

**RULES AND REGULATIONS
OF
THE MEDICAL STAFF
OF
TUALITY COMMUNITY HOSPITAL**

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RULES AND REGULATIONS
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**RULES AND REGULATIONS
OF THE MEDICAL STAFF OF
TUALITY COMMUNITY HOSPITAL**

SECTION I. MEETINGS OF THE MEDICAL STAFF

- (a) ¹²The annual meeting shall be held on a date after the third Monday in May and before the third Monday in June each year.
- (b) Special meetings shall be held at the time and place specified in the announcement of the meeting.

SECTION II. ADMISSIONS AND DISCHARGES

- (a) ³⁴⁵⁶A medical screening examination (MSE) provided in compliance with the Emergency Medical Treatment and Active Labor Act (EMTALA) will be performed and documented by a physician, or a qualified medical person such as a, nurse practitioner, physician assistant, certified nurse midwife, or Birth Center Registered Nurse who has completed training and demonstrated competence to perform the MSE.

⁷⁸⁹If the MSE determines that the patient has an emergency medical condition or labor contractions and the patient requests or requires a transfer and the physician is not physically present, the physician shall determine risks and benefits of transfer over the phone in consultation with the registered nurse or nurse midwife, nurse practitioner, or physician assistants who may sign the risks and benefits summary.

- (b)¹⁰ Except in emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been documented. In case of emergency, the provisional diagnosis shall be documented as soon after the admission as feasible.
- (c)¹¹ The hospital shall admit patients suffering from all types of diseases. However, the physicians admitting patients shall be held responsible for

¹ Revised 1/25/2007
² Revised 1/24/2013
³ Revised 10/22/98
⁴ Revised 12/12/2000
⁵ Revised 5/28/2009
⁶ Amended 9/21/2014
⁷ Revised 8/22/99
⁸ Revised 12/12/2000
⁹ Revised 5/28/2009
¹⁰ Amended 9/21/2014
¹¹ Amended 9/21/2014

giving such information as may be necessary to assure the protection of other hospital personnel, except as proscribed by law.

- (d)¹² Except in extreme emergencies, an operative/invasive procedure is performed only after an appropriate history, physical examination, and any indicated laboratory and x-ray examinations have been completed and recorded in the medical record. An extreme emergency is defined as imminent death, or threat of loss of neurological function, or loss of limb without immediate surgical intervention.
- (e)³ In the case of a patient applying for admission who has no attending physician, he shall be assigned to that physician "on-call" for the emergency room, or his/her designee. The physician to whom he is assigned shall assume his/her medical care, arranging such consultation or referral as may be indicated.
- (f)⁴⁵⁶⁷ Every patient admitted to the hospital will have an attending physician. This individual will be the staff physician who documents the provisional diagnosis and enters orders into the electronic health record (EHR). Exceptions will be made per policy. The attending physician is the admitting physician until and unless relieved. This individual is the patient's own physician (PCP), hospitalist, or the physician who accepts the obligation to care for the patient through the hospital emergency room call list or the physician covering the practice of a colleague in one of the formal call schedules on file at the hospital Admitting/Emergency Department. It is the duty of the admitting physician to care for the patient when admitted to the hospital or to call for the appropriate physician he/she feels is best equipped to address the patient's problem. It is his/her duty to arrange for consultation or transfer to other care if that is needed. He/she is expected to be available for immediate patient care needs until alternate coverage can be obtained, which includes the transfer of patient care to another physician. If the admitting physician does not have the credentials to provide the care the patient needs, he/she is responsible to arrange for another appropriately credentialed provider to provide the patient's care. The Chief of Staff and Clinical Service Chiefs may be called upon by the physicians involved or the nursing supervisor on duty to assist where controversies arise, and their decision at the time, with the best information available to them at the time, is to be followed.

¹ Amended 9/21/2014

² Revised 10/6/95

³ Revised 8/27/2015

⁴ Revised 5/28/2009

⁵ Revised 7/23/2009

⁶ Revised 2/28/2013

⁷ Amended 9/21/2014

- (g) A consultation is required whenever the needs of the patient exceed the limits of the privileges of the attending physician. Physicians are responsible for seeking the consultation through physician-to-physician contact.
- (h)¹ In case of emergency or in special circumstances, a physician not on the Medical Staff may admit or attend a patient. If not an emergency, permission to attend a patient shall be secured from the CEO or his/her designee after consultation with the Chief of Staff or Clinical Service Chief.
- (i)²³ Each member of the Medical Staff temporarily unable to attend patients because of illness or absence from the community shall name a member of the Medical Staff to be called to attend his/her patients in an emergency, unless incapacitated to do so. Failure to name a substitute shall constitute a violation of these Rules & Regulations. If such a substitute is not named, the Chief of Staff or Clinical Service Chief shall have the authority to call an appropriate member of the Medical Staff.
- (j) ⁴⁵Patients shall be discharged only on order of an attending physician. Prior to discharge the physician is responsible for entering the discharge order, discharge diagnosis, follow up and a discharge note if needed.
- (k) ⁶Medication reconciliation will be done at the time of admission by the admitting physician and discharge by the discharging physician. This will be done in the electronic medical record and handwritten when the electronic medical record is unavailable.
- (l) ⁷Pre-admission work-up requirements shall be set by departmental policy.

