



**LEGACY GOOD SAMARITAN HOSPITAL
AND MEDICAL CENTER**

**MEDICAL STAFF
RULES AND REGULATIONS**

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RULES AND REGULATIONS

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MEDICAL STAFF RULES AND REGULATIONS

I. ADMITTING PROCEDURES

1. Responsibility for Medical Care

Each patient shall be the responsibility of a member of the Medical Staff, who has the appropriate privileges and who shall also supervise house staff care provided to the patient according to policies established by each department.

A. Transfer: Whenever responsibilities are transferred to another practitioner, a note covering the transfer of responsibility and acceptance of the same shall be on the order sheet and progress notes of the medical records.

B. Emergency Admission: In the case of an emergency admission, patients who do not have a private practitioner may have a choice of any known practitioner in the department or service in which he is to be admitted, with concurrence of the practitioner, or be assigned in rotation to a member of the Medical Staff on duty in the appropriate service or department. The Chairman of each department or service shall provide an assignment schedule for this purpose.

C. Emergency Admission Justification: Practitioners admitting emergency cases may be required to justify to the Chairman of the department or President of the Staff and the President of the Hospital that said emergency was a bona fide emergency.

2. Provisional Diagnosis

Except in emergency, no patient shall be admitted to the Hospital until a provisional diagnosis has been stated. In case of an emergency, such statement shall be recorded as soon after admission as possible.

3. Dental Admission.

All patients admitted to the Hospital for inpatient dental procedures shall have a prompt medical evaluation by a practitioner who has such privileges. Each patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff. Discharge of the patient shall be on written order of the dentist member of the Medical Staff.

A. Dentist Responsibilities:

- 1) A detailed dental history justifying hospital admission;
- 2) A detailed description of the examination of the oral cavity and a preoperative diagnosis;
- 3) A complete operative report in accordance with Section III.5 of these Rules & Regulations;
- 4) Progress notes as are pertinent to the oral condition; and

5) Discharge summary.

4. Oral Surgeon's Admissions.

Oral Surgeons may be granted the privilege to complete pre-anesthesia history and physicals for all A.S.A. categories, provided that appropriate medical consultation is obtained whenever necessary to assure optimum standards of patient care and anesthesia safety. Discharge of the patient shall be on written order of the oral surgeon member of the Medical Staff.

A. Oral Surgeon's Responsibilities:

- 1) A detailed oral surgery history justifying hospital admission;
- 2) A medical history pertinent to the patient's general health;
- 3) A physical examination to determine the patient's condition prior to anesthesia and oral surgery;
- 4) A complete operative report in accordance with Section III.5 of these Rules & Regulations;
- 5) Progress notes as are pertinent to the oral and physical condition; and
- 6) Discharge summary.

5. Podiatry Admission.

All patients admitted to the Hospital for inpatient podiatric surgery shall have a prompt medical evaluation performed by a practitioner who has such privileges. Each patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff.

Podiatrists may be granted the privilege to admit and complete history and physicals for all podiatric patients, provided that appropriate medical consultation is obtained whenever necessary to assure optimum standards of patient care and anesthesia safety. Discharge of the patient shall be on written order of the podiatrist member of the Medical Staff.

A. Podiatrist Responsibilities:

- 1) A detailed podiatric history justifying hospital admission;
- 2) A detailed description of the examination of the extremity and preoperative diagnosis;
- 3) A complete operative report; in accordance with Section III.5 of these Rules & Regulations;
- 4) Progress notes as are pertinent to the podiatric condition; and
- 5) Discharge summary.

6. Psychology Admission.

All patients admitted to the Hospital by a Psychologist for treatment shall have a prompt medical evaluation performed by a practitioner who has such privileges. Each patient's general medical condition is the responsibility of a qualified physician member of the Medical Staff. Appropriate

consultation shall be obtained whenever necessary to assure optimum standards of patient care. Discharge of the patient shall be on written order of the psychologist member of the Medical Staff.

