

MERCYONE CEDAR FALLS MEDICAL CENTER
RULES AND REGULATIONS OF THE MEDICAL STAFF

Approved February 2, 2023

GENERAL:

1. A patient may be admitted to the Hospital by a Physician member of the Medical Staff or an advance practice provider in the Hospitalist or Psychiatry departments.
2. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis for admission has been stated. In the case of an emergency, such statement shall be recorded within twenty-four (24) hours of admission.
3. Providers admitting private patients shall be responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger from any cause whatever, or to assure protection of the patient from self-harm.
4. A member of the Medical or Allied Health Staff shall be responsible for:
 - a. The medical care and treatment of each patient in the Hospital.
 - b. The prompt completeness and accuracy of the medical record.
 - c. Necessary special instructions.
 - d. Transmitting reports of the condition of the patient to the referring Medical or Allied Health Staff Member and to relatives of the patient subject to authorization of the patient.
 - 1) Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered into the medical record.
5. Physician Definitions
 - a. The PRIMARY/ATTENDING provider will be responsible for all aspects of management of patient care including designating the lines of responsibility and communicating with providers, patient and family. The PRIMARY/ATTENDING provider is to be informed of changes in the patient status and results of medical interventions.
 - b. The ADMITTING provider shall designate the PRIMARY/ATTENDING provider in the admitting orders.
 - c. The CONSULTANT is that physician called in on a case to give professional advice.
 - d. The PERSONAL physician is the physician regularly called by the family to care for the patient in times of medical need. The PERSONAL/PRIVATE physician, who has hospital privileges, may write orders for care as appropriate.
 - e. The ADMITTING provider can be the PERSONAL, ATTENDING/PRIMARY physician or the CONSULTANT.

6. Prior to admission, the Emergency Department Physician (EDP) will consult with the patient's private physician. If the patient has no private physician, a staff physician will be obtained according to the physician on-call schedule.
 - a. Admission provider orders should be entered by the patient's admitting provider in the medical record
 - b. Provisional orders may be entered by the EDP upon agreement between the EDP and admitting physician.
 - c. After a patient is admitted to the hospital, patient care becomes the responsibility of the attending physician.
7. The attending staff member is required to document a plan of care, which supports the medical necessity of admission and continued stay. This documentation must contain:
 - a. An adequate record of the reason for admission and continued hospitalization;
 - b. The clinical goals/outcomes and treatment plan;
 - c. Plans for post-hospitalization
 - d. The estimated period of time the patient will remain in the Hospital

Upon request of the Utilization Management Committee, the attending practitioner must document justification of the necessity for continued hospitalization, including an estimate of the number of additional days of stay and the reason therefore.

8. A general treatment consent form, signed by or on behalf of every patient admitted to the hospital will be obtained at the time of admission.
9. A staff member's power plan, when applicable to a given patient, shall be selected in the patient's record. A staff member's admission laboratory and X-ray orders will be individually selected and dependent on the clinical diagnostic and therapeutic needs of each patient.

Providers may use individual standing orders, which may be implemented based on the practitioner's verbal authorization. All standing orders must be authenticated on a case-by-case basis. All standing orders will be reviewed on a periodic basis, revised as appropriate and authenticated as to the correctness by the practitioner.

Standing orders are authorized on a unit-specific basis. These orders must be approved in advance by the unit's Medical Director and/or Medical Staff committee/department responsible for the unit. Specific reference by the practitioner to the initiation of these standing orders is required.

10. If a physician will be unavailable because of planned absence, he/she will notify the hospital of the physician designated to provide coverage for his/her patients. In the case of

group physicians in practice together who provide a call schedule to the hospital, it shall be understood that the partner listed as “on call” shall be the covering physician in the absence of any such notification as specified above.

- a. In case of failure to name such member, the President of the Medical Staff or Department Chairperson or Hospital President shall have the authority to call any member of the staff.
 - b. Failure to comply with these provisions shall be considered a serious breach and may be condition for corrective action.
11. Patients who have attempted suicide or taken an overdose will be offered psychiatric consultation by the attending provider, and this fact noted on the chart.
 12. Pertinent progress notes shall be recorded daily by a physician, nurse practitioner, or physician assistant. Orders shall be entered into the medical record by the practitioner. Whenever possible, each of the patient’s clinical problems shall be clearly identified in the progress notes with specific orders as well as the results of tests and treatments. For all patients in the acute care hospital, except the Senior Behavioral Health Unit, progress notes shall be documented at least daily, more frequently if indicated, in critically ill patients, especially if there is difficulty in diagnosis or treatment. The scope of services provided in the Senior Behavioral Health Unit is focused in nature and coordinated by the Medical Director. If patients are clinically stable, a visit by the Psychiatrist is necessary five days per week, more frequent if the patient condition warrants.
 13. A multiple trauma patient admitted through the Emergency Room must have a general surgeon as the coordinator of care.
 14. There shall be an automatic stop order on Schedule II drugs including narcotics and antibiotics for five days, unless physician orders a course of treatment for a specific length of time.
 15. If a staff nurse has reason to question the medical care provided to a patient, he/she should contact his/her immediate supervisor.
 - a. The immediate supervisor shall notify the Director of Patient Services or House Supervisor.
 - b. The Director of Patient Services or House Supervisor shall contact the provider or direct the nurse to contact the provider.
 - c. If, following the discussion with the practitioner, a question still persists, the Director of Patient Services or the House Supervisor shall call the Medical Director/Medical Advisor/Department Chair of the Unit/Area concerned.
 - d. If unable to contact the Medical Director/Medical Advisor/Department Chair, or if a question still persists, the Director of Patient Services or designee shall be notified and shall decide whether or not the President of the Medical Staff or his (or her) alternate should be contacted.
 - e. If the Director of Patient Services or designee are unable to contact the Medical Staff President, or the issue is not resolved, he or she shall immediately notify the President of the Hospital or the Administrative Officer on call.
 16. All patients admitted to the ICU shall be visited within four hours by their attending physician.

