

Mercy Medical Center
Dyersville
Medical Staff
Bylaws

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1. DEFINITIONS

- 1.1. **Admitting Privileges** means the authority to hospitalize patients that is granted to Medical Staff members who assume and discharge overall clinical responsibility for their patient's care.
- 1.2. **Allied Health Professionals** means those individuals other than members of the Medical Staff who possess a license, certificate, or other credentials required by Iowa law and who are approved by the Board to provide patient care services in Hospital under the sponsorship and direction of a member of the Medical Staff. (See the Credentials Manual.)
- 1.3. **Board** means the Mercy Medical Center-Dyersville Board of Trustees which is the body established and appointed by the Mercy Medical Center-Dubuque Board of Trustees and the Trinity Health Board of Directors to perform and carry out those duties and responsibilities attributable to the Member Organization in the Trinity Health Bylaws.
- 1.4. **Clinical Privileges** means the permission granted to a Medical Staff member to order or perform specific diagnostic, therapeutic, medical, dental or surgical services.
- 1.5. **Credentialing and Privileging Manual** means a manual that delineates the credentialing and privileging process and procedures of the credentialing program which is incorporated by reference as part of the Bylaws.
- 1.6. **Dentist** means an individual with a D.D.S. or D.M.D. degree who is licensed in the state of Iowa to practice dentistry.
- 1.7. **Director** means the individual appointed by the Board to act on its behalf in the overall management of HOSPITAL. Wherever the term Director is used in these Bylaws, it shall include persons designated by the Director to act in his or her behalf.
- 1.8. **Executive Committee** means the Executive Committee of the Medical Staff as defined in these Bylaws unless specific reference is made to the Executive Committee of the Board.
- 1.9. **Fair Hearing Procedure Manual** means a manual that delineates methods for review, hearing and appeal of certain types of recommendations made or actions taken with respect to Medical Staff membership and/or clinical privileges and which is incorporated by reference as part of the Bylaws.
- 1.10. **Governance Documents** means the System Authority Matrix, articles or certificate of incorporation, and corporate bylaws, if the entity's form of legal organization is a corporation, and the partnership agreement, articles of organization and operating agreement, or comparable documents, if the entity's form of legal organization is other than a corporation.

- 1.11. **Hospital** means Mercy Medical Center-Dyersville, a hospital owned by Mercy Medical Center-Dubuque, a Member Organization of Trinity Health.
- 1.12. **Joint Operating Agreement** means that certain Joint Operating Agreement among Mercy Health Network, Inc., Trinity Health Corporation, Catholic Health Initiatives, Mercy Health Services-Iowa, Corp., and Catholic Health Initiatives-Iowa, Corp., effective as of March 1, 2016.
- 1.13. **Medical Staff Assistants** mean those individuals who do not possess a state license or other certification but are trained to perform certain health related tasks as approved by the Board under the sponsorship and direction of a member of the Medical Staff. (See the Credentials Manual.)
- 1.14. **Medical Staff** means, in a broad sense, a collective description of all practitioners who have been approved by the board for one of the categories of membership as described hereafter in these Bylaws. However, unless otherwise expressly noted, it will specifically mean those required to attend meetings, serve on committees, and who are eligible to vote in all medical staff affairs (i.e. Active Medical/Dental and Associate Medical).
- 1.15. **Medical Staff Services Office** means office at Mercy Medical Center-Dubuque providing medical staff services to Hospital.
- 1.16. **Medical Staff Year** means the twelve (12) month period commencing on January 1 each year and ending December 31 of the same year.
- 1.17. **MHN** means Mercy Health Network, Inc.
- 1.18. **MHN Authorities Matrix** means the governance matrix set forth as Exhibit A of the Bylaws of MHN, and as may be amended by the corporate members of MHN from time to time. The MHN Authorities Matrix, dated as of January 1, 2017, is attached hereto as Exhibit C.
- 1.19. **PAC** means the Professional Activities Committee.
- 1.20. **Physician** means an individual with an M.D. or D.O. degree who is licensed in the state of Iowa to practice medicine.
- 1.21. **Practice Privileges** mean the permission granted to an Allied Health Professional or Medical Assistant to participate in the provision of certain patient care services.
- 1.22. **Practitioner** means, unless otherwise expressly provided, any Iowa licensed physician, dentist, podiatrist, or doctoral level psychologist applying for or exercising clinical privileges at Hospital.

- 1.23. **Rules and Regulations Manual** means a manual that delineates the policies and procedures that govern the day-to-day activities of the Medical Staff and which is incorporated by reference as part of the Bylaws.
- 1.24. **Signed** means affixing your signature either on paper or electronically.
- 1.25. **Special Notice** means a written notification sent by certified mail, return receipt requested, or by special delivery with signed acknowledgement.
- 1.26. **Written** means either on paper or electronically within the patient record.

2. PURPOSE OF THE MEDICAL STAFF

2.1. Name.

The practitioners privileged to attend to patients pursuant to these Bylaws shall be referred to as the Medical Staff of Mercy Medical Center-Dyersville, Iowa.

2.2. Purposes.

The purposes of the Medical Staff of Mercy Medical Center-Dyersville, Iowa, shall be:

- 2.2.1. To act on behalf of the governing Board regarding credentialing, quality assessment and peer review activities;
- 2.2.2. To be responsible and accountable to the Board for the discharge of the duties and responsibilities delegated to it by the Board;
- 2.2.3. To provide all patients admitted to, or treated in, any of the facilities, departments, or services of Hospital, care that is consistent with generally recognized standards of care;
- 2.2.4. To monitor a high level of professional performance by all practitioners who are members of the medical staff through the appropriate delineation of clinical privileges, and through an ongoing review and evaluation of each practitioner's performance at Hospital;
- 2.2.5. To provide all members an appropriate educational setting that will maintain medical standards and lead to advancement and professional knowledge and skill;
- 2.2.6. To initiate and maintain the Bylaws, Policies and Procedures for the self-governance of the Medical Staff.
- 2.2.7. To provide a means by which members of the Active Medical Staff can work with the Board and Hospital's Director for the joint solution of medical/administrative problems and provide recommendations for Hospital's policy making and planning process.
- 2.2.8. To cooperate with affiliated medical schools and other educational institutions in undergraduate, graduate and post-graduate education; and
- 2.2.9. To encourage and participate in programs of clinical research to develop improved methods of patient care.

