such deaths.

(ORS145.100 (b))

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 (ORS146.103 (4)).

2. An autopsy is encouraged, but not required by law when:
   a. Deaths in which autopsy may help to explain unknown and unanticipated medical complications to the attending physician.
   b. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.
   c. Cases in which autopsy may help to allay concerns of the family and/or the public regarding the death, and to provide reassurance to them regarding same.
   d. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
   e. Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards.
   f. Unexpected or unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction.
   g. Natural deaths which are subject to, but waived by, a forensic medical jurisdiction such as (a) persons dead on arrival at hospitals (b) deaths occurring in hospitals within 24 hours of admission, and (c) deaths in which the patient sustained or apparently sustained an injury while hospitalized.
   h. Deaths resulting from high-risk infectious and contagious diseases.
   i. All obstetric deaths.
   j. All perinatal and pediatric deaths.
   k. Deaths at any age in which it is believed that autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs.
   l. Deaths known or suspected to have resulted from environmental or occupational hazards.

Reference: Criteria for Autopsies by the College of American Pathologists, reaffirmed 2/97.

CONDUCT GENERALLY

1. When exercise stress testing is performed, there shall be appropriate monitoring and resuscitative equipment and persons trained in cardiopulmonary resuscitative techniques physically present.

2. All grievances are to be adjudicated by the proper authorities and no practitioner shall take it upon him or her self to discipline any hospital employee. Complaints relative to patient care should be delivered to the Director of Nursing Services or the Administrator.

3. At various times, health profession students may, under the supervision of a staff physician of this hospital, perform the duties of physical diagnosis. These students will at all times be under the supervision of, and the responsibility of, the patient's attending physician or his or her designed. If the student's report of his or her examination is to constitute the required physical examination, the attending physician shall edit and co-sign the report; thus making it his or her responsibility as to accuracy.

CONSULTATION

1. Good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the seriousness of the illness and questions of doubt as to the diagnosis and treatment rest with the medical staff member responsible for the care of the patient. On the other hand, it is the duty of the organized medical staff, through its department chiefs and Medical Executive Committee, to see that practitioners do not fail in the matter of calling consultants when needed.

2. Except in an emergency, consultation is recommended in the following situations:

In cases which:

A. The patient is not a good risk for operation or treatment.

B. The diagnosis is obscure, after ordinary diagnostic procedures have been completed.

C. There is doubt as to the choice of therapeutic measures.

D. There is an unusual or complicated situation requiring skills of other practitioners.

3. The attending medical staff member is primarily responsible for requesting consultation, and must do so verbally and on the order sheet.

4. A consultant must be qualified to give an opinion in the field in which his or her opinion is sought. The status of the consultant is determined by the Medical Executive Committee on the basis of his or her training, experience and competence.

5. If a nurse has any reason to question the care provided to any patient or feels that appropriate consultation is needed and has not been obtained, he or she shall call this to the attention of the attending practitioner first. If satisfaction is not received, the nurse shall call this to the attention of his or her supervisor, who in turn shall refer the matter to the Director of Nursing Services. If it appears to be warranted, the Director of Nursing Services shall notify the chief of the department wherein the medical staff member has clinical privileges or the Chief of Staff who, if appropriate, may request a consultation.

6. Consultations shall include examination of the patient and a review of the patient's record, findings by the consultant, an opinion and recommendation. A limited statement such as "I concur" does not constitute an acceptable report of consultation. Except in a verifiable emergency, when operative procedures are involved, the consultation note shall be recorded prior to operation.

DELINEATION OF PRIVILEGES

1. Qualifications of practitioners shall be determined by their respective departments on the basis of education, training, expertise, and demonstrated competence. Each practitioner shall request privileges for those procedures he or she is competent to perform. The Medical Executive Committee shall review these requests on initial appointment as well as reappointment to the medical staff. The Medical Executive Committee shall approve those privileges it feels the practitioner can satisfactorily perform. In the event of any disagreements between the practitioner's requests and the recommendations of the Medical Executive Committee the burden of proof shall

rest with the practitioner. The procedure outlined by the Medical Staff bylaws may be utilized as requested by the practitioner.

