Saint Alphonsus Medical Center- Baker City

HOSPITAL MEDICAL STAFF RULES AND REGULATIONS

A. Admission and Discharge of Patients

A-1. Patient Admission. Only a member in good standing of the Active, Provisional, or Temporary/Locum Tenens Medical Staff with admitting privileges may admit patients to the Hospital. In cases of patients admitted through the Emergency Department, the admitting physician should complete an admission note and provide initial orders at the time of admission.

A-2. Inpatient Status. Patients with medical conditions requiring acute care who meet criteria as determined by the hospital pre-admission screening contractor should be admitted as inpatients.

A-3. Admitting Diagnosis. Except in an emergency as determined by the admitting physician, no patient shall be admitted to the Hospital unless a provisional diagnosis has been given. In the case of emergency, a provisional diagnosis shall be given as soon as possible.

A-4. Attending Physician. Each patient admitted to the hospital shall be the responsibility of a member of the Medical Staff who shall be responsible for the care of the patient, for prompt completion and accuracy of the medical record, and for appropriate communication with the patient and their family.

A-6. Qualified Practitioner. A qualified practitioner is a member in good standing of either the Medical or Allied Health Practitioner staff who is properly credentialed to perform the specified task.

A-5. Change in Attending Physician. Whenever responsibility for care is transferred to another Medical Staff member, the attending physician will be responsible for patient care until he or she has personally contacted the accepting Medical Staff member and that member agrees to assume acceptance. A note documenting the transfer of care responsibility shall be entered on the order sheet of the medical record and the patient shall be informed of the change by the attending physician.

A-7. Patient Visitation. Each hospital inpatient admitted to the Hospital shall be seen by a qualified practitioner at least once each day. Patients admitted to Swing Bed status will be seen no less than stated in the Medical Staff Swing Bed Physician Responsibility Policy.

A-8. Hospitalized Patient Coverage. Each member of the Medical Staff who is not available in the immediate vicinity shall designate an alternative member of the Medical Staff or other qualified individual/facility who may be called to attend his or her patients in an emergency or until he or she arrives. In case of failure to name such associate, the

President of the Medical Staff, the Chief Executive Officer, or the advisor of the service concerned shall have the authority to call any member of the Medical Staff in such an event. A practitioner who will be out of town shall arrange for the continuity of the care of his or her patients during his or her absence.

A-9. Continued Stay Justification. The attending physician is required to document the need for continued hospitalization on a daily basis.

A-10. Psychological Evaluation or Referral. Any patient known or suspected to be suicidal or suffering from the effects of alcoholism or drug abuse, or who has taken a chemical overdose**,** should be referred for appropriate psychological evaluation.

A-11. Discharge. A patient may be discharge only on the order of the attending physician. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge order, the attending physician or designee shall be notified and a notation of the incident shall be made in the patient's medical record. The patient shall be requested to sign an Against Medical Advice release.

A-12. Death. In the event of a Hospital death, the deceased shall be pronounced by the attending physician or his or her designee. In the case of anticipated death, the attending Registered Nurse may pronounce the patient dead. An entry shall then be entered into the patient chart and signed by the individual pronouncing death.

Autopsies. Members of the Medical Staff shall be interested in securing meaningful autopsies whenever possible. An autopsy may be performed only with a written consent signed in accordance with Oregon State law. All autopsies shall be performed by the Hospital pathologist or by a physician delegated this responsibility. The physician performing the autopsy shall make a reasonable attempt to notify the attending physician when the autopsy is being performed. Provisional anatomic diagnoses shall be recorded in the medical record within three days and the complete autopsy report shall be included in the medical record within 60 days unless the Medical Staff President approves an exception for the purposes of special studies.

Criteria for Autopsies. Autopsies are encouraged in the following situations:

- Deaths in which an autopsy may help to explain unknown an unanticipated medical complications to the attending physician;
- Deaths in which the cause of death is not known with certainty on clinical grounds;
- Cases in which autopsies may help to allay concerns of the family and/or the public regarding the death and to provide reassurance to them regarding same;
- All unexpected or unexplained deaths;
- Deaths of patients who have participated in clinical trials (protocols) approved by institutional review boards;
- Deaths resulting from high risk infectious and contagious diseases;

- Deaths in which it is believed that an autopsy would disclose a known or suspected illness which also may have a bearing on survivors or recipients of transplant organs; and
- Deaths known or suspected to have resulted from environmental or occupational hazards.

