

# Rules and Regulations of MercyOne Centerville Medical Staff

## **Preamble**

The following Rules and Regulations define the parameters surrounding the exercise of clinical privileges and prerogatives associated with Staff membership and /or associated with privileges granted to non-physician independent practitioners. Failure to comply with these Rules and Regulations may result in disciplinary action as defined in the MercyOne Centerville Medical Center Medical Staff Bylaws (“Bylaws”) and related policies and procedures. All capitalized terms not otherwise defined in these Rules and Regulations shall have the meaning assigned to them in the Bylaws.

## **A. Admission and Treatment of Patients**

1. Only physicians who have been duly appointed to membership on the Active or Courtesy Staff and have been granted clinical privileges for the admission of patients may admit patients. However, an Advanced Practice Provider (APP) who has an agreement with the Hospital may also be granted clinical privileges for the admission of patients at the Hospital consistent with the Bylaws and applicable law. Consulting and Affiliate Staff may admit patients in association with a physician member of the Active Staff. Emergency Department Staff does not have admitting privileges, but can enter initial orders after consultation with the on call/attending Practitioner.
2. The admitting Staff member is the attending Practitioner and assumes care of the patient unless otherwise documented in the medical record. In the event management of care is being transferred to another Staff member, the orders must reflect documentation that management of care is transferred and being assumed by a specific Staff member.

Where the attending Practitioner has failed to designate another Practitioner to care for his or her patient in his or her absence, the Chief of Staff shall be responsible for arranging continuing care.

An admitting APP shall contact the attending physician when reasonably practicable and appropriate as required by applicable law. Acute patient transfers require immediate contact with a physician (not physician receiving the patient). The attending physician will also be contacted regarding admissions. These contacts will be documented in the patient’s medical record.

Inpatients (observation, acute) will be seen daily. Skilled patients will be seen at least weekly or more often if deemed necessary due to a change in condition, patient request, etc.

3. The attending Practitioner retains the ultimate responsibility for the management of patient care and completion of required documentation.
4. The last designated attending Practitioner during the first 24 hours of hospitalization is responsible for completing the history and physical within 24 hours of admission. The last attending Practitioner documented is responsible for the final diagnoses and discharge summary.
5. It is the responsibility of attending Medical Staff Member to communicate with the designated attending Practitioner regarding management of patient care when they provide coverage.

## **B. Medical Records**

1. All clinical entries in the patient's medical record shall be accurately dated, timed and signed.
2. A complete history and physical (H&P) shall include the following elements as appropriate: patient identification, physician, date of admission, chief complaint, history of present illness, current medications, allergies, past medical history, past surgical history, family history, social history, review of systems, physical examination as appropriate to the diagnoses, impression/diagnosis, and plan. A complete admission history and physical examination shall be completed within the first twenty four hours of admission to inpatient services, observation services, and swing bed. For scheduled patients, the H&P may be performed within a thirty day (30) time period prior to elective procedures. If the H&P has been performed within thirty days prior to the planned admission/procedure, it would be acceptable only if a legible copy is provided on the medical record and reviewed by the attending physician. An update is to be performed and documented by the responsible physician/surgeon. The review is to include any components of the patient's current medical status that may have changed since the prior H&P, address any areas where more current data is needed, confirms that the necessity for the procedure/care is still present. The H&P update must be dated, time, and signed by the responsible practitioner/surgeon.
3. With pre-operative H&P, all or part of this document may be delegated to other practitioners in accordance with State law and Hospital policy, but the surgeon must sign the H&P and assume full responsibility.
4. When a patient is admitted to inpatient following an observation stay, the history and physical done while the patient was in observation status may be used for the subsequent inpatient admission history and physical with addendums added as appropriate. Also, when a patient is admitted to swing bed status following an inpatient stay, the history and physical done while the

patient was inpatient may be used for the subsequent swing bed history and physical with addendums added as appropriate.

5. The physician may use their Consultation Report for the H&P if it meets all prescribed elements of an H&P, is done in the 30 day time frame prior to the procedure and is updated as appropriate.
6. When the H&P/consultation examinations are not recorded before an operation or diagnostic procedure requiring anesthesia, the procedure shall be postponed until a H&P/Consultation is obtained, unless the attending practitioner documents in the record that such delay would be detrimental to the patient.
7. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be recorded at least daily on all observation and inpatient care patients. On the day of discharge a Discharge Summary may be completed with the daily progress note for that day incorporated into the summary. If the Discharge summary is completed at a later date then a progress note must be completed for the last day of the admission and a Discharge summary completed within 30 days. Progress notes shall be dated, timed and signed. Progress notes are required at least weekly on skilled or swing bed patients.
8. Operative reports shall include a preoperative and postoperative diagnosis, detailed account of the findings at surgery, complications that may have developed during the procedure and the condition of the patient at the end of the surgical procedure as well as the details of the surgical technique. A brief op note progress note shall be completed before the patient leaves the surgical department unless the full operative report is completed. The operative report shall be documented within 24 hours and shall be made a part of the patient's medical record.
9. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examinations of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record and completed within 48 hours. A brief note shall be entered into the record at the time of the consult.
10. Symbols and abbreviations may be used only when the medical staff has approved them. Stedman's Abbreviations, Acronyms & Symbols is the approved reference.