MEDICAL RECORDS:

1. Release of Records: Written consent of the patient or in the case of a minor, a parent or legal guardian, is required for release of medical information to persons not otherwise authorized to receive this information.

Iowa law permits a minor to make personal applications for substance abuse treatment, and this fact may not be disclosed to a parent or legal guardian without the minor's consent. The federal regulations provide that where a state has a law that authorizes drug or alcohol abuse treatments to minors without parental consent, then the consent of the minor is all that is needed for disclosure of information

Any person 18 years or older or the person's legal representative may consent to disclosure of mental health information by signing a voluntary written authorization.

2. Treatment Consent: A general treatment consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission, except in those situations wherein the patient's life or limb is in jeopardy and authorization cannot be obtained due to the condition of the patient. The reason for not obtaining the consent must be documented.
3. Surgical Consent: Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life or limb is in jeopardy, or permanent injury will occur, and authorization cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from patient, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.
4. All Medical records and X-ray films are the property of the Hospital and shall not be removed from the premises of MercyOne Cedar Falls Medical Center except by court order, subpoena, or statute, or pursuant to policies approved by the Medical Staff and Hospital Administration. In case of re-admission of a patient, all previous records shall be available for the use of the attending Medical Staff member. This shall apply whether the patient is attended by the same Medical Staff member or by another. Unauthorized removal of the charts from the Hospital is grounds for suspension of the Medical Staff member for a period to be determined by the Executive Committee of the Medical Staff.
5. All documentation in the medical record must be in electronic format. Practitioners are encouraged to use Pownotes/Dynamic Documentation or Dragon voice recognition. An exception to this rule occurs during system downtimes. Practitioners should follow downtime protocols during planned or unplanned periods of downtime
6. The appropriate member of the medical/allied staff shall be responsible for the preparation of a complete medical record for each inpatient. The record content shall be pertinent and current. All entries in the medical record must be authenticated. At a minimum, the record shall include:
 - a. identification data
 - b. chief complaint
 - c. history of present illness
 - d. review of systems

- e. complete personal, social, past and family history
- f. review or symptoms
- g. physical examination
- h. provisional diagnosis
- i. reports of consultations
- j. clinical laboratory, imaging, and other diagnostic results
- k. any medical or surgical treatment
- l. operative report
- m. pathological findings
- n. progress notes
- o. final diagnosis
- p. condition on discharge
- q. allergies
- r. current medications
- s. discharge note/clinical resume including:
 - i. the reason for admit
 - ii. pertinent findings
 - iii. interventions relative to the findings
 - iv. condition on discharge
 - v. instructions to the patient and/or family, particularly in regards to activity, medication, diet, and post-hospitalization care
 - vi. autopsy report, when performed

7. Rules regarding Histories & Physicals:

- a. The medical history & physical exam must be completed no more than 30 days before or 24 hours after admission for each patient, but prior to surgery, an invasive procedure or moderate/conscious sedation. When the medical history and physical exam is completed within 30 days before admission, an updated medical record entry documenting an examination for any changes in the patient's condition must be completed and documented in the patient's medical record within 24 hours after admission, but before surgery or applicable procedure. It is the responsibility of the anesthesiologist or the physician administering the sedation to complete the update within 24 hours after admission, but before surgery or applicable procedure. *Exception: A history and physical is not required for mental health observation.*
- b. A current history and physical exam must be in the patient's medical record prior to surgery or the surgical procedure shall be cancelled, unless the attending practitioner states in writing that such a delay would be detrimental to the patient.
- c. The history and physical needs to be completed in the standard hospital format, as approved by the Executive Committee as follows:
 - Chief Complaint
 - History (detail) of present illness
 - Past Medical History (include current medications and allergies)
 - Family and Social History (if relevant)
 - Physical Exam to include: General Exam, Vital Signs, HEENT, Heart, Lungs, Chest, Abdomen, Extremities, Neurological, and any other exam deemed relevant.
 - Initial Impression / Reason for Admission
 - Plan for Treatment

- d. For procedures involving conscious sedation, and for which present a moderate risk to the health and safety of the patient (Example: endoscopy) a condensed version of the history and physical examination may be used as an acceptable alternative to the full history and physical. The condensed version needs to contain:
 - Procedure to be performed
 - Pre-Operative Diagnosis
 - History Pertinent to Procedure
 - Physical Assessment (at least heart and lung)
- di. Completed by Appropriate Physician: History and physical exams may be performed by physicians (MD/DO), physician assistants or nurse practitioners. The history and physical exams of physician assistants must be cosigned by the supervising physician.
- dii. If a Practitioner (see item e) who is not a current member of the Medical/AHP Staff completes an H&P Exam, the license of the Practitioner shall be verified with the state licensing board to be Active.

8. **Completion of Medical Record:**

Quality patient care requires that all medical records be completed in a timely fashion, in accordance with applicable law, regulations and standards.