A-13. Observation Status. Admission to observation status may be provided as an alternative to inpatient care for those patients whose presenting problem, in the opinion of the admitting physician at the time of admission, can be reasonably expected to resolve within 24 hours.

Physician Responsibility. The practitioner's admitting order (whether written or verbal) must indicate Observation Status. If continued observation status is expected to extend beyond 24 hours after admission, the attending practitioner must document why he or she believes the patient needs to stay in Observation Status. The practitioner may complete a combined History and Physical and Discharge Summary for those observation patients discharged within 24 hours.

Observation Hour Limits. There is no mandated hourly limit for observation patients. Twenty-four (24) hours is a benchmark. In only rare and exceptional cases does reasonable and necessary observation status span more than 48 hours.

Transition to Inpatient Status. If the practitioner determines that inpatient status is required, he or she must provide a written or verbal order indicating the change.

A-14. Outpatient Status. Patients may be admitted to the hospital for outpatient treatment by a qualified practitioner and must have appropriate medical records. The attending practitioner is not required to visit the patient or record progress notes during every patient visit. However, the practitioner shall provide documentation on an appropriate periodic basis of the care being provided to the patient to provide evidence of care continuity.

Outpatient Records. Outpatient records shall be maintained and available to practitioners within the facility and shall contain:

(a) Patient identification;
(b) Admitting diagnosis, chief complaint, and brief history of the disease or injury;
(c) Appropriate physical examination;
(d) Laboratory and x-ray reports (if performed), as well as reports on any special examinations;
(e) Diagnosis;
(f) Record of treatment, including medications; and
(g) Disposition of case with instructions to the patient.

Stress Tests. Stress tests performed by a qualified privileged practitioner will require an informed procedure consent, to be completed & signed immediately prior to the procedure. A complete office note within 30 days prior to stress test is required as well. That note must be reviewed and co-signed by the physician performing the stress test prior to the procedure beginning.

Diagnostic Procedures. Diagnostic procedures performed for and authorized by qualified practitioners under their respective scope of practice by referral to the hospital's ancillary departments, or health screenings, are excluded from the outpatient records requirements above.

Continuing Ambulatory Care Services. To promote the continuity of care, both over time and among providers, the hospital must maintain a record for any patient who is seen for a series of three or more outpatient visits within a twelve month period. The record shall contain a summary list containing the chief complaint and admitting diagnosis, a problem list or past medical history, any adverse or allergic drug reactions, and current medications including over-the-counter medications. Such patients are required to have an updated History and Physical every 90 days from the date of the initial History and Physical, or whenever a significant change in the patient's condition occurs.

B. Medical Records

B-1. Complete Medical Record. The attending practitioner shall be held responsible for the preparation of a complete and legible medical record for each patient which shall include but not be limited to a History and Physical Examination report; orders; appropriate informed consent; reports of operative and other procedures; laboratory, radiologic, and other test reports; progress notes; and Discharge Summary.

B-2. History and Physical Examination. A History and Physical Examination shall be recorded by a qualified practitioner no more than 30 days prior to or within twenty-four (24) hours after admission, but prior to surgery or a procedure requiring anesthesia services or conscious sedation. For a History and Physical Examination that was completed within 30 days prior to admission, an interval update note documenting any changes in the patient's condition shall be completed within 24 hours after admission, prior to surgery, a procedure requiring anesthesia or conscious sedation. History and Physical Examination reports shall include at least the following: chief complaint; history of present illness; past medical history; allergies; medications; pertinent family history, social history, and review of systems; physical examination; pertinent laboratory, radiographic, and other test results; assessment; and plan. If a History and Physical Examination is not recorded before an elective operation or any hazardous diagnostic procedure, the procedure shall be cancelled unless the attending physician states in a signed and dated chart note that such a delay would be detrimental to the patient.

B-3. Authentication. Qualified practitioners shall date, time, and authenticate by signature each of his/her entries in the medical record.

B-4. Progress Notes. Pertinent progress notes shall be recorded, dated, timed, and signed at the time of observation, sufficient to permit continuity of care and transferability. The patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and response to treatment. Progress notes shall be written at least daily on acute care inpatients. Progress notes written by a member of the Allied Health Staff must be countersigned by the responsible physician.

