

SAINT ALPHONSUS MEDICAL CENTER  
ONTARIO

POLICY & PLANS

# **POLICY & PLANS**

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## **I. DEFINITIONS.**

All terms used in these Policy and Plans shall have the same meaning as is ascribed to such terms in the Saint Alphonsus Medical Center - Ontario Bylaws.

## **II. ADMISSION AND DISCHARGE OF PATIENTS**

### **PART A. PATIENTS ADMITTED**

The Hospital shall accept all patients for care and treatment except those requesting elective abortions or elective male sterilization.

### **PART B. ADMISSIONS.**

A patient may be admitted to the Hospital only by an active (provisional or non provisional) or courtesy (provisional or non provisional) member of the Medical Staff. All practitioners shall be governed by the official admitting policies of the Hospital. A dentist with limited clinical privilege, with the concurrence of an appropriate physician member of the Medical Staff, may admit a patient. The concurring physician shall immediately assume responsibility for all medical aspects of the patient's care while in the Hospital including taking a medical history and performing a physical examination. Patients admitted to the Hospital for dental care shall be given the same basic medical appraisal as patients admitted for other services.

### **PART C. RESPONSIBILITY FOR PATIENTS**

Each patient admitted to and in the Hospital shall have a member of Medical Staff responsible for that patient's medical care and treatment. That Medical Staff member shall be responsible for:

1. Preparing a complete and accurate medical record;
2. Carrying out or ordering appropriate diagnostic and therapeutic measures and procedures.
3. Transmitting reports of the medical condition of the patient to the referring practitioner and to relatives of the patient.

If these responsibilities are transferred to another staff member, the transfer shall be entered in the EHR.

“Medical Staff shall not care for a family member and cannot be a primary care physician or surgeon for the patient. Medical Staff can: a) provide care in an emergent situation b) assist or consult within their scope of privileges with the approval of the primary care physician, surgeon and anesthesiologist (where appropriate) c) provide routine care while being the designated on-call person. Family member is defined as parent, spouse, or child.”

**PART D. PROVISIONAL DIAGNOSIS - EMERGENCY ADMISSIONS.**

Except in an emergency, no patient shall be admitted to the Hospital (including surgery, observation, or out-patient surgery) unless a provisional diagnosis or valid reason for admission has been stated and placed in the patient's medical record. In the case of an emergency, such statement shall be recorded in the patient's medical record as soon as possible following admission.

**PART E. REQUIREMENTS OF OMPRO.**

The requirements of the Oregon Medical Professional Review Organization regarding admission and discharge shall be carried out according to prevailing Policy and Plans of the OMPRO.

**PART F. EMERGENCY ASSIGNMENT.**

A patient who does not have a private physician and who must be admitted on an emergency basis shall be assigned to a member of the Medical Staff in accordance with the prevailing method of Medical Staff assignment.

**PART G. PHYSICIAN AVAILABILITY.**

A member of the Medical Staff must be available within a reasonable time to respond to an emergency or urgent patient need occurring within the Hospital. Each member of the staff who does not reside in the immediate vicinity ("non-local member") shall designate a member of the Medical Staff who resides in the local area ("local member") who may be called to attend the non-local member's patients in an emergency or until he arrives. Should the non-local member fail to name such local member, the administrator (or his designee), the Chief of the Medical Staff, or the Chief of the service to which the non-local member belongs, shall have the authority to call any member of the active Medical Staff to attend the patient. In an emergency, initial response may be made by the emergency physician on duty until either the designated physician arrives or the attending physician arrives. Failure of an attending practitioner to make arrangements for timely, adequate professional care in his absence may result in his or her loss of clinical privileges. The patient's attending physician shall clearly designate in the patient's medical record which other member of the Medical Staff will be primarily responsible for the patient's care should the attending physician anticipate being absent and not available to care for the patient. In the case of shared coverage, the attending physician's order shall clearly indicate each physician's area of responsibility.

**PART H. ADMISSION PRIORITIES.**

The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each service and approved by the Medical Staff executive committee.

**PART I. ADMISSIONS TO AND DISCHARGES FROM CRITICAL CARE UNIT.**

The protocol established by the Medical Staff regarding admission to and discharge from the critical care unit shall be followed. That protocol may be changed by action of the Medical Staff.

**PART J. LABORATORY WORK.**

Admitting, in-patient, and preoperative laboratory work shall be performed in the Hospital laboratory or in an outside laboratory approved by the Medical Staff. Pre-admission lab reports shall be done within fourteen (14) days of scheduled procedure unless more current results are required by the patient's condition.