2. All practitioners granted new or additional privileges that require a substantial variation of previous skills shall be monitored by the respective department chief or his or her designed, to determine competency and proficiency. Operative and invasive procedures shall be monitored by the Medical Executive Committee's review of five (5), or what Medical Executive Committee accepts as demonstration of competency, Observer's Evaluation Forms. Nonoperative, noninvasive procedures shall monitored by the Medical Executive Committee's review and evaluation of at least five (5), or what Medical Executive Committee accepts as demonstration of competency, completed patient medical records.

3. In the event the department chief or Chief of Staff suspects impairment of a practitioner's capabilities which does not necessitate immediate revocation or suspension of staff privileges, either may designate a practitioner monitor for the hospital patient care of said practitioner. The practitioner shall be advised in writing of the appointment of a monitor by the department chief or Chief of Staff. The monitor shall be responsible to observe and report to the department chief the practitioner's quality of care and capabilities. In such instances, the monitor shall be advised by the practitioner in a timely manner of any admissions, discharges, operative or invasive procedures, and treatment plans for hospitalized patients. After adequate monitoring of the physician's performance and capabilities, the department chief or Chief of Staff may terminate the monitor's responsibilities after determining if any action is indicated.

4. A practitioner requesting privileges for new medical technology or new medical procedure will follow WVH New Technology and New procedures medical staff policy.

DISCHARGE OF PATIENTS

1. Patients shall be discharged only on a written order of the attending medical staff member. Prior to discharge, the attending practitioner shall determine whether there is a need for a discharge planning assessment. Should a patient leave the hospital against the advice of the attending practitioner or without a proper discharge, a notation of the incident shall be made in the patient's medical record and the form "Release from Responsibility for Leaving Hospital" will be signed by the patient.

2. No patient shall be transferred or discharged for purposes of effecting a transfer from a hospital to another health facility unless arrangements have been made in advance for admission to such health facility, and the person legally responsible for the patient has been notified or attempts have been made and a responsible person cannot be reached. Transfer or discharge shall not be carried out if in the opinion of the patient's attending practitioner, such transfer or discharge would create a medical hazard. Transfer information shall accompany the patient. Transfer information shall include, but not be limited to, facility from which transferred, name of physician or other practitioner to assume care at the receiving facility, date and time of discharge, current medical finding, current nursing assessment, current history and physical, diagnosis, orders from a physician or other individual authorized within the scope of his/her individual professional license for immediate care of the patient; operative report, if applicable; TB test, if applicable, other information germane to patient condition. If a discharge summary is not available at the time of transfer, it shall be transmitted as soon as available.

3. In the event of a hospital death, the deceased shall be pronounced dead by the attending medical staff member, or his/her designee, within a reasonable length of time. The body shall not be released until an entry has been made and signed, in the medical record of the deceased by a member of the medical staff. Policies with respect to release of bodies shall conform to law.

4. Patients with critical burns shall be treated in a burn center unless transfer of the patient is contra-indicated in the judgment of his attending practitioner.

EMERGENCY SERVICES

1. Procedure Manual.

The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to the facility.

2. Emergency Medical Screening Examination.
All individuals seeking emergency care must be screened to determine whether or not an emergency medical condition exists. The medical screening examination will be conducted by a physician (M.D., D.O.), Nurse Practitioner or Physician Assistant with clinical privileges in Emergency Medicine. An "emergency medical condition" means:

A. A medical condition manifested by acute symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

B. With respect to a pregnant woman who is having contractions, that: (1) there is inadequate time to effect safe transfer to another hospital before delivery, or (2) a transfer may pose a threat to the health and safety of the patient or the unborn child.

3. Transfer of Emergency Patients.
When an Emergency physician examines an Emergency patient and feels that the patient is not is such a condition that the patient can be moved to another hospital, and where the on-call practitioner called requests a transfer to another hospital, the Emergency physician's opinion will prevail, unless the on-call practitioner requesting the transfer comes to the hospital Emergency Department, examines the patient and signs for transfer. The receiving hospital and physician must accept the patient prior to the transfer, and the patient or party responsible for the care of the patient must consent in writing to the transfer. Any transfer shall follow that procedure outlined in the procedure manual.