A. Psychologist Responsibilities:

- 1) Detailed psychological history justifying hospital admission;
- 2) Obtain medical consultation for admission history and physical and any indicated medical management;
- 3) Obtain psychiatric consultation to assess need for psychotropic medication prescription and for medication management;
- 4) Progress notes as pertinent to psychological condition and treatment; and
- 5) Discharge summary.

7. Nurse Practitioner Admission.

Due to the diverse medical specialties in which nurse practitioners/nurse midwives have responsibility, specifics regarding their scope of practice and completion of hospital records will be addressed during the privileging process. Privilege request forms for each group shall define any appropriate and/or necessary relationships with physician associates.

II. DISCHARGE PROCEDURES

1. Discharge Procedures

Patients shall be discharged only on approval of the attending practitioner or designee.

- A. Against Advice: Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, notation of the incident shall be made a part of the patient's medical record.
- B. Discharge Hour: Patients shall be required to be out of the Hospital by a specified hour on the day of discharge as determined by Administration in consultation with the Executive Committee. This does not apply to one day surgical admissions.
- C. Final Diagnosis: Final diagnosis shall be placed on the chart at the time of discharge whenever possible.

III. MEDICAL RECORDS

1. Responsibility.

The completion of a patient's medical record shall be the responsibility of the attending practitioner. Allied Health Professionals or other individuals acting within the scope of their professional licenses who have been authorized to do so shall complete those portions of records which pertain to their care of patients.

2. General Description

A. The medical record for inpatients shall include identification data; emergency care provided to the patient prior to arrival, if any; medical history, including chief complaint; details of present illness; relevant past, social and family histories; an inventory of body systems; a summary of the patient's psychosocial status, as appropriate to patient's age; a report of relevant physical examinations; a statement of the conclusions or impressions drawn from the admission history and physical examination; a statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate; diagnostic and therapeutic orders; evidence of appropriate informed consent; clinical observations, including the results of therapy; progress notes made by the medical staff and other authorized staff; consultation reports; reports of operative and other invasive procedures, tests, and their results; reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatment; records of donation and receipt of transplants or implants; final diagnosis(es); conclusions at termination of hospitalization; clinical resumes and discharge summaries; discharge instructions to the patient or family; and when performed, results of autopsy.

B. Emergency Department, outpatient and clinic records shall be maintained and available to the other professional services of the Hospital. These records shall include identification data, chief complaint, a brief history of the disease or injury treated, physical findings, laboratory and radiology reports, reports on any special examinations, diagnosis, record of treatment, disposition of case, instructions to the patient, a copy of the pre-hospital report form (when a patient is brought in by ambulance), the signature or authentication of the attending practitioner and signed consents for surgery, anesthesia, other procedures involving substantial risk (or the reason consent was not obtained) and the report of any autopsy.

C. Electronic Health Record Use and Responsibilities

Legacy's electronic health record (EHR) system has the potential to offer many advantages over paper records, including improving the quality of care for patients, reducing medical errors, promoting best practices, and decreasing the cost of care. Like all new technology, however, the EHR, if used improperly, could potentially result in medical errors and patient harm. The purpose of these rules is to set forth the expectations of the Medical Staff for the proper use of the EHR in order to ensure patient safety and high quality health care.

As the EHR is implemented at the Hospital, practitioners will actively and meaningfully use the EHR for all patients for whom they care for in the Hospital. Practitioners document all patient encounters in the EHR in a prompt and timely manner, and in all cases within the time frames as required by law and set forth in these Rules and Regulations. Practitioners must complete EHR documentation within the times frames required by law and these Rules & Regulations.

Demonstration of Competency

A Practitioner will be granted access to the EHR once the Practitioner demonstrates that he/she can utilize the system in the Hospital in a competent, safe and effective manner.

Basic competence is defined as the role-specific ability of any Practitioner to perform his/her usual work flows in the care of the patient, including the specific components below. The Hospital will provide appropriate training for all Practitioners.

Computer Practitioner Order Management

All clinicians will use Computer Practitioner Order Management (CPOM) for entering orders into the EHR. Verbal orders (including telephone orders) will only be given in urgent situations, when immediate access to CPOM is not feasible and orders are needed promptly to address changes in the patient's condition. All verbal orders must be dated, timed and authenticated as required by law and these Rules & Regulations.