**PART K. DISCHARGE.**

Patients shall be discharged only on written order of the attending practitioner. If the patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record. Attending practitioners shall discharge their patients as early in the day as is possible.

**III. MEDICAL RECORDS**

**PART A. CONTENT.**

The attending physician shall be responsible for the preparation of the complete and legible medical record for each of his or her patients. The content of each medical record shall be pertinent and current. The record shall include at least the following:

1. Identification data;
2. Complaint;
3. Personal history;
4. Family history;
5. History of present illness;
6. Physical examination;
7. Special reports such as consultations, clinical laboratory and radiology services, and other;
8. Provisional diagnosis;
9. Medical or surgical treatment;
10. Operative report;
11. Pathological findings;
12. Results of diagnostic tests and therapy rendered;
13. Progress notes;
14. Final diagnosis;
15. Condition on discharge;
16. Summary or discharge summary;
17. Clinical resume;
18. Autopsy report when performed.

**PART B. PROGRESS NOTES.**

Pertinent progress notes, including appropriate admission notes, shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as with results of tests and treatments. Progress notes shall be entered in the EHR at least daily or more frequently, and, in any event, whenever there is a change in the patient's condition.

**PART C. OPERATIVE REPORTS.**

Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be written or dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's medical record. Any practitioner who fails to dictate operative reports immediately following the operation shall have his operative privileges reviewed, as provided in Article X, Part C, Section 4. In addition, a post-procedure progress note including the nature of the procedure performed, the identities of the surgeon or practitioner and any assistants, if applicable, estimated blood loss, if any, specimens removed, if any, and patient status shall be completed after any surgical procedure, endoscopy, cardiac catheterization, invasive radiological procedures, etc.

**PART D. CONSULTATION.**

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 recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, except in emergency situations, the consultation note shall be recorded prior to operation.

**PART E. OBSTETRICAL RECORDS.**

Obstetrical records shall include prenatal records. The prenatal record may be a legible copy of the attending practitioner's office record transferred from the practitioner's office to the Hospital prior to admission. If this practice is followed, an interval admission note shall be written that includes pertinent additions to the history of the patient and any subsequent changes in physical findings. In the event of a caesarean section delivery, a surgical history and physical examination shall be performed and recorded on that patient's chart, which can be from the attending practitioner's office prenatal form that has equivalent information of a History and Physical transferred to the hospital for vaginal and cesarean births. (MEC approval 7/10/12)

**PART F. SYMBOLS AND ABBREVIATIONS**

Symbols and abbreviations may be used in the medical record only when the Executive Committee has approved them. Any official record of approved abbreviations shall be kept on file in the medical records department. Final diagnosis shall, at all times, be recorded in full without the use of symbols or abbreviations.

**PART G. DISCHARGE SUMMARY AND ASSESSMENTS.**

1. A discharge summary shall be included in medical records of all in-patients except for normal newborns and normal deliveries;
2. A discharge assessment shall be required for all observation patients.

The summary or assessment shall be written or dictated within seven (7) days of discharge. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries and assessments shall be signed by the attending physician.

**PART H. RELEASE, OWNERSHIP AND AVAILABILITY OF AND ACCESS TO PATIENT RECORDS.**

Written consent of the patient is required for release of medical records to persons not otherwise authorized to receive information. All releases of medical records shall comply with all applicable law, Policy and Plans.

All original records are the property of the Hospital. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a Court order, subpoena, statute, or Hospital policy. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another practitioner. Unauthorized removal of charts from the Hospital or unauthorized disclosure of medical records is cause for automatic suspension.

Access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research projects in accordance with all federal and state laws and regulations regarding the confidentiality of such records. The confidentiality of patient information must at all times be preserved. All such projects shall be approved by the Medical Staff executive committee before records can be studied. Subject to the discretion of the President/Chief Executive Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

**PART I. FORM OF PRACTITIONER'S ORDERS.**

A practitioner's orders, if not given on an order sheet, shall be reproduced in detail on the appropriate patient's order sheet shall be countersigned by the practitioner who gave the order no later than the date the chart is closed (see paragraph 11 below). Use of a printed checklist or printed order is acceptable.