SECTION III. AUTOPSIES

⁸⁹¹⁰Every member of the Medical Staff is expected to be actively interested in securing autopsies. When a patient expires, the physician is to decide if an autopsy should be sought. The physician will request an autopsy (postmortem examination) if applicable and an autopsy will be sought:

¹ Revised 8/27/2015
² Revised 9/21/2014
³ Revised 8/27/2015
⁴ Revised 1/24/2013
⁵ Revised 2/28/2013
⁶ Revised 1/24/2013
⁷ Revised 2/28/2013
⁸ Revised 6/27/2002
⁹ Revised 9/18/2011
¹⁰ Revised 4/30/2015

¹If the death is due to an unknown cause and/or the physician has questions that need to be answered an autopsy should be considered and the Pathologists can be consulted.

²Note: An autopsy will NOT be performed on patients in whom the diagnosis of Creutzfeldt-Jakob Disease (CJD) is suspected or cases of rapidly progressive dementia, dementia with seizures, especially myoclonic seizures, dementia associated with cerebellar or lower motor neuron signs, or on patients suspected of highly infectious diseases.

No autopsy will be performed without written consent from the patient's next of kin as required by the Oregon Revised Statutes §97.082.

³Refer to Tuality Healthcare Corporate Clinical Policy C-01L Autopsy Request (Postmortem Examination)

SECTION IV. CONSULTATIONS

- (a) Required consultations. Except in an emergency, consultations with another qualified physician are required in:
 - (1) Cases in which according to the judgment of the physician:
 - a. the patient is not a good risk for operation or treatment;
 - b. the diagnosis is obscure;
 - c. there is doubt as to the best therapeutic measures to be utilized.
 - ⁴(2) Intensivist consult is required for admission to the Intensive Care Unit (ICU) for all medical patients and within 24 hours after ICU admission for surgical and neurosurgical patients, except if the admitting physician is a Cardiologist.
- (b)⁵ Consultant. A consultant must be well qualified to give an opinion in the field in which his/her opinion is sought. That status of the consultant is determined by the Medical Staff on the basis of an individual's training, experience, and competence.
- (c) ⁶Essentials of consultation. A satisfactory consultation includes examination of the patient and the record. An opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the

¹ Revised 4/30/2015

² Amended 9/21/2014

³ Revised 4/30/2015

⁴ Revised 2/28/2013

⁵ Revised 8/27/2015

⁶ Revised 2/28/2013

consultation note, except in emergency, shall be recorded prior to the operation.

SECTION V. CRITICAL CARE UNITS¹

- (a)² Admission. Admission of patients to the Critical Care Units is at the discretion of the attending physician. In his/her absence, any member of the Medical Staff may make the decision to transfer a patient to the Critical Care Units.
- (b)³ ⁴Visitation: All patients in the Critical Care Units must be seen on a daily basis and a progress note entered in the chart by the attending physician or his/her designee. The patient's acuity level may require more frequent evaluation.
- (c) ⁵Consultation: A consultation is required whenever the needs of the patient exceed the limits of the privileges of the attending physician. Physicians are responsible for seeking the consultation through physician-to-physician contact. Consultation with an Intensivist is required for admission or transfer to the Intensive Care Unit (ICU) for all medical patients and within 24 hours after ICU admission for surgical and neurosurgical patients, except when the attending physician is a Cardiologist.
- (d) ⁶Transfer or Discharge: Transfers or discharges from the Critical Care Units are at the discretion of the attending physician with the advice of consultants participating in care. When the beds in the units are full, the charge nurse may suggest early transfer of recovering patients to accommodate new arrivals. If resolution cannot be affected, the decision will be made by the appropriate Medicine or Surgery Clinical Service Chief.

¹ Amended 10/30/2014

² Revised 8/27/2015

³ Revised 8/27/2015

⁴ Revised 2/28/2013

⁵ Revised 2/28/2013

⁶ Revised 2/28/2013

SECTION VI. DISASTERS: MANAGEMENT OF DISASTERS AND MASS CASUALTIES

A detailed plan of conduct of the Medical Staff and all hospital personnel in the event of a major disaster or the arrival at the hospital of multiple casualties shall be formulated. This plan shall be approved by the Medical Staff and the Governing Board, shall be reviewed and revised annually or as needed, and shall be rehearsed at least twice a year.

¹SECTION VII. EMERGENCY DEPARTMENT AND OB/NEWBORN COVERAGE

(a)^{2 3} Introduction

TCH provides Emergency Department and Obstetrics services to the patients of its community. The medical staff of the hospital also have privileges and obligations to provide services to patients presenting to the Emergency and Obstetrics Department for medical care. Triage will be done by a registered nurse.