Problem List Maintenance

Practitioners will update the active Problem List, within the scope of their clinical expertise, at each clinical encounter. The Problem List is for the acute and/or chronic active problems of the patient. An accurate and up to date Problem List in the EHR is essential for ensuring safe and high quality patient care.

Medication Management

Practitioners will update the Discrete Medication List at each clinical encounter. All medications, including PRN medications available for current use, chronic OTC medications, vitamins, supplements, homeopathic remedies, medications prescribed for chronic use by non-Legacy practitioners, should be on the Discrete Medication List. Duplicate medications should be removed from the Discrete Medication List.

Online Results Retrieval

Inpatient practitioners will utilize the online results retrieval in the EHR and communicate results to patients in a timely manner.

Failure to Properly Use the EHR

A Medical Staff appointee must properly use the EHR as set forth in these Rules. After notice from the Medical Staff for failure to properly use the EHR and opportunity to come into compliance, a Medical Staff appointee's admitting and clinical privileges (elective and emergency) shall be automatically relinquished, for failure to comply. Clinical privileges shall be formally reinstated once the appointee (1) meets the requirements established by Legacy Information Services for EHR training and demonstration of competency and (2) agrees in writing to properly use the EHR as set forth in these Rules. Failure to complete training, demonstrate competency and agree to properly use the EHR within sixty (60) days from the date privileges were relinquished shall constitute an automatic relinquishment of all admitting and clinical privileges and voluntary resignation from the Medical Staff.

3. Admission History and Physical Examination

The history and physical examination is completed by a physician member of the medical staff, or a licensed independent practitioner (LIP) who has been granted privileges, or a by individuals who are not LIPs who have been authorized to do so, under the supervision of, or through appropriate delegation by, a specific qualified physician who is accountable for the patient's medical history and physical examination. The history and physical is completed within the first 24 hours after admission and prior to an invasive procedure requiring sedation.

If the procedure requires only a local anesthetic and no sedation, then an H&P does not need to be completed. Sedation is defined as ANY medication given for anti- anxiety or sedation via ANY route. This includes po, IV, IM, IN, PR, SQ. A patient may take his or her own prior to the procedure; however, if a medication is ordered and removed from the Pyxis for the purpose of sedation or anti-anxiety, then an H&P is required.

If a history and physical examination was documented greater than 24 hours (but no greater than 30 days) before admission or an invasive procedure requiring sedation, such as in the office of a physician staff member or, when appropriate, the office of a qualified oral-maxillofacial surgeon staff member, a durable, legible copy of this report may be used in the patient's medical record. An interval note documenting any changes in the history or the physical exam must be entered in the EHR or, prior to EHR implementation, written at the time of admission (in the first 24 hours and prior to the procedure). In the case where there are no changes, the history and physical can be signed and dated, or authenticated in the EHR, on the day of admission with a note documenting "no change". The physician staff member or qualified oral-maxillofacial surgeon staff member entering such a copy of a history and physical examination shall authenticate the copy. If a patient is readmitted for treatment for the same or related problem within 30 days following discharge from the Hospital, an interval history and physical examination report explaining subsequent changes may be used in the medical record provided that the original information is available. A history and physical examination performed by a non-physician member of the medical staff may be accepted if the above requirements are met and a physician staff member privileged to perform history and physicals authenticates (dates and signs) the copy.

A H&P is required for all surgical procedures and any diagnostic procedure involving substantial risk; referring to diagnostic procedures that require sedation. There shall be a pre-sedation assessment and a second assessment immediately prior to induction for all patients receiving sedation in accordance with Legacy Policy 900.2311 *Care of the Patient Receiving Sedation for Diagnostic, Therapeutic or Surgical Procedures*.

4. Consultations

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. All consultations must be recorded, signed and made a part of hospital records. When the needs of the patient exceed the privileges of the medical practitioner, a consult must be called.

5. Surgical Record Requirements.

Surgery is performed only after a history, physical examination, and the preoperative diagnosis have

been completed and recorded in the patient's medical record by the licensed independent practitioner. Any indicated diagnostic tests have been completed and recorded in the medical record. In emergency situations in which there is inadequate time to record the history and physical examination before surgery, a brief note, including the preoperative diagnosis, is recorded before surgery.