- a. Practitioners will be subject to the following procedure regarding delinquent medical records:
 1. Operative Reports must be completed within the timeframe specified in the Surgery section, item 10.
 2. Discharge summaries must be completed within 48 hours after discharge. If not completed within 48 hours, the practitioner's privileges will be automatically suspended if such records are not completed within two (2) days of the notification from Health Information Management.
 3. If the record(s) identified in the notice of delinquency are not completed within thirty (30) days of discharge, a notice of automatic suspension will be sent to the Practitioner, suspending the Practitioner's clinical privileges until such time as the delinquent records have been completed. A copy of this notice will be placed in the Practitioner's Professional File. Such suspension shall be effective as of the date of mailing. A suspension for delinquent medical records does not require reporting to the National Practitioner Data Bank or entitle the affected Practitioner to any of the hearing and appeal rights otherwise afforded under the Medical Staff Bylaws. Reactivation of the suspended clinical privileges will require completion of the medical record(s).
 4. A list of Practitioners with delinquent medical records may be posted in the Health Information Management department, with copies distributed to the Vice President of Medical Affairs, the appropriate department chair, and the manager of the Health Information Management department.
 5. At the discretion of Hospital, flexibility may be provided for

illnesses of seven (7) days' duration or longer, or for other extenuating circumstances. Physicians should provide seven (7) days' prior notification to the Health Information Management department of any such circumstances.

- b. During an automatic suspension for delinquent medical records, a Practitioner may continue with the medical care of: (i) emergency and obstetric admissions; and (ii) any patients who were under his or her care in the hospital at the time of the suspension.
 - c. If a practitioner has been suspended for delinquent medical records three (3) occurrences in any 12 consecutive months, or if one (1) suspension for delinquent medical records lasts longer than ninety (90) days, a \$500 (five hundred) dollar fine will be imposed upon the Practitioner. Reactivation of suspended Medical Staff Clinical Privileges will be arranged and conducted during normal HIM business hours after:
 1. Verification of completion of the delinquent medical record(s), and
 2. Receipt of payment of the fine by the HIM department, and the practitioner appears before the Executive Committee for consideration of additional disciplinary action, to include possible dismissal from the Medical Staff. If the Practitioner is dismissed from the Medical Staff on this basis, s/he must apply and be processed as a new applicant for initial membership and privileges in order to re-join the medical Staff.
6. All clinical entries in the patient's record shall be authenticated by the physician, nurse practitioner, or physician assistant who authorized the entry. No one shall authenticate entries in the patient's medical record on behalf of someone else.
 7. The Medical Staff Executive Committee has approved the use of abbreviations and symbols in accordance with the MercyOne Northeast Iowa Abbreviations and Symbols Policy and Procedure. Unapproved symbols and abbreviations should not be used in the medical record.
 8. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, authenticated by the responsible physician, nurse practitioner, or physician assistant at the time of discharge of all patients. Final diagnoses must be recorded in the final progress notes or discharge summary. Providers shall work in cooperation with Health Information Management personnel to ensure timely and accurate documentation and sequencing of final diagnoses and procedures.
 9. A discharge summary shall be documented upon discharge for all inpatients, all psychiatric patients, and observation patients that are in the hospital more than 48 hours. The discharge summary must be recorded within 48 hours from the day of patient discharge. Discharge instructions will be provided to the patient prior to discharge from the hospital.
 - a. The discharge summary should summarize the reason for hospitalization, significant findings, procedures performed, treatment rendered, the outcome of hospitalization, the condition of the patient on discharge, and any specific instructions given to the patient and/or family (i.e. activity, medications, diet, the disposition of the case, instructions for post hospital care.) The content of the summary shall be sufficient to justify the diagnosis and warrant the

treatment and the end result.

Patients will receive discharge instructions prior to discharge. Patients shall be discharged only with an order by the attending provider or his/ her nurse practitioner, or physician assistant. Should a patient leave the Hospital against the advice of the attending, and without proper discharge procedure, a notation of the incident shall be made in the patient's medical record. Refer to the Discharge of Patient policy, or its current replacement policy, for additional information regarding the discharge process and for discharge against medical advice (AMA).

10. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study, research, and review consistent with preserving the confidentiality of personal information concerning the individual patients.
 - a. The Chief of Staff/President of the Medical Staff, the Chief Medical Officer and the manager of Health Information Management shall approve all requests.
 - b. Former members of the Medical Staff shall be permitted access to the medical records of their patients.
 - c. Requests for such access to records shall be specified in writing for each individual case and authorized by the Chief Medical Officer, or designee, on the former member's request.
11. All orders for treatment shall be entered into the electronic medical record by the practitioner. Computerized practitioner order entry (CPOE) rate of compliance will be considered at reappointment.
12. All verbal orders shall be signed by the person to whom dictated, with the name of the physician, nurse practitioner, or physician assistant, per his/her own name. The individual who verbalized the order shall authenticate such orders within 30 days of patient discharge. *See also Medical Staff "Verbal & Telephone Orders" policy*
 - a. The following people may accept/transcribe telephone/verbal orders:
 - 1) Registered Nurse
 - 2) LPN's
 - 3) Unit Secretaries/Unit Assistants may accept/transcribe telephone/verbal orders with the exception of orders for IV's, blood products, code status or medications.
 - b. The following people may accept telephone/verbal orders as they relate to their respective specialty:
 - 1) Licensed Pharmacists
 - 2) Clinical Psychologists
 - 3) Certified or Registered Medical Technologists
 - 4) Credentialed Cardiopulmonary Services personnel
 - 5) Certified or Registered Respiratory Therapists
 - 6) Licensed Physical Therapists
 - 7) Registered Speech Pathologists
 - 8) Registered Radiology Technicians
 - 9) Medical Social Service Workers
 - 10) Registered Dieticians
 - 11) Registered Recreational Therapists
 - 12) Registered Occupational Therapists

13. Hospital approved Residents are authorized to write orders on patients hospitalized and

assigned to their care. While each order need not be countersigned, there shall be sufficient documentation to demonstrate the supervision of the patient's care by a Medical Staff member. Exception: All orders in the ICU need to be countersigned.