(b)⁴ Admission to Emergency Department

Inquiry will be made as to the severity of the emergency condition and the immediacy of need for care. The Emergency Department provider will be the judge of priority of care and treatment based on assessment of the care needs. In each case, an effort will be made to ascertain if the patient has a private physician and act accordingly.

(c)⁵ TCH Medical Staff

(1) Emergency Department Responsibilities: An Emergency Department call list will be maintained comprising the members of the Active staff who will provide care for those patients who do not have a private provider. On occasion the Emergency Department physician may summon the on-call providers to assist in times of heavy use of the facility. The responsibility for the patient care transfers to the admitting provider when the patient leaves the Emergency Department.

⁶(2) Obstetrics Department Responsibilities: An Obstetrics Department call list will be maintained comprising the members of the Active staff who will provide care for those patients. There shall be two lists. One list for

¹ Revised 2/27/2014

² Revised 10/22/98

³ Revised 2/27/2014

⁴ Revised 2/27/2014

⁵ Revised 2/27/2014

⁶ Revised 2/27/2014

Obstetrics and a list for Newborns. The Obstetrics list shall be the same list as the Obstetrics list for the Emergency Department. The newborn list will be those individuals with inpatient newborn privileges.

- ¹²³⁴(3) Emergency and Obstetrics Department call list: The Medical Staff Office will maintain a call list of providers by specialty. All members of the Active staff have the responsibility of providing Emergency and/or Obstetrics Department call as a condition of maintaining Active medical staff privileges. Courtesy staff providers may be allowed or required to participate in this duty when recommended by the Clinical Service Chief after approved by the Medical Executive Committee (MEC). Scheduling change information should be made available to the Emergency and Obstetrics Department as well as the Medical Staff Office. Providers absent during a period of their call list obligation will make arrangements for coverage by another staff provider with appropriate privileges, and will make this information readily available to the Emergency and Obstetrics Department.

⁵⁶Call list providers are also responsible to admit patients when appropriate. Medical Staff members responding to the Emergency Department call list are obligated to provide an opportunity for at least one follow-up visit, if necessary, to any Emergency Department patient assigned to them. The ultimate responsibility for inpatient or outpatient care for unassigned patients is that of the provider on call at the conclusion of the current Emergency Department visit unless other arrangements have been made.

- ⁷(4) ⁸⁹¹⁰Tuality Community Hospital will maintain one Primary Care Provider Call list, which will include all eligible Family Practitioners and Internists. The Primary Care Provider Emergency Department Call List will be utilized for coverage at all Tuality Healthcare Emergency and Urgent Care locations. Primary care providers serving on the inpatient newborn call list may elect to opt out of the Emergency Department Call list.

- (5) ^{11 1 2}Availability: ³Providers on the **Emergency Department** call list are responsible for providing consultation to the Emergency

¹ Revised 6/27/2002

² Revised 10/27/2005

³ Revised 1/24/2008

⁴ Revised 2/27/2014

⁵ Revised 12/20/2012

⁶ Revised 2/27/2014

⁷ Revised 5/1/97

⁸ Revised 12/14/99

⁹ Revised 1/24/2008

¹⁰ Revised 2/27/2014

¹¹ Revised 1/27/2005

Department physician on duty, both by telephone and in the Emergency Department when called. The Medical Staff provider responsible for Emergency Department call coverage is expected to respond to telephone calls within 20 minutes and when requested to be on-site at Tuality Community Hospital within 40 minutes of the first telephone call request by the Emergency Department. With the exception that Interventional Cardiologists on call, are expected to respond to telephone calls within 5 minutes and when requested to be on-site at Tuality Community Hospital within 30 minutes of the first telephone call requested by the Emergency Department.

⁴Obstetricians on the Call List are required to respond to telephone calls within 5 minutes and when requested to be on site within 20 minutes of the first call requested. Providers with newborn privileges who are on call shall respond to any call 24 hours a day, 7 days a week. The providers on call for the Obstetrics/Newborn call shall be available to respond even if it is not their assigned patient. Obstetricians on the call list must have C-section privileges.

⁵(6) ⁶Exceptions:

- a. ⁷Any provider experiencing ill health anytime during his/her career or wishing to be excluded from the Emergency and/or Obstetrics Department call list can petition the Chief of the Clinical Service to be excluded from the Emergency and/or Obstetrics Department call list. The Chief can obtain Medical Executive Committee approval. Those providers who are excluded from the Emergency Department call list prior to August 31, 1995, will continue to be excluded.
- b. Providers who have served 30 years on Tuality Emergency and/or Obstetrics Department call, or are age 65 with at least 20 years on Tuality's Emergency Department call schedule may petition the MEC to be taken off Emergency Department call. The MEC may or may not approve the request based on relevant factors, e.g. if the number of Active staff providers remaining in that specialty would drop below 3 to cover call etc.