Reports of operations shall include a detailed account of the surgical findings and of surgical technique. Reports of operations shall be entered in the EHR or, prior to EHR implementation, written immediately following surgery for all patients and the report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

The operative report shall include the following:

- ◆ Name of primary surgeon and any assistants
- ◆ Name of procedure
- ◆ Findings
- ◆ Technical procedures used
- ◆ Specimens removed
- ◆ Estimated blood loss, as indicated
- ◆ Post-operative diagnosis
- ◆ Disposition of each specimen if not noted elsewhere.

When an operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately.

6. Pre-anesthesia and Post-anesthesia Note

The anesthesiologist shall document a pre-surgical evaluation. No pre-operative sedative medications shall be administered before the anesthesiologist's evaluation. A post-anesthesia note shall be recorded in the record after the patient has recovered from the anesthetic procedure. The post-anesthesia note may be delegated to another physician with anesthesia privileges.

7. Progress Notes

Pertinent progress notes sufficient to permit continuity of care and transferability shall be recorded at the time of observation. The condition of the patient will determine the frequency with which they are made.

8. Orders

All orders for treatment shall be entered in the EHR or, prior to EHR implementation, in writing. However, practitioners acting within the scope of their licenses may give emergent verbal orders (including telephone orders) if they are authorized to give orders. Verbal orders shall be considered to be in writing if given to a duly authorized person acting within the scope of their license. Verbal orders must be signed, dated and timed by the ordering practitioner or another practitioner who is responsible for the care of the patient within 48 hours of when the order was given. All verbal orders, including those dictated over the telephone, shall be dated, timed and authenticated by the person to whom they are given and shall state the name of the practitioner who gave the order. The following persons are authorized to receive verbal orders:

1. registered nurses
2. licensed practical nurses
3. utilization review analysts relating to admission status

4. laboratory, radiology, nuclear medicine, ultrasound, dietary, cardio-respiratory, pharmacy, physical therapy, occupational therapy and speech pathology staff, and clinical resource coordinators (CRC) functioning within their sphere of competence when approved by their department head. Unlicensed (*e.g.*, CNAs) and clerical personnel (*e.g.*, admitting personnel and unit secretaries) are NOT authorized to accept and document verbal orders
5. Medical Assistants
6. Physician Assistants
7. Perfusionists
8. ECMO techs
9. Genetic counselors
10. LVNA LCSWs and MSWs may accept orders for medical social work services
11. Ophthalmic technicians
12. In the Legacy Clinics orders may be accepted by RNs, LPNs and MAs functioning within their competencies when approved by the medical director.

Orders must be entered in the EHR or, prior to EHR implementation, written clearly, legibly and completely (dated, timed and contains all elements as defined in Legacy policy). Hand-written orders which are illegible or improperly/incompletely written will not be carried out until understood by the nurse. Orders may be utilized in the following formats:

A. Protocols - **Protocols** are medically directed care (set of linked orders) for a specific diagnosis, emergent condition, procedure, treatment, or symptom. Protocols include: medications, treatments, diagnostic testing, monitoring and assessment parameters in response to a patient's condition. Except in emergency situations, protocols are initiated by an order from a credentialed practitioner who is authorized to give orders.

Protocols are developed by specific departments or programs with input from physicians and approved by the Medical Executive Committee. Protocols containing medications must be approved by the Medication Use Committee.

B. Preprinted Orders - **Preprinted orders** will be documented on an order sheet and do not require approval of the Medical Executive Committee. Preprinted orders will be modified utilized for specific practitioners and for specific diagnoses. Preprinted orders will be modified as appropriate for individual patients and are initiated by an order from a credentialed practitioner who is authorized to give orders. Preprinted orders containing medications must be approved by the Medication Use Committee.

