GOOD SAMARITAN HOSPITAL

Rules and Regulations

Approval Dates
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ARTICLE I
GENERAL

1.0 Definitions

Admitting Physician is the Medical Staff member who orders admission of a patient to the Hospital for inpatient or outpatient services.

Allied Health Professional – AHP means an individual, other than a licensed physician, dentist, oral surgeon or podiatrist, who exercises independent judgment within the areas of his or her professional competence and the limits established by the Governing Body, the Medical Staff, and applicable State laws; who is licensed or certified to render direct or indirect medical, dental, or podiatric care; and who may be eligible to exercise privileges and prerogatives in conformity with the rules adopted by the Governing Body, the Medical Staff and these Bylaws. AHPs are not eligible for Medical Staff membership.

Attending Physician is the Staff member who is appropriately credentialed and has primary responsibility for a patient.

Consulting Physician is the staff member who is appropriately credentialed who assists the Attending Physician in the evaluation and/or management of the patient upon request of the Attending Physician.

Covering Physician means an appropriately credentialed Medical Staff Member with substantially the same privileges as the Attending physician who is filling in for the Attending or Consulting Physician.

Discharge means the termination of Hospital services to and the release of an inpatient or outpatient from a Hospital facility.

Physician is an individual with an M.D. or D.O degree who is currently licensed to practice medicine.

Practitioner means, unless otherwise expressly limited, any currently licensed Physician (M.D. or D.O.), dentist, oral surgeon, or podiatrist.

Medical Service – The departments or divisions of the Medical Staff to which Medical Staff Members are assigned based on such Members' practices

1 1.1 **Professional Relations**

2 Medical Staff members who have complaints/concerns about operational
3 matters, or who question the professional judgment or conduct of an individual
4 Medical Staff member or Hospital personnel should communicate their
5 complaint/concern as follows:

6 a. Complaint/concerns about other Medical Staff members should be
7 communicated to the Chief of Staff, other Medical Staff officer, Service
8 chair, Medical Staff committee, a member of the Hospital executive team; or
9 to the Governing Body, in line with the Code of Conduct policy.

10 b. Members should attempt to resolve complaints/concerns about Hospital
11 personnel and operational matters when and where the issue arises in a
12 respectful manner. If the problem cannot be resolved in that manner,
13 Members should communicate their concern to the Chief Medical Officer,
14 Chief of Staff, or the Administrator on Call in an effort to resolve the
15 problem promptly.

16

17 1.2 **Annual Influenza Vaccination**

18 Each Medical Staff Member must annually submit to the Medical Staff Office
19 proof that the Member has received a current, CDC-approved influenza
20 vaccination for the upcoming influenza season. Exceptions shall be granted
21 only based on strongly held personal or religious beliefs or medical reasons
22 that have been approved by MultiCare Health System.

23 a. A Medical Staff member opposed to vaccination must follow the MHS
24 process in effect for reviewing and approving exceptions.

25 b. The privileges of any Medical Staff member who fails to timely provide proof
26 of vaccination or an exception shall automatically be suspended effective the
27 day following the published deadline. Such automatic suspension will not be
28 related to the Medical Staff member's professional conduct or competence,
29 shall not be reported to the National Practitioner Data Bank or state licensing
30 board and the member shall be afforded no hearing rights.

31 c. Automatic suspension imposed under this Section shall terminate and the
32 suspended privileges shall be restored upon the Medical Staff member's
33 submission of a written statement of current influenza vaccination or at the
34 end of the designated flu season, privileges will be restored.

35

1.3 Process for Privileging and Re-Privileging Practitioners

Process for Privileging and Re-Privileging Practitioners is set forth in the *Medical Staff Credentialing Policy*.

1.4 Proctoring and Monitoring

1.4-1 Proctor or monitoring Requirements.

A proctor or monitoring shall be required when:

a. A Practitioner requests privileges to perform a service or procedure without evidence of training and/or clinical experience.

b. The Medical Executive Committee determines the need for a proctoring plan as part of a Practitioner's improvement or corrective action plan.

c. A Practitioner requests assignment of a proctor.

1.4-2 Proctoring or Monitoring Assignment Process.

a. When a Practitioner requests additional privileges or the assignment of a proctor, the Practitioner shall propose a proctor, alternatively the Medical Staff may assist with the assignment of a proctor. The appropriate oversight committee (Service, Medical Executive or Governing Body) will approve or reject assignment of such proctor. If the committee rejects recommended proctor, the committee shall provide a written reason and shall suggest an alternative proctor.

b. When the Medical Executive Committee determines the need for a proctor, the committee shall either direct the provider to find an acceptable proctor that is approved by the committee and/or assign a proctor.

c. The committee will determine the number of cases and/or time period for completion of the proctoring arrangement. This period should not exceed one year. At the conclusion of the proctoring a final report will be provided to the appropriate oversight committee.

d. All related expenses for proctoring shall be assumed by the practitioner.

1.4-3 **Eligibility to Serve as a Proctor**.
To serve as a proctor, the proctor must:

a. Be a Medical Staff member in good standing **or** a recognized expert who meets criteria for Medical Staff appointment and privileges for the procedures or practice being performed.

b. If the proctor is to participate in the care of the patient, he/she must hold current privileges at the hospital in which the health care services are to be performed. If the role of the proctor is to review/observe care, the proctor must either hold privileges or be eligible for privileges to perform procedure(s) or practice.

c. Have documented evidence of clinical competence in the procedure or practice being proctored.

d. Agree to provide objective, written evaluation to the practitioner being proctored and the to the committee recommending the proctor.

ARTICLE II

ADMISSIONS

2.1 **Provisional Diagnosis:** Except in an emergency, the Admitting Physician must provide a provisional diagnosis or valid reason for admission when ordering that a patient be admitted.

2.2 **A Complete History and Physical is required within 24 hours** from time of admission.