4. Admission of Emergency Patients.
When the Emergency physician believes that a patient should be admitted and the on-call practitioner, by telephone, requests that the patient be sent home, in such cases the Emergency physician's opinion should prevail and the patient shall be admitted unless the on-call practitioner comes to the hospital, examines the patient, and signs for his discharge home. Physicians with emergency room privileges only shall not admit patients to the hospital on their own and are not permitted to treat inpatients at the hospital except in acute emergency situations when neither the patient's physician nor any other qualified member of the medical staff is available within the time limits dictated necessary by good medical judgment.

5. On-Call Practitioner.

A. Emergency patients who have an attending practitioner on the Medical Staff shall be referred to that practitioner. As needed, the Emergency physician shall consult with that practitioner. In addition, a copy of the Emergency Department record will be sent to that practitioner.

B. If the patient's practitioner or alternate is not available within a reasonable length of time, the appropriate on-call practitioner is to be contacted.

C. Patients without a private practitioner treated by the Emergency physician and requiring follow-up care may be referred to an appropriate on-call practitioner. The necessary records will be sent to the practitioner and the patient informed that it is the patient's responsibility to contact the practitioner for follow-up care. The practitioner will not be responsible for the patient until the patient has pursued the patient's obligation. A patient without a private practitioner treated by the Emergency physician and requiring hospital admission will be assigned to an on-call practitioner.

D. A roster, by specialty, shall be maintained of all practitioners who are available to treat emergency referrals. Practitioner's on-call is required to be available to be in attendance in the emergency department within thirty (30) minutes if necessary.

Upon written request the Medical Executive Committee may relieve any Staff member from duties under this section for such time and under such circumstances and conditions as the Executive Committee shall consider appropriate and in the best interest of the hospital.

E. The assignment of a patient to the appropriate on-call practitioner shall be made on the basis of the Emergency physician's determination of the primary medical needs of the patient in consultation with the on-call practitioner. Subsequently, it is the on-call practitioner's responsibility to determine whether additional consultations are necessary and to select those consultants he or she desires.

F. Each department will prepare the emergency room on-call roster responsible for each staff category in their respective department. The respective departments may grant individual exceptions to on-call responsibility upon the request of the practitioner. If a practitioner on-call is repeatedly not available, the matter shall be referred to the respective departments for action.

6. Emergency Department Records.
Emergency Department records shall be maintained and available to the other professional services of the hospital and shall contain:

A. Patient identification.

B. Admitting diagnosis, chief complaint and brief history of the disease or injury.

C. Physical findings.

D. Laboratory and x-ray reports (if performed), as well as reports on any special examinations. The original report shall be signed, initialed or authenticated and recorded in the patient's medical record.

E. Diagnosis.

F. Record of treatment, including medications.

G. Disposition of case with instructions to the patient.

H. Signature or authentication of attending physician.

I. A record of the pre-hospital report form (when patient is brought in by ambulance) shall be attached to the Emergency Department record.

7. House Emergencies.
When a life-saving emergency occurs in the house and the attending practitioner is not readily available, the Emergency physician shall render any life-saving measures immediately, regardless of circumstances.

Certified Registered Nurse Anesthetist (CRNA)

1. Certified Registered Nurse Anesthetist (CRNA)
   - A. Definitions.
     1) Certified Registered Nurse Anesthetist (CRNA) means a registered nurse licensed by the Oregon State Board of Nursing as a Certified Registered Nurse Anesthetist.
   - B. Services and Functions Allowed.
     1) The CRNA may provide only those services specifically authorized and delineated by the Board of Directors, Oregon statutes, and Oregon State Board of Nursing administrative rules.