C. Standing orders, order sets, and protocols may be used only as permitted by federal and state law. Such orders and protocols must be:

- (i) Reviewed and approved by the medical staff and nursing and pharmacy leadership;
- (ii) Consistent with nationally recognized and evidence-based guidelines;
- (iii) Periodically and regularly reviewed; and

- (iv) Dated, timed, and authenticated promptly by the ordering practitioner or by another practitioner responsible for the care of the patient.

9. Final Diagnosis

The final diagnosis shall be recorded in full either on the face sheet, final progress note, or discharge summary for all patients. Symbols and abbreviations may not be used.

10. Discharge Summary

At discharge from inpatient care, a discharge summary shall concisely summarize the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the patient's condition on discharge; and any specific instructions given to the patient and/or family.

11. Final Progress Note.

A final progress note may be substituted for the discharge summary only for those patients with problems and interventions of a minor nature who require less than a 48-hour period of hospitalization and in the case of normal newborn infants and uncomplicated obstetric deliveries. The final progress note must include the final diagnosis (if not documented on the face sheet), the outcome of hospitalization, the disposition of the case, and the provision for follow-up care.

12. Pronouncement of Death

In the event of a hospital death, it is the responsibility of the attending practitioner that the deceased be pronounced dead within a reasonable time period.

13. Autopsy

When an autopsy is performed, provisional anatomic diagnosis must be recorded in the medical record within three days, and the complete protocol will be included in the record within 60 days unless the medical staff establishes exceptions for special studies. Refer to Legacy Policy 900.2151 on Postmortem Care, Adult, Pediatric Newborn.

Autopsies should be solicited in the following instances:

1. Deaths from unknown causes;
2. Deaths that are unexpected;
3. Deaths occurring during surgery or under anesthesia, or complications thereof; and
4. Iatrogenic or nosocomial deaths.

14. Emergency Services.

When emergency, urgent or immediate care is provided, the time and means of arrival are documented. Pertinent history of the illness or injury and physical findings, including the patient's vital signs; emergency care provided to the patient prior to arrival; diagnostic and therapeutic orders; clinical observations, including the results of treatment; reports of, tests and results; diagnostic impression; conclusion at the termination of evaluation/treatment, including final disposition, of the patient's condition on discharge or transfer; and a patient's leaving against medical advice.

The medical record is dated, timed and authenticated by the practitioner who is responsible for its clinical accuracy.

15. Transfers.

Whenever responsibilities are transferred to another practitioner, a note covering the transfer of responsibility and acceptance of the same shall be on the order sheet and progress notes of the medical records.

Prior to the transfer of a patient to another facility, the attending practitioner shall provide a transfer summary which includes: reason for hospitalization; a current History and Physical; medical findings; diagnosis; receiving facility and physician; and any other information relative to the care of the patient. When a patient is transferred to another acute care facility from either an inpatient or outpatient status, a hospital transfer form must be completed, dated, timed, and authenticated by the responsible practitioner.

16. Record Completion

A patient's medical record should be completed at the time of discharge. The attending practitioner shall be responsible for the completion of the medical record for each patient. No record shall be filed until it is complete or unless it is on order of the Medical Staff President.

Practitioners will be notified of incomplete records by mail. Only one notice will be sent. This notice will list records that are incomplete. Practitioners not completing records within 30 days of discharge will be placed on the No Admit list. Placement on the No Admit list will result in automatic suspension in the form of withdrawal of admitting (except emergencies), or other related privileges, including scheduling, assisting in surgery, and administering anesthesia. Practitioners staffing the ED are not excluded from suspension of privileges due to delinquent charts. Automatic suspension will remain in effect until the delinquent medical records are completed and the suspension has been officially lifted. In the event the practitioner is unable to complete his medical records, it is permissible for a partner or associate to assume this task so long as this practitioner has participated in the care of the patient and has sufficient information as to allow the record to be meaningful, factual and current. One No Admit List will be generated monthly for the Hospital. Notification of placement on the No Admit List shall be done in accordance with established Health Information Services policy.

17. Authentication of Records

All entries in the record are timed, dated, author identified and authenticated. Authentication of an entry may include written signatures, initials, or computer signatures.

18. Symbols and Abbreviations

The current list of prohibited abbreviations or symbols is posted on the nursing units, in the clinics and in records as an insert and will be updated as needed. Compliance with Legacy policy 700.12

Approved Abbreviations and Do Not Use List is required for all Medical Staff and employees of Legacy Health.