14. Cancellation of Orders When Patients go to Surgery:
 - a. A change in code status during the perioperative period will be consistent with the Cardiopulmonary Resuscitation Policy and Procedure.
 - b. For all other orders, previous orders are cancelled when the patient goes to surgery with the exception of minor procedures done under local anesthesia. Orders that take effect postoperatively will not be cancelled.
15. Physicians providing temporary or locum coverage must have records completed within the timeframes above and must have all records complete and signed before the end of their current assignment.

According to The Joint Commission, medical records must be completed within 30 days of a patient's discharge.

CONSULTATION:

1. The practitioner requesting a consultation should not rely on the electronic medical record for communicating the request for consultation.
2. 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. A full report should be entered into the record soon after the consultation but within 24 hours and prior to an operative procedure.
3. The consultant may be a nurse practitioner or physician assistant. The provider who requests the consult may require that the consult be completed by a physician.
4. STAT consultations require direct peer-to-peer communication at the time of the consultation request and again after the consultant has seen the patient to provide his/her recommendations. Routine consultations require evaluation by the consultant within twenty-four (24) hours of the consultation request.
See also "Provider to Provider Communication" policy
5. The specific reason for the consultation must be documented in the medical record at the time of the consultation.
6. All orders for consultations must specify the name of the group and/or practitioner being requested to do the consult.
7. Consultation Guidelines: The following circumstances require consultation:
 - A. When the patient is not a good risk for operation or treatment;
 - B. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - C. Any procedure for which the Attending of Record does not have privileges;
 - D. Where there is doubt as to the choices of therapeutic measures to be utilized;
 - E. In unusually complicated situations where specific skills of other Practitioners may be needed;
 - F. In instances in which the patient exhibits behavior suggesting harm to self or others;

- G. When requested by the patient or patient's family, as deemed appropriate by the Attending physician.

AUTOPSIES:

1. Each member of the Medical Staff shall be actively interested in securing autopsies whenever possible.
 - a. None shall be performed without written consent of a responsible relative, except by order of the Medical Examiner.
 - b. Hospital Pathologists, or state or local Medical Examiners shall perform autopsies.
2. The provider requesting an autopsy shall enter the order in the chart and is responsible for obtaining the necessary permission.

SURGERY:

1. The following rules shall apply to surgical patients:
 - a. There will be no automatic pre-op labs, X-rays, or EKG's ordered.
 - b. The patient can be seen by Anesthesia up to 48 hours prior to surgery for their pre-anesthesia visit. The patient must be reevaluated immediately before administering moderate or deep sedation or anesthesia.
2. Specimens that need not to be sent to Pathology, unless requested by the surgeon include:
 - a. Specimens that by their nature or condition do not permit fruitful examination such as orthopedic appliances, or a portion of a rib removed only to enhance exposure.
 - b. Therapeutic radioactive sources, the removal of which shall be guided by radiation safety monitoring equipment.
 - c. Foreign bodies (for example, bullets) that for legal reasons are given directly to law enforcement representatives.
 - d. Newborn and pediatric (up to the age of 12) circumcision.
 - e. Teeth, provided the number, including fragments, is recorded in the medical record.
 - f. Placentas (held in the Lab for 48 hours to a week).
 - g. Tonsils and adenoids, if 18 years or younger.
 - h. Lens.
 - i. Hernia sacs.
 - j. Non-pathologic bone fragments, such as bunionectomy specimens, laminectomy specimens, and specimens from correction of hammer toe.
 - k. Cartilage fragments, including meniscus.
 - l. Ureteral stents.
 - m. Scars.
3. Femoral head (if X-ray clearly documents arthritis). Only authorized persons shall be allowed in the OR. Exceptions will be arranged in advance with the Nurse Manager of the OR Complex.
4. A surgical procedure shall be performed only with a written, signed, informed consent of the patient or his/her legal representative, and obtained prior to the operative procedure, except in those situations wherein the patient's life is in jeopardy and authorization cannot be obtained due to the condition of the patient.

In emergencies involving a minor or unconscious patient in which consent for surgery¹⁰ cannot be immediately obtained from the patient, guardian, or next-of-kin, these

circumstances should be fully explained on the patient's medical record and the administrative officer on call shall be notified immediately. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

5. Surgeons will be in the Operating Room and ready to commence at the time scheduled, and in no case shall the Operating Room be held longer than 15 minutes after the time scheduled, except when the delay does not affect another surgeon and patient.
6. General anesthesia will not be induced until the surgeon is in the Surgery Suite.
7. Infection control policies as developed for the Operating Room Suite will be followed and enforced.
8. Each patient's physical, psychological and social status are assessed before surgery. Any patient for whom moderate or deep sedation or anesthesia is contemplated receives a pre-sedation or pre-anesthesia assessment.
9. Before surgery, the patient's physical examination and medical history, and any indicated diagnostic tests, and a preoperative diagnosis are completed and recorded in the patient's medical record.
 - a. Under a life threatening condition or if there is a risk of mortality or morbidity if the procedure is delayed, the patient may be taken to the Operating Room after the required workup has been completed and before official documentation is on the chart.
 - b. The verbal report should go to the Operating Room team assigned to that patient which includes nurses and anesthesia administrator.
10. A full operative report must be completed immediately after an operative or other invasive procedure in order to manage the patient throughout the postoperative period and to facilitate patient hand-off to the next level of care. If the Practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be completed in the new unit or area of care.
 1. If the full operative report is placed on the chart immediately after the procedure, there are no further expectations.
 2. If the full operative report is not on the medical record immediately, then a brief post op note must be entered into the patient's record before the patient can be moved to the next level of care. The brief post op note must contain the following:
 - Date of Surgery
 - Name(s) of primary surgeon and assistant(s),
 - Procedure(s) performed, description & findings
 - Type of Anesthesia
 - Estimated blood loss,
 - Specimen(s) removed,
 - Postoperative diagnosis.