B-5. Written and Verbal Orders. All orders shall be entered directly by the qualified practitioner directly into the Computer Practitioner Order Entry (CPOE) system. The use of verbal orders is limited to clinical situations where it is impractical for orders to be entered into the medical record (e.g. while performing a procedure), emergent situations, or situations when physicians do not have access to remote computer devices or the patient chart. Verbal orders are given only to personnel who are authorized to receive and input the verbal order into the medical record, as outlined below. The individual receiving the order must immediately enter the verbal order into the medical record. An authorized individual may refuse to accept verbal orders that are not clearly expressed or are capable of misinterpretation, and will so inform the practitioner. All verbal orders must be read back to the practitioner immediately after they have been entered into the medical record to ensure accuracy.

B-6. Standing Orders and Treatment Protocols. By agreement of the Medical Staff, standing orders may be written for specific service areas. All such standing orders and treatment protocols shall be available on the CPOE.

B-7. Discontinuation of Orders. All orders shall be suspended when a patient is moved to surgery or cancelled when transferred to a different level of care.

B-8. Consultations. The attending physician is responsible for obtaining consultations when medically indicated. Consultations shall be documented by written order and communicate the nature of the problem and reason for the consultation to the consultant. A qualified practitioner who requests a consultation should also specify the level of care he/she is requesting (i.e., to provide recommendations, to follow in the patient's care, or to assume care of the patient). An initial consultation note should be provided by the consultant within 24 hours from the time a consultation is requested unless otherwise specified by the requesting practitioner. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendation. This report shall be made part of the patient's medical record. When operative procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to the operation. Should nursing staff feel that a consultation is appropriate, that opinion should be discussed with the attending physician. If such discussion results in inadequate resolution of the nurse's concern, he/she should then discuss the situation with the nursing supervisor and/or the

Medical Staff President. In the circumstance of grave urgency, or when consultation is required by the rules of the Hospital, the Medical Staff President or the Hospital Administrator shall have the right to obtain consultation or consultants after conferring with available members of the Medical Executive Committee.

B-9. Obstetrical Record. The obstetrical record shall include a complete prenatal record, if available, and at least the patient's obstetrical history and physical examination and pertinent laboratory tests. The prenatal record may be a copy of the attending practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings**.**

B-10. Symbols and Abbreviations. Standardized terminology, abbreviations, acronyms and symbols may be used. Medical Staff shall not use prohibited abbreviations, acronyms or symbols as defined by the Medical Staff Unapproved Abbreviations Policy.

B-11. Discharge Summary. A discharge summary shall be written or dictated by the attending physician upon discharge for inpatients, ER patients and outpatient surgery patients. The discharge summary must include the reason for hospitalization; significant findings; procedures performed and treatment rendered; primary and secondary diagnoses; the patient's condition at discharge; and instructions to the patient regarding diet, medication, activity and follow-up. A final progress note may be substituted for the discharge summary for healthy newborns, uncomplicated vaginal deliveries, and patients hospitalized for less than 48 hours with minor problems. The final progress note must document the patient's diagnoses, procedures, condition at discharge, medications, and discharge instructions including any follow-up care recommended. A discharge summary is required for all patient deaths.

B-12. Death Summary. A death summary is required in the case of patient death.

B-13. Consent for Release of Information. Written consent by the patient is required for the release of medical information to persons not otherwise authorized to receive information without consent.

B-14. Ownership of Hospital Records. Original records are the property of the Hospital and may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. In the event a record is removed from the Hospital, the attending physician shall be notified. In the case of readmission of a patient, all previous records shall be available for the use of the attending physician. Unauthorized removal of records from the Hospital is grounds for suspension of the practitioner for a period to be determined by the Medical Executive Committee and the Governing Body.

B-15. Access to Medical Records. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual

patients. Subject to the discretion of the Hospital Administrator, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

B-16. Filing of Medical Records. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Medical Staff.

B-17. Incomplete and Delinquent Medical Records. Should a medical record be incomplete 12 (twelve) work days after discharge, the practitioner shall be notified by letter that he/she shall receive an automatic suspension of privileges 3 (three) work days from the time of notice if the record remains incomplete, as outlined in Article 7.4-3 of the Medical Staff Bylaws. Exceptions shall not be made for work days off. However, exceptions may be made for vacations or conferences if the practitioner has made an attempt to complete his or her outstanding records prior to leaving.

B-18. Completion of Medical Record. A member of the active Medical Staff may be appointed by the Medical Staff President to complete the medical records of a practitioner who is no longer able to do so due to illness or death.