2) The CRNA may deliver the prescribed anesthesia services in connection with a procedure in a hospital independently.
3) The CRNA is responsible for recognizing his or her limits of knowledge and experience and for consulting with or referring patients to other health care practitioners as appropriate.
4) The CRNA may provide only those anesthesia services within the scope of practice for which he or she is educationally prepared and for which competency has been established and maintained. Educational preparation includes academic course work and workshops or seminars, provided both theory and clinical experience are included.

C. General Responsibilities of the CRNA.

The CRNA may deliver the following services independently in connection with a procedure performed in the hospital.

1. The CRNA may make an assessment of the health status of the patient as that status relates to the relative risks associated with anesthetic management of the patient. In doing so, the CRNA may:

i) perform and document a pre-anesthetic assessment and evaluation of the patient;
ii) request and obtain consultations, laboratory and diagnostic studies;
iii) select, obtain, order or administer pre-anesthetic medications and fluids; and
iv) obtain informed consent or confirm that the patient has given informed consent for the services to be furnished.

2. The CRNA may determine and administer an appropriate anesthesia plan. This includes:

i) selecting**,** ordering and initiating the anesthetic technique;
ii) selecting, applying and inserting invasive and non-invasive monitoring modalities;
iii) selecting and providing supports for airway management and monitoring;
iv) providing life support functions;
v) selecting, obtaining, ordering or administering anesthetic agents and adjuvant drugs;
vi) selecting and providing mechanical support; and
vii) selecting and providing fluids, electrolytes and blood components.

3. The CRNA may take action necessary to counteract problems that may develop during implementation of the anesthesia plan. In doing so, the CRNA may:

i) conduct ongoing assessment to identify problems and provide corrective or preventative action;
ii) order laboratory tests, blood gases and other necessary interventions;
iii) select, obtain, order or administer drugs, fluid, blood and electrolyte components;
iv) direct and implement emergency resuscitative techniques; and
v) provide clinical support functions.

4. The CRNA may perform necessary or routine post anesthesia care. In doing so, the CRNA may:

i) select, obtain, order or administer drugs for implementing and managing pain management techniques during the post anesthesia period and to prevent or manage complications; and
ii) perform post anesthesia evaluations, discharge from the post anesthesia care unit and follow-up evaluation and care.

D. Anesthesiologist's or Other Anesthesia Provider Responsibilities.

1. An anesthesiologist or other anesthesia provider will assist the hospital in connection with the credentialing and performance review of the CRNA.

MASS CASUALTY PLAN

There shall be a plan for the care of mass casualties at the time of disaster, based upon the hospital's capabilities in conjunction with nearby emergency facilities. It shall be developed by a disaster planning committee. The plan shall be approved by the medical staff and governing body.

The disaster plan should make provisions within the hospital for:

1. Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.

2. An efficient system for notifying and assigning personnel.

3. Unified medical command under the direction of a designated physician.

4. Conversion of all usable space into clearly defined areas for efficient triage, patient observation, and immediate care.

5. Prompt transfer, when necessary, after preliminary medical or surgical attentions have been rendered, to the facility most appropriate for administration of definitive care.

6. A special disaster medical record, such as an appropriately designed tag, that is to accompany the casualty as he or she is moved.

7. The prompt discharge or transfer of hospital inpatients who can be moved without jeopardy.

8. Maintain security designed to keep relative and curious persons out of the triage area.

9. Establishment of a public information center with assignment of public relations liaison duties to qualified individuals. Advance arrangements with communications media to provide organized dissemination of information.

The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The realistic drill must involve the medical staff, as well as administration, nursing and other hospital personnel. Actual evacuation of patients during drills is optional. There should be a written report and evaluation of all drills.

MEDICAL RECORDS GENERALLY

1. Medical Record

The attending physician shall be responsible for the preparation 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.

2. Content of Medical Record

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.