Any full operative report not available within 24 hours of procedure completion will be considered delinquent and result in the practitioner being unable to schedule additional elective surgeries or procedures until such time as the deficiency is corrected. The physician will also receive a letter in his/her quality file noting the suspension. ¹¹

Note: *Immediately* as defined in this section means, "Upon completion of the surgery or procedure, and before the patient is transferred to the next level of care."

11. Laboratory tests performed outside MercyOne Cedar Falls Medical Center will be acceptable if the laboratory is certified by CLIA (Clinical Laboratory Improvement Amendments.)
12. Electrocardiograms are to be read by a cardiologist or internist. A computer generated report is not acceptable unless it is read by an internist or cardiologist.
13. Using approved discharge criteria, a Registered Nurse may discharge patients to the nursing unit from Post-Anesthesia Care Unit and to home from the Ambulatory Surgery Unit.
14. In the absence of a qualified physician, a Registered Nurse who possesses appropriate knowledge and technical skills shall be considered to be a qualified non-physician and serve as first assistant.
15. The following are the types of elective invasive procedures performed outside the operating rooms by MercyOne Cedar Falls Medical Center credentialed physicians:
 - a. Biopsies (e.g. breast lymph nodes, liver, lung, kidney, prostate, excision, etc.)
 - b. Removal of cysts, lipomas, lesions, etc.
 - c. Wound care (e.g. debridement, incision and drainage)
 - d. Revision of simple scars, skin grafting, etc.
 - e. Laser procedures
 - f. Cystos, place and remove stents, circumcisions (babies and adults)
 - g. Oscopies (e.g. endo, gastro, colon, procto, flexible, sigmoid, cyst), TEE, ERCP, bronchoscope, PEG, Scleral therapy, etc.)
 - h. Hemorrhoid treatment
 - i. Gynecology procedures (e.g. dilatation & curettage, suction & curettage, hysteroscopy, LEEP, thermal ablation, etc.)
 - j. Pain Management (e.g. epidurals, pump refills, etc.)
 - k. Diagnostic tests (e.g. lumbar puncture, bone marrow, EMG, CMG, catheterization, arteriogram, myelogram, etc.)
- l. Other: PICC lines, port access, paracentesis, thoracentesis, chest tube insertion, pacemaker insertion, intubation, cardioversion, bone reduction, arterial lines, swan ganz, ECT, etc.

PHARMACY:

1. The following drug classes require a renewal of discontinuance order by the provider in accordance with time limits set forth below:
 - a. Schedule II Controlled Substances require a renewal order after five days of the original order time/previous renewal.
 - b. Antibiotics, defined in the American Hospital Formulary Service Category 8:12, require a renewal order after five days administration.
 - c. Oral anticoagulants must be ordered daily during initiation of therapy.
 - d. Antineoplastic agents, defined in the American Hospital Formulary Service Category 10:00, shall be ordered either on a one-time only basis or for a specific number of days of administration of a given dose.

- 1) All unqualified orders with respect to the number of doses or days of administration shall be considered to be one-time only orders.
2. Previous pharmacy orders will be cancelled when patients go to surgery with the exception of orders that take affect postoperatively. (This does not apply to patients undergoing diagnostic or minor procedures done under local anesthesia.)

EMERGENCY: WORKING RULES

1. Staffing:
 - a. Once assuming responsibility for Emergency Room Coverage, the physician shall not leave the immediate hospital grounds unless acceptable provisions are made with an equally qualified physician for coverage and with the approval of EPA or Medical Director.
 - b. The Emergency Department staff will be aware of the Emergency Department Physician's whereabouts at all times.
2. Patient Care:
 - a. The EDP is responsible for patients presenting to the Emergency Department and is expected to evaluate and treat each patient, except those specifically treated by their private physician.
 - 1) In the event the patient does not wish to see their private physician, or a longer than 30 minute wait is anticipated before the private physician is able to respond to the Emergency Department, the EDP on duty should evaluate and treat to ensure optimum efficiency in the Emergency Department.
 - b. If at any point a patient appears or becomes unstable, the EDP should be notified immediately to examine and treat, regardless of any previous physician arrangements.
 - c. Medical screening of each patient will include the use of ancillary services routinely available.
3. Patient Admissions:
 - a. Prior to admission, the EDP will consult with the patient's private provider.
 1. If the patient has no private physician, a staff physician will be obtained according to the on-call guidelines
 - b. Admission orders should be entered by the patient's attending provider.
 - c. Provisional orders may be entered by the EDP upon agreement between the EDP and attending provider.
4. Patient Transfers: (See MercyOne Northeast Iowa Transfer policy).

5. Patient Discharge:
 - a. Complete discharge instructions will accompany each patient discharged from the Emergency Department. Provisions for follow up care should also be documented if indicated.
 - b. Discharge instructions should be acknowledged and signed by the patient (or responsible person) with a written copy sent with him/her.

6. Physician On-Call Guidelines:

A schedule of physicians on-call shall be maintained in the Emergency Room.