2.3 **Required Physician Visits**

a. After the initial visit by the Attending Physician each patient must be examined daily by the Attending Physician or Covering Physician. Credentialed Allied Health Practitioners may perform these duties provided they are under the supervision of the attending or covering physician with authentication of note. Discharging physicians need not see the patient on day of discharge if the discharge order was written within 24 hours prior to discharge and there has been no significant subsequent change in the patient's condition.

b. Newborns must be seen within 24 hours by a physician or an appropriately privileged AHP.

c. Obstetric patients may be admitted and seen daily by Certified Nurse Midwives (CNM).

d. Patients admitted for less than forty-eight (48) hour length of stays (e.g. diagnostic coronary and peripheral angiography, cardiac and peripheral interventional procedures, GI procedures, GYN procedures) may be seen daily by a Physician Assistant, CNM, or Advance Registered Nurse Practitioner provided the Attending or Covering Physician performed and documented an initial examination within the first 24 hours after admission.

e. Behavioral health patients may be admitted and seen daily by an ARNP credentialed in behavioral health.

f. Hospitalized surgical patients shall be seen by the surgeon performing the procedure or their coverage designee for a pre-operative evaluation, on post-operative-day one, and prior to discharge or sign off of care, with the concurrence of the attending physician. For simple procedures, the surgeon may sign off on the day of surgery, with the concurrence of the attending physician.

ARTICLE III
CONSULTATION

3.1 **Consultations**. Physicians are responsible for arranging/ordering necessary patient consultations. While on call for the Emergency Department, medical staff members shall be responsible for providing consultation on hospital patients requested during the member's on-call period.

3.2 **Consultation Report Shall:**

a. Include documentation of the consultant's findings, opinions and recommendations in the patient's medical record.

b. Be documented within 24 hours of the consultation and, if the consultation pertains to the decision to operate, before the operation (except in a documented emergency).

3.3 **Ordering Consultation**

a. A physician is responsible for ordering a consultation whenever patients in his/her care require services that fall outside the physician's scope of clinical privileges.

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

1. When the patient is not a good candidate for surgery or medical treatment;

2. Where the diagnosis remains obscure after usual diagnostic procedures have been completed;

3. Where there is doubt as to the choice of therapeutic measures to be utilized;

4. In unusually complicated situations where specific skills of other practitioners may benefit the patient;

5. When reasonably requested by the patient, patient's family or patient's legal representative.

c. Requests for consults shall be in writing and shall include:

1. The reason for the consultation;

2. The urgency of the consultation. (Emergent consults are to be completed within the timeframe agreed upon between the ordering and consulting physicians. Non-emergent consults must be completed within 24 hours of the request);

d. Emergent consults require verbal communication.

ARTICLE IV

PHYSICIAN RESPONSIBILITIES FOR DISCHARGE AND TRANSFERS

4.1 Discharge Plan

4.1-1 Attending Physician Responsibilities- The Attending Physician [or authorized designee]:

a. Must document an order for discharge and detailed follow-up and care instructions Hospital prior to the patient's discharge.

b. Must sign the discharge summary that includes a description of the patient's medical condition and the medical services provided.

4.2 Discharge Orders and Instructions

Patients shall be discharged or transferred only upon the order of the attending physician or his/her designee who shall provide, or assist Hospital personnel in providing, written discharge instructions in a form that can be understood by all individuals and organizations responsible for the patient's care. These instructions should include, if appropriate:

a. A list of all medications the patient is to take post-discharge;
b. Dietary instructions and modifications;
c. Medical equipment and supplies;
d. Instructions for pain management;
e. Any restrictions or modification of activity;
f. Follow up appointments and continuing care instructions;
g. Referrals to rehabilitation, physical therapy, and home health services;
h. Recommended lifestyle changes, such as smoking cessation.

4.3 Transfers

Attending and Covering Physicians must comply with MHS policy when ordering transfers of a patient to another healthcare facility. Refer to Patient *Transfer and Transport to Another Facility* policy.

ARTICLE V

CRITICAL CARE SERVICES/INTENSIVE CARE UNITS

5.1 **Admission and Discharge:** The Attending Physician, Covering Physician, (or a Consulting Physician who has assumed responsibility for the patient in accordance with these Rules) determines whether a patient should be admitted to or discharged from the ICU in accordance with criteria approved by the Medical Staff. ICU patients must be evaluated by a physician within 4 hours of admission to the unit or per department policy

5.1-1 All Medical Staff Members with hospital admitting privileges may admit to the ICU or per department policy.

5.1-2 Patients who meet ICU discharge criteria will be transferred out of the ICU only upon physician order with the concurrence of the Attending Physician or Covering Physician.

5.2 **Rounds:** ICU patients must be seen by the Attending Physician or Covering Physician daily. Surgeons must see their post-op ICU patient daily.

5.3 **ICU Primary Patient Responsibility:** Unless primary responsibility is properly transferred, the physician admitting the patient to a ICU is responsible for the patient's care and for coordinating the care provided by other physicians to the patient.

ARTICLE VI

COVERAGE AND CALL

6.1 Coverage

a. Every Medical Staff Member shall provide, or arrange for the provision of, continuous and appropriate care and supervision for his/her Hospital patients. Failures to provide appropriate coverage shall be reported to the Medical Executive Committee (MEC).

b. **Substitute Coverage**

1. In the event a Medical Staff Member is unable to fulfill his/her coverage obligation, it is his/her responsibility to arrange for a substitute and to notify the Emergency Department. Failure to notify the Emergency Department of a substitute may result in the initiation of disciplinary action.

2. Each Medical Staff Member shall provide the Hospital with the name of at least one (1) Covering Physician (usually a member of his/her group practice holding equivalent privileges) who shall be responsible for providing care and outpatient follow-up for such Medical Staff Member’s patients during periods of the Medical Staff Member’s unavailability. The Covering Physician must acknowledge and consent to the coverage arrangement. In cases where a Medical Staff Member belongs to a specialty in which arranging substitute coverage is difficult due to the limited number of physicians of that specialty on the Hospital Medical Staff, such Medical Staff Member’s substitute coverage plan is subject to advance review and approval by the Medical Executive Committee.