⁸(7) ¹Compensation for Emergency and Obstetrics Department call and/or uninsured patients is Tuality Healthcare's responsibility based on

¹ Revised 9/19/2013

² Revised 2/27/2014

³ Revised 12/20/2012

⁴ Revised 2/27/2014

⁵ Revised 2/27/2014

⁶ Revised 1/24/2008

⁷ Revised 8/27/2015

⁸ Revised 2/27/2014

practices at other hospitals of similar size, market trends, and budgets permitting, but the methodology utilized for compensation should be applied consistently and fairly and requires the MEC concurrence.

- ²(8) ³Maintaining block time in the Operating Room requires Active staff membership and Emergency Department call coverage. Active staff physicians excluded from the Emergency Room call list with block time prior to October 1, 2007 will be excluded from this requirement.
- ⁴(9) ⁵A separate Medical Staff policy regarding the Emergency and Obstetrics Department on-call assignment process will be maintained.

SECTION VIII INFECTION CONTROL

- (a) The Infection Control program is a hospital-wide program directed by the Interprofessional Committee. The Committee meets in accordance with the Bylaws or more often when necessary.
- (b) Authority
 - (1) The Committee, acting through the Chairperson, will have complete authority to enforce rules relevant for infection control management, and to approve a system of reporting and surveying infections among patients and personnel.
 - (2)⁶ The committee has the authority to institute surveillance, prevention and control measures or studies when there is reason to believe that an epidemic exists in the community or an outbreak of infectious disease occurs in the hospital.
 - (3)⁷ The Chairperson personally or through an appointed designee will;
 - (a) Initiate action in matters of infection control as established by the Committee.
 - (b) Determine temporary policy or regulations as needed.
 - (c) Cooperate with local State and National health agencies in the study or control of infection.

¹ Revised 1/24/2008

² Revised 2/27/2014

³ Revised 1/24/2008

⁴ Revised 2/27/2014

⁵ Revised 1/24/2008

⁶ Amended 12/18/2014

⁷ Amended 12/18/2014

(d)¹ Have full authority to institute appropriate control measures or studies when there is a perceived danger to patients or personnel.

(c) Responsibilities

(1) The Committee will review and approve infection control policies and procedures.

(2) The Committee is responsible for reviewing and analyzing infection control reports and making recommendations for corrective action and focused studies to be done.

SECTION IX. MEDICAL RECORDS

²(a) Chart entries are to be dated, timed and signed.

³⁴⁵(b) A complete history and physical examination (H&P) is to be on the chart within 24 hours after admission (inpatient or observation).

(c) A consultation that contains all the elements of an H & P is acceptable.

(d) An H & P is to be on the chart at the time of outpatient services that require an H & P.

(e) An H & P cannot be done more than 30 days prior to admission.

(1) ⁶If the H & P is more than 30 days old then a new H & P must be performed. This requires either dictating a new H & P or entering the H & P into the electronic medical record using a format that assures all the elements are included.

(f)⁷ A current H & P is required before an operative or invasive procedure. It must be on the chart before the patient is taken to the Holding Area or procedure room.

⁸(g) A Consult or a Progress note by the Surgeon outlining the surgical plan will be placed in the electronic medical record prior to the patient being taken to the OR any time the initial H&P was done by a provider other than the

¹ Amended 12/18/2014

² Revised 4/23/2009

³ Revised 9/17/2000

⁴ Revised 4/27/2006

⁵ Revised 6/22/2006

⁶ Revised 1/24/2013

⁷ Revised 10/22/2009

⁸ Revised 6/25/2015

Surgeon.

- ¹(h) A medical clearance H & P does not substitute for the surgical H & P.
- (i) An update is required for all H & P's performed prior to admission. The update needs to accurately reflect the findings: either that there are no changes or a detailed description of all the changes. This update must be documented within 24 hours of admission or prior to outpatient services for which an H & P is required.
- (j) The admission H & P is good for the entire length of stay. There is no requirement to update the H & P within 24 hours prior to inpatient surgery. Any changes to the patient's condition would be documented in the Progress Notes.
 - (1) If the H & P is dictated, that fact should be stated and an adequate admitting note must be on the chart. The record should include a statement of the conclusions or impressions drawn from the admission H & P.
- ²(k) Admissions from the Emergency Department (ED) who are discharged in less than 24 hours do not require a new H & P. The ED physician's Clinical Note will suffice.
- ³(l) Admissions from the Emergency Department (inpatient and observation) require completion of the ED providers' Clinical Note at the time of admission.
- (m) ⁴The Service Chief or Hospital-Based Independent Department Chiefs will define which outpatient procedures require a history and physical. If a history and physical is required, it will be clarified if full history and physical is required or if a minor procedure history and physical will be acceptable.
- (n) ^{5,6}When admitting a patient for a surgical or other invasive procedure, the preoperative order must be on the chart before the procedure and include, but not be limited to, the following data elements: (ORS 333-510-0010 Patient Admission and Treatment Orders)
 - 1. Patient Name
 - 2. Patient Date of Birth
 - 3. Unit to be admitted to
 - 4. Procedure to be completed
 - 5. Diagnosis
 - 6. Admit status (IP-AM Admit, OP, OP-EDS)