 - a. Physicians on-call are to provide the same level of care to all individuals regardless of their ability to pay.
 - b. Physicians on-call will be expected to respond to the Emergency Room within a reasonable period of time.
 - c. If the attending physician refuses to come to the Emergency Room to see and evaluate a patient, the Emergency Department physician will:
 1. Notify the House Supervisor of the situation,
 2. Forward the chart and all information related to the case, by the end of their shift, to that physician's respective department chair for review the following day,
 3. For unassigned (undoctored) patients, the Emergency Department physician will go to another appropriate on call physician.

7. Medical Control:
 - a. The EDP shall respond to in-house Code Blue situations and be in charge of patient care until care is relinquished to another qualified physician.
 1. If two Codes are simultaneously occurring, the EDP's first responsibility is to the patient presenting in the Emergency Room. Other actions may be taken at the EDP's direction.
 - b. The EDP shall act as the Medical Control for incoming emergency medical transports in agreement with the Iowa Pre-Hospital Care Laws and Metro Protocols of emergency care.

8. EMTALA Compliance
 - a. All Members of the Medical and Allied Health Staff are expected to abide by the requirements of the Emergency Medical Treatment and Labor Act. Hospital Administrative Policy CC 003 "EMTALA: On Call Physicians" and Policy CC 002 "EMTALA: Medical Screening and Stabilizing Treatment" provide detailed EMTALA information. Key points include:

An emergency medical condition is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain, psychiatric disturbances, and/or symptoms of substance abuse) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual in serious jeopardy; result in serious impairment to bodily functions; serious dysfunction of any bodily organ or part. In the case of a pregnant woman having contractions, an emergency medical condition exists if there is inadequate time to affect a safe transfer to another hospital before delivery or the transfer may pose a threat to the health or safety of the woman or the unborn child.
 - b. An individual is considered to have "come to the emergency department" if the individual has:

1. Presented at the hospital's dedicated emergency department or on hospital property and requests examination or treatment for a potential emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request, a request on behalf of the individual will be considered to exist if a prudent layperson would believe, on the basis of the individual's appearance or behavior, that the individual needs examination or treatment for a medical condition;
 2. Is in a hospital-owned ambulance for the purpose of examination and treatment for a medical condition at the hospital's dedicated emergency department. In the case of an infant birth, the federal Born-Alive Infants Protection Act of 2002 protects and extends protections under EMTALA to any infant born alive at any stage of development.
- c. Any patient who comes to the Hospital's dedicated emergency department and requests or has a request made on his or her behalf for emergency examination and treatment or who a prudent layperson would believe, on the basis of the individual's appearance or behavior, requires examination or treatment for a medical condition, will be provided an appropriate medical screening examination within the capabilities of the Hospital to determine whether an emergency medical condition exists regardless of their ability to pay for medical care.
 - d. When the medical screening examination reveals that the person has an emergency medical condition, the Hospital will provide further medical examination and stabilizing treatment as required to stabilize the medical condition or will transfer the patient in accordance with its EMTALA: Patient Transfer to Another Acute Care Facility Policy.
 - e. The Hospital will maintain a list of on-call physicians who can provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.
 - f. When on the Emergency Department on-call schedule, the only acceptable reasons for failure to respond to a request for consultation by the Emergency Department is sudden illness, unavoidable detainment such as attending to another emergency, or other event that physically prohibits the on-call physician from appearing in the hospital.
 - g. Failure to respond to a request for consultation by the Emergency Department when on the Emergency Department on-call schedule, may constitute a violation of the EMTALA guidelines, may result in a personal fine assessed by CMS, and may result in corrective action by the Medical Staff.
 - h. A medical screening exam may be performed by a physician or "qualified medical person." A "qualified medical person" is defined as an individual, in addition to a licensed physician, who is licensed or certified in the State of Iowa and who has demonstrated current competence in the performance of medical screening examinations. Qualified Medical Person(s) include:
 1. Emergency Department: Physicians, Physician Assistants, Nurse Practitioners and the Psychiatric Nurse Case Manager in the Emergency Department.

2. In the event the Emergency Department Physician, Physician Assistant, Nurse Practitioner or Psychiatric Nurse Manager is unavailable, an Emergency Department registered nurse is designated as the alternative qualified medical provider.
 3. Paramedics in the pre-hospital setting, within the scope of their license to practice
9. Documentation:
- a. Patients presenting to the Emergency Room will have a medical record instituted to document the visit. The record shall include:
 - 1) Adequate patient identification.
 - 2) Information concerning the time of the patient's arrival, means of arrival, and by whom transported.
 - 3) Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to arrive at the hospital.
 - 4) Description of significant clinical, laboratory and roentgenologic findings.
 - 5) Diagnosis.
 - 6) Treatment given.
 - 7) Condition of the patient on discharge or transfer.
 - 8) Final disposition, including instruction given to the patient and/or family, relative to necessary follow up care.
 - b. Emergency medical records need to be completed within one (1) day following the end of the provider's shift when he/she treated the patient. This may result in the provider being removed from the schedule until records are complete.
10. Disaster Plan Provisions:
- a. In the event of mass casualties, the EDP or the House Supervisor will assume the role of Disaster Chairperson and be responsible for the delivery of care according to the Emergency Department Emergency Preparedness Plan.
 - b. Drills will be held at least twice a year to evaluate and update the institutional plan.
11. Prohibited Procedures:
- a. Procedures which cannot be done in the Emergency Room area include:
 1. Any procedure that requires general anesthesia.
 2. Any procedure that cannot be done with the instrumentation and personnel available in the ER and still meet the needs of other patients in the department.
 - b. The following procedures may not be performed by the EDP in the Emergency Room unless specific privileges have been granted:
 1. Tendon Repair.
 2. Application of circumferential casts.
 3. Nerve or artery repair.
 4. Anesthesia (except for local infiltration or digital block).
 5. Sigmoidoscopy.
 6. Biopsy
 7. Scrub for surgery.
12. Departmental Medical Director:
- a. Appointed biannually, the Emergency Department Medical Director shall be the physician responsible for the overall supervision of the clinical work performed in the Emergency Department.