**PART J. COMPLETION/CLOSING OF MEDICAL RECORDS.**

Unless ordered otherwise by the Medical Executive Committee, a medical record shall not be closed and permanently filed unless completed by the attending practitioner. The attending practitioner shall complete and sign the medical record within twenty-eight (28) days after the date of discharge. Prior to signing the medical record, the attending practitioner shall make all reasonable attempts to secure all authenticating signatures required by law, and Medical Staff Bylaws, Policy and Plans. Said records shall include that information reflected in Paragraph 1 of this Section C. If the medical record remains incomplete after four (4) weeks of the date of discharge, the attending physician shall notify the supervisor of the medical records service or President/Chief Executive Officer of any deficits made by other practitioners and the supervisor of medical records shall notify the President/Chief Executive Officer of any deficits or delinquencies of the attending physician. The supervisor of the medical records service or the President/Chief Executive Officer 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 admitting service shall be notified of this action. Admission of the suspended practitioner's patients under the name of another practitioner shall not be allowed unless the other practitioner, in writing, has formally assumed responsibility for the patient and the medical record chart work pertaining to the patient.



The affected practitioner's privileges shall remain suspended until all records have been completed in accordance with the provisions of these Policy and Plans and the Bylaws of the Medical Staff. If a physician is unavailable for an extended period of time (greater than one week), the physician shall contact the Director of Medical Records to make appropriate arrangements regarding completion of medical records prior to departure.

**PART K. SECRETARIAL ASSISTANCE.**

The Hospital will furnish a secretary for the medical records committee for the purpose of assisting in performance of the medical record committee's quality assurance responsibilities. The secretary shall maintain copies of study results and shall take minutes at the committee meetings. Copies of all study results shall be made available to the executive committee of the Medical Staff, the administration, and the Hospital Board of Directors. The Hospital shall provide a secretary for all other Medical Staff committees if necessary.

**PART L. SIGNATURE, DATE AND TIME.**

All medical entries to the EHR must be e-signed by the practitioner who made the entry. A countersignature or authenticating signature is an "entry" and must therefore be dated and timed, which the EHR does automatically. For purposes of this Section C and the following Section D, the terms "signed"; "countersigned"; "authenticated"; and the like all mean that the practitioner who made an entry, directed an entry, or made an order resulting in an entry to a medical record has personally reviewed and approved the actual entry in the EHR by e-signing.

**PART M. FACSIMILE SIGNATURES.**

Should a practitioner wish to use a rubber stamp or other signature facsimile device on medical records, he shall first apply to the executive committee of the Medical Staff and the Chief Executive Officer for approval of the stamp or device. Following approval by both parties, he shall deliver a signed statement to the administrator that he is the person who has the stamp and the only person who will use the stamp. Use of such stamp or facsimile device may not be delegated.

**PART N. UNAVOIDABLY INCOMPLETE MEDICAL RECORDS.**

When a member of Medical Staff is unable to complete a medical record because of death, permanent disability or other protracted absence, the medical records department shall contact the chief of the service where the affected patient was treated. The chief of that service shall make sure that the practitioner then responsible for the patient completes the affected patient's record to the best of his ability based on his knowledge of the situation and of the patient. If the record involves a discharged patient or deceased patient, the appropriate chief of service shall prepare a statement which shall be added to the patient's medical record explaining why the record was not completed and providing any other information he believes may be relevant.

**PART O. TRAINING IN THE ELECTRONIC MEDICAL RECORD**

Medical Staff recognizes the implementation of an electronic health record in May, 2013. Training will be necessary for the individual physician or Credentialed Providers in order to fulfill regulatory documentation requirements (CMS and Joint Commission). All documents will be electronic, with remote signage capability. Effective usage of the electronic health record requires training. The informatics staff and trainers are available for one-on-one training, classroom

training and online training is available. For reasons of patient safety and promotion of clinician competency and efficiency, medical staff leadership is setting the following training expectations:

New physicians and allied health providers (expected to begin work after May 2013) are required to receive their EHR training applicable to their area of clinical practice and consistent with their projected scope of practice in the hospital prior to receiving privileges.

#### **PART P. REPEATED SUSPENSIONS**

A provider who has his or her admitting privileges suspended five times in a two-year appointment or reappointment period for incomplete medical records will be placed on a provisional one-year appointment. During the provisional one-year appointment, the provider will undergo a Focused Professional Practice Evaluation (FPPE) which will include the creation of an action plan and a periodic review of the providers progress with the Chief of the Medical Staff and/or the Chief Medical Officer. If the provider is suspended for incomplete medical records during the provisional one-year appointment, the matter will be referred to the Medical Executive Committee for consideration of additional action such as financial penalty or dismissal from the medical staff.