¹ Revised 10/25/2007

² Revised 4/23/2009

³ Revised 9/19/2013

⁴ Revised 2/24/2000

⁵ Revised 10/22/2009

⁶ Revised 2/28/2013

7. Labs or other Diagnostic tests

^{12(3o)} ⁴The medical record thoroughly documents operative or other procedures and the use of sedation or anesthesia. The provider who performs the surgery or procedure records a preoperative diagnosis before beginning surgery or the procedure. Two postoperative/procedure recordings are required:

- 1) An Operative/procedure progress note is entered into the medical record immediately after the surgery/procedure is performed and records:
 - a. The name of the provider who performed the surgery/procedure
 - b. Assistant
 - c. Anesthesiologist
 - d. The procedure performed
 - e. Findings
 - f. The postoperative/post-procedure diagnosis.
 - g. ⁵Estimated blood loss

- 2) ⁶An operative/procedure report is dictated or entered into the electronic medical record immediately after the procedure and records:
 - a. The name of the primary physician who performed the surgery/procedure
 - b. Assistant
 - c. Anesthesiologist
 - d. Findings
 - e. The procedure(s) performed
 - f. Description of the procedure(s)
 - g. Estimated blood loss
 - h. Specimen(s) removed
 - i. The postoperative diagnosis.

- 3) ⁷⁸If a complete operative report is immediately entered into the EHR and available in the electronic medical record, an immediate progress note is not required.

⁹The completed operative/procedure report is authenticated by the provider performing the surgery/procedure and filed in the medical record as soon as possible after surgery or the procedure is

¹ Revised 6/27/2002

² Revised 12/14/99

³ Revised 6/22/2000

⁴ Revised 12/16/2004

⁵ Revised 9/20/2012

⁶ Revised 1/24/2013

⁷ Revised 9/20/2012

⁸ Revised 2/28/2013

⁹ Revised 1/24/2013

performed. Delivery reports should be dictated or entered into the electronic medical record chart immediately following a vaginal delivery or a Cesarean Section.

- ¹²(p) ³Medical records must be completed within 30 days of date of discharge. The medical record is considered past due when it has not been completed within 21 days following the patient's discharge.⁴
- (q) An admitting note indicating the reason for hospitalization, the working diagnosis, and immediate plan of therapy should be on the Progress Notes within 12 hours after admission.
- (r) When a general or regional anesthetic is anticipated there must be a preanesthesia note in the medical record. ⁵A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, no later than 48 hours after surgery or a procedure requiring anesthesia services.
- (s) The responsible dentist shall document a detailed description of the dental problems of dental patients in their medical records.
- (t)⁶ The original medical record, or contents may not be removed from the hospital except by a court order, subpoena, or as otherwise required by law.
- (u)⁷⁸ Progress notes are required to be entered daily. The progress notes must give a pertinent chronological report of the patient's course in the hospital and reflect any change in condition and the results of treatment.
- ⁹Non-physicians who are approved to take verbal or telephone orders may document a summary note on the Progress Notes as a means of communication, provided that discipline does not have a specific form on which to document.
- (v) All final diagnosis should be recorded in full, without abbreviations or symbols.
- (w) There will be an adequate explanatory legend for abbreviations and symbols used in the medical record. This will be approved by the Medical Staff and

¹ Revised 2/26/2015

² Revised 8/22/99

³ Revised 2/27/2003

⁴ Revised 5/1/95

⁵ Revised 1/23/2014

⁶ Revised 9/18/2011

⁷ Revised 6/27/2002

⁸ Revised 2/28/2013

⁹ Revised 4/24/2003

available to all those authorized to make entries and to those who must interpret them.

- ¹²³(x) All entries in the medical record must be timed, dated and authenticated.
- (y)⁴ All queries submitted to the practitioner by coding staff for clarification of diagnosis and/or present on admission status will be answered and authenticated by the physician prior to the completion of the record.
- (z)⁵⁶ Failure of individuals to abide by these Rules & Regulations can only work to the detriment of the entire Staff. The Governing Board, on recommendation of the Medical Executive Committee of the Medical Staff, will enforce the rules to the point of suspension of all hospital privileges, if necessary, of any Staff member whose behavior is not in the best interest of his/her patients and of the hospital as a whole.
- (aa) ⁷A discharge note will be used for short stay admission (less than 48 hours).

SECTION X. OPERATING ROOM

- (a) Scheduling of surgical procedures

Refer to the policy that has been established by the Operating Room.

- (b)⁸ Informed Consents

1. ⁹All procedures of a surgical type (including those not done in the Operating Room), e.g., circumcisions of infants, shall have a patient informed consent signed by the patient or legal representative prior to the procedure. Refer to Section XV for policy on informed consents.
2. ¹⁰Every therapeutic or diagnostic procedure, e.g. lumbar puncture, bone marrow, biopsy, paracentesis, thoracentesis, etc., that require (or could require) the use of local anesthesia shall have a patient informed consent signed by the patient or legal representative prior to the procedure. Refer to Section XV for policy on informed consents.