11. The attending Practitioner shall report the final diagnosis on discharge of the patient. Except for Outpatient Observation (OPO) or Outpatient Surgery (OPS), a discharge summary shall be dictated or electronically recorded on all medical records of inpatients. The content of the discharge summary shall be sufficient to justify the diagnosis, treatment and end results. The discharge summary must include the principal and additional or associated diagnoses. The discharge summary must be completed within 30 days of discharge. All relevant diagnoses established by the time of discharge, as well as all operative procedures performed. The discharge summary must concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent. It should also include discharge instructions relating to physical activity, medications, diet and follow up care. The condition of the patient on discharge must be stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology such as "improved." The short stay discharge summary may be utilized for those patients with problems of an uncomplicated nature who require less than a twenty-four hour period of hospitalization. The final progress note must include any instructions given to the patient and/or family. In the event of death, the discharge summary should include your judgment as to the cause of death. All summaries shall be signed by the responsible Practitioner.
12. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information. When patients request to view their medical record, the attending Practitioner will be notified.
13. Records may be removed from the hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. Unauthorized removal of charts from the hospital is grounds for initiation of corrective action in accordance with the bylaws.
14. Medical records of all patients shall be afforded to Members of the Medical Staff for study and research consistent with preserving the confidentiality of patient information concerning the individual patient, but aggregated medical data may be used. All such projects shall be approved by the Medical Executive Committee before the records can be studied.

### **C. Medical Record Delinquency**

1. The responsibility for control of delinquent medical records shall be delegated to the Medical Executive Committee or its designated body.

2. The clinically important records (such as the H&P) should be completed within 24 hours and are classified as delinquent and penalties will be incurred if not completed within thirty (30) days of discharge.
3. A Staff member who fails to complete the medical record(s) within five (5) days of written or approved electronic communication will have his admitting privileges automatically suspended until such time as the delinquent medical records are completed.
4. If the failure to complete the medical record is beyond the control of the Practitioner, the Chief of Staff, in his discretion, may revoke such suspension or take other action which he deems appropriate under the circumstances.

#### **D. Orders**

1. All orders for treatment shall be electronically entered (except according to policy; i.e., downtime, emergency, etc.). To be in compliance with federal law and payer requirements, all medical orders must be medically necessary. Medical record documentation must reflect the medical necessity for the orders. Inpatient orders may be entered electronically or given verbally (according to policy), by Staff physicians. Physician Assistants, Podiatrists, Dentists, Nurse Practitioners, Certified Registered Nurse Anesthetists and other APPs who are credentialed and granted privileges in accordance with the Bylaws may also give orders. All orders must be dated, timed, and signed by the authorized person, including the supervising physician if required by applicable law.
2. Verbal and phone orders are to be kept to a minimum and restricted to one time orders or single dose orders whenever possible. Verbal orders may be given to RN's, LPN's physical therapists, occupational therapists, pharmacists, lab technicians, speech therapist, dieticians, radiology techs, respiratory care technicians and social workers within the scope of their licensure. Verbal orders must be read back and verified by the person received the order. This "read back and verify" should be noted in the chart. All orders dictated over the telephone shall be signed by the appropriately authorized person with the name of the Practitioner, his/her own name and title. The orders need to be reviewed and signed by the prescribing practitioner as soon as possible, preferably the next time the practitioner accesses the patient's chart, but no later than thirty (30) days post discharge, failure to do so shall be brought to the MEC's attention for appropriate action.
3. The practitioner's orders must be entered electronically with exceptions according to policy, and they shall be dated, timed, and signed. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.

4. When a patient is discharged, the order should include: destination, medications, and any follow-up or special instructions.
5. The attending Practitioner is primarily responsible for requesting a consultation.