6.2 **Emergency Call**

a. For the purposes of this section, the term, “call schedule,” refers to a call roster required by the Emergency Medical Treatment and Active Labor Act (“EMTALA”).

b. **Call Schedule**: The Hospital is required under EMTALA to maintain an on-call list of physicians on the Medical Staff to meet the needs of emergency patients within the resources available to the Hospital. Nothing contained in this provision shall be construed to require a Medical Staff Member to provide services that are outside the scope of clinical privileges granted by the Hospital. Specialty sections of a medical staff service or division shall develop specialty-specific schedules for the call schedule with adjudication, when needed, by the service chair. The Clinical Service Chairs shall be responsible for ensuring appropriate call coverage per CMS guidelines. Call shall be from 0700 to 0659 the following day, unless other times are mutually agreed upon by the majority of physicians on that call schedule. Call schedules shall be published by the first of the month. Call schedules shall also be used by (1) the Emergency Department in appropriate determination and disposition for unassigned patients and for (2) consults for hospitalized patients.

c. Exclusion: Medical staff members 65 and over may request exclusion from the Emergency Call Panel. The request must be in writing to the Service Chair no sooner than 3 months before the 65th birthday. The Service Line may deny the request.

d. Any other requests for exemption from call responsibilities shall be considered extraordinary and must first be approved by a majority of the physicians on that call schedule. The MEC and the Regional Board shall be responsible for granting exemptions.

e. Unless otherwise indicated by the patient’s clinical condition, Emergency Services physicians shall make specialty referrals to the on-call specialist listed on the Emergency Services call schedule.

f. **Response Time**: It is the responsibility of the physician to respond in an appropriate time frame. Physicians must respond to calls from the Emergency Department or the Hospital within 30 minutes. If required by the Emergency Department physician, it is expected that physicians arrive in the Emergency Department within 1 hour of initial contact or at a time determined by the Emergency Department physician. Individual Services may specify tighter response times as indicated by Department policies/standards. Failure to respond in a timely manner may result in the initiation of disciplinary action.

g. **Substitute for Call**: In the event the Medical Staff Member is unable to fulfill his/her call obligation, he/she is responsible to arrange for a substitute and to notify the Emergency Department. Failure to notify the Emergency Department of a substitute for call may result in the initiation of disciplinary action.

6.3 Patients Not Requiring Admission

In cases where the Emergency Department physician consults with the on-call specialist and no admission is deemed necessary, the Emergency Department physician shall provide appropriate care/treatment and discharge the patient with arrangements made for follow-up care. The on-call specialist is responsible for providing a timely and appropriate outpatient follow-up evaluation for the patient following the Emergency Department visit. The timeframe of the follow-up visit shall be determined by the Emergency Department physician and the on-call specialist. If the Emergency Department physician and the on-call specialist are unable to agree upon the time for follow-up, the Emergency Department shall make that determination. Failure to comply may result in disciplinary action as determined by the MEC.

6.4 Unassigned Patients

Unassigned patients who present to the Emergency Department shall be referred to the specialist on-call that day.

6.5 Dispute Resolution

Disputes arising with regard to the interpretation of any of the requirements of this Rule 6 shall be referred to the appropriate Medical Staff Service Chair. As authorized by the Medical Staff Bylaws, the Medical Staff Service Chair may initiate an immediate corrective action investigation if an on-call physician fails to comply with the on-call requirements outlined above set forth in the MHS "Policy On Compliance with Emergency Medical Treatment and Active Labor (EMTALA)".

6.6 Corrective Action for Physicians Who Fail to meet On-Call Obligation

The following steps will take place upon validation:

a. 1st offense – letter to provider inviting provider to attend Medical Executive Committee to explain reasons for not being able to fulfill call obligations

b. 2nd offense - automatic suspension, up to 14 days, and a letter inviting the provider to attend the next Medical Executive Committee meeting.

c. 3rd offense – automatic 31-day suspension

d. 4th offense – revocation of medical staff privileges.

A provider subject to automatic suspension as outlined above is not entitled to procedural rights or a formal hearing.

ARTICLE VII

INFORMED CONSENT; TREATMENT REFUSAL; MEDICAL DECISION-MAKING

7.1 Informed Consent

7.1-1 Medical Staff Members shall comply with the MHS *Informed Consent and Patient Competency* policy and, except in an emergency, must not provide treatment or perform procedures on a patient who has not given informed consent (as evidenced by a signed general or special consent form or documentation by the Medical Staff Member in the patient's medical record).

7.1-2 Procedural Consent-The Medical Staff member performing the surgical or invasive procedures is responsible for obtaining and documenting informed consent from the patient or patient's legal representative prior to the procedure. This is a non-delegable duty under Washington law.

7.1-3 Informed consent must include, in a manner and language that the patient can be reasonably expected to understand, the following:

a. The proposed treatment and/or procedure to be performed and nature of the condition for which the procedure is to be performed
b. The anticipated benefits and serious possible risks and complications and;
c. Any alternative forms of treatment, including non-treatment.

7.1-4 Pre-Sedation, Pre-Anesthesia: An appropriately credentialed and privileged provider administering moderate or deep sedation must advise the patient of the anesthesia to be used and document the discussion leading to informed consent to anesthesia or moderate or deep sedation, except in an emergency.

ARTICLE VIII

MEDICAL RECORDS

8.1 Authentication of Entries

All clinical entries in the patient's medical record shall be accurately dated, timed, and legibly authenticated (signed) by the author.

8.2 Abbreviations and Symbols

Prohibited Abbreviations, Acronyms, and Symbols: The Medical Staff shall comply with the list of 'Do Not Use' abbreviations as currently required by The Joint Commission and listed in the MHS Policy, **ABBREVIATIONS-DO NOT USE.**

8.3 History and Physical Examination

Pursuant to the Medical Staff Bylaws a Practitioner holding Clinical Privileges at the Hospital must complete a patient history and physical examinations within thirty (30) days prior to admission and/or procedure, or within twenty-four (24) hours after admission. History and physical examinations completed prior to admission must be accompanied by either an updated physical exam documenting any changes to the patient's condition, or the Practitioner's written statement that he/she has examined the patient and that there have been no changes. Such history and physical examination or Practitioner's statement must be completed within twenty-four (24) hours after admission or prior to surgery.