3. Admission, History and Physical.

Section 1. History and Physical Examination: The history and physical examination must be performed and recorded by a Licensed Independent Practitioner (LIP) who has been granted privileges to do so and is responsible for the patient.

a) A complete history and results of a physical examination shall be written or dictated no later than 24 hours after admission of the patient, and will become a permanent portion of the chart. A written, legible note indicating significant history and physical findings shall be on the chart within 24 hours of admission or prior to any surgical or invasive procedure. If a complete history and physical examination are not confirmed, the procedure shall be postponed, except in cases of emergency.

b) A complete history and physical examination is defined to include, at a minimum:

1) A medical history which includes information from the patient and/or family, prior medical testing, and results of prior medical treatment;
2) The presence or absence of significant allergies;
3) Current medications which are pertinent to the reason for admission or procedure;
4) Physical and/or mental evaluation which is pertinent to the admission or procedure; and
5) Conclusion, impression and/or diagnosis and the plan.

Additional items, including chief complaint, detailed past medical history, psychosocial/personal history, family history, and review of systems, should be included as appropriate.

c) If the history and physical examination was done more than 24 hours (but no greater than 30 days) prior to the admission or invasive procedure (such as in the office of a physician staff member), a durable legible copy of this report may be used in the patient's medical record. An H & P Interval Note documenting any changes in the history or the physical examination must be written at the time of admission (in the first 24 hours and prior to the procedure). In the case where there are no changes, the History and Physical Interval Note can be signed and dated on the day of admission with a note documenting "no change." The Medical Staff member entering such a copy of a history and physical examination shall authenticate (date and sign) the copy.

d) A complete hospital admission history and physical examination performed within a month prior to readmission for the same condition, when supplemented with an interval progress note that provides interval history and pertinent current physical examination is sufficient compliance with this rule.

e) A history and physical more than 30 days old may NOT be used for this purpose.

Section 2. Outpatient Invasive Procedures:

a) Definition: 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, endoscopies, and implantations, and excluding venipuncture and intravenous therapy.

b) A physician's legible note indicating significant history and physical findings must be present on the chart prior to the procedure. The brief History and Physical examination must address issues pertinent to the specific procedure. It must include indications for procedure, pertinent medical history, vital signs and evaluation of heart and lungs and the part to be affected by the procedure.

c) If the history and physical examination was done more than seven (7) days prior to the admission or invasive procedure, a durable legible copy of this report may be used in the medical record. This copy must be accompanied by an interval note that provides interval history and pertinent current physical examination. A history and physical more than 30 days old may NOT be used for this purpose.

Section 3. History and Physical Examinations for Podiatric Patients:

a) In addition to the History and Physical Examination, as outlined in Admission, History and Physical 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 or III outpatients.

Section 4. Short Stay:
For uncomplicated cases with a stay of less than 48 hours, the short stay format approved by the Medical Staff may be used. Within 24 hours after admission, a legible note will be written indicating significant history and physical findings. By the time of discharge, an appropriate history and physical, description of operations and procedures performed, summary of hospital course, and the discharge status of the patient shall be written or dictated. The discharge status of the patient will include the medical condition of the patient, and any instructions provided the patient and/or family and follow-up care. A complete history and physical will be dictated if the patient is still in the hospital at the end of 48 hours.

Section 5: Protocol for Outpatient Invasive Procedures:

A physician'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 Section 1(c) (above). The physician ordering the procedure will provide the H&P, and the practitioner performing the procedure will complete the H&P Interval Note.

(a) 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) If the patient is admitted to West Valley Hospital for an overnight stay, the attending physician shall be the referring physician regardless of the indication for the admission. The physician performing the procedure shall remain involved in the case as a consultant to deal with complications directly related to the procedure.

(c) The referring physician will be notified of the admission by the department in which the invasive procedure is done and see the patient as indicated. Completion of the brief history and physical form will suffice for the medical record.

(d) 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 (b) above.

(e) 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, department chair and approved by the Medical Staff Executive Committee, is sufficient.