¹ Revised 6/27/2002

² Revised 10/22/2009

³ Revised 2/28/2013

⁴ Revised 10/22/2009

⁵ Revised 6/28/2001

⁶ Revised 8/27/2015

⁷ Revised 2/27/2003

⁸ Revised 4/30/2015

⁹ Revised 4/30/2015

¹⁰ Revised 4/30/2015

3. ^{1 2}To complete the patient informed consent form, the name of the surgical procedure to be performed is to be provided to the hospital by the surgeon in the form of an order, a verbal order recorded on the chart, or on the surgeon's patient informed consent document.

(c) Post Anesthesia Recovery

Post-operative patients will be discharged from the recovery area according to standards approved by the Anesthesia Subcommittee.

³A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia, no later than 48 hours after surgery or a procedure requiring anesthesia services.

(d) Handling of Tissue

Refer to the policy that has been established by Surgery and Pathology.

SECTION XI. DAY SURGERY PROGRAM

(a) Surgical Admissions to DSU

- ⁴⁵(1) Day Surgery Coordinator must notify Operating Room supervisor and surgeon if chart is not complete when patient reports for admission.
- (2) Case may be canceled or delayed by Operating Room supervisor after consultation with anesthesiologist.

(b) Day Surgery Admissions

- (1) Patient Classification: Patients not expected to require overnight hospitalization.
- (⁶2) Preoperative fasting guidelines for patients who receive general anesthesia, monitored anesthesia, or regional anesthesia care: Refer to the Anesthesia Manual for TCH and TFGH.

SECTION XII. ORDERS

¹ Revised 2/28/2013

² Revised 4/30/2015

³ Revised 1/23/2014

⁴ Revised 6/27/2002

⁵ Revised 6/2/97

⁶ Revised 12/14/99

- (a) ¹²³⁴⁵⁶All orders shall be placed in the electronic health record (EHR). Tuality Healthcare will maintain corporate policies approved by the Medical Executive Committee (MEC), which further defines acceptable and unacceptable orders. Any changes to these corporate policies will be approved by the MEC.
- (b) ⁷Computerized Provider Order Entry (CPOE) is the primary method for placing patient orders. Verbal, telephone, or written orders shall be allowed only in the following circumstances (goal is no more than 20% of each practitioner's total orders).
- (1) Telephone Orders
- a. The practitioner does not have access to the electronic order entry system (e.g. in their car or otherwise temporarily away from a computer).
 - b. Entering orders in the computer would delay necessary patient care.
 - c. The practitioner is involved in an emergency situation.
 - d. The practitioner is gloved or otherwise occupied with a clinical procedure.
 - e. One time orders in the middle of the night (e.g. pain medication, stat labs, etc.). This does not include things like admission orders or medication reconciliation.
 - f. The nurse will enter the orders along with the name of the practitioner into the EHR while the practitioner remains on the telephone, reads back the order along with the text of all Best Practice Alerts which may be presented to them. Only after the practitioner verifies the accuracy of the orders can the nurse sign them.
 - g. Practitioner will receive an alert in Message Center reminding them to sign the orders.
 - h. Practitioner (the one ordering or another practitioner who is responsible for the care of the patient and who is authorized to write orders) is to authenticate/sign the order within 48 hours.
- (2) Verbal Orders
- a. The practitioner is involved in an emergency situation.

¹ Revised 2/28/2002

² Revised 12/14/99

³ Revised 4/27/2000

⁴ Revised 6/22/2006

⁵ Revised 2/28/2013

⁶ Revised 4/2/2015

⁷ Revised 2/28/2013

- b. The practitioner is gloved or otherwise occupied with a clinical procedure.
- c. Practitioners will receive an alert in Message Center reminding them to sign the orders.
- d. Practitioner (the one ordering or another practitioner who is responsible for the care of the patient and who is authorized to write orders) is to authenticate/sign the order within 48 hours.

(3) Written Orders

- ¹a. Physician/provider written (handwritten) or preprinted order sets may be used only if the EHR system is not available.
- ²b. Chemotherapy and CRRT/dialysis orders will be written or ordered electronically when available. Heparin IV, TPN and other pharmacy managed medications shall be entered into the EHR by the ordering physician as pharmacy consults. Order details may be written for these complicated medications to ensure patient safety (i.e. TPN parameters).
- ³c. Physician written orders per exceptions #(a) and #(b) above will be:
 - ⁴i. Printed on a *Medication and Treatment Order Form* (physician order sheet):
 - ii. Activated by:
 - 1) Signature of physician/provider
 - 2) Verbal order of physician/provider
 - 3) Telephone order of physician/provider
- d. Practitioner (the one ordering or another practitioner who is responsible for the care of the patient and who is authorized to write orders) is to authenticate/sign the order within 48 hours.

⁵(c) Order sets may originate from any Medical Staff member or group or hospital department with physician input (example: X-ray, Anesthesia, Dietary, and Laboratory).

(d) ⁶All verbal and telephone orders need to be authenticated within 48 hours.

(e) ⁷When there is not a specific order to withhold resuscitation, resuscitation efforts will be initiated using BLS and ACLS protocols.