B-19. Delinquent Records Process. The Health Information Management Manager or designee may provide the practitioner who did not complete or timely authenticate a medical record with written notice that the practitioner has forfeited his or her admitting privileges or that his or her admitting privileges have been automatically suspended and shall remain suspended until such records have been completed. The HIM Manager or designee will notify the Medical Staff Office, Admitting, Administration and the Clinical Coordinators of suspension. The affected practitioner's privileges shall remain suspended until all records have been completed in accordance with the provisions of these rules and regulations and the Bylaws of the Medical Staff. If a physician is unavailable for an extended period (greater than one week), the physician will contact Medical Records to make appropriate arrangements regarding completion of medical records prior to departure.

C. General Conduct of Care

C-1. Informed Consent. Qualified practitioners performing procedures of administering treatments are responsible for explaining the risks, benefits, and alternatives of such treatments. Except in emergency situations, the process of obtaining informed consent or refusal should be documented in the medical record in accordance with the hospital informed consent policy.

C-2. Drugs and Medications. The Medical Staff shall have a process by which formulary drugs and medications are selected based on the balance of efficacy, safety, and cost. All such formulary agents shall be either FDA approved or listed in the latest edition of United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or AMA Drug Evaluations. Drugs for bona fide clinical investigations may be excepted, however such drugs 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.

C-3. Notification of Stop. Certain drugs ordered without a time limitation of dosage may be automatically discontinued after a period of time recommended by the Pharmacy and Therapeutics Committee and approved by the Medical Staff. However, such drugs are not to be discontinued without notifying the prescribing practitioner. At least 24 hours prior to an automatic stop order, a notice will be provided to the prescribing practitioner. If an order expires after normal working hours, it should be called to the attention of the practitioner the following morning.

C-4. Therapeutic Substitution. The Pharmacy is authorized to substitute therapeutic FDA-approved drugs any time a trade name drug is ordered subject to approval by the Medical Staff upon recommendation by the Pharmacy and Therapeutics Committee.

C-5. Patient Fees. No practitioner shall give to or receive from another practitioner any part of the fee received from a patient. Practitioners shall render accounts separately and give separate receipts. Violation of this provision is grounds for summary suspension and revocation of medical staff privileges.

C-6. Patient Transfer. Transfer of patients to another facility shall be accomplished in accordance with the Medical Staff Patient Transfer Policy. Following acceptance of the patient transfer by the receiving facility/physician, copies of all pertinent medical records shall be provided to the receiving facility/physician.

D. General Rules Regarding Surgical Care

D-1. Preoperative Diagnosis. A preoperative diagnosis shall be recorded in the patient's medical record prior to surgery by the practitioner responsible for the patient.

D-2. Surgery Assistants. The primary operating surgeon shall determine the level and number of assistants commensurate with the complexity of the procedure being undertaken, generally recognized standards of care for the procedure in question, particular patient conditions, and any other circumstances present. The patient should be informed of the identity of all operating surgeons and assistants if possible.

D-3. Informed Consent. A surgical procedure may be performed only with the informed consent of the patient or his or her legal representative, except in emergencies. Such consent shall be documented in the patient's medical record prior to surgery. In emergencies in which informed consent for surgery cannot be immediately obtained from the patient or the patient's parents, guardian or next of kin, the circumstances shall be fully explained on the patient's medical record.

D-4. Dental Care. A patient admitted for dental care is a dual responsibility involving the dentist and a designated physician member of the Medical Staff.

a. **Dentist's responsibilities**:

i. A detailed dental history justifying Hospital admission.
ii. A detailed description of the examination of the oral cavity and pre-operative diagnosis.
iii. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including the teeth and fragments, shall be sent to the Hospital's pathology department for examination.

b. **Designated Physician's responsibilities**:

i. A history and physical examination documenting the patient's medical history and condition prior to anesthesia and surgery.

ii. Supervision of the patient's general health status while hospitalized.

c. **Both:**

i. Discharge of the patient shall be on written order of the dentist member of the Medical Staff with the approval of the designated physician member of the Medical Staff.

D-5. Podiatric Care. A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a designated physician member of the Medical Staff.

a. **Podiatrist's responsibilities**:

i. A detailed podiatric history justifying Hospital admission.
ii. A detailed description of the examination of the patient pertaining to podiatry and a pre-operative diagnosis.
iii. A complete operative report describing the findings and technique. All tissue removed shall be sent to the Hospital's pathology department for examination.

b**. Designated Physician's responsibilities**:

i. A history and physical examination documenting the patient's medical history and condition prior to anesthesia and surgery.
ii. Supervision of the patient's general health status while hospitalized.

c. **Both:**

i. Discharge of the patient shall be on written order of the podiatrist member of the Medical Staff with the approval of the designated physician member of the Medical Staff.