4. 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 only if the Hospital Representative and Medical Staff:

a. Establish that such orders and protocols have been reviewed and approved by the Medical Staff and the Hospital's Nursing and Pharmacy leadership;
b. Demonstrate that such orders and protocols are consistent with nationally recognized and evidence-based guidelines;
c. Ensure that the periodic and regular review of 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
d. Ensure that such orders and protocols are dated, timed and authenticated as permitted in these Rules & Regulations, and by Hospital policies.
e. Physicians/practitioners retain the right to modify, cancel, void, or refuse to authenticate standing orders that the responsible physician/practitioner determined were not medical necessary. (76 FR 65896, October 24, 2011)

5. Treatment Orders

Patient Orders shall be electronic using the Salem Health EMR. Verbal and telephone orders shall be electronically signed by the ordering practitioner or another practitioner who is responsible for the care of the patient. It is recommended that 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.

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.
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.
c. The physician must be called on admission of patient if no orders were given preadmission.
d. Nurse Practitioners may write orders within the scope of their hospital privileges.
e. Physician Assistants may write orders within the scope of their practice, as approved by the Board of Trustees. History & physical examinations, admission orders and discharge summaries must be co-signed by supervising physician or designated agent.
f. Medical student orders must be verified by the designated preceptor prior to implementation.

6. Abbreviations

Only abbreviations which have been approved and are available in an explanatory legend shall be used in the medical record.

7. Complications.

Complications are to be entered and documented on operative reports, progress notes or discharge summary. A complication is defined as any condition arising after the patient's admission to the hospital which modifies the course of the patient's illness or the medical care required.

8. General Record Requirements.
The completion of the medical records shall be the responsibility of the attending practitioner. A dentist, podiatrist, nurse practitioner or other individual authorized within the scope of their professional license shall complete those portions of the record which pertain to their portion of the patient's care. The appropriate individual shall separately sign or authenticate the history and physical examination, operative report, progress notes, orders and a summary. Medical records must be completed by the appropriate practitioner within thirty (30) days following the patient's discharge.

9. Progress Notes.
The attending practitioner of record or the covering practitioner 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 rounds. The only exception to daily progress notes are patients who meet discharge criteria, 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) Any change in condition of the patient that requires the provider to perform a bedside evaluation.

Progress notes shall give a pertinent chronological report of the patient's course in the hospital, reflect any changes in the patient's condition, the results of treatment, and any changes in plan of care. Preferred format for progress notes is S.O.A.P. format. Final progress notes should include instructions to the patient and/or family.

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.

10. Discharge Summary.
A discharge summary (clinical resume) which shall briefly recapitulate the significant findings including complications, and events of the patient's hospitalization, the patient's condition on discharge, the recommendations and arrangements for future care and the final diagnosis at the time of discharge shall be written or dictated on all medical records of patients. All summaries shall be properly authenticated by the responsible practitioner. In the event of death, the clinical resume should include the reason for admission, the findings, hospital course, events leading to death and the cause of death. A final progress note may be substituted for the resume in the case of patients with problems of a minor nature who require less than a forty-eight (48) hour period of hospitalization. A final note shall be sufficient to justify the diagnosis, warrant the treatment and the end results, and include specific discharge instructions to the patient. All summaries shall be authenticated by the responsible physician.

11. Permanent File.
A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Executive Committee.

12. Delinquent Charts:
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 and signatures. ~~Chart Count Determination and Policy.~~
~~All medical records shall be completed by the physician, dentist, podiatrist or other individual authorized within the scope of his or her professional license within four weeks following the patient's discharge.~~
~~A. Practitioners will receive a notice of incomplete charts weekly.~~

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~~B. IN ORDER TO ALLOW TIME TO COMPLY with this requirement you will receive a mailed notice of "PENDING" suspension for incomplete charts over 21 days (from discharge).~~

~~C. Failure to complete medical records within four weeks (28 days) from discharge shall result in suspension of practitioner's privileges until medical records are complete.~~