(f) ¹Patients who are receiving on-going care in outpatient departments shall have their orders renewed at least every twelve (12) months, including future orders.

¹ Revised 4/2/2015

² Revised 4/2/2015

³ Revised 4/2/2015

⁴ Revised 4/2/2015

⁵ Revised 2/28/2013

⁶ Revised 3/22/2012

⁷ Revised 4/2/2015

SECTION XIII. PHARMACY AND DRUGS

- (a) Drugs used shall meet the standards of the U.S. Pharmacopoeia, National Formulary and New and Nonofficial Drugs. It shall be the responsibility of each individual prescribing physician to use drugs in proper dosage, for the proper purpose, and in compatible combinations.
- ²³⁴(b) ⁵Practitioner orders for schedule II injectable narcotics controlled substances shall be updated every five (5) days.
- (c) ⁶⁷It is not acceptable to use “blanket orders”: for medication use such as “continue previous meds,” “resume preoperative meds,” “discharge on current meds,” etc. Medication orders must be entered into the EHR so as to eliminate ambiguity. Complete medication orders contain the name of the drug, strength, dosage form, route of administration, dosage regimen and PRN indication if needed.

⁸SECTION XIV. PHYSICIAN RESPONSE TO CALLS FROM DEPARTMENTS AT TUALITY HEALTHCARE

Physicians are responsible for providing consultation to departments within the Tuality Healthcare system both by telephone and in person when requested. The Medical Staff physician on-call when contacted by hospital departments such as the nursing wards, Intensive Care Unit and Operating Room are expected to respond to telephone calls within 20 minutes and when requested to be on-site at Tuality Community Hospital or Tuality Forest Grove Hospital within 40 minutes of the first telephone call request. ⁹Physicians on-call for Labor and Delivery are to respond within 5 minutes and when requested to be on-site within 20 minutes of the contact is first initiated.

¹ Revised 4/2/2015

² Revised 2/26/2004

³ Revised 6/22/2006

⁴ Revised 2/26/2004

⁵ Revised 5/28/2015

⁶ Revised 1/24/2013

⁷ Revised 2/28/2013

⁸ Revised 4/25/2013

⁹ Revised 12/14/2017

SECTION XV. PRIVILEGES¹ STATUS²³⁴

(a) General Standards/Privileges

There shall be standard privilege delineation lists for each specialty, approved by the Medical Executive Committee. These lists will be reviewed by the clinical services and hospital-based independent departments on a regular schedule, with any changes being approved by the Medical Executive Committee.

(b) FPPE/OPPE Status

- (1) All practitioners who have been granted privileges will go through an initial Focused Professional Practice Evaluation (FPPE) process at time of initial appointment. Medical Staff policy #MS-34 outlines the FPPE process. Once a practitioner has successfully completed the FPPE process, and upon recommendation by the Chief/Medical Director of their services and approval by the MEC, the practitioner will be placed in the Ongoing Professional Practice Evaluation (OPPE) process. Medical Staff policy #MS-27 outlines the OPPE process.
- (2) Any existing practitioner granted additional clinical privileges after initial appointment, will go through an FPPE for the additional privilege(s) granted. Medical Staff policy #MS-34 outlines the FPPE process. Once the practitioner has successfully completed the FPPE process, and upon recommendation by the Chief/Medical Director of their services and approval by the MEC, the practitioner will be placed in the OPPE process. Medical Staff policy #MS-27 outlines the OPPE process.
- (3) Any existing practitioner that has specific concerns identified during the course of their appointment will be placed in a FPPE. Medical Staff policy #MS-34 outlines the FPPE process. Once a practitioner has successfully completed the FPPE process, and upon recommendation by the Chief/Medical Director of their services and approval by the MEC, the practitioner will be placed in the OPPE process. Medical Staff policy #MS-27 outlines the OPPE process.

¹ Revised 3/6/95

² Revised 10/3/96

³ Revised 9/25/97

⁴ Revised 6/25/2015

- (4) The following practitioners are exempt from the FPPE and OPPE processes;
- a. Practitioners who are affiliated with the Medical Staff but who have not been granted any clinical privileges,
 - b. Practitioners who are granted only *Referral and Visitation Only* privileges, and
 - c. Practitioners who have been granted one-time temporary privileges to serve as a monitor/proctor for a procedure being performed at Tuality Healthcare, or when the one-time temporary privileges granted are tied to a specific patient or procedure

SECTION XVI. INFORMED CONSENTS

- (a) Written, signed, and informed consents to hospital, emergency, medical care or surgical procedures shall be obtained prior to the care or procedure except in the following situations:
- (1) Where the patient is in a life-threatening emergency and the patient is unable to consent for himself.
 - (2) ¹²Where the patient is not in a life-threatening emergency, but is under 15 years of age (subject to be found within the jurisdiction of the Oregon Juvenile Court) and because of the general state of the child's health or any particular condition, the physician, dentist, or responsible official of the hospital determines in his/her medical judgment prompt action is reasonably necessary to avoid unnecessary suffering or discomfort, or to effect a more expedient or effective cure, and it is impossible or highly impractical to obtain consent for treating the child from the child's caring agency, the child's parent, or the child's legal guardian.
 - a) Under both (1) and (2), the attending physician or dentist shall document and detail the nature of the emergency or the state of the child's health indicating prompt action absent a consent, and with said statements to be entered in the patient's medical record. Additionally, where reasonable and feasible, the attending physician or dentist may seek the opinion or a medical staff member commenting upon the need to proceed without a consent.
 - b) As to a mentally incompetent person in a non-emergency situation, consent shall be obtained from a legally authorized person.