2.3. Principles of Medical Ethics.

Acceptance of membership on the Medical Staff constitutes agreement that he/she will abide by the principles and ethics of American Medical Association or the American Osteopathic Association. It is further recognized that the Hospital is a Catholic institution and these Bylaws must conform with the Ethical and Religious Directives for Catholic Care Services, authored by the National Conference of Catholic Bishops.

2.4. History and Physical Examination.

A medical history and physical examination shall be completed no more than thirty (30) days before or twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The medical history and physical examination must be completed and documented by a physician, an oral and maxillofacial surgeon, or other qualified licensed individual in accordance with state law and the Rules and Regulations. The history and physical shall be countersigned by the attending Physician.

When the medical history and physical examination is completed within thirty (30) days before admission or registration, the Physician must complete and document an updated examination of the patient within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. The updated examination of the patient, including any changes in the patient's condition must be completed and documented by a Physician, an oral and maxillofacial surgeon or other qualified licensed individual in accordance with state law and the Rules and Regulations.

3. MEDICAL STAFF MEMBERSHIP

3.1. Hospital.

- 3.1.1. The physicians, dentists, and podiatrists practicing in the Hospital hereby organize themselves into a Medical Staff, in conformity with these Bylaws.

3.2. Nature of Medical Staff Membership.

- 3.2.1. Membership on the Medical Staff is a privilege granted by the Board that shall be extended only to professionally competent practitioners who continuously meet the qualifications, standards and requirements required by Iowa law and these Bylaws.
- 3.2.2. Membership on the Medical Staff may be revoked at any time by the Board as provided for by the procedures set forth in these Bylaws and the governing documents of Hospital.

3.3. Criteria for Membership.

- 3.3.1. Only practitioners licensed to practice in the State of Iowa who can document the following shall be qualified for Medical Staff membership:
 - 3.3.1.1. appropriate education and training, background and experience, and professional competence;
 - 3.3.1.2. adherence to this ethics of the practitioner's profession as defined by appropriate professional societies;
 - 3.3.1.3. good personal and professional reputations;
 - 3.3.1.4. satisfactory physical and mental health;
 - 3.3.1.5. adequate professional liability insurance coverage as defined by Hospital;
 - 3.3.1.6. ability to work with others; and
 - 3.3.1.7. all other information relevant to the provision of medical care and participation as a staff member of Hospital.
- 3.3.2. Documentation of satisfaction of these criteria must be presented with sufficient adequacy to assure the Medical Staff and the Board that any patient treated by the practitioner at Hospital will be given care that is consistent with community standards, and that the efficient operation of Hospital will not be disrupted by the practitioner's care of patients within the hospital.

- 3.3.3. No practitioner shall be entitled to membership on the Medical Staff merely by virtue of the fact that the practitioner is duly licensed to practice in the State of Iowa or any state, or that the practitioner is a member of any professional organization, or that the practitioner has or has had privileges at any other hospital.
- 3.3.4. No practitioner will be denied Medical Staff membership or clinical privileges on the basis of race, sex, color, religion, national origin, age, sexual orientation or handicap.

3.4. Inability to Accommodate.

Medical Staff membership and the granting of specific privileges may be dependent on the ability of Hospital to provide adequate facilities and supportive services for the applicant and his/her patients.

3.5. Provisional Appointments.

3.5.1. Members of the Medical Staff will serve a provisional status for a minimum of twelve (12) months to allow sufficient time for evaluation. Provisional status may be extended for an additional period of up to twelve (12) months. During this provisional period their professional competence and ethical and moral conduct shall be observed by the President of the Medical Staff or designee. At the end of the twelve-month provisional period, the President of the Medical Staff will submit a written report to the Medical Staff Executive Committee indicating whether the practitioner is recommended for full staff status in the appropriate department or whether the provisional periods should be extended, indicating a recommended period of time. A practitioner who is not recommended for full staff status and whose provisional period has not been extended shall no longer be a member of the Medical Staff.

3.5.2. During the provisional period the practitioner:

3.5.2.1. may admit patients if their category permits;

3.5.2.2. will serve on at least one hospital committee as assigned; and

3.5.2.3. must attend assigned medical staff or committee meetings, but is not eligible to vote.

3.6. Conditions of Acceptance.

3.6.1. By accepting membership on the Medical Staff a practitioner agrees that he or she:

- 3.6.1.1. will provide patient care in Hospital in accordance with the clinical privileges granted to the practitioner by the Board;
- 3.6.1.2. has read these Bylaws and the Credentialing and Privileging Manual, Policies and Procedures and Fair Hearing Procedure manuals and agrees to abide by such Bylaws and manuals, including any subsequent amendments thereto, and any applicable Hospital policies that may from time to time be put into effect;
- 3.6.1.3. grants full immunity from liability under the provisions of the Fair Hearing Procedure Manual section of these Bylaws;
- 3.6.1.4. shall provide for a practitioner with the necessary clinical privileges available to care for the practitioner's patients in Hospital in the practitioner's absence;
- 3.6.1.5. if not residing within a reasonable distance from Hospital as to assume and discharge primary medical responsibilities for patients, shall arrange for a practitioner with the necessary clinical privileges to care for the practitioner's patients in Hospital in the practitioner's absence;
- 3.6.1.6. shall not rebate a portion of a fee, or accept inducements in exchange for a patient referral;
- 3.6.1.7. shall not deceive a patient as to the identity of an operating surgeon or any other practitioner providing treatment or a service to the patient;
- 3.6.1.8. shall not delegate the responsibility for the diagnosis or care of any patient of Hospital to any practitioner or other person who is not licensed or professionally qualified to undertake this responsibility;
- 3.6.1.9. shall continue to maintain in force professional liability insurance in an amount that will not be less than specified by Trinity Health;
- 3.6.1.10. shall agree to abide by those regulations imposed on the hospital by regulatory agencies and law;
- 3.6.1.11. has read and agrees to abide by the Ethical and Religious Directives for Catholic Health Care Services;
- 3.6.1.12. shall agree to abide by the Notice of Privacy Practices;
- 3.6.1.13. shall participate in the care of the indigent patients; and