8.3-1 **Pre-Operative History and Physical**

Except in an emergency, a history and physical examination shall be documented in the medical record prior to any procedure requiring more than local anesthesia for any patient undergoing surgery and/or any patient expected to be admitted after surgery. The surgical services leadership has the authority to cancel or delay the surgical procedure if the history and physical and H&P update (if applicable) is not available on the chart. In certain circumstances, the surgical services leader may permit the patient to be transferred to the Pre-Anesthesia area for performance of the history & physical.

8.4 Compliance with Documentation Guidelines

The minimal content of the history and physical for each patient must include: chief complaint, history of present illness, past medical and surgical history

(when applicable), documentation of review of medications and allergies, relevant physical examination, assessment, psycho/social history, immunization status for pediatric patients and plan for care. (If medication and/or allergy documentation is documented elsewhere in the patient's current encounter within Epic, they do not need to be documented in the history and physical).

For outpatient services related to minor scheduled treatments such as blood transfusions, therapeutic phlebotomies, medication administration, contrast administration, a complete H&P is not required, but orders with indications for the services must be documented in the medical record by the ordering physician.

8.5 Progress Notes

The Attending Physician, or his/her designee, shall record a daily progress note of each patient encounter on each of Attending Physician's hospitalized patients. Progress notes shall include justification for continued acute care hospitalization.

8.6 Operative/Procedure Reports

Operative/procedure reports shall be documented or dictated after surgery/procedure (within 24 hours) and the report promptly signed by the surgeon. Operative/procedure reports shall include:

1. Name of surgeon and assistant.
2. Name of procedure performed.
3. Description of procedure.
4. Pre and post-op diagnosis.
5. Findings and Complications.
6. Specimens removed.
7. Anesthesia administered.
8. Estimated blood loss.

8.7 Immediate Post-Operative/Procedure Notes

Prior to transition of care, at a minimum, an interval operative/procedure note is recorded in the progress notes, outlining the procedure performed. Operative/procedure notes shall include:

1. Name of primary surgeon and assistant.
2. Procedure performed.
3. Description of each finding.
4. Estimated blood loss.
5. Specimens removed.

6. Postoperative diagnosis.

8.8 Anesthesia Assessment

For all patients undergoing general, regional, or monitored anesthesia there shall be a pre-anesthesia assessment, an intraoperative anesthesia record, and a post-anesthesia note. The post-anesthesia note shall be completed within forty-eight (48) hours of the completion of anesthesia and prior to discharge home.

8.9 Consultations

A short summary of the consultation shall be entered into the medical record at the time of completion of the consultation.

8.10 **An Emergency Department** record shall be completed by the responsible Medical Staff Member within forty-eight (48) hours of patient discharge from the Emergency Department.

8.11 Obstetrical Record

The office prenatal record will suffice for an uncomplicated obstetric patient's history & physical as long as it is updated to include pertinent additions to the history and subsequent changes in physical findings at the time of admission. In the absence of a prenatal record, a complete history and physical must be documented. H&P's for healthy term newborns are to be documented on the newborn record.

8.12 Discharge Summaries

All discharge summaries shall be the responsibility of the Attending Physician or his/her designee.

a. **Content**: A discharge summary shall be documented or dictated upon the discharge or transfer of each hospitalized patient except as provided in subsection 8.13(b) below.

1. Reason for hospitalization;
2. Summary of hospital course, including significant clinical findings, the procedures performed, and treatment rendered;
3. Condition of the patient at discharge;
4. Discharge medications, referrals, follow-up appointments, and final diagnosis.
5. Discharge disposition.

b. **Short-term Stays**: For encounters with a stay of less than forty-eight (48) hours, including uncomplicated vaginal deliveries and normal newborns, a summation note containing all requirements for a history and physical examination and the discharge summary may be used.

c. **Death Summary**: A death summary is required on all patients who expired during their hospitalization. Death summaries and shall include:

1. Reason for admission;
2. Summary of hospital course;
3. Final diagnoses including cause of death.

d. **Timing**: A Discharge/Death Summary shall be entered in the medical record within five (5) days of discharge, transfer, or death.

8.13 Diagnostic Reports

Diagnostic reports (including but not limited to EKGs, echocardiograms, stress tests, Doppler studies, EEGs, pathology studies, pulmonary function tests, etc.) shall be read and documented by the physician scheduled to provide the interpretation in a timeframe determined by contract or by the appropriate clinical service. Diagnostic tests may be ordered as a stat read. Failure to provide prompt interpretation of diagnostic tests may result in removal from the reading list.

8.14 Access and Confidentiality

Medical records may be accessed for patient care per MHS policy.

8.15 Counter-Authentication (Endorsement)

8.15-1 Physician Assistants
The physician assistant shall identify in the record the supervising attending physician for each encounter. Each clinical event must be documented as soon as possible after its occurrence.

8.15-2 Nurse Practitioners
Except as otherwise delineated in clinical privileges, the nurse practitioner shall identify in the record the supervising attending physician for each encounter. Each clinical event must be documented as soon as possible after its occurrence.

8.15-3 Medical Students

a) 1st & 2nd Year- Access to view the patient chart only. May not document in the medical record.

b) 3rd & 4th Year- Any and all documentation must be endorsed and/or countersigned by the supervising attending physician. Medical students may not enter orders.

8.15-4 Residents and Fellows

Requirements for countersignatures will be established and monitored by specific training programs. Each clinical event must be documented as soon as possible after its occurrence. Appropriate monitoring must be taken by the respective training programs.

8.15-5 **Guidelines for Documentation to Support an Evaluation and Management (E&M) Billable Service Involving Participation by Medical Students**

Medical students are permitted to document services in the record; however, the teaching provider should follow CMS rules addressing the use the student's documentation for purposes of billing an E&M service. The teaching provider must verify and personally perform and re-document the physical examination and medical decision making. The teaching provider should not copy/paste or copy forward the physical examination or any medical decision-making activities from the student's documentation.

8.16 **Completion of Medical Records** – Medical Records, including discharge summaries, should be completed within twenty-one (21) days following discharge. Medical Records shall not be permanently filed until complete, except on the order of the Health Information Management Committee.