TRAUMA SERVICES:

1. TRAUMA ALERT POLICY:

- a. The Trauma Alert Policy is developed, reviewed and revised by the Trauma Services Committee. It shall encompass all necessary elements to comply with the Iowa State Department of Health Standards. The Trauma Alert Policy and Procedure is located in the Patient Care Policy and Procedure Manual.

2. ORGANIZATIONAL STRUCTURE:

- a. The President of the Medical Staff shall designate a qualified general surgeon as the Trauma Services Medical Director. A copy of the Trauma Services Medical Director's role description is available to the medical staff in the Emergency Department.
- b. The Trauma Services Medical Director is the Chair of the Trauma Services Committee. The Trauma Services Medical Director reports to the Medical Staff Executive Committee. The Trauma Services Medical Director reviews and communicates recommendations concerning requests for trauma privileges to the Chair of the Surgery Department.
- c. The Trauma Nurse Coordinator reports directly to the Trauma Services Medical Director and coordinates the communication across the continuum of the trauma patient's care.

3. ADMISSION POLICY:

All multiple system or major injury trauma patients will be admitted to the general surgeon on call for trauma services. Compliance with this policy will be monitored on a continual basis. This policy is formalized in the Trauma Alert Policy.

ANESTHESIA:

Prep for Elective Anesthesia:

Patients presenting for elective general or regional anesthesia are required to have a pre-anesthesia evaluation completed. There shall be no required screening studies mandated. A workup including any clinically indicated studies individualized to specific patient needs may be ordered at the discretion of the involved physicians.

Post-Anesthesia Care Unit (PACU):

1. Purpose:

Care of patients who are immediately post-operative in status and recovering from general anesthesia, regional anesthesia, local anesthesia plus sedation, or who are at high risk from drugs or operative procedures.

2. Method:

Patients will remain in the Post Anesthesia Care Unit (PACU) until such time as vital signs are stable, state of consciousness is adequate as defined by PACU discharge criteria, and effects of anesthesia are dissipating. They will be discharged according to written discharge policies when discharge is ordered to be made per criteria. In the absence of such an order or when there exists a variance from criteria, then discharge is at the discretion of the anesthesiologist per specific order.

3. Administration of Pain Medication in PACU:

- a. Nursing personnel will be directly responsible to the Anesthesiologist with regard to administration of medications. Approval will be obtained before post-operative

drugs are administered.

- b. Patient medications given in the PACU will be by order, or with the knowledge of the anesthesiologist or anesthetizing CRNA. Registered nurses in the PACU will be expected to administer direct I.V. medications, including those for pain or for rapid treatment of hemodynamic instability, on the verbal order of the Anesthesiologist or attending physician.

Administration of oxygen may be started at the discretion of the regular PACU staff nurse or the supervisor. The Anesthesiologist will be informed. (As a matter of routine, patients who have had general anesthesia or major regional anesthesia will be given supplemental oxygen).

4. Supplies in the PACU:

There will be adequate supplies available for intravenous fluid administration, pain medication (parenteral), and resuscitation, including oxygen, suction, standard drugs, endotracheal tubes, laryngoscope, self-inflating bag, oral airways, and nasal airways. An EKG monitor and defibrillator will be immediately available. A mechanical ventilator will be readily available. Oxygen catheters and suction will be available. An EKG monitor, pulse oximeter, and accurate means of determining arterial blood pressure will be used for each patient recovering in the PACU.

5. Hours and staffing of PACU:

The PACU will be open from 0700 through 1600, Monday through Friday, staffed by two RN's. At other times, patients will be returned to the Intensive Care Unit for recovery unless the patient is considered a contaminated case.

6. Recovery of Patients in the Intensive Care Unit:

- a. The Intensive Care Unit will be utilized to recover patients returning from surgery after approximately 3:30 p.m. during the work week, or for emergency surgery at night or on weekends or holidays. The PACU will be closed at approximately 4:00 p.m. each work day.
- b. Patients will not be admitted to the Intensive Care Unit, but will remain on the Recovery stretcher. PACU forms and procedures will be utilized.
- c. If, after two hours, the patient is not stable and PACU discharge criteria are not met, or the patient is otherwise unfit for PACU discharge, the attending physician should be notified and the patient should be admitted to the Intensive Care Unit.
- d. The Anesthesiologist or Nurse Anesthetist and surgeon will determine which patients should be recovered in the Intensive Care Unit.

7. Admission to the PACU and Transfer to PACU:

- a. Patients who are immediately post-operative in status and recovering from general or major regional anesthesia, shall be admitted to the PACU. Other post-operative patients who require the nursing care and specialized monitoring available in the PACU shall also be admitted if it is desired by the surgeon or the Anesthesiologist/Anesthetist.
- b. The Operating Room personnel will bring the patient to the PACU. The Anesthesiologist/Anesthetist will accompany the patient to the PACU and discuss the current status of the patient with the PACU nurse, giving the nurse an appropriate report. Unusual orders or procedures should be brought to the nurse's attention at this time.
- c. Unstable patients will be transferred to the PACU on the electrical monitoring

equipment, accompanied by Anesthesia personnel, who will inform personnel of any specific problems presented by the patient's condition. The monitoring will continue until discharge of the patient to the post-operative care and beyond, as appropriate.