#### **E. Anesthesia Services**

Physicians and nurse anesthetists must request and be granted clinical privileges for administration of anesthetic agents in any setting at the Hospital with the exception of local or topical anesthetics. Administration of anesthetic agents, general, spinal, major regional or IV analgesia or sedation requires compliance with guidelines or policies regarding these agents. Informed consent for anesthesia is required as well as a plan of care developed for pre-, intra-, and post-procedures monitoring. Patients leaving the surgical suite or post anesthesia care unit must either be discharged by a physician or meet specific discharge criteria approved by the Medical Staff.

#### **F. General Conduct of Care**

1. If hospital personnel question the care provided to a patient, the staff member may discuss the matter with the attending physician. The hospital personnel may call the matter to the attention of his/her supervisor who in turn may refer the matter to the VP of Patient Services. If warranted, the VP of Patient Services shall bring the matter to the attention of the Chief of Staff or Chief of Service and to the President of the hospital. The Chief of Staff or Chief of Service shall consult with the involved physician and shall then determine if it is necessary to recommend specific action as outlined in the Staff Bylaws.
2. Practitioners who have patients in the Hospital or are on call must be available (or have coverage arranged) for response and direct patient care within thirty (30) minutes. Practitioners on call as a specialist must also be available (or have coverage arranged) for response and direct patient care within thirty (30) minutes. Physicians that are supervising hospitalist coverage shall be available by phone for consultation and to direct care as appropriate.
3. Text messages containing electronic protected health information should not be sent from or sent to an unencrypted device.

Where possible, CHI messaging should be initiated at the Electronic Health Record (EHR) system-of-record to maintain an audit trail, subject to discovery, including responses. The primary business purpose for using device to device messaging should be to alert/notify the recipient (usually Practitioners) for a call back. The intended use is NOT to provide triage of a

patient or for continuing conversations and discussions analogous to an email thread.

## **G. Consents for Treatment**

1. General Consent for Treatment and Release of Information: A consent form for treatment and release of information is signed by each patient or authorized representative prior to admission or prior to providing ambulatory care, and is retained as part of the permanent medical record.
2. Required Consents: In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment (as more particularly required by Hospital policy, as such policy may be amended from time to time) or surgical and invasive procedures shall be obtained from the patient or his or her surrogate decision maker.
3. Informed Consent/Practitioner's Responsibility: It is the Practitioner's responsibility to obtain informed consent. Documentation in the medical record must reflect that he/she has provided the patient with information regarding the benefits, risks and possible side effects associated with the procedure, alternative procedures or methods of treatment and the risks of no treatment. Disclosure of information should be made in language that the patient can understand.
4. Emergency consent for Treatment: A Practitioner may perform emergency medical or surgical treatment when consent cannot be obtained due to the condition of the patient or if the patient is a minor, and there is an inability to obtain timely consent from the parent/guardian or authorized representative. There must be a good faith belief that delay in treatment will result in a threat to life or adverse outcome, or further deterioration of the condition. Circumstances surrounding the decision to treat without written consent, including attempts to locate a parent/guardian/authorized representative must be fully explained in the medical record.
5. Telephone Consents: Any consent received by telephone from a person eligible to give such consent requires that two persons listen to the person giving consent, date and sign the consent form, clearly indicating that this was a telephone consent and write the name of the person giving the consent, together with signature of the person making the entries.

## **H. Autopsies**

Certain death investigations fall under the jurisdiction of the Appanoose County Medical Examiner's office. In such cases, the decision to perform an autopsy is solely the decision of the Medical Examiner or his designated deputy.

In cases that do not come under the Medical Examiner's jurisdiction, a Staff member may wish to obtain an autopsy where information obtained would be useful to the family, physicians, or institution. No autopsies shall be performed without proper written consent of the next of kin or legally authorized agent. In exceptional circumstances, witnessed telephone consent may be accepted.

### **I. Mass Casualty Assignments**

The disaster plan of action written for the hospital by the Safety committee shall be the plan followed for mass casualty situations and assignments.

Physicians and other Practitioners, who do not possess Medical Staff or practice privileges, may be accepted to work during an emergency or disaster. (See Medical Staff Bylaws on Emergency & Disaster Privileges.)

### **J. Discharge of Patients**

1. Patients shall be discharged only on order of the attending Practitioner or by his/her designee.
2. Should a patient leave the hospital against the advice of the attending Practitioner or without the proper documented discharge order, such conduct shall be documented in accordance with Hospital policy.
3. In the event of hospital death, the deceased shall be pronounced dead by a Practitioner or by an RN in accordance with Hospital policy. Policies with respect to the release of dead bodies shall conform to the legal requirements of the State of Iowa.