8.17 **Medical Record Deficiencies**– Providers are advised of, and can gain access to, incomplete medical records via the provider's in-basket within the electronic health record.

The Health Information Management Department will notify providers, in writing, of any medical records remaining incomplete sixteen (16) or more days following discharge. Any provider with medical records remaining incomplete over twenty-one (21) days will have his/her privileges suspended the following Wednesday. This is the only written notice the provider will receive.

The Health Information Management Department will notify the Chief of Staff and Medical Staff Services of those providers' subject to suspension each Wednesday.

If a vacation prevents a Medical Staff Member from completing his/her medical records the Member must notify the Health Information Management Department in advance of the vacation; otherwise the suspension will remain in effect until the delinquent medical record is completed. The Medical Staff Member must make every effort to complete his/her medical record deficiencies in advance of vacation.

If there are extenuating circumstances (defined as illness, extended absences) that prevent the practitioner from completing his/her medical records, the physician or the physician's office must notify the Health Information Management Department.

ARTICLE IX

ORDERS

9.1 General Information

9.1-1 A physician order is required to admit a patient, place a patient in observation, ambulatory status or to transfer a patient to another physician.

9.1-2 All orders must be entered and authenticated within forty-eight (48) hours. Admission orders must be authenticated prior to the patient being discharged.

9.1-3 Whenever possible, orders must be entered by the ordering provider directly into the electronic health record (EHR.)

9.1-4 If physicians or providers do not have the ability to access the EHR to input orders themselves, or if a delay in accepting the order could adversely affect patient care, telephone/verbal orders may be accepted by appropriate facility personnel see MHS ***ORDERS: WRITTEN, PRE-PRINTED, FAXED, VERBAL, TELEPHONED*** policy

9.1-5. All orders must be reviewed and continued or discontinued when a patient is transferred from one level of care to another (e.g., from the Emergency Department to an inpatient unit, to or from intensive care units, and/or pre and post-surgery). An order entered into Epic

will be continued until such time as the order is discontinued or modified.

9.2 Verbal and Telephone Orders

9.2-1 Verbal orders will only be accepted in situations that are potentially life threatening, that hasten medical care in an appropriate emergent condition, or during circumstances in which the provider is physically unable to write the order. A provider gives a verbal order in person to an authorized caregiver.

9.2-2 Verbal orders will NOT be accepted for Do Not Resuscitate, chemotherapy or complex medication regimes.

9.2-3 Telephone orders may be given in situations intended to eliminate patient discomfort, anxiety or hasten medical care.

9.2-4 All telephone orders should adhere to the following process:

a. The patient for whom the order is being provided will be identified. The provider and the individual qualified to receive the order will ensure that they have identified the same patient for the order by verbally repeating the name and confirming.

b. The order should be entered at the time received and then read back to the provider who will confirm the accuracy of the order.

c. When an order is received from other than the provider, document the name of the person relaying the order, the name of the provider and the signature of the individual receiving the order.

9.3 Medication Orders: Physician Responsibilities

a. Medication Orders will be entered per hospital policy.

9.4 Home Medications

a. A specific order is required for medications brought into the hospital by a patient.

b. Follow facility policies regarding Home Medications-MHS policy *Patient's Own Medications: Use and Storage*

9.5 Restraint Orders

a. All episodes of restraint will be in accordance with an order by a physician responsible for the care of the patient and authorized to order restraint or seclusion.

b. Orders may never be written as standing or PRN orders.

c. Physician must respond in appropriate time frames for assessments and renewals of restraints. *See MHS policy Restraint and Seclusion.*

9.6 Orders for Surgery

A physician order is needed to obtain a hospital consent for surgery. The order will state the specific procedure to be performed

9. 7 Stat Orders

"Stat" or "now" orders should only be used when the Medical Staff Member expects hospital personnel to discontinue all other tasks so that they may execute the order as soon as possible. "Stat" and "now" orders should be reserved for true emergency situations, and should not be used for the convenience of the practitioner. Inappropriate use of "stat" and "now" orders can result in disciplinary action from the MEC.

9.8 Do Not Attempt Resuscitation Orders

a. DNAR orders must be entered in the electronic medical record and authenticated by a Medical Staff Member. A properly documented no code/AND order must include the medical reasons for the order. Discussion with the patient's family or with the patient should be documented in the progress note.

b. All orders not to attempt resuscitation must be written by the physician providing care for the patient. Telephone orders are acceptable only if the attending physician is not readily available to write the order and it must be documented in EPIC by two Registered Nurses who both sign the order.

ARTICLE X

SURGERY and OTHER PROCEDURES USING ANESTHESIA OR MODERATE AND DEEP SEDATION

This Rule governs responsibilities of physicians performing invasive procedures anywhere in the Hospital including the O.R.

"Surgeon" in this chapter means the physician responsible for performing the invasive procedure.

10.1 Scheduling Physician Responsibilities

10.1-1 Elective Cases

a. Only the Surgeon or his/her office may schedule elective cases. The scheduling surgeon must specify the procedure and estimate the time required for the procedure.

b. The surgeon is expected to be available when the case is ready unless notice is provided.

10.1-2 Emergency Cases

a. Only the Surgeon or his/her office may schedule emergency cases.

b. Emergency cases take precedence over other procedures and are to be performed as soon as an OR is available.

- Emergency cases are accommodated either by "bumping" a scheduled case or by opening an additional operating room.

c. The surgeon should personally request the physician whose case is to be bumped to permit the change.

- Disputes as to priority or emergency will be adjudicated by Hospital Leadership.

10.2 Pre-Procedure Physician Responsibilities

10.2-2 Assessments

a. Pre-Operative Diagnosis – Prior to surgical procedures, the physician performing the procedure is responsible for:

1. Documenting the preoperative diagnosis in the medical record and
2. Reviewing any relevant results of lab studies, imaging and other diagnostic tests and H&P in the medical record.

b. Pre-Sedation Assessment – The physician with sedation privileges who orders moderate or deep sedation is responsible for:

1. Ensuring appropriate patient assessment immediately prior to sedation,
2. Co-signing an assessment performed by another,
3. Being present in the room during initiation of moderate or deep sedation administration.

c. Pre-Anesthesia Assessments must be in accordance with Anesthesiology Department policies and Article VIII of the Rules and Regulations.