### **IV. GENERAL CONDUCT OF CARE**

#### **PART A. GENERALLY**

A general consent form signed by or on behalf of every patient admitted to the Hospital, must be obtained at time of admission or as soon thereafter as possible should the patient be admitted on an emergency basis. The attending practitioner shall be notified whenever such consent has not been obtained. When so notified, except in emergency situations, it shall be the practitioner's obligation to obtain proper consent before the patient is treated in the Hospital.

In addition to obtaining the patient's general consent for treatment and diagnostic procedures (including x-rays), It is the policy of Saint Alphonsus Medical Center-Ontario, that a patient or patient representative gives voluntary and informed consent for all care, treatment and services involving material risk.

The purpose of obtaining informed consent is to provide information to the patient regarding his/her health status, diagnosis, prognosis and appropriate care, treatment and services options. This is a process of information exchange that allows the patient to make an informed choice.

In cases other than an emergency (and certain other limited and clearly defined cases), the patient must receive a clear explanation of his/her health status, diagnosis, prognosis and proposed invasive procedures or of proposed non-invasive procedures that carry a material risk of adverse outcome. The patient must be informed of the possible benefits of the care, treatment and services, possibilities of any material risks of side effects of the care, treatment and services, and alternative forms of care, to include refusal of medical or surgical interventions. The patient will be allowed to participate in the development of the plan of care and care after discharge from the Medical Center.

## **PART B. ORDERS**

- 1. Policy Statement:** Orders must be clear, legible and complete. Orders that are illegible or incomplete will not be carried out until rewritten or clarified.
- 2. Definitions:**
  1. A patient care order directs the performance or administration of a diagnostic test, treatment, procedure, prescribed medication, intervention or therapy. Such orders may be created by providers within the scope of their practice and license
- 3. Equipment:**
  1. Electronic Health Record (EHR)
- 4. Procedure:**
  1. All orders will be dated, timed, and authenticated by written or electronic signature.
  2. Illegible handwritten signatures must be accompanied by a legible printed name.
  3. Orders must be adequately clear, specific and complete to direct patient care. For example, orders such as "continue previous meds," "resume preoperative meds," or "discharge on current meds" are not authorized.
  4. Order sets (eg paper sets, EHR Favorites or Power Plans) are authorized when dated, timed and authenticated by written or electronic signature.
  5. Unapproved abbreviations and symbols, as defined by medical center policy, may not be used in orders, dictations, or other medical record entries.
  6. Orders may not be sent via text, email, EHR tasking/instant messages, in progress notes or via Halo Spectrum.
    - a. 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).
    - b. The following Saint Alphonsus colleagues are authorized to receive and input the verbal order into the medical record:
      - i. Registered Nurse (RN)
      - ii. Licensed Practical Nurse (LPN)
      - iii. Registered Therapist
      - iv. Respiratory Care Practitioner
      - v. Pharmacist
      - vi. Dietitian
      - vii. Physician's Assistant (PA)
      - viii. Nurse Practitioner (NP)
      - ix. Medical Assistant (MA) in outpatient Clinics
      - x. Specialized Procedures Technologists
      - xi. Registered Radiology Technologist
      - xii. Radiation Therapist
      - xiii. Radiation Dosimetrist
      - xiv. Radiation Physicist

- c. When a verbal/telephone order is taken, it must be documented and read back to the authorized person giving the order to confirm. The order should contain a statement that the order was confirmed after being read back. For Example:
  - i. For paper based medical records
    - 1. VORB (Verbal Order Read Back), followed by the signature of the person taking the order.
  - ii. For electronic medical records
    - 1. Select appropriate communication order type eg 'verbal order' or 'phone order.'
    - 2. These orders are routed to the provider for electronic signature
- d. As soon as possible, verbal orders must be authenticated through written or electronic signature by the provider who originated the order or another provider who is responsible for the care of the patient and who is authorized to write orders.
- e. An authorized individual may decline to accept verbal orders which are not clearly expressed or are capable of misinterpretation and will so inform the provider. If an agreement is not met, Chain of Command communication will be instituted prior to initiation of order.

**PART C. DRUGS.**

Drugs and medication brought into the Hospital by a patient shall be immediately placed in the custody of the pharmacy and shall remain in the pharmacist's custody until the patient is discharged. Patient's medications held by the Pharmacy shall not be dispensed unless the formulary does not have a supply of medication or is not available.