19. Ownership

All records, either in original, electronic or microfilm form, are the property of the Hospital and shall not be taken from the Hospital except as required by court order, subpoena or state statute.

20. Use of Records

- ◆ For treating patients: In case of readmission of any patient, all previous records shall be available for the use of the current attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital
- ◆ For Scientific Purposes: Hospital records may be used by the Medical Staff for scientific purposes, to the extent permitted by law, on approval of the Legacy Institutional Review Board. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research. Research plans shall provide for confidentiality of personal information and shall conform with applicable law. Projects as appropriate shall be referred to the Legacy Institutional Review Board and/or a designated review body and a Human Research Committee, if appropriate, before records can be studied.

21. Availability of Practitioner

Each member of the Medical Staff shall make prior arrangements with another appropriate practitioner to provide appropriate professional care for any patient in the Hospital or patient who may be admitted to the Hospital for whom he is the attending practitioner when the practitioner is otherwise unable to attend his patients.

22. Statement of Nursing Responsibility

If a nurse believes that proper care is not being provided or observes an undesirable situation which might have a deleterious effect on the physical and mental well-being of the patient, it is the responsibility of the nurse to notify the practitioner of these observation and concerns. If the practitioner does not or cannot respond within a reasonable length of time, the nurse should follow-up with the proper authority as described in Hospital Policy Legacy Policy 100.34 to ensure that prompt and adequate measures are taken to safeguard the patient. Administration should be advised through appropriate nursing authority when it is believed that such measures are not forthcoming.

23. Consents

Informed consent to examine and/or treat shall be obtained by a LIP prior to examination or treatment for the following (except in those situations where the patient's life is in jeopardy and consent cannot be obtained due to the condition of the patient):

1. Surgery which involves an entry into the body through an incision or through one of the natural body openings, excluding vaginal childbirth.
2. Invasive procedures involving puncture or incision of the skin, or insertion of an instrument or foreign material into the body, including, but not limited to, percutaneous aspiration, biopsies, cardiac and vascular catheterizations, endoscopies, angioplasties, and implantations, but excluding venipuncture and intravenous therapy.
3. Administration of blood/blood products.
4. Administration of anesthesia or sedation.
5. When determined to be appropriate by the LIP.

In emergencies involving a minor as defined by the statute for medical treatment or involving an unconscious patient for whom consent cannot be immediately obtained from parents, guardians, or next of kin, the circumstances should be noted on the patient's medical record.

Documentation of the informed consent can be done on the Legacy consent form or a form of your own choosing and must include (a) name of patient, and when appropriate, patient's legal guardian, (b) name of hospital, (c) name of procedure(s), (d) name of practitioner(s) performing the procedure(s) or important aspects of the procedure(s), as well as the names or titles and specific significant surgical tasks (*e.g.*, opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues) that will be conducted by practitioners other than the primary surgeon/practitioner, (e) risks, (f) alternative procedures, treatments or therapies, (g) signature of patient or legal guardian, (h) date and time consent is obtained, (i) statement that procedure was explained to patient or guardian, (j) signature of person witnessing the consent and (k) name/signature of person who explained the procedure to the patient or guardian.

24. Authorization for Use and Disclosure of Protected Health Information

Written authorization of the patient or other authorized person is required for release of medical information to persons not otherwise authorized to receive this information. See Legacy Policy 700.18, Use and Disclosure of Protected Health Information, available online and in the Health Information Services Department.

25. Confidentiality

Information generated through contact between patients and health care providers at the Hospital is privileged and confidential. This privilege extends to all forms and formats in which the information is maintained and stored, including, but not limited to, hard copy, photocopy, microfilm, or automated/electronic form.

26. Surgery

The operating room will function in accordance with rules established by the Surgery Executive Committee, subject to the approval of the Executive Committee.