10.2-3 Prior to the start of any invasive procedure, the MHS Policy, *Verification of Correct Patient, Procedure and/or Site/Side Pre-Procedure* will be followed.

10.3 Post-Procedure Physician Responsibilities

10.3-1 Surgical Specimens must be submitted to Pathology in accordance with MHS Policy *Pathology Specimen Management.*

10.3-2 Documentation

a. Comprehensive Post-Operative Progress Report – Documentation requirements are laid out in Chapter VIII of these Rules and Regulations.

b. Post-Operative Orders – The surgeon is responsible for documenting post-operative orders.

10.3-3 Post-Surgical Availability

a. A provider must remain in the facility and readily available until surgical patients are safely in the Recovery Room or directly admitted to an Intensive Care Unit.

ARTICLE XI

PATIENT DEATH AND DYING

11.1 In-Hospital Death

11.1-1 Notification of next of kin – The Attending Physician is responsible for notifying the family of a patient’s death. Social Services will assist in identifying and contacting the next of kin.

11.1-2 Death Certificate, Cause of Death – Except when the decedent’s body has been referred to the County Medical Examiner, the attending physician who, for purposes of this Rule, is any Physician (including in the ER and Critical Care Units) who actively treated or cared for the patient or who was in charge of the Patient’s care for the illness or condition that resulted in death, shall complete and sign the medical certification of a cause of death within 72 hours of the death. The attending physician must write “pending further examination” when unable to certify cause of death due to pathology report delay.

11.2 Organ Procurement

When death is imminent, physicians should assist the Hospital in making a referral to its designated organ procurement organization before a potential donor is removed from a ventilator and while the potential organs are still viable.

11.3 Autopsy

It is the duty of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medico legal or educational interest. A provisional anatomic diagnosis shall be recorded on the medical record within three (3) days, and the complete autopsy report shall be made part of the medical record within thirty (30) days unless an explanatory note is entered.

ARTICLE XII

DISCLOSURE OF UNANTICIPATED OUTCOMES TO PATIENTS/FAMILIES

12.1 Disclosure of Unanticipated Outcomes to Patients/Families.

Medical Staff members are responsible for disclosure of unanticipated adverse events in accordance with MHS policy.

ARTICLE XIII

MEDICAL & CLINICAL EDUCATION

13.1 Supervision

All Residents and Fellows work under supervision. The Resident staff work under increasing levels of responsibility outlined by their Residency program. The Residency Program and/or Supervising Physician is responsible for providing information to MultiCare regarding Resident Physicians functioning in the hospital.

13.2 Assignment

Fellows, Residents, and Medical Students may be assigned to the Hospital and its Staff for training and they may attend patients pursuant to the provisions of approved affiliation agreements. The precise definition of such educational programs shall be set forth in written form by each affected service and each service shall be responsible for participants in its approved program. Residents will be licensed Physicians, as appropriate.

13.3 Notification to Patients of Residents Involvement in Care

Patients will be notified at admission that this is a teaching hospital and that trainees under the supervision of a Staff Preceptor/Attending Physician may render portions of their care. If they decline same, this must be discussed between patient and Attending Physician with resolution prior to Resident and Medical Student care.

13.4 Privileges

Residents from an accredited ACGME or AOA institution shall require no specific privileging if their practice is to remain within their scope and their Residency area of specialty. All Residents shall have a written description of each rotation experience, goals and objectives.

13.5 Preceptors

Medical Staff Members must notify the MultiCare's GME Office of all students they are supervising. Medical students, residents and fellows will be under the supervision of a Preceptor and/or Attending Physician at all times. Preceptor is defined as the Physician who has undertaken to supervise the trainee. Attending is defined as the Physician primarily responsible for the patient from the beginning of the hospital episode. The same Physician may be both the Preceptor and the Attending Physician. The Attending Physician shall be ultimately responsible for all aspects of patient care. All patient care administered by the Medical students, residents and fellows shall be coordinated with the Preceptor and/or Attending Physician. The Preceptor and/or Attending Physician may supervise within their delineated clinical privileges. When a Resident contacts a Preceptor and/or Attending Physician and requests his or her presence to help manage a patient, the Preceptor and/or Attending Physician will respond to this request in an appropriate fashion.

13.6 Care of Patients and Entry in the Medical Record

All patients must be seen at least on a daily basis and that visit recorded in the Medical Record. If the Preceptor and/or Attending Physician are the Primary Physician, then entry of that daily visit by the Preceptor is expected. If the Preceptor and/or Attending Physician are a consultant only on the case, then each visit, daily or not, shall be entered. Progress notes and orders completed by Fellows do not need to be countersigned.

13.7 Ability to Perform Procedures

The Preceptor and/or Attending Physician shall determine the competency of the Resident in specific procedures, within the scope of training of the Resident. Each Service should specify those procedures that require another Surgeon to act as First Assistant, in which case the Resident may act as Second Assistant. The competency of the Resident to first assist on any surgical procedure shall be determined by the Preceptor and/or Attending Physician and be within the scope of training of the Resident. Trainees may participate in deliveries and cesarean sections at the discretion and under the supervision of the Preceptor and/or Attending Physician. Participation of Trainees (with any level of training) in surgery or performing invasive procedures (including first assistant in surgery) will be at the discretion of the Surgeon. Induction of Anesthesia for surgical or obstetrical procedures should not, in general, be initiated prior to the arrival of the Preceptor and/or Attending Physician. Exceptions to this general policy may be made via direct contact between the Attending Physician and the Anesthesiologist.

13.8 Authority

Patients may be admitted or transferred to a Critical Care Unit by a Resident under the supervision of the Preceptor and/or Attending Physician if the Preceptor is appropriately privileged to provide services in the critical care units. Alternately, an Attending Physician with clinical privileges adequate to provide intensive care services who has agreed to attend the patient may either assume full care or assume responsibilities as Preceptor for the Resident. Medical care within critical care units may only be provided by Residents in conjunction with an appropriately privileged Preceptor and/or Attending Physician. Specifics of care of individual patients will be closely coordinated with the appropriately privileged Preceptor and/or Attending Physician in all circumstances. Nursing staff will carry out Resident and Fellow patient orders. If there is a question on appropriateness of any order or procedure to be performed on the unit, Hospital personnel will verify the order with the Resident/Fellow then, if indicated, directly contact the Preceptor and/or Attending Physician to verify the treatment plan.