**MS.03.01.03.05**

**V. CONSULTATIONS.**

**PART A. ATTENDING PHYSICIAN RESPONSIBILITY.**

The attending physician shall be responsible for requesting and obtaining consultation when appropriate. The attending physician shall provide written authorization to permit another practitioner to attend or examine his patient except in an emergency.

**PART B. SITUATIONS WHERE CONSULTATION IS DESIRABLE.**

1. Except in emergencies, consultation is desirable in the following situations:
2. Where, within 5 days of admission, and after ordinary diagnostic procedures have been completed, the diagnosis remains obscure.
3. Where there is doubt as to the choice of therapeutic measures.
4. In unusually complicated situations where specific skills of other practitioners may be of assistance.

5. When the patient is a poor risk for operation or treatment.
6. Where tissue to be removed is likely to be normal under microscopic examination.
7. Where abdominal or other surgery is contemplated in intrauterine pregnancy cases.
8. Where sterilization is contemplated.
9. When requested by the patient or his family.
10. When privileges needed to provide needed care are outside of the attending physician's privileges.

**PART C. AVAILABILITY FOR CONSULTATION.**

Qualified practitioners with clinical privileges in the Hospital may be called for consultation within areas of that practitioner's expertise.

**PART D. NURSE RESPONSIBILITY.**

If a nurse has any compelling reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she, after attempting to resolve any concerns with the attending physician, shall notify her supervisor. In addition, she may contact any physician or other appropriate professional should she deem such contact to be necessary for the expeditious provision of appropriate care. This contact is normally, but not always, with the chief of service wherein the practitioner holds clinical privileges or with the chief of the Medical Staff. Where circumstances justify such action, the chief of the respective service, or the chief of Medical Staff may request consultation.

**VI. GENERAL RULES REGARDING SURGICAL CARE**

**PART A. PRE-SURGERY REQUIREMENTS.**

Except in severe emergencies, the preoperative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In any emergency, the practitioner shall make at least an appropriate note regarding the patient's condition prior to induction of anesthesia and initiation of surgery.

**PART B. GENERAL SURGICAL CONSIDERATIONS.**

1. The patient's medical records must reflect whether or not the patient is an in-patient or an out-patient. A surgical out-patient is one who will undergo a procedure in the surgical suite, under local or general anesthesia, and is expected to be discharged within 24 hours after the procedure is performed.
2. General surgery and local anesthesia rooms are available per the schedule maintained by the Director of the OR.
3. When an elective surgery schedule fills to near eight hours in any day, the rooms may be closed to further scheduling by the operating room supervisor.

4. If an emergency case arises during the operative day, the operating room supervisor, upon notification, will adjust the schedule as necessary. The surgeon desiring priority shall personally discuss this schedule change with those surgeons who are affected by the change.
5. Emergency surgery during the "off-hours" is to be scheduled through the nursing service supervisor. The nursing service supervisor will notify surgery personnel of such emergency surgery.
6. A physician who wishes to preempt another physician must personally contact the other physician and discuss the proposed preemption.

#### **PART C. RESERVATIONS.**

The operating room shall not be held open for more than 15 minutes beyond the beginning time scheduled for any operation. If the surgeon fails to appear within this time (without acceptable excuse), the operation shall be canceled and the next physician's case shall be scheduled.

#### **PART D. CRITERIA FOR EMERGENCY OPERATIONS.**

Emergency operations shall be prioritized as follows:

1. Those performed to preserve life and limb.
2. Those performed when hazardous to wait until the following day.

#### **PART E. REQUIREMENTS PRIOR TO ANESTHESIA AND OPERATION.**

1. Except in cases of emergency, no patients shall enter the surgical suite without a proper identification bracelet.
2. Preoperative evaluation and documentation (including a pre-anesthesia consent, evaluation and pre-induction assessment):
  - A. Both inpatient and outpatient surgical procedures shall require a complete medical history and physical examination as specified in Policy and Plans Section C, 2.
3. At the discretion of the attending physician, any recommended studies from the Surgical and Anesthesia Services established preoperative guidelines may be postponed, but in all instances where the physician delays laboratory tests, he must indicate in writing the reason for and duration of his deferment. In-patient and preoperative laboratory work shall be performed in the hospital laboratory or by a certified laboratory acceptable to the Medical Staff. Reports shall be dated no earlier than four weeks prior to hospitalization. (This requirement may be avoided if older lab tests are available and are mutually acceptable to the treating physician and the anesthesiologist and this approach is documented and placed the medical record.
4. A patient admitted for dental care (other than oral surgery to be performed by an oral surgeon) or podiatric care is a dual responsibility involving the dentist or podiatrist and the physician member of the Medical Staff.

A. Responsibilities of the physician are:

1. A detailed history justifying Hospital admission;
2. A detailed description of the examination of the affected body part and a preoperative diagnosis;
3. A complete operative report, describing the finding and technique. In cases of extracted teeth, the dentist shall clearly state the number of teeth and fragments removed and the location of all fragments prior to removal. All tissue including the teeth and fragments and bone shall be sent to the Hospital pathologist for examination;
4. Those progress notes pertinent to the condition of the patient;
5. A clinical resume or summary;
6. The discharge of the patient shall be on written order of the dentist or podiatrist member of the Medical Staff, with the concurrence of the physician involved.

B. Responsibilities of the physician are:

1. To take a medical history pertinent to the patient's general health;
  2. To perform a physical examination to determine the patient's condition prior to anesthesia and surgery;
  3. To supervise the patient's general health status while hospitalized.
5. A written, signed, informed surgical consent shall be obtained by the operating surgeon prior to any operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in whom consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.
  6. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, the anesthesia plan (including ASA classification), and post-anesthetic follow-up of the patient's condition.
  7. For major surgical procedures, with unusual risk or hazard, a surgical assistant, qualified to assist, shall be present.

For some indicated major and minor surgical procedures, with no unusual risk, a qualified non-physician assistant, or no assistant may be acceptable. The qualifications of non-physician surgical assistants, privileges and their responsibilities shall be in accord with the Oregon Code and these Bylaws, Policy

and Plans and in all instances their work will be under the full direction of and under the full responsibility of a member of the Medical Staff.

8. All tissues removed at the operation, except those exempt by Medical Staff policy, shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at a tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

## **VII. EMERGENCY SERVICES.**

### **PART A. MEDICAL STAFF COVERAGE**

The Medical Staff shall devise a method of providing full-time medical coverage for emergency services. This shall be in accord with the Hospital's basic plan for the delivery of such services by all physicians who render emergency care including physicians who substitute for those whose services are under the contract with the Hospital. All Active and Provisional Active Staff Members shall accept reasonable emergency call assignments. The on-call requirements for each physician shall be established by each service line chief and submitted to the Executive Committee for approval. Requirements for emergency coverage to be provided in each specialty shall be determined considering community need, the number of specialists and subspecialists in the service line and any other demands on those specialists and sub specialists in a particular field. Physicians are not required to take more than 7 days of call per month, but may do so if they choose. If a service line finds it difficult to reasonably provide on-call coverage for the emergency room on a full time basis, then the practitioners will work with the service line chief, Executive Committee, and Hospital Administration to develop appropriate methods of coverage for that particular specialty such that the hospital will have a physician on call for each specialty for which the Hospital provides inpatient services. Physicians who have served the Hospital for more than twenty (20) years of service may, but do not have to, opt out of emergency call. Physicians who elect to opt out of such call coverage following twenty (20) years of service will work with the Hospital Administration and the service line chief to ensure an orderly transition from their call coverage responsibilities, including giving at least 120 days' notice prior to dropping off of emergency coverage.

### **PART B. MEDICAL SCREENING EXAMINATIONS.**

All persons who present themselves to the Hospital with a request for examination or treatment of a medical condition will receive an appropriate Medical Screening Examination and treatment required by the Emergency Medical Treatment and Labor Act (EMTALA) and the Hospital's EMTALA Compliance Policy. The results of this medical screening examination and a determination whether the patient has an emergency medical condition, will be documented in the medical record.

### **PART C. EMERGENCY ADMISSIONS.**

In the case of emergency admissions, patients who do not already have a personal admitting physician will be assigned to a Medical Staff appointee with privileges in the clinical department to which the diagnosis indicates an assignment. Where departmental responsibility is not clear, the ranking available officer of the Medical Staff shall have the ultimate responsibility to determine the appropriate clinical department. The chairman of each service line shall provide an assignment schedule for attendance to such patients. Appointees who receive an emergency



admission shall, at a minimum, and without regard to ability to pay, provide all treatment required to stabilize the patient and shall otherwise comply with the requirements of EMTALA.

**PART D. UNSTABILIZED EMERGENCY MEDICAL CONDITIONS.**

A patient with an unstabilized emergency medical condition may only be transferred to another medical facility if either the physician certifies that the medical benefits reasonably expected from treatment of the patient at another medical facility outweigh the risks of transfer, or the patient requests in writing a transfer against medical advice. Any transfer of a patient with an unstabilized emergency medical condition must be conducted in compliance with EMTALA and the requirements set forth in the Hospital's EMTALA Compliance Policy.

**PART E. EMERGENCY CALL.**

Any Medical Staff Appointee who has been scheduled to serve on the Hospital's Emergency Call Panel ("Panelist") shall provide "timely consultation" when requested to do so by or at the direction of another Medical Staff member in accordance with EMTALA. Each Panelist must inform the Emergency Room how to reach him or her immediately while on call, and must remain in a location from which he can reach the Hospital within thirty (30) minutes of call. For purposes of this subsection, "timely consultation" means not more than twenty (20) minutes telephone response time and physical presence within a reasonable period of time as dictated by the patient's condition but not more than thirty (30) minutes. A Panelist who is not at a location which would enable panelist to reach the hospital within thirty (30) minutes and is not available for telephone consultation within twenty (20) minutes shall be responsible for arranging, in advance, for coverage by another equally qualified Medical Staff member with appropriate clinical privileges. If a Panelist does not provide timely consultation when requested or cannot be reached, the matter will be referred to the Executive Committee for appropriate corrective action. Additionally, if a patient must be transferred to another medical facility because of a Panelist's refusal or failure to timely appear when requested to provide stabilizing treatment, the name and address of the Panelist must be documented on the transfer form as required by EMTALA.

A panelist who does not take care of life and limb threatening emergencies may request in writing through the ER service for an extension of the time to reach the hospital to 60 minutes. If the ER service accepts the request, it is the forwarded to the MEC for final approval.

**PART F. USE OF REGISTERED NURSES, NURSE PRACTITIONERS AND PHYSICIAN ASSISTANTS TO CERTIFY TRANSFERS UNDER EMTALA.**

Registered Nurses, Nurse Practitioners and Physician Assistants are authorized, pursuant to federal law, to sign a certification for transfer to another facility in consultation with a Medical Staff Appointee. The Medical Staff Appointee shall countersign the certification within twenty-four (24) hours.

**PART G. TREATMENT OF PATIENTS IN THE EMERGENCY DEPARTMENT BY NON-EMERGENCY DEPARTMENT PHYSICIANS.**

Members of the Medical Staff who are not under contract to provide emergency medicine services in the Emergency Department may meet their patients, for the purpose of providing medical treatment, in the Emergency Department, subject to the following conditions and requirements:

1. All patients who present to the Emergency Department will be triaged and will receive a Medical Screening Examination by an Emergency Department Physician unless their personal physician is physically present in the Emergency Department. In that case, the personal physician may conduct the Medical Screening Examination provided he/she has privileges at the hospital to do so. All such examinations shall be conducted in accordance with the Hospital and Emergency Department policies, protocols and procedures and the federal anti-dumping laws and regulations. The results of the Medical Screening Examination and a determination whether the patient has an emergency medical condition, will be documented in the medical record by the examiner.

#### **PART H. OTHER QUALIFIED MEDICAL PERSONNEL FOR MEDICAL SCREENING EXAMS.**

A CNM or 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 protocols.

Patients who have arranged to meet their personal physician in the Emergency Department will be triaged and classified as "emergent", "urgent", or "non urgent" by an Emergency Department RN and will have a Medical Screening Examination initiated by either their personal physician, or the Emergency Department Physician, within the following timelines.

1. Emergent – immediately;
2. Urgent – within 10 minutes; and
3. Non-urgent – within 120 minutes.

#### **PART I. MEDICAL RECORD**

An appropriate medical record shall be kept for every patient receiving emergency service and shall be incorporated in the patient's Hospital record if such exists. The record shall include:

1. Adequate patient identification;
2. Information reflecting the time of the patient's arrival, means of arrival and by whom transported;
3. Pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital;
4. Description of significant clinical laboratory and roentgen logic findings;
5. Diagnosis;
6. Treatment given;
7. Condition of the patient on discharge or transfer;

8. Final disposition, including instructions given to the patient and/or his family, relative to necessary follow up care.
9. Each patient's medical record shall be signed by the practitioner in attendance, which is responsible for its clinical accuracy.
10. There shall be a periodic review of emergency room medical records by the Emergency Medicine Committee, and by appropriate clinical services to evaluate emergency medical care. Minutes shall be submitted to the Executive Committee of the Medical Staff following each meeting.
11. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community or immediate surrounding area. It shall be developed by a committee which includes at least two (2) members of the Medical Staff, the Director of Nursing Service or his designee, and a representative from Hospital Administration. It shall be approved by the Medical Staff. (This responsibility may be fulfilled by the Emergency Medicine and Disaster Committee or by this Committee.)
12. The disaster plan should make provision within the Hospital for:
  - A. Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials;
  - B. An efficient system of notifying and assigning of personnel;
  - C. Unified medical command under the direction of the Emergency Department physician on duty at the time;
  - D. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care;
13. The disaster plan should be reviewed at least once a year, preferably as part of the coordinated drill in which other community emergency service agencies participate.

## **VIII.SPECIAL CARE UNITS.**

### **PART A.     DIRECTOR OF CRITICAL CARE UNIT.**

The function of the Director of the Critical Care Unit shall be:

1. Assure that the quality, safety, and appropriateness of medical care in the critical care unit be monitored in accordance with the Joint Commission on Accreditation of Healthcare Organizations' standards guidelines.
2. Carry out the policies as formulated by the critical care unit committee.

3. When their patient load exceeds the optimal operational capacity of the critical care unit or cardiac monitoring facilities, the Director will make decisions, in consultation with the responsible physician, for the disposition of patients.
4. Maintain close coordination with the nursing and respiratory therapy staff and be readily available for administrative and consultative decisions.
5. During the absence of the Director, his designated representative shall be the internist on call.

**PART B. ORGAN DONOR PROGRAM:**

1. Protocol to be followed will be per Oregon law and per Hospital policy.
2. Definition of clinical death shall be as follows:
  - A. A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the irreversible absence of spontaneous respiration and circulatory function and/or irreversible cessation of spontaneous brain function, and because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and in this event, death will have occurred at the time these functions ceased; or
  - B. A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; it is suggested an EEG times two, one to six hours apart for an adult with no response or an EEG times two, twenty-four hours apart with no response for a child, and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before artificial means of supporting respiratory and circulatory functions are terminated and before vital organ are removed for purposes of transplantation. Such death shall be pronounced by a physician other than the one recovering the organ.

**IX. SUPERVISION OF MEDICAL RESIDENTS AND STUDENTS IN PROFESSIONAL EDUCATION PROGRAMS.**

Periodically, the Hospital may have both medical students and medical residents doing a clinical rotation under the supervision of a physician. The Hospital's policy entitled "Medical Residents or Student Rotation at Saint Alphonsus Medical Center - Ontario", policy as from time to time amended prescribes the mechanisms by which such residents or students in educational programs are supervised.

## **X. CLINICAL SERVICES.**

**PART A.** Each special clinical service shall establish its own regulations and procedural rules in writing and these regulations should be subject to approval of the Executive Committee.

**PART B.** Each clinical service shall maintain a roster of all physicians to be utilized by the Emergency Department physicians for those patients requiring consultation and/or admission to the Hospital

## **XI. STERILIZATION REVIEW AND APPROVAL.**

The Subcommittee of the Ethics Committee shall review all cases. The attending physicians will complete the Tubal Litigation Decision Form and submit the request to the President/CEO at least one month prior to the surgery. (Emergency cases will be reviewed on a retrospective basis.) The attending physician can be invited to participate in the deliberations of the Subcommittee.

Each case shall rest on its merits to include medical, psychiatric, obstetrical, surgical and socio-economical conditions which under good medical practice would make further pregnancies inadvisable.

## **XII. POLICY REVIEW**

Policies of the Medical Staff, services, and departments within services, shall be reviewed by the group which formulated the policy or by its designee, no less than once every two years.

## **XIII. ICD-10 TRAINING**

Physicians and Allied Health Providers are required to receive ICD-10 training through Saint Alphonsus, another area hospital or professional society. Must be completed by September 30, 2015 or prior to initial appointment. (Effective February 2015")

## **XIV. ELECTRONIC HEALTH RECORD TRAINING**

New physicians and Advanced Practice Providers are required to receive their Electronic Health Records (HER) training applicable to their area of clinical practice and consistent with their projected scope of practice in the hospital prior to receiving privileges.

APPROVED by the Medical Staff this 20<sup>th</sup> day February, 2020.

ADOPTED by the Board on the 10<sup>th</sup> day of March, 2020.