### **K. General Rules and Regulations for Surgical Patients**

1. At the time an operation is scheduled, a tentative diagnosis and the contemplated procedures shall be given to the scheduling person.
2. A pre-anesthesia assessment will determine the most appropriate form of anesthesia to be used. This written assessment or electronically documented assessment must also contain an informed consent for anesthesia and the choice of anesthesia. The complete assessment must be signed by the anesthesia provider.
3. A post-anesthesia note shall be made by the anesthesia provider immediately following surgery describing the presence or absence of anesthesia complications.



4. Tissues removed at operation shall be sent to the pathology laboratory for evaluations and such examination as the pathologist deems necessary to arrive at a diagnosis. A signed report of the pathologist's opinion shall become a part of the patient's medical record. If a surgical pathologic assessment was deemed unnecessary, documentation of specimens receipt and disposal will be documented with a case number assigned.
5. Diagnostic tests appropriate to the patient's condition should be on the patient's chart prior to admission to the surgical suite.
6. Direct sterilization of either men or women, whether permanent or temporary, is not permitted when its sole immediate effect is to prevent conception. Procedures that induce sterility are permitted when their direct effect is the cure or alleviation of a present pathology and a simpler treatment is not available.
7. Hysterectomy, in the presence of pregnancy and even before viability, is permitted when directed to the removal of a dangerous pathological condition of the uterus of such serious nature that the operation cannot be safely postponed until the fetus is viable.

#### **L. Emergency Services**

1. The Emergency Department shall be open twenty-four (24) hours a day with a Practitioner present/or on call in accordance with state and federal law.
2. All patients are to receive a medical screening by the ED Practitioner to determine if a medical emergency exists. No one is to be denied emergency medical care.
3. Physicians who are members of the Active Medical Staff shall be on call in the emergency services area for an amount of time determined by considering community needs for that specialty, the number of physicians in the specialty, and any other demands on those physicians. A call schedule providing for coverage in the Emergency Department shall be posted and available in the ED. The affected physicians must agree upon modifications in the schedule. In the event a physician listed to provide on call service in the Emergency Department refuses to do so within the allowed time, disciplinary action may be initiated as determined by the Medical Executive Committee.
4. The Chief of Staff shall bi-annually appoint a member of the Staff to act as Director for the Emergency Services.

The Director of Emergency Services shall be accountable for the functions and activities of this department. He or she shall act as liaison officer between the Emergency Services and Administration.

5. The Emergency Service shall maintain well-documented medical records on each patient. Medical record documentation will include appropriate information regarding the medical screening provided except where a person refuses, then a notation of refusal; physician documentation of presence or absence of an emergency medical condition or active labor; risk and benefits of transfer; physician documentation of transfer or discharge, stating the basis for transfer or discharge; and where transfer occurs, identity of the facility of transfer, acceptance of the patient by the facility of transfer, and means of transfer of the patient.

**M. Affiliate Staff and Other Privileged Individuals (Also see administrative policy on Advance Practice Providers)**

1. Physician Assistants: Active Staff physicians who have been approved for sponsorship and supervision of Physician Assistants by the State Board of Medical Examiners may use physician assistants in their Hospital practice, provided the physician assistant has been appointed to the Affiliate Staff and properly credentialed and privileged in accordance with the Bylaws. The sponsoring physician shall provide supervision as required under Iowa law and be responsible for all acts of the Physician assistant.
2. Podiatrists and Dentists:
  - a. Podiatrists and dentists who are members of the Affiliate Staff and have been properly credentialed and granted privileges in accordance with the Bylaws may, with concurrence of a physician member of the Staff, initiate admission or discharge of a patient and may, within the limits of his/her license, enter orders and prescribe medications.
  - b. A Practitioner who is an Active Staff member shall be responsible for the medical problems of patients admitted for podiatric or dental care. Podiatrists and dentists are responsible for the part of their patients' history and physical examination that relates to their discipline. The physician shall be responsible for the patient's basic medical appraisal including a history, a physical examination and an evaluation of the overall risk.
3. APPs who appropriately credentialed and privileged in accordance with the Bylaws may provide medical services within the scope of their license and certification, to patients in the Hospital.

4. Medical Students: M-1 and M-2 students may not transcribe orders. M-3 and M-4 students may, with the written consent of a sponsoring physician, transcribe or electronically enter any of the standing orders which the physician has on file at the nursing stations. Permission to transcribe or electronically enter more extensive orders must be given in writing by a sponsoring physician and the orders must be listed for the nursing staff and the student. All orders transcribed or electronically entered by students must be countersigned by a sponsoring physician prior to being implemented.
5. Physician Assistant Students: A sponsoring physician for a physician assistant student shall determine the capability of the student to transcribe or electronically entered orders. Permission to transcribe or electronically enter more extensive orders must be given in writing by a sponsoring physician and the orders must be listed for the nursing staff and the student. All orders transcribed or electronically entered by students must be countersigned by a sponsoring physician prior to being implemented.
6. Other individuals will be reviewed and credentialed on an individual basis in accordance with the Medical Staff Bylaws.