13.9 Medical Records

When Residents and Students are actively involved in the care of patients and are making entries in the Medical Record, the Attending Physician should be recording evidence of active participation in supervision of the Resident's and/or Student's patient care in the Medical Record. With the consent of the Attending Physician, Residents may dictate histories and Physicals, discharge summaries, and operative reports. The Preceptor and/or Attending Physician shall co-sign all Resident orders to admit to the hospital for admission and observation care. Completion of the Medical Record is ultimately the responsibility of the Attending Physician. The Residency Director will act as an intermediary to resolve any issues of records delinquency by a Resident.

ARTICLE XIV

14.1 Services

The Medical Staff of Good Samaritan Hospital shall be comprised of the following Services and corresponding Service Committees, if appropriate:

a. Adult Medical Services
b. Anesthesia Services
c. Credentialing Committee

d. Emergency Services
e. Medical Imaging Services
f. Obstetrics and Gynecology Services
g. Pediatric Services
h. Surgical Services
   - Orthopedic Surgical Subcommittee

14.2 Service Committee Composition and Officers

14.2-1 Each Medical Staff Service shall have a standing committee. The composition of each Service Committee shall be as follows

a. Adult Medical Services. The Committee shall be made up of physician representation from Family Practice, Internal Medicine, Medical Specialties, (i.e. Cardiology, Gastroenterology, Pulmonology, Oncology), Hospitalist, Intensive Care. Additional membership includes MHS representation from nursing, laboratory, respiratory therapy, imaging, pharmacy, clinical informatics and administration.

b. Anesthesia and Sedation Services. The Committee shall be made up of physician representation from Anesthesia. Additional membership may include MHS representatives from nursing, laboratory, respiratory therapy, pharmacy, clinical informatics and administration.

c. Credentialing Committee. The Committee shall be made up of

d. Emergency Services. The Committee shall be made up of physician representation from Emergency Medicine. Additional membership may include MHS representatives from nursing, laboratory, respiratory therapy, pharmacy, clinical informatics and administration.

e. Medical Imaging Services. The Committee shall be made up physician representation from Radiology,. Additional membership includes MHS representation from nursing, laboratory, imaging, pharmacy, clinical informatics and administration.

f. Obstetrics/Gynecology Services. The Committee shall be made up of physician representation from Anesthesia, Family Practice, Obstetrics. Additional membership will include MHS representatives from nursing, laboratory, respiratory therapy, pharmacy, clinical informatics and administration.

g. **Pediatric Medicine Services.** This Committee shall be comprised of: physician representation from Pediatric Medicine, Pediatric Specialties (i.e. Gastroenterology, Cardiology, Neurology, Pulmonology, Oncology), Pediatric Intensivist, Hospitalist, Family Practice, Emergency Medicine, Pathology, and Radiology. Additional members include MHS representation from nursing, laboratory, respiratory therapy, imaging, pharmacy, clinical informatics and administration.

h. **Surgical Services.** The Committee shall be made up of physician representation from Anesthesia, Adult and Pediatric Surgical Specialties (i.e. Cardiac, ENT, General, Gynecology, Neuro, Ophthalmology, Orthopedics, Urology, Vascular). Additional members include MHS representatives from nursing, laboratory, imaging, pharmacy, clinical informatics and administration. A subcommittee of Orthopedics will meet separately.

14.2.2 Officers of the Committee shall include a Chair and Chair-elect. The term of office for the Chair and Chair-elect shall be two calendar years.

14.2-3 If the Chair is unable to complete his/her term, the Chair-elect shall assume the role of Chair and the Committee shall elect a new Chair-elect who shall serve for the remainder of the term.

14.3 Procedures for Selecting Service Committee Officers

14.3-1 Each Service Committee shall nominate at least one person meeting the qualifications for the Chair-elect for the next term.

14.3-2 Each Service Committee shall elect a new Chair-elect by October of each new term. The approved slate shall go to the Governing Body for approval.

14.4 Responsibilities of Service Committees

14.4-1 Each Service Committee and its Officers shall be responsible for:

a. Oversight, assessment and improvement of the quality of clinical care provided by and professional performance of Members assigned to the Service.

b. Oversight of the administrative activities of the Service.

c. Integrating the activities of the Service with the other Services and committees to maintain and improve the quality of care of MHS patients.

d. Developing and implementing policies and procedures that guide and support the provision of care in the Service.

e. Recommending qualified and competent practitioners through the privileging process to provide care in the Service.

f. Delineating the privileges and the criteria for granting such privileges in the Service.

g. Participate in quality control and improvement programs, as appropriate and in coordination with the MHS Performance Improvement Plan.

h. Making recommendations regarding space and other resources needed by the Service.

i. Making recommendations to the relevant hospital authority with respect to off-site resources needed for patient care services not provided by the Service or MHS.

j. Providing representation on Service sub-committees and ad hoc committees.

k. Maintaining and distributing Service Committee minutes.

l. Providing representation by Chair (or in his/her absence, Chair-elect) on the Medical Executive Committee.

m. Performing such additional responsibilities as may be delegated by the Medical Executive Committee, Chief of Staff or the President of the Medical Staff.

n. Service Committees shall meet at least quarterly per year or as defined by the Committee.

ARTICLE XV

PARTICPATION IN ORGANIZED HEALTH CARE ARRANGEMENT (OHCA)

Purpose: In order to provide quality patient care in a clinically integrated setting, MHS (including its employed professional staff) and independent Practitioners, AHPs and other health care professionals providing services at the Hospital (collectively, “OHCA Participants”) are required to share protected health information for treatment purposes, as well as for a broad range of activities that support and improve their healthcare operations, including without limitation, payment and billing functions, quality improvement initiatives and operations management and planning. The OHCA described herein has been declared and established, in accordance with the HIPAA "Standards for Privacy of Individually Identifiable Health Information" ("Privacy Rules), 45 C.F.R. Subtitle A, Subchapter C, Parts 160 and 164, and for the purpose of better serving MHS patients and facilitating the exchange of “protected health information” among MHS, Practitioners, AHPs and other health care professionals providing care at the Hospital.