3.6.1.14. agrees that at the time of application, initial appointment, reappointment, or at any other time, the Board, acting upon a written request from the Executive Committee, may direct that the practitioner undergo a physical and/or mental evaluation by a physician or licensed psychologist who is not affiliated with Hospital. This agreement constitutes a waiver of confidentiality to the extent of the procedures set forth in this Section. Failure to comply with the Board's request will be grounds for rejection of a pending application for appointment or reappointment to the Medical Staff, or the immediate summary suspension of a practitioner who had already been accorded Medical Staff Membership. Provisions for fair hearing and appellate review are provided for in the Fair Hearing Procedure Manual, which by reference is incorporated as part of these Bylaws. The non-affiliated physician selected to perform the evaluation will be mutually acceptable to both the practitioner and the President of the Medical Staff. In the event that such mutual acceptance is not possible, the non-affiliated physician shall be jointly selected by the Chairperson of the Board, the Director and the President of the Medical Staff. Hospital will pay only the professional fee(s) of the selected non-affiliated physician performing the evaluation, as well as the professional fees or other direct expenses incurred as the result of ancillary examinations or procedures requested or directed for the non-affiliated physician. The report of the non-affiliated physician will be forwarded to the Executive Committee.

3.7. Leave of Absence.

- 3.7.1. A member of the Medical Staff may, for good cause, request a Leave of Absence for up to a 12 month period by submitting a written request to the Executive Committee and the Director. If the regularly scheduled reappointment date occurs during that period, the practitioner must follow the reappointment process. A Leave of Absence does not extend the normal two-year appointment cycle. Notification of reappointment will note the practitioner is on a Leave of Absence until a designated date.
- 3.7.2. When the practitioner returns from a Leave of Absence of any length, copies of current licenses, malpractice insurance, information concerning any legal actions and written documentation of the practitioner's professionally related activities during the Leave of Absence shall be provided to the Medical Staff Services Office. If the leave of absence was for medical reasons, the returning practitioner must submit a report from his/her attending physician confirming that the practitioner is physically and/or mentally capable of resuming a hospital practice and exercising the clinical privileges requested.

- 3.7.3. It is the practitioner's responsibility to notify the Medical Staff Services Office of Hospital, when he/she plans to return from a Leave of Absence. Failure to return or obtain an authorized extension by the date of the end of the Leave of Absence shall constitute a voluntary resignation of Medical Staff membership and shall not entitle the practitioner to any type of hearing under the Fair Hearing Procedures.

4. CATEGORIES OF THE MEDICAL STAFF

4.1. The Medical Staff.

The Medical Staff is divided into Honorary, Active Medical, Consulting/Courtesy and Associate categories. Each member of the Medical Staff shall be assigned to a staff category and shall be subject to the responsibilities and prerogatives of that category as defined in these Bylaws and the Rules and Regulations Manual, which by reference is incorporated as part of these Bylaws.

4.2. Honorary Medical Staff.

4.2.1. Honorary Medical Staff consists of those retired practitioners who have practiced at Hospital for at least 15 years but are not currently active at Hospital. A written request for Honorary Staff status shall be submitted to the President of the Medical Staff.

4.2.2. Members of the Honorary Staff:

4.2.2.1. are not eligible for admitting and clinical privileges;

4.2.2.2. are not eligible to hold elected Medical Staff office, or to be assigned to Medical Staff committees;

4.2.2.3. cannot vote Medical Staff affairs; and

4.2.2.4. may attend educational conferences and programs at Hospital.

4.3. Active Medical Staff.

4.3.1. The Active Medical Staff consists of physicians who reside in the community or practice within a reasonable driving distance of Hospital and who are capable and willing to assume all functions of the Active Medical Staff.

4.3.2. The members of the Active Medical Staff:

4.3.2.1. may have admitting and clinical privileges if so indicated on the individual's Delineation of Privileges form and approved by the Board;

4.3.2.2. are eligible for elected medical staff office;

4.3.2.3. are required to serve on committees as designated by the President of the Medical Staff;

4.3.2.4. may vote in all medical staff affairs;

- 4.3.2.5. are expected to participate actively in the business and meetings of the medical staff;
- 4.3.2.6. are required to provide or arrange twenty-four hour emergency call coverage; and
- 4.3.2.7. shall assume responsibility for a timely history and physical and for the care of any medical problems that may be present or arise during hospitalization for the patients of dentists or Associate Medical Staff.

4.4. Consulting/Courtesy Staff.

- 4.4.1. The Consulting/Courtesy Medical Staff shall consist of physicians and dentists otherwise qualified for Staff membership who:
 - 4.4.1.1. practice at another facility outside of the Dyersville community;
 - 4.4.1.2. are not active in the affairs of the medical staff; and
 - 4.4.1.3. wish to act as a consultant or provide limited medical services such as history and physical examinations.
- 4.4.2. Members of the Consulting/Courtesy Medical Staff:
 - 4.4.2.1. if physicians, may apply for admitting privileges within the limits of their assigned clinical privileges;
 - 4.4.2.2. if dentists, may initiate the process for admitting a patient after an appropriate physician member of the Active Medical Staff has agreed to perform a timely history and examination and to care for any medical problems that may be present or arise during hospitalization;
 - 4.4.2.3. are required to retain responsibility within their area of professional competence for the care and supervision of each patient in the hospital for whom they are providing services or arrange for a suitable alternative for such care and supervision;
 - 4.4.2.4. are not eligible for elective Medical Staff office;
 - 4.4.2.5. have no vote in Medical Staff affairs;
 - 4.4.2.6. are not obligated to attend Medical Staff meetings;
 - 4.4.2.7. may attend education conferences and programs at Hospital;

4.4.2.8. have a standing invitation to attend medical staff meetings; and

4.4.2.9. are required to go through routine reappointment.

4.5. Associate Medical Staff.

4.5.1. The Associate Medical Staff consists of podiatrists and psychologists.

4.5.1.1. Associate Staff Psychologist means a practitioner who possesses a doctoral degree in psychology from a regionally accredited university and a current Iowa license issued by the Iowa State Board of Psychology Examiners. Such practitioners must have had at least one (1) year supervised practical experience in an accredited hospital providing inpatient mental health services and must be a member of the National Register of Health Services Providers in Psychology.

4.5.1.2. Podiatrist means a practitioner who possesses a current license to practice podiatry from the State of Iowa.

4.5.2. Members of the Associate Medical Staff:

4.5.2.1. may initiate the process for admitting a patient after an appropriate physician member of the Active Medical Staff has agreed to perform a timely history and physical and to care for any medical problems that may be present or arise during hospitalization;

4.5.2.2. are responsible for and shall record that portion of the patient's history and physical examination related to their specialty;

4.5.2.3. exercise limited clinical privileges as delineated and granted;

4.5.2.4. may not home Medical Staff office;

4.5.2.5. may vote in all Medical Staff affairs;

4.5.2.6. are required to serve on committees as designated by the President of the Medical Staff;

4.5.2.7. may attend educational conferences and programs at Hospital; and

4.5.2.8. are expected to participate actively in the business and meetings of the Medical Staff.

4.6. Salaried (Medical-Administrative) Staff and/or Contract Practitioners.

4.6.1. Salaried and/or contract practitioners must qualify for and maintain medical staff membership and privileges in the same manner prescribed for Active members of the Medical Staff. Membership on the Medical Staff may be made contingent on continuing in a medical/administrative position. Any practitioner who's engagement by Hospital requires membership on the Medical Staff as described above shall not have his/her medical privileges terminated without the same fair hearing provisions as must be provided for any other member of the Medical Staff, unless otherwise stated in the contract.

4.7. Reciprocal Privileges with Mercy Medical Center-Dubuque.

4.7.1. Any medical staff member in good standing at Mercy Medical Center — Dubuque may reciprocally exercise their delineated privileges at Hospital to order tests and treatments, such as, but not limited to: lab, radiology, physical therapy, injections and infusions. The credential file must be available upon request.

5. PROCEDURE FOR APPOINTMENT AND REAPPOINTMENT

All applications for appointment to the Medical Staff or Allied Health category shall be in writing, shall be completed and signed by the applicant, and shall be submitted on a form prescribed by the Executive Committee. (Additional details and procedures for initial appointment to the Medical Staff and reappointment to the Medical Staff are outlined in the Credentials Manual which by reference is included as part of these Bylaws and which may be amended by the Executive Committee.)

6. OFFICERS

6.1. Officers of the Medical Staff.

6.1.1. Officers of the Medical Staff shall provide effective governance of its affairs so as to ensure proper acceptance and discharge of the overall responsibility for the medical care delegated to the Medical Staff by the Board.

The officers of the Medical Staff shall be:

6.1.1.1. President

6.1.1.2. Vice-President

6.1.1.3. Secretary-Treasurer

6.2. Qualifications of Officers.

6.2.1. Officers must be members of the Active Medical Staff at the time of nominations and election and must remain members in good standing during their term in office. Failure to maintain such status shall immediately create a vacancy in the office involved. Officers shall be chosen on the basis of ability and commitment. The president of the staff must be an M.D. or D.O.

6.3. Election of Officers.

6.3.1. Officers shall be elected at the annual meeting of the Medical Staff subject to Board approval. Only members of the Medical Staff shall be eligible to vote. Voting may be by a show of hands unless more than one has been nominated for a specific office. In such case, written ballot must be utilized. When more than two nominees are slated and one does not receive a majority vote, the candidate receiving the least number of votes will be omitted from each successive balloting until a majority vote is received by one candidate

6.3.2. Nominations may be made from the floor by any member of the active Medical Staff at the October Medical Staff meeting.

6.4. Term of Office.

All officers shall serve a two (2) year term from their election date. Officers shall take office on the first day of the Medical Staff year, or January 1. An officer is eligible for re-election to his or her office.

6.5. Vacancies in Office.

Vacancies in office during the Medical Staff year, except for the presidency, shall be elected by the Executive Committee of the Medical Staff. If there is a vacancy of the office of the President, the Vice-President shall serve out the remaining term.

6.6. Duties of Officers.

6.6.1. President (sometimes referred to as “Chief of Staff”)

The President shall serve as the Chief Administrative Officer of the Medical Staff to:

- 6.6.1.1. coordinate and cooperate with the Director in all matters of mutual concern;
- 6.6.1.2. call, preside at, and be responsible for the agenda of all meetings of the Medical Staff;
- 6.6.1.3. serve as chairperson of the Executive Committee;
- 6.6.1.4. serve as ex-officio member of all other Medical Staff committees without vote;
- 6.6.1.5. be responsible for the enforcement of the Medical Staff Bylaws, Rules and Regulations, for the implementation of sanctions where these are authorized by the Board, and for the Medical Staff's compliance with procedural safeguards in all instances where corrective action has been requested against a practitioner;
- 6.6.1.6. appoint, in consultation with the Director, members to all standing and special Medical Staff committees, which may be multidisciplinary, except the Executive Committee;
- 6.6.1.7. represent the views, policies, needs and grievances of the Medical Staff to the Director and when appropriate, through the Director to the Board;
- 6.6.1.8. receive and interpret the policies of the Board on the performance and maintenance of quality with respect to the Medical Staff's delegated responsibility to provide medical care;
- 6.6.1.9. be the spokesperson for the Medical Staff in its external professional and public relations; and
- 6.6.1.10. participate in medical staff leadership activities sponsored by Trinity Health.

6.6.2. Vice-President

The Vice President shall:

- 6.6.2.1. assume all duties and have all authority in the absence of the President;
- 6.6.2.2. succeed the President when he/she is unable to serve for any reason;
- 6.6.2.3. serve as a member of the Executive Committee; and
- 6.6.2.4. perform such other duties as assigned by the President or the Executive Committee.

6.6.3. Secretary-Treasurer

The Secretary-Treasurer shall:

- 6.6.3.1. keep, or cause to be kept, accurate and complete minutes of all Medical Staff meetings;
- 6.6.3.2. call Medical Staff meetings on order of the President;
- 6.6.3.3. attend to all correspondence;
- 6.6.3.4. serve as a member of the Executive Committee; and
- 6.6.3.5. perform such other duties as may be assigned by the President or the Executive Committee.

6.7. Removal of Officers.

6.7.1. Subject to the approval of the Board, an officer may be removed from office for the following reasons:

- 6.7.1.1. failure to comply with applicable policies, by-laws, or rules and regulations;
- 6.7.1.2. failure to perform the duties of office;
- 6.7.1.3. exhibiting conduct detrimental to the interests of Hospital and/or the Medical Staff; or
- 6.7.1.4. suffering from an infirmity that renders the individual incapable of fulfilling the duties of office.

- 6.7.2. Removal of an officer requires a two-thirds (2/3) vote of the Medical Staff Executive Committee members in attendance at a meeting in which a quorum is present, or by a two-thirds (2/3) vote of voting members of the Medical Staff in attendance at a meeting in which a quorum is present.

7. ORGANIZATION OF SERVICES

7.1. Organization of Services.

The Active Medical Staff is organized as a Committee of the Whole and is composed of practitioners practicing in the clinical services of family practice, general surgery, ophthalmology, otolaryngology, pathology and radiology. Associate staff is composed of podiatrists and psychologists. Consulting/Courtesy Staff is composed of physicians who wish to act as a consultant and provide limited medical services such as history and physical examinations.

8. MEDICAL STAFF COMMITTEES

8.1. Executive Committee.

8.1.1. Composition

The Executive Committee shall be a standing committee and shall consist of the officers of the Medical Staff and the Director, who shall be ex-officio.

8.1.2. Duties of the Executive Committee

8.1.2.1. To represent and to act on behalf of the Medical Staff, subject to such limitations as may be imposed by these Bylaws;

8.1.2.2. To provide a liaison between Medical Staff, the Director and the Board of Trustees;

8.1.2.3. To take reasonable steps to ensure professionally ethical conduct and competent clinical performance on the part of all members of the Medical Staff, including the initiation of and/or participation in Medical Staff corrective or review measures when warranted;

8.1.2.4. To initiate, investigate, review and report on corrective action matters and on any other matters involving the clinical, ethical, or professional conduct of any practitioner;

8.1.2.5. Serve as the credentials committee to review the credentials of applicants and to make recommendations for staff membership and delineation of clinical privileges.

8.1.3. Meetings

The Executive Committee shall meet as often as necessary to fulfill its responsibility and maintain a permanent record of its proceedings and actions. Special meetings of the Executive Committee may be called at any time by the President of the Medical Staff and/or the Director.

8.2. Committee of the Whole.

8.2.1. Composition

The Committee of the Whole shall consist of all active members of the Medical Staff and the Director, who shall be ex-officio.

8.2.2. Duties

- 8.2.2.1. Receive, coordinate and act upon as necessary the written reports and recommendations from committees, other officers concerning the functions assigned to them and the discharge of their delegated administrative responsibilities;
- 8.2.2.2. Report to the Board for the overall quality and efficiency of patient care;
- 8.2.2.3. Make recommendations on medico-administrative and hospital management matters;
- 8.2.2.4. Act on all matters of Medical Staff business, except as otherwise provided in the Medical Staff Bylaws;
- 8.2.2.5. Implement policies of the Medical Staff;
- 8.2.2.6. Participate in evaluating existing programs, services, and facilities of Hospital, and the Medical Staff and make recommendations on such matters to the Board through the Director and Medical Staff representative(s) to the Board;
- 8.2.2.7. Fulfill the Medical Staff's accountability to the Board for the medical care rendered to patients in the Hospital;
- 8.2.2.8. Work with Administration and hospital staff in supporting the licensure status of the Hospital;
- 8.2.2.9. Conduct periodic review of the Bylaws and related manuals and forms promulgated in connection with them and submit written recommendations to the Board for changes in these documents;
- 8.2.2.10. Identify nominees for election as Medical Staff officers.

8.2.3. Meetings

The Committee of the Whole shall meet a minimum of ten (10) times annually. Physicians, dentists, podiatrists, ARNPs, CNS, and Pas may attend the meetings.

8.3. Professional Activities Committee.

8.3.1. Composition

The Professional Activities Committee shall be composed of active Medical Staff members, and the Director, who will be ex-officio.

8.3.2. Function

The Professional Activities Committee shall be responsible for Medical Staff monitoring and evaluation functions including: surgical/invasive/mortality case review, blood usage review, drug use evaluation, infection control, diagnostic imaging quality review, physicians' quality improvement, utilization review, risk management, credentialing, and medical records review.

8.3.2.1. Monitoring Activities

Adopt, modify, supervise, and coordinate the conduct and findings of patient care monitoring activities.

8.3.2.1.1. Surgical Case/Tissue Review

8.3.2.1.1.1. Conduct monthly surgical case review, including tissue review, evaluation, and comparison of preoperative and postoperative diagnosis, indications for surgery, actual diagnosis of tissue removed, and situations in which no tissues were removed.

8.3.2.1.1.2. Preliminary tissue review is conducted by the pathologist. A summary of findings is presented to the Professional Activities Committee for monitoring activities.

8.3.2.1.2. Blood Utilization

8.3.2.1.2.1. Conduct regular blood usage reviews, including evaluation of appropriateness of all transfusions (packed cells and blood components), review of all confirmed transfusion reactions, and review of practices for blood and blood products including the amount requested, the amount used, and the amount wasted.

8.3.2.1.2.2. A summary of findings are presented to the Professional Activities Committee for monitoring.

8.3.2.1.3. Infection Control

8.3.2.1.3.1. Review, trend, and evaluate on an ongoing basis the incidence of nosocomial infections, clean and clean-contaminated surgical infections; reporting conclusions, recommendations, actions taken, and action results.

8.3.2.1.3.2. The Infection Control Committee meets bi-monthly to review and summarize all infection control data and activities. Findings are summarized and presented every other month to the Professional Activities Committee.

8.3.2.1.4. Review and evaluate on an ongoing basis the effectiveness of radiographic studies; reporting conclusions, recommendations, actions taken, and action results.

8.3.2.1.5. Review and evaluate on an ongoing basis the effectiveness of Patient Satisfaction Surveys; reporting conclusions, recommendations, action taken, and action results.

8.3.2.1.6. Review on a continuous basis other general indicators of the quality of care and of clinical performance, including unexpected patient care management events.

8.3.2.1.7. Review on a continuous basis, and enforce or coordinate compliance with, consultation requirements and other established policies and protocols relating to clinical practice.

8.3.2.1.8. Those responsible for conducting any of these monitoring activities shall submit written reports of results and progress to any Medical Staff organizational entity with a need to know. The Board receives a report of the overall activity of the Medical Staff meeting minutes.

8.3.2.2. Utilization of Review

8.3.2.2.1. Define utilization management criteria that must apply to all patients regardless of payment source, outline the

confidentiality and conflict of interest policy, and include provisions for at least:

- 8.3.2.2.2. Review of the appropriateness and medical necessity of admissions, continued hospital stays, and the use of clinical support services;
- 8.3.2.2.3. Discharge Planning;
- 8.3.2.2.4. Data collection and reporting requirements;
- 8.3.2.2.5. Review and monitor that the criteria, in effect, are known to the Medical Staff members, and functioning at all times.
- 8.3.2.2.6. Analyze utilization profiles on a periodic basis and prepare written evaluations of the utilization review and management activities on a continuous basis, including a determination of their effectiveness in allocating resources;
- 8.3.2.2.7. Conduct studies, take actions, submit reports, and make recommendations as determined by utilization criteria.

8.3.2.3. Risk Management:

- 8.3.2.3.1. Analyze trends of hazardous and risk management events, determine effective solutions, and recommend action to enhance the quality and safety of patient care.
- 8.3.2.3.2. Submit a written report monthly, including a summary of the findings of and specific recommendations resulting from the program to the Board via the Medical Staff meeting minutes.

8.3.2.4. Medical Records:

- 8.3.2.4.1. Review and evaluate medical records to determine that they:
 - 8.3.2.4.1.1. Properly describe the condition and progress of the patient, the therapy and tests provided, the results thereof, and the identification of responsibility for all actions taken;

8.3.2.4.1.2. Are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services at Hospital.

9. MEDICAL STAFF MEETINGS

9.1. Annual Meeting.

The annual meeting of the Medical Staff shall be held each year in April. At this meeting the officers shall report on the activities and financial condition of the corporation. Officers for the next term shall be elected if the current officers' terms expire at the end of that Medical Staff year. Members of the Medical Staff shall be given written notice at least three (3) days prior to the date set for the annual meeting that includes a description of any matter which must be considered for approval by the members.

9.2. Special Meetings.

Special meetings of the Medical Staff may be called at any time by the President of the Medical Staff, the Board, the Executive Committee, or one-fourth of the members of the active Medical Staff. At any meeting special meeting, no business shall be transacted except that stated in the notice of the meeting. Members of the Medical Staff shall be given written notice stating the place, day and time of any special meeting at least three (3) days prior to the date set for a special meeting.

9.3. Attendance Requirements for Meetings.

9.3.1. Members of the Medical Staff are encouraged to attend meetings of the Medical Staff. Meeting attendance may be used in evaluating members at the time of reappointment. Executive Committee Members are expected to attend at least sixty percent (60%) of the meetings held.

9.3.2. Allied Health Professionals may attend any meeting of the Medical staff. Allied Health Professionals shall not vote or be counted in determining the existence of a quorum.

9.3.3. The Director and any representative assigned by the Director may attend any committee meeting of the Medical Staff.

9.4. Quorum.

A simple majority of at least fifty-one percent (51%) of the total membership of the Active Medical Staff who are eligible to vote shall constitute a quorum at the annual or special meetings of the Medical Staff.

9.5. Rights of Ex Officio Members.

Except as otherwise provided in these Bylaws, persons serving as ex officio members of a committee shall have all rights and privileges of regular members thereof, except they shall not vote or be counted in determining the existence of a quorum.

9.6. Minutes

Minutes of each regular and special meeting of the Medical Staff and of each committee shall be prepared and shall include a record of attendance of members and of votes taken on each matter. The minutes shall be made available to the President unless otherwise specified. Minutes of each committee meeting shall be maintained in a permanent file. The minutes of the Medical Staff meetings shall be presented to the Board for review.

10. CORRECTIVE ACTION, SUMMARY SUSPENSION AND AUTOMATIC SUSPENSION

10.1. Initiation of Corrective Action.

10.1.1. Whenever the activities or professional conduct of any practitioner with clinical privileges are considered to be lower than the standards of the Medical Staff, a possible threat to the well-being of patients in Hospital, disruptive to the operations of Hospital or where the practitioner has failed to attend a mandatory meeting whose purpose is to discuss an apparent or suspected deviation from standard clinical practice, corrective action may be requested in accordance with Section 10.1.2 by:

10.1.1.1. any officer of the Medical Staff;

10.1.1.2. the chairperson of any standing committee of the Medical Staff;

10.1.1.3. the Director; or

10.1.1.4. the Chairperson of the Board.

10.1.2. All requests for corrective action shall be made in writing to the Executive Committee and shall make reference to the specific activities or conduct which constitute the grounds for the request.

10.1.3. Upon receipt of a request for corrective action, the President of the Medical Staff will establish an ad hoc committee to investigate the request. The ad hoc committee will be comprised of:

10.1.3.1. the Director;

10.1.3.2. President of the Medical Staff; and

10.1.3.3. One or more members of the Active Medical Staff appointed by the President of the Medical Staff.

10.2. Informal Investigation.

10.2.1. Upon their appointment, the ad hoc committee will immediately proceed to investigate, in any manner it deems appropriate under the circumstances, the allegations contained in the request for corrective action. It shall be the purpose of the ad hoc committee to attempt to ascertain the facts surrounding the request for corrective action, and, if possible, to work with the affected practitioner and the person requesting corrective action to informally resolve the problems that have led to the request for corrective action. Prior to making its report, the ad hoc committee will give the affected practitioner the opportunity for an

interview to discuss the request for corrective action. The actions of the ad hoc committee shall be informal in nature, but it shall make a record of all such appearances. The affected practitioner has no right to legal counsel or other representation at this informal investigation stage of the proceedings. None of the procedural rules provided in these Bylaws or the appended Fair Hearing Procedure Manual with respect to hearing or appeals shall apply.

- 10.2.2. Within fourteen days after their appointment, the ad hoc committee will prepare a written report of its investigation and attempts at resolution and made a recommendation to the Executive Committee on what action, if any, should be taken regarding the request for corrective action.
- 10.2.3. In the event that the ad hoc committee finds that the practitioner's actions are due to impairment of any type and the practitioner agrees to voluntarily relinquish clinical privileges on a temporary basis and undergo appropriate rehabilitation, the committee may hold its report in abeyance pending completion of rehabilitation as outlined in the Board's Impaired Medical Staff Member Policy. If the practitioner discontinues rehabilitation prior to completion of an agreed upon program, the ad hoc committee will make an immediate report to Executive Committee.
- 10.2.4. The ad hoc committee may recommend any one or more of the following actions regarding the request for corrective action:
 - 10.2.4.1. dismissal on the basis of an informal settlement;
 - 10.2.4.2. rejection;
 - 10.2.4.3. modification;
 - 10.2.4.4. acceptance and the practitioner:
 - 10.2.4.4.1. be issued a warning;
 - 10.2.4.4.2. be given a letter of admonition;
 - 10.2.4.4.3. be formally reprimanded;
 - 10.2.4.4.4. be subject to specific terms of probation;
 - 10.2.4.4.5. be required to undergo consultation or a physical or mental examination;
 - 10.2.4.4.6. have clinical privileges reduced, suspended or revoked;

10.2.4.4.7. have an already imposed summary suspension of clinical privileges terminated, modified or sustained; or

10.2.4.4.8. have the practitioner's Medical Staff membership suspended or revoked.

10.2.5. The report of the ad hoc committee shall be delivered to the Executive Committee and the Director, and a copy of the report and recommendation of the ad hoc committee will be sent by certified mail, return receipt requested, to the affected practitioner. The affected practitioner shall be advised that he or she has ten days to respond in writing to the Executive Committee regarding the ad hoc committee's report and recommendations.

10.3. Action on Ad Hoc Committee Recommendations.

10.3.1. At the next regularly scheduled meeting of the Executive Committee after the affected practitioner has submitted written comments, or, if no comments have been submitted and the time for filing written comments has expired, the Executive Committee shall review the report and recommendations of the ad hoc committee and the written comments, if any, submitted by the affected practitioner. The Executive Committee shall determine a recommendation to be made to the Board on the request for corrective action and transmit such recommendation to the Board through the Director.

10.3.2. Any action by the Executive Committee to reduce, suspend, or revoke clinical privileges or to suspend or to revoke Medical Staff membership shall confer upon the Medical Staff member the procedural rights set forth in the appropriate section of the Fair Hearing Procedure of these Bylaws.

10.4. Summary Suspension.

10.4.1. Whenever a medical staff member's activities or professional conduct, including any oral or written act, either within or outside of the hospital, are of a serious nature and/or reasonably likely to be, contrary to patient safety or the delivery of quality patient care, disruptive to hospital operations or the continued effective operation of the hospital, such that immediate action is required, the President of the Medical Staff, the Director or the Chairperson of the Board shall have the authority to summarily suspend the medical staff membership status of all or any portion of clinical privileges of such staff members. Any summary suspension imposed shall be effective immediately upon imposition and shall, in the event that corrective action is recommended, continued pending resolution of the request for corrective action, except as otherwise determined by the Director.

10.4.2. When all or a portion of the clinical privileges of a practitioner are suspended in accordance with this section, the Director shall immediately give notice of such

action to the affected practitioner by certified mail, return receipt requested, and also given notice to the Executive Committee.

10.4.3. Upon receipt of a notice of summary suspension, the Executive Committee, within twenty-four hours, shall review the action of the Director and either:

10.4.3.1. lift the summary suspension and treat the Director's action as a request for corrective action to be processed in accordance with the provisions of this Section 10; or

10.4.3.2. maintain the summary suspension in effect and proceed to process the Director's action as a request for corrective action to be processed in accordance with the provisions of this Section 10.

10.5. Automatic Suspension.

10.5.1. Any practitioner whose license to practice is revoked or suspended by any agency of the State of Iowa shall automatically have all admitting and clinical privileges at Hospital suspended. A staff member who has been placed on probation by the Iowa State Board of Medical Examiners may be automatically suspended or his/her privileges may be retained subject to such conditions as are imposed by the Executive Committee of the Board.

10.5.2. Any practitioner who fails to complete medical records in a timely manner shall have all admitting and clinical privileges suspended as outlined in the Rules and Regulations Manual.

10.5.3. Any practitioner who fails to attend any committee or service meeting with respect to which the practitioner was given notice that attendance was mandatory shall, unless excused for good cause as determined in its sole discretion by the Executive Committee, automatically have suspended all or a portion of the practitioner's clinical privileges as the Executive Committee may direct. Such suspension shall remain in effect until the matter is resolved through any mechanism that the Executive Committee determines to be appropriate under the circumstances.

10.5.4. Any practitioner who fails to renew and/or provide evidence of a current license to practice shall automatically have all admitting and clinical privileges at Hospital suspended.

10.5.5. Any practitioner who fails to renew and/or provide evidence of current malpractice insurance with limits as established the Trinity Health shall automatically have all admitting and clinical privileges at Hospital suspended.

10.5.6. Any practitioner who is convicted of a felony shall automatically have all admitting and clinical privileges at Hospital suspended.

10.5.7. In the event of an automatic suspension pursuant to this section, the affected practitioner may petition the Medical Executive Committee for reinstatement of his/her clinical privileges when the event giving rise to automatic suspension has been satisfactorily addressed. The Medical Executive Committee may process such petition for reinstatement in any manner it believes is appropriate under the circumstances.

11. IMMUNITY FROM LIABILITY

11.1. Practitioner's Release from Liability.

11.1.1. Any practitioner who makes application for appointment or reappointment to the Medical Staff, and each practitioner who is a member of the Medical Staff hereby agrees as follows:

11.1.1.1. To the fullest extent permitted by law, each practitioner releases and gives full immunity from civil liability to all members of the Medical Staff, all representatives, agents, committees, and employees of Hospital, the Board, and all third parties for all acts, communications, reports, recommendations or disclosures, made in good faith and without malice, performed or made in connection with Hospital or any other health care institution's activities related to:

11.1.1.1.1. application for appointment or clinical privileges;

11.1.1.1.2. periodic reappraisals for reappointment or clinical privileges;

11.1.1.1.3. corrective action, including summary suspension;

11.1.1.1.4. hearings and appellate reviews;

11.1.1.1.5. medical care evaluations;

11.1.1.1.6. utilization review;

11.1.1.1.7. peer review;

11.1.1.1.8. any committee of the Medical Staff; and

11.1.1.1.9. any other activities related to patient care and professional conduct.

11.1.1.2. The acts, communications, reports, recommendations and disclosures referred to in this Section 11 may relate to a practitioner's professional qualification, clinical competency, character, mental or physical well-being, ethics, ability to get along with others, or any other matter that related directly or indirectly to the practitioner's ability to care for patients in a hospital setting; and

11.1.1.3. The term "third parties" as used in this Section 11 means both individuals and organizations, in whatever form, from whom information has been requested relating to the practitioner.

- 11.1.2. Each practitioner shall, upon the request of the Medical Staff or Hospital, execute a release in accordance with the provisions of Section 11.1.1 above, in favor of the individuals specified therein, subject to the limitation that such releases only apply to acts, communications, reports, recommendations or disclosures made in good faith and without malice.

12. FAIR HEARING AND APPELLATE REVIEW

A Fair Hearing Procedure Manual is attached and by reference is included as part of these Bylaws. This manual can be amended from time to time by the Executive Committee, and adopted by the Board.

13. RULES AND REGULATIONS

The Medical Staff shall adopt such Rules and Regulations as may be necessary to implement more specifically the general principles found within these Bylaws, subject to approval of the Board. These shall relate to the proper conduct of the Medical Staff organizational activities as well as embody the level of practice that is to be required of each practitioner in the hospital.

Such Rules and Regulations shall be included in a separate attached manual which by reference is made part of these Bylaws. They may be amended or repealed by a two-thirds vote of the Executive Committee at a meeting where a quorum is present subject to the approval of the Board.

14. MISCELLANEOUS

14.1. Conflicts with Joint Operating Agreement

Notwithstanding anything to the contrary contained in its Governance Documents, the Board of Directors and Member of the Corporation have approved certain delegations of authority to MHN, pursuant to the terms and conditions of the Joint Operating Agreement, including, without limitation, the authority set forth in the MHN Authorities Matrix, which is incorporated herein by reference. To the extent the terms and conditions regarding such delegations set forth in the Joint Operating Agreement do not comply with the requirements of the Governance Documents of this Corporation, the requirements of the Governance Documents of this Corporation regarding such provision are waived and the provisions of the Joint Operating Agreement shall be controlling.

15. BYLAWS AMENDMENT

15.1. Procedure for Amendment.

- 15.1.1. These Bylaws may be amended, in whole or in part, by an affirmative vote of two-thirds (2/3) of the voting Medical Staff present where notice of such proposed amendment has been given in accordance with Section 9 of these Bylaws. The Credentialing, Policies and Procedures and Fair Hearing Procedure Manuals can be amended by the Executive Committee at a meeting at which a quorum is present.
- 15.1.2. Any amendment so adopted shall be subject to, and effective upon, the approval of the Board.
- 15.1.3. Amendment to these Bylaws are accomplished through a cooperative process involving both the Medical Staff and the Board. Neither party may unilaterally amend these Bylaws.

16. ADOPTION

16.1. Adoption of these Bylaws.

- 16.1.1. These Bylaws, when adopted at any regular or special meeting of the Medical Staff, shall be recommended to replace any previous Bylaws.
- 16.1.2. These Bylaws shall be subject to, and effective upon, approval of the Board. They shall, when adopted and approved, be equally binding on the Board and Medical Staff.

**ADOPTED BY THE MEDICAL STAFF OF MERCY MEDICAL
CENTER-DYERSVILLE.**

APPROVED by the Medical Staff on
_____, 20__.

Chief of Staff

APPROVED by the Board on
_____, 20__.

Chair, Board of Directors

ARTICLE I: RULES AND REGULATIONS

Section 1. General: Pertaining To All Practitioners

- A. A patient may be admitted to the hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the hospital.
- B. Provisional diagnosis must be available at the time of admission.
- C. A patient to be admitted on an emergency basis who does not have a private practitioner may request any practitioner on the medical staff with appropriate privileges to attend to him/her. Where no such selection is made or if the physician is unavailable or declines, the member of the Active Staff on call will be assigned to the patient.
- D. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.
- E. A practitioner whose privileges have been suspended for non-compliance with Rules F. of this section or N. of Medical Records shall not admit patients under a colleague's or partner's name, nor may patients be admitted to the care of a practitioner whose privileges are suspended.
- F. A complete history and physical shall be done no more than seven (7) days before or 48 hours after an admission for each patient by a doctor of medicine or osteopathy. This report shall include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and a physical examination performed 30 days prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medial record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the medical staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 48 hours.
- G. A member of the Medical Staff shall be responsible for the medical care and treatment of his/her patients in the hospital, for necessary special instructions, and for transmitting reports on the condition of the patient to the referring practitioner, to the patient and/or to relatives of the patient. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility shall be entered on the order sheet of the medical records, or as an order within the electronic medical record.

- H. All orders shall be in writing or electronic form. An order shall be considered to be in writing if dictated to a registered nurse, registered therapist, registered pharmacist, x-ray technologist, registered nuclear medicine technologist, registered lab technician, registered or certified respiratory therapist, registered or certified medical technologist, registered or certified or licensed dietician or x-ray secretary (only noninvasive studies) employed by the hospital and signed either on paper or electronically by the attending practitioner. Such orders