~~Charts will be available one (1) working day following discharge.~~

13. ~~Internal Control of Admission Privileges Denial Because of Records.~~
Penalties for Non-Completion of Delinquent Medical Records by Noon on the Effective Date of Suspension:
(a) First Non-Completion of Delinquent Medical Records:
(1) 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.
(2) A personal telephone call to the practitioner from the Section Chief or Department Chair.
(3) All outstanding medical records must be completed.
(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:
(1) Administrative Suspension of Privileges will be invoked.
(2) Disciplinary fine of $250, to be collected prior to privileges being reinstated.
(3) All outstanding medical records must be completed.
(c) Third Non-Completion of Delinquent Medical Records:
(1) Administrative Suspension of Privileges will be invoked.
(2) Disciplinary fine of $500, to be collected prior to privileges being reinstated.
(3) All outstanding medical records must be completed.
(4) Mandatory one-week disciplinary suspension.
(d) Fourth Non-Completion of Delinquent Medical Records:
(1) Administrative Suspension of Privileges will be invoked.
(2) Disciplinary fine of $1,000, to be collected prior to privileges being reinstated.
(3) Mandatory two-week disciplinary suspension.
(4) Mandatory meeting with the MEC to provide an explanation for repeated non-compliance.
(e) Fifth Non-Completion of Delinquent Medical Records:
(1) Deemed to constitute voluntary resignation from the Medical Staff.
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 member of the medical staff will have 28 days from the date of notification of chart review to complete chart review. Failure to complete the chart review shall result in suspension of privileges until review is complete.~~

MEDICATIONS

1. All drugs and medications administered to patients shall be those listed in the hospital formulary. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

2. When a pharmacist is available, a pharmacist will review each prescription or order for medication and contact the prescriber or orderer when questions arise. Medication orders obtained by non-pharmacists, when the pharmacy is closed, are reviewed ideally within 24 hours, but no longer than 72 hours after distribution. This rules does not apply when a practitioner with appropriate clinical privileges controls prescription or ordering,

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preparation and administration as in endoscopy, surgery or during cardiorespiratory arrest or emergency orders when times does not permit.

3. All medications dispensed to patients are appropriately and safely labeled using a standardized method.

4. The policy of this hospital pharmacy is it supports the safe self administration of medications brought from home into the hospital by a patient. The admitting practitioner must assess and review the appropriate continued use of such medications and write an order reflecting proper administration of any such medications in the chart, the order will then be reviewed by the pharmacist in accordance with pharmacy procedure.

5. A method to control the use of dangerous and toxic drugs shall developed by the medical staff through its Medical Care Advisory Committee.

6. Narcotics and hypnotics that are ordered without time limitations of dosage shall automatically be discontinued after three (3) days. Antibiotics will be discontinued after seven (7) days, unless otherwise specified. Drugs should not be discontinued without notifying the physician.

NUTRITION CARE

1. Each patient's nutrition care is planned and a nutrition prescription or order is necessary for all patients, even those who are not at nutritional risk. An interdisciplinary nutrition therapy plan will be developed and periodically updated for patients at nutrition risk.

2. All patients who are not receiving nutrients by mouth are automatically referred by the attending practitioner to a Registered Dietitian for assessment. The Practitioner will choose parenteral or enteral tube feeding based on assessment of the patient's nutritional status and needs. Any patient with a functional gastrointestinal tract should be fed with enteral feeding. Candidates for enteral feeding include those who cannot swallow or cannot eat sufficient quantities due to loss of appetite.

GENERAL RULES REGARDING SURGICAL CARE

1. Informed Consent.

Written, informed surgical consent and anesthesia consent shall be signed by the patient prior to the operative procedure, except in those situations wherein life is in jeopardy and suitable signatures cannot be obtained because of the patient's condition. In emergencies involving a minor or unconscious patient, in which surgical consent cannot be obtained immediately from parents or guardian the circumstances should be fully documented on the medical record and signed by at least two (2) physicians. It is the responsibility of the involved practitioner to obtain informed consent to the surgery and anesthesia in accordance with Oregon law prior to the patient signing the informed consent. It is the hospital's authority to verify that such consent has been obtained.

2. Changes in Technique or Procedure.

No major changes in present technique or procedure used in the operating room shall be made without approval of the Chief of Surgery, and the Medical Executive Committee.