Terms of OHCA Participation: In accordance with the obligations arising under the Bylaws and these Rules, the OHCA Participants shall participate in the OHCA described herein on the terms set forth in the Bylaws and as set forth below.

a. Pursuant to the Privacy Rules, MHS has developed a notice of privacy practices that will be distributed to or made available to the OHCA Participants in accordance with applicable MHS policies (“Privacy Notice”) that provides MHS patients with information about the uses and disclosures of patient “Protected Health Information” or “PHI” at MHS. The Privacy Notice indicates to patients that, among other things (i) MHS and the OHCA Participants participate in an OHCA in a clinically integrated setting at the Hospital, and (ii) MHS and the OHCA Participants will share PHI as necessary to carry out treatment, payment and operations relating to the OHCA in accordance with the Privacy Rules. The Privacy Notice, along with the OHCA described herein, shall become effective on the Privacy Rules compliance deadline of April 14, 2003.

b. The Privacy Notice includes a “joint notice” provision that generally describes the class of separate covered entities to which the Privacy Notice applies for health care delivered at MHS facilities, which class includes the OHCA Participants. MHS and OHCA Participants acknowledge and agree to abide by the terms of the Privacy Notice in connection with the use and disclosure of PHI related to care or other services provided at the Hospital. Through the execution of the appointment and reappointment application form, OHCA Participants agree with MHS to abide by the terms of the Privacy Notice, as it may be revised from time to time by MHS in accordance with these Rules, with respect to PHI created or received by either of them as part of their participation in the OHCA described herein.

c. MHS may from time to time (prior to and following the Privacy Rules compliance revisions to the Privacy Notice in accordance with applicable MHS policies and such revisions shall be binding on OHCA Participants without further action by MHS or any OHCA Participant.

d. An OHCA Participant's participation in the OHCA described herein shall terminate automatically to the extent that an OHCA Participant's Privileges at the Hospital are terminated or suspended. Except as described below, no OHCA Participant shall be entitled to voluntarily withdraw from the OHCA described herein while maintaining Privileges at the Hospital. MHS, by amendment to the Bylaws and Rules, reserves the right in its sole discretion to withdraw from and terminate the OHCA described herein.

e. The OHCA described herein has been established for the sole and limited purpose of meeting the OHCA requirements set forth in the Privacy Rules. OHCA Participants shall exercise medical judgment free of any direction or control by MHS within the areas of such participant's professional competence and the limits established by the Bylaws, and the terms of any employment relationship between MHS and an OHCA Participant or other agreement between an OHCA Participant and MHS. The OHCA described herein shall not be construed to (i) constitute MHS or any independent OHCA Participant as partners, joint ventures, co-owners or otherwise as participants in a joint or common undertaking of any kind whatsoever, or (ii) allow either party to create or assume any obligation on behalf of the other party for any purpose whatsoever. To this end, OHCA Participants shall not be permitted to act on behalf of MHS with respect to MHS' compliance obligations under the Privacy Rules or any other similar law or regulation, including without limitation, the right to (i) agree to restrictions regarding the use PHI or agree to amend PHI or records about an individual maintained by MHS.

f. OHCA Participants shall be responsible for their respective compliance obligations under the Privacy Rules, the HIPAA "Administrative Simplification" regulations or any other applicable law or regulation, including without limitation the obligation to prepare and use, if applicable, separate notices of privacy practices for medical practices in offices or facilities separate from MHS. Other than as to the limited responsibilities as participants in the OHCA described herein, neither MHS nor any OHCA Participant is undertaking any responsibility whatsoever in relation to compliance obligations of any other covered entity or OHCA Participant under the Privacy Rules or other HIPAA Administrative Simplification regulations.

g. In accordance with the definition of “business associate” found in 45 C.F.R. § 103 of the Privacy Rules, no participant in the OHCA described herein shall become a “business associate” of any other OHCA participant solely through the performance of any function or activity described in such definition on behalf of the OHCA described herein.

h. MHS and OHCA Participants shall comply with all applicable laws, and regulations, including without limitation, state and federal laws and regulations related to health information privacy, security, confidentiality, consent, access and disclosure, including the Privacy Rules and Washington Uniform Health Information Act, RCW Chapter. 70.02.

ARTICLE XVI

CONFILCT BETWEEN RULES AND BYLAWS

In the event of a conflict between the Medical Staff Bylaws and the Rules, the Bylaws shall prevail.

ARTICLE XVII

17.1 Adoption and Amendment

These Rules may be adopted, amended or repealed upon a recommendation and approval of the Medical Executive Committee and approval of the Governing Body. Further, in recognition of the ultimate legal and fiduciary responsibility of the Governing Body, the organized Medical Staff acknowledges, in the event the Staff unreasonably fails to exercise its responsibility and after notice from the Governing Body to such effect, including a reasonable period of time for response, the Governing Body may impose conditions on the Medical Staff that are required for continued State licensure, approval by accrediting bodies or to comply with a court judgment. In such event, the Governing Body in its actions shall carefully consider Medical Staff recommendations and views.

17.2 Technical and Editorial Amendments

The Medical Executive Committee shall have the power to adopt such amendments to the Rules as are, in its judgment, technical modifications or clarifications, reorganization or renumbering of the Rules, or amendments made necessary because of punctuation, spelling, or other errors of grammar or expression, or inaccurate cross- references. Such amendments shall be effective immediately and shall be permanent if not disapproved by the Medical Executive Committee or the Governing Body.

17.3 Approval

These Rules of the Medical Staff of Good Samaritan Hospital were approved by the Governing Body on pursuant to Medical Staff recommendations based on affirmative vote of the Medical Executive Committee, to be effective December 2017 in full substitution and replacement for any and all previous Rules of Good Samaritan Hospital Medical Staff.