#### **N. ORGANIZED HEALTH CARE ARRANGEMENT (“OHCA”)**

The Hospital, Members of the Medical Staff and Practitioners with clinical privileges at the Hospital are required to comply with the provisions of the Health Insurance Portability and Accountability Act (“HIPAA”) Privacy Rules (45 C.F.R. Parts 160 and 164) relating to the use and disclosure of individually identifiable health information. The Hospital is an integrated health care setting in which the individual receives treatment from not only Hospital personnel but also Members of the Medical Staff and other Non-Member Practitioners with clinical privileges (“Practitioners”). The Hospital, Members of the Medical Staff and Practitioners operate under an Organized Health Care Arrangement or “OHCA” as permitted under HIPAA to facilitate the use and disclosure of individually identifiable health information in order to provide for efficient delivery of quality health care services.

1. Participants. The participants are the Hospital and Members of the Medical Staff and Practitioners at the Hospital.
2. Hospital. The Hospital consists of the inpatient and outpatient services, Long Term Care, and swing-beds.
3. Scope of OHCA activities. The scope of the OHCA between the Hospital, Members of the Medical Staff (“Member”) and Practitioners is limited to the inpatient and outpatient services, Long Term Care, and swing-beds. The OHCA and these Rules and Regulations do not apply to:

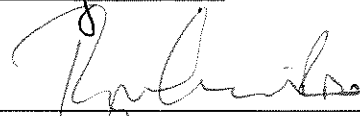
- a. The Member or Practitioner's independent professional services or individual practice's privacy practices. (For example, the OHCA does not apply to the Member's office practice's use and disclosure of its individually identifiable health information that is maintained by the Member's office for treatment, payment and operations).
  - b. Activities unrelated to Privacy Practices. The rule does not imply joint and several responsibilities between Hospital, the Member, or Practitioner for the provision of clinical services. The Member or Practitioner is an independent provider of clinical services and these rules and regulations do not alter in any way the independent status of these individuals.
4. Notice of Privacy Practices. The Hospital's Notice of Privacy Practices describes the OHCA and its participants and also serves as the OHCA's Notice of Privacy Practices. The Notice of Privacy Practices govern the information practices that Hospital, Members of the Medical Staff and Practitioners agree to comply with for the provision of services to the individual while at Hospital. The Hospital will be responsible for furnishing the individual with the Notice of Privacy Practices and to obtain the individual's written acknowledgement of receipt (or document the reasonable efforts to obtain such and/or reason(s) for not obtaining the acknowledgement.)
5. Records and Designated Record Sets. The Hospital's HIPAA Compliance Plan will determine which records are included as the "designated record sets" and those records that are subject to the HIPAA record retention requirements. The Hospital is responsible for maintaining these records in accordance with the HIPAA record retention requirements.
6. Voluntary Restrictions. Members of the Medical Staff and Practitioners as participants in the OHCA are prohibited from agreeing to any voluntary restrictions on the use or disclosure of individually identifiable health information that would be binding on other parties to the OHCA. The Hospital has sole authority to determine voluntary restrictions on the use or disclosure of individually identifiable health information and notification of OHCA participants of the voluntary restriction.
7. HIPAA Compliance Plan, Policies and Procedures. The Hospital Compliance Plan, and the policies, procedures, forms and processes developed by Hospital for HIPAA compliance serve as the same policies, procedures, forms and processes and Compliance Plan for the OHCA. Members of the Medical Staff and Practitioners in the OHCA shall refer individual requests to rights granted under HIPAA, including right to access, amendment, accounting for disclosures, voluntary restrictions, and complaints to the Hospital Privacy

Official. Hospital Privacy Official is responsible for oversight and implementation of HIPAA compliance.

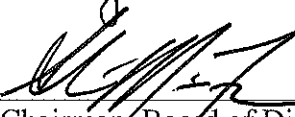
**O. Amendments to Rules and Regulations**

An amendment to these Rules and Regulations may be made under the provisions of Section 14 of the Medical Staff Bylaws.

**ADOPTED** by the Medical Staff on:

Aug. 16, 2021  
  
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Chief of Staff

**ADOPTED** by the Board of Directors on:

Aug 26, 2021  
  
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Chairman, Board of Directors