Certain surgical procedures may require the presence of a qualified assistant. When such a surgery is being performed, there shall always be an appropriately credentialed assistant scrubbed and present throughout the procedure who is capable of protecting the patient in the event of incapacity of the surgeon until a qualified surgeon can be summoned to complete the case. The primary operating surgeon shall determine the level and number of assistants required (*e.g.*, qualified nurse or surgical technician/physician's assistant, qualified surgeon, other qualified physician) commensurate with the gravity and complexity of the procedure being undertaken, generally recognized professional standards of care for the performance of the procedure, particular medical conditions which the patient may have which require active care during surgery, and any other exceptional circumstances present.

Attending Supervision of Residents in the O.R.: The attending should be in the Operating Room Suite and scrubbed during key parts of the case and present in the Operating Room with scrubs on during the rest of the case.

27. Therapeutic Abortion

Therapeutic abortion may be carried out by a physician member of the Medical Staff of the Hospital providing only that all conditions accord with the laws of the State of Oregon, and the Bylaws, Rules and Regulations of the Hospital Medical Staff. A signed request by the patient for therapeutic abortion and/or voluntary sterilization should be made part of the patient's record prior to the procedure of abortion being carried out. Administration and/or Medical Staff shall set up suitable mechanisms for the implementation of this section.

28. Reporting Contagious Diseases

When the attending practitioner or any member of the Hospital becomes aware of, or is reasonably suspicious of, the presence of an acute infectious or contagious disease within the Hospital, he shall immediately notify the Nursing Staff regarding such patient, in order that proper measures be instituted.

IV. RESPONSIBILITY FOR MEDICAL CARE

1. Medical Screening Examination

Medical screening examination of emergency patients to rule out the presence of an emergent condition may be performed by an Emergency Department physician assistant who has demonstrated competency through training and skills verification, a nurse practitioner who has demonstrated competency through training and skills verification, or by a physician. Medical screening examination of patients who present to OB Departments to determine whether the patient is in active labor may be performed by a registered nurse who has demonstrated competency through training and skills verification, a certified nurse midwife or physician.

2. Emergency Admission Call Responsibility

In the case of an emergency admission, patients who do not have a private practitioner may have a choice of any known practitioner in the department or service in which he is to be admitted, with concurrence of the practitioner, or be assigned in rotation a member of the Medical Staff on duty in the appropriate service or department. The Chairman of each department or section shall provide an assignment schedule for this purpose.

Active and Active Provisional Staff members have a general duty to serve in a rotational manner on the emergency room "Call" list and other rotational obligations if asked to do so by the Medical Executive Committee. The call list shall contain individual names, rather than group names, of those individuals assigned to provide emergency call coverage. Physicians must be within a thirty (30) minute response time of the Hospital when on call. On-call physicians may be on simultaneous call at another hospital or perform elective surgeries while on-call. The on-call physician shall attempt to identify another member of the Medical Staff ("Substitute Physician") who can respond to emergencies in the event that the on-call physician is unable to respond to an emergency call within thirty (30) minutes because he or she is taking simultaneous call or performing an elective surgery. If an on-call physician is unable to identify a Substitute Physician and a patient is in need of emergency services in the on-call physician's specialty, the patient will be transferred according to Hospital's policies. Courtesy and Courtesy Provisional members must also participate in emergency service and other rotational obligations if asked to do so by the Medical Executive Committee. It is the responsibility of Departments to provide adequate call coverage of the emergency department. Subspecialist physicians on the call schedule are expected to comply with these Rules and Regulations. A subspecialist physician concerned about his/her ability to meet these call responsibilities (e.g., lack of current competence to perform certain procedures) can provide initial management and treatment to the patient, arrange for a substitute physician to assume his/her call responsibility (complete or particular cases) or arrange for an EMTALA-compliant transfer in accordance with hospital policy.

If, after an initial examination, a physician determines that the individual requires the services of a physician listed by the Hospital on the ED roster and notifies the on-call physician and the physician fails or refuses to appear within a reasonable period of time, and all other resources* have been exhausted, the physician will order the transfer of the individual when physician determines that without the services of the on-call physician the benefits of transfer outweigh the risks of transfer. Documentation on the medical record will include name of physician called, time of call, time of response or lack of response and reason for transfer.