8. Visitors and Traffic Control in the PACU:
 - a. Visitor's Policy: There will be no visitors allowed in the PACU. Family will be given progress reports as necessary by the nurse in charge.
 - b. Traffic Control: The PACU will be considered a part of the Operating Room suite.
 - c. At the same time, it will be accessible to personnel from the Laboratory, X-ray, and physicians who have need to enter the PACU from time to time. It will not be necessary for these people to change into scrub clothes in order to gain access to the unit.

ORGANIZED HEALTH CARE ARRANGEMENTS AND SHARING OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION BY THE HOSPITAL AND ITS MEDICAL AND ALLIED HEALTH STAFF MEMBERS:

1. GENERAL BACKGROUND ON HIPAA PRIVACY RULES:

- a. The Health Insurance Portability Act of 1996 and its implementing regulations ("HIPAA"), among other things, regulate how providers can use and disclose individually identifiable protected health information ("PHI") with one another.
- b. HIPAA also requires a provider with a direct treatment relationship with an individual (including, among others, hospitals, providers and allied health professionals) to provide the individual with a notice of its privacy practices. The notice must afford the individual with adequate notice of the provider's uses and disclosures of PHI, the individual's rights and the provider's responsibilities with respect to PHI. The notice of privacy practices must be furnished to the individual upon the first service delivery, except in emergency situations, in which case it may be provided as soon as reasonably practicable.
- c. HIPAA further requires a provider with a direct treatment relationship with an individual to make a good faith effort to obtain a written acknowledgment of the individual's receipt of the provider's notice of its privacy practices. If the acknowledgment cannot be obtained, the provider must document in good faith its efforts to obtain such acknowledgment and the reason why the acknowledgment was not obtained.
- d. Under HIPAA, if two or more providers (including a hospital and its medical staff) are part of the same "Organized Health Care Arrangement" ("OHCA"), they may issue a joint notice of their privacy practices and obtain a joint acknowledgment from the individual. Accordingly, for patients treated through the OHCA, only one notice and one acknowledgment are required for all of the providers in the OHCA.
- e. Notwithstanding, under HIPAA, if a provider is a member of an OHCA, and that same provider also has his or her own private practice, and his or her privacy practices in his private office are different than that of the OHCA, for patients that provider treats outside of the OHCA, the provider must still deliver his/her own notice of privacy practices and obtain his/her own acknowledgment.

2. HOSPITAL AND MEDICAL STAFF ARE AN OHCA

The Hospital and its Medical and Allied Health Staff Members (referred to for purposes of this Article as "Members") operate as an OHCA in that they provide direct patient care services through clinically integrated settings (e.g., inpatient or outpatient hospital setting

3. **JOINT ACKNOWLEDGMENT AND JOINT NOTICE OF PRIVACY PRACTICES:**
 - a. Members treating patients at any of the clinically integrated settings of the Hospital's OHCA shall use a joint acknowledgment and joint notice of privacy practices, as described herein.
 - b. The joint acknowledgment and joint notice of privacy practices shall be in such forms as are designated by the Hospital and such joint acknowledgment and joint notice of privacy practices shall meet the requirements of HIPAA.
 - c. Each Member shall abide by the terms of the joint notice of privacy practices with respect to PHI created or received by such Member as part of its participation in the Hospital's OHCA.
 - d. Each Member shall take reasonable steps to ensure the privacy and security of all PHI, including PHI created, used, transmitted or maintained as part of the Hospital's OHCA. Such reasonable steps should be in place for all PHI, in all forms, including verbal, written and/or electronic (including but not limited to email, Personal Data/Digital Assistants and other means).

4. **CORRECTIVE ACTION**

Failure of any Member to comply with the requirements of this Article may subject such Member to corrective action as provided in the Medical and/or Allied Health Staff Bylaws.

5. **DISCLAIMER OF LIABILITY**

Notwithstanding the foregoing OHCA relationship described in this Article, the Hospital hereby explicitly disclaims any and all liability to Members and/or any third parties, whether under theories of apparent agency or any other theory of liability, for the acts and omissions of its Members.

PROFESSIONAL LIABILITY INSURANCE COVERAGE:

Each Medical Staff Member and Allied Health Professional needs to hold malpractice liability insurance approved by the Iowa Insurance Commissioner or other evidence of financial responsibility approved by the board of directors.

Medical Staff Members and Allied Health Professionals, with the exception of non-operating general dentists, shall show evidence of current malpractice insurance coverage or other evidence of financial responsibility at a minimum of \$1,000,000/\$3,000,000. A copy of the certificate of insurance, or copy of the policy, showing such minimum coverage, is required in order to obtain or maintain Medical Staff membership/privileges.

Non-operating general dentist members of the Medical Staff shall show evidence of current malpractice insurance coverage or other evidence of financial responsibility at a minimum of \$500,000/\$500,000. A copy of the certificate of insurance, or copy of the policy, showing such minimum coverage, is required in order to obtain or maintain Medical Staff membership/privileges.

ADOPTION AND AMENDMENT:

These Rules and Regulations may be adopted or amended in accordance with the

Requirements set forth in the Medical Staff Bylaws for adopting Medical Staff Rules and Regulations.

APPROVED DATE:

Effective February 2, 2023 the Board of Directors have approved these Rules and Regulations.