3. Failure to Complete Preoperative History or Physical.

When the history and physical is not recorded before an operation or a potentially hazardous diagnostic procedure, the operation or procedure shall be canceled, unless the attending doctor states, in writing, that delay would be detrimental, in which case the history and physical will be recorded immediately following surgery. Cancellation will be made by the Chief of Staff, Chief Surgery Department, or Administrator.

4. Dictated/Non-Transcribed Preoperative History and Physical.

When a case is brought to the surgery suite and the history and physical have been dictated but are not yet on the chart, a progress note stating the chief complaint, type of surgery to be done and anything pertinent to the case must be put on the chart prior to the patient entering surgery.

5. Operative Reports.

An operative report must be dictated or written immediately following surgery and must include a complete description of the operation procedures and findings, post operative diagnostic impression, and a description of the tissues and appliances, if any, removed.

6. Time of Operation.

a. In the event that a surgeon is unavoidably detained, he shall notify the operating room so stating and giving his expected time of arrival. At the discretion of the operating room supervisor and/or chief of the department the following case may be moved up to best utilize the time.

b. In the event that a surgeon is twenty (20) minutes late without notifying the operating room, the case may be canceled and must be rescheduled.

c. A surgeon who is repeatedly late will be referred to the Chief of Surgery for explanation.

7. Standard Operating Room Procedures.

All surgeons shall be governed by the rules and procedures of the operating room. These procedures and changes will be reviewed and approved by the Surgery Committee.

8. Observers.

All observers must be carefully screened and a written consent must be obtained from the patient. The operating room supervisor and the attending surgeon will be responsible for any observer in surgery that is there for teaching purposes.

9. Orders.

All previous orders are canceled when a patient enters surgery and "Renew preoperative orders" following surgery is not acceptable.

10. Tissue examination.

a. Medicare Patients: All tissue removed at operation shall be sent to the hospital pathologist for examination.

b. Non-Medicare Patients: All specimens removed at operation shall be sent to the hospital pathologist with the following exceptions:

1) Orthopedic appliance;
2) Foreign bodies (bullets, etc.);
3) Portion of rib removed only to enhance operative exposure;
4) Removal of radioactive sources;
5) Foreskin of newborns and pediatric patients;
6) Placentas that are grossly normal removed in the course of operative and nonoperative obstetrics;
7) Teeth, provided the number, including fragments, is recorded in the medical record;
8) Scar tissue when done for cosmetic purposes;
9) Cataracts;
10) Bunions;
11) Traumatic amputations (unless exam for medical or legal reason is indicated);
12) Proximal interphalangeal joints;
13) Products of iridectomy.

The hospital pathologists will make such examination as he may consider necessary to arrive at a tissue diagnosis. His report shall be made a part of the patient's medical record.

11. Emergency Call.

All specialists (surgery) on the active staff must take back-up emergency call for Emergency Department on a rotating basis. Failure to do so or non-compliance are grounds for disciplinary action and loss of privileges in the specialty.

12. Sterilization.

Surgical procedures performed solely for the purpose of sterilization shall be performed in accordance with state laws. The sterilization consents will be forwarded to the hospital by the physician.

SWING BED

1) Acute Discharge (WVH Inpatients to Swing Bed Status)
   a) Physician shall write or dictate an order for discharge of the patient from inpatient status.
   b) Physician shall write or dictate a discharge summary as described above (see Medical Records Generally, Discharge Summary).

2) Admission
   a) Physician shall write admission orders for skilled care/Swing Bed.

3) History & Physical
   a) Physician shall write or dictate a complete history and physical within 24 hours after admission of the patient. This will include reasons for admission, plan of care, estimated length of stay and discharge plan.

or

   b) A copy of the acute care H&P and Discharge summary from acute to which the admitting physician will add the data as to the reason the patient is being transferred to a skilled bed, i.e., plan of care, estimated length of stay and discharge plan. This includes any physician licensed in the State of Oregon transferring patients to the care of West Valley Hospital.

4) Progress Notes
   a) Progress Notes shall be written at a minimum of one time a week, can be daily with a documented need.

5) Discharge Summary
   a) A Discharge Summary to include a summary of SNF level services along with patients status, discharge site and follow up plan.