*The chain-of-command will be to call the Chair of the Department or Section and then the Medical Staff President.

If clinically indicated, patients (a) seen in the Emergency Department by the on-call physician or (b) referred by the Emergency Department to the on-call physician will be scheduled for at least one follow up visit, regardless of the patient's ability to pay, for the problem which precipitated the initial visit to the Emergency Department. This obligation ends if the patient does not

contact the physician's office within two (2) weeks of the Emergency Department visit to request an appointment. Further aftercare may be referred elsewhere at the discretion of the physician.

3. Residents and Clinical Fellows

- A. Each patient admitted to the Hospital or the teaching clinics at the Hospital shall be the responsibility of a medical staff member with appropriate clinical privileges who, if authorized by a residency program director, may also supervise the care provided to his/her patient by a resident or clinical fellow.

The attending physician must be available to the resident or clinical fellow at all times via phone or pager. The attending physician or designee must have the capability to be physically present in the Hospital within 30 minutes of notification if his/her presence is required to care for his/her patients.

For procedures performed in the operating room, the attending physician should be in the operating room suite and scrubbed during key parts of the case and present in the operating room department with scrubs on immediately available during the rest of the case.

At no time may a resident's or clinical fellow's scope of practice exceed the scope of privileges of the attending physician.

Each physician of record has the responsibility to make rounds on his or her patients and to communicate effectively with the residents or clinical fellows participating in the care of this patient at a frequency appropriate to the changing care needs of the patients.

- A. Residents and clinical fellows may give orders for all patients under their care, with appropriate supervision by the attending physicians.
- B. More detailed descriptions of the types of supervision which must be provided for residents and clinical fellows, the roles, responsibilities, and patient care activities of the participants are included in the GME Policy "Supervision of Residents and Clinical Fellows" which policy is approved by the MEC and the Board and posted in the shared folders of Outlook (Medical Staff).

APPENDIX A - DEFINITIONS

1. HOSPITAL: means Legacy Good Samaritan Hospital and Medical Center.
2. MEDICAL STAFF: means the formal organization under these Bylaws of all physicians, oral surgeons, dentists, podiatrists, clinical psychologists, and nurse practitioners/midwives.
3. PHYSICIAN: means an individual with an M.D. or D.O. degree who is licensed to practice medicine in the state of Oregon, pursuant to ORS Chapter 677.

4. PRACTITIONER: means any physician, oral surgeon, dentist, podiatrist, clinical psychologist, or nurse practitioner/midwife, applying for or exercising clinical privileges in the Hospital.
5. ALLIED HEALTH PROFESSIONAL: means a licensed individual other than a licensed physician, oral surgeon, dentist, podiatrist, clinical psychologist, or nurse practitioner/midwife, who exercises judgment within the areas of their professional competence, and who is qualified to participate in care under an appropriate level of supervision by or in coordination with the physician who has been accorded privileges to provide such care in the Hospital.
6. PRIVATE PRACTITIONER: means a practitioner who is known to be the patient's physician of record.
7. ATTENDING PRACTITIONER: a practitioner who has admitted or accepted responsibility for the care of a patient during the course of hospitalization for an illness or injury.

Adopted by the Medical Staff:

/s/Leslie Root, MD, PhD Date: 9/13/10

President of the Legacy Good Samaritan Hospital and Medical Center Medical Staff

Approved by the Legacy Health Board:

/s/ Jeffrey Fullman., M.D. Date: 9/16/10

Revised by the Medical Staff:

/Donald A. Wiens, MD Date: 3/25/11

President of the Legacy Good Samaritan Hospital and Medical Center Medical Staff

Revised by the Legacy Health Board:

/s/ Jeffrey Fullman, MD Date: 3/31/11

Revised by the Medical Staff:

/s/ James Borden, MD Date: 2/15/12

President of the Legacy Good Samaritan Hospital and Medical Center Medical Staff

Revised by the Medical Staff:

Revised by the Legacy Health Board:

/s/s Jeffrey Fullman, MD Date: 1/17/13

Revised by the Medical Staff:

Revised by the Legacy Health Board:

/s/s Jeffrey Fullman, MD Date: 4/16/15