¹ Revised 6/25/2015

² Revised 8/27/2015

- ¹²c) A child 15 years or older, a married or emancipated person, may consent on his/her own behalf.
- ³⁴⁵d) Regarding unemancipated or children under age 15; consent should be obtained from a parent, guardian, or other legally authorized person. An exception is noted in the case of a minor child who has contracted a sexually transmitted disease and said child may give consent to the furnishing of hospital, medical or surgical care related to the diagnosis or treatment of such disease on his/her own behalf if the disease or condition is one which is required by law or regulation adopted pursuant to the law to be reported to the local or state health officer or board.
- (b) A written consent form will be required for all sterilizations and therapeutic abortions.
- (c) As to abortions, consents must be obtained in compliance with the provisions of ORS 677.097 as follows:
- (1) Consent of the pregnant woman.
 - (2) Written consent of a person who has custody or the guardian if the pregnant woman is an unmarried minor (below age 15).
 - (3) The written consent of the guardian if the pregnant woman has been judicially declared a mentally incompetent person.
- (d) A copy of the consent shall be made a part of the hospital record.
- ⁶(e) In non-emergency situations where consent is not given by reason of religious convictions, hospital legal counsel should be contacted to obtain a court order.
- (f) When consent is given for a mentally incompetent person by legal representative, any question regarding sufficiency of legal documentation should be referred to hospital legal counsel.

¹ Revised 6/25/2015

² Revised 8/27/2015

³ Revised 8/22/2002

⁴ Revised 6/25/2015

⁵ Revised 8/27/2015

⁶ Revised 6/25/2015

SECTION XVII. PHYSICIAN RESPONSE TO MEDICAL CODE ¹²

- (a) ³⁴Physicians with appropriate skill levels within the hospital should respond to all medical codes.
- (b) ⁵As with all members of the medical staff, the emergency physicians will respond to medical code situations. Because the emergency physician's primary obligation and duty is to care for patients present or arriving in the Emergency Department, it must be recognized a conflict between Emergency Room patient's life threatening needs and a code might arise, delaying or preventing the emergency physician's response.
- (c) Upon being notified, the attending physician should be present within a reasonable period of time or delegate to someone who is willing to accept the responsibility of the code. ⁶The responding physician will sign off to the attending physician who will determine if a consult is needed and contact that consultant.

SECTION XVIII. PSYCHIATRY – CENTER FOR GERIATRIC PSYCHIATRY⁷⁸⁹¹⁰¹¹

- (a) A History and Physical must be completed on all admissions by a physician or Limited License Independent Practitioner within 24 hours and will include neurological assessment.¹²
- (b) A Psychiatric Admission Evaluation (PAE) and Mental Status must be completed for all psychiatric admissions within 24 hours.¹³
- (c) All patients shall be admitted to the Center for Geriatric Psychiatry by an attending Psychiatrist who is a member of and privileged by the Medical Staff.¹⁴

- (1) The Psychiatric Admission Evaluations (PAE), ongoing assessment and treatment, medication management, treatment planning, progress

¹ Revised 2/26/2004

² Revised 6/25/2015

³ Revised 6/28/2001

⁴ Revised 6/25/2015

⁵ Revised 6/25/2015

⁶ Revised 1/29/2009

⁷ Revised 8/7/97

⁸ Revised 4/27/2000

⁹ Revised 12/19/2002

¹⁰ Revised 2/26/2004

¹¹ Revised 2/25/2016

¹² Revised 2/25/2016

¹³ Revised 2/25/2016

¹⁴ Revised 2/25/2016

notes and discharge summaries may be completed by credentialed Limited License Independent Practitioners under the supervision of a psychiatrist. The supervising psychiatrist will review and countersign the PAE and discharge summary.¹

- (d) The Attending Psychiatrist (or his/her supervised designee/Limited License Independent Practitioner) will be available on call 24 hours per day to meet the needs of the patients.²
- (e) The Attending Psychiatrist or Limited License Independent Practitioner is responsible for the coordination and supervision of treatment. He or she will guide the discharge/aftercare plan and evaluate all patients 24 hours prior to discharge.³

SECTION XIX. SANCTIONS ⁴

Failure to meet the expectations of these Rules and Regulations may result in actions as provided for in Article VI of the Bylaws.

¹ Revised 2/25/2016

² Revised 2/25/2016

³ Revised 2/25/2016

⁴ Revised 9/12/2004