D-6. Operative Report. Operative reports should be written or dictated immediately following surgery and before the patient is transferred to the next level of care. The report should contain at least the date of the surgery, the name of the primary surgeon and assistants, the surgical procedure performed, preoperative and postoperative diagnoses, a detailed account of the findings at surgery, all details of the surgical technique, and a

narrative description of the procedure which should include estimated blood loss, drains utilized and any complications. A dictated report is not required for routine dressings, dressing changes, cast changes, or suture of minor lacerations. A brief written description should be entered on the patient's medical record in these cases. The medical record of obstetrical patients undergoing major surgery, such a Cesarean Section, shall have, in addition to the office prenatal record, a history and physical examination as is done for all other major surgery patients.

D-7. Anesthesia Evaluation. A pre-anesthesia evaluation must be conducted and documented in the medical record prior to surgery which shall include information regarding procedure anticipated, choice of anesthesia, pertinent history including prior anesthetic experience, ASA classification, and other pertinent information. The anesthesia provider shall also maintain a complete intraoperative anesthesia record as well as post-anesthetic documentation of patient's condition, including the presence or absence of anesthesia-related complications.

D-8. Tissue. All significant tissue removed at an operation shall be sent to the approved pathology agency for examination necessary to arrive at a tissue/pathological diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

E. General Rules Regarding Emergency Services

E-1. Coverage. The Medical Staff shall adopt a method of providing medical coverage for the Emergency Department including the delineation of clinical privileges for all practitioners who render emergency care. Primary care physicians (Family Medicine, Obstetrics, and Internal Medicine) and general surgeons on the Active or Provisional Staff shall serve, on a rotational basis, on an Emergency Department unassigned patient call list in their respective specialty. Active staff physicians who suffer from a documented disability or are of the age of 55 years or older and who have served for a minimum of 25 years on the staff of St. Alphonsus Medical Center – Baker City may, at their request, be excused from this requirement.

E-2. Medical Record. An appropriate medical record shall be kept for every patient receiving emergency service. The record shall include:

a. Patient identification.
b. Information concerning the time and means of the patient's arrival.
c. Admitting diagnosis, chief complaint and brief history of the disease or injury.
d. Record of pre-hospital care when brought in by ambulance.
e. Description of significant physical, clinical, laboratory and radiological findings, including temperature and vital signs.
f. Diagnoses.
g. Treatment given.
h. Condition of the patient on discharge or transfer.
i. Final disposition, including instruction given to the patient and/or his or her family relative to necessary follow-up care, diet, medication and activity.

j. Practitioner's signature.

E-3. MEDICAL SCREENING EXAMINATIONS

a. Emergency Department
Emergency Department: Nurse practitioners and physician assistants working in the Emergency Department are determined, pursuant to EMTALA, to be qualified to provide medical screening examination to persons who present to the Saint Alphonsus Emergency Department with a request for examination and treatment of a medical condition, in accordance with their respective Board approved scope of practice.

b. Birth Center
Birth Center: A RN following the protocols established by the OB Committee may conduct a medical screening examination in the OB department. The protocols may include determination of labor, determination of fetal heart rate and other protocols established by the OB Committee. The patient's physician or the ED physician will be contacted as soon as it is determined that the patient has an emergency medical condition or falls outside the parameters set by the OB protocol.

F. Adoption and Amendments

F-1. Adoption. These Rules and Regulations shall be adopted by the Medical Staff at a regular meeting during which a quorum is present for the purpose of adopting them. Medical staff members shall be provided with copies of the approved Rules and Regulations.

F-2. Amendments. These Rules and Regulations may be amended by submission of the proposed amendment(s) at any regular meeting of the Medical Staff during which a quorum is present for the purpose of adopting the amendment(s). Medical staff members shall be provided with copies of the amended Rules and Regulations.

Adopted at the regular meeting of the Medical Staff on:

President of Medical Staff: _____3/1/2021_____

Secretary of Medical Staff: _____3/1/2021_____

Adopted at the regular meeting of the Governing Body on:

Chair, Governing Body: _____1/25/2021_____
No longer requiring CHB Approval as of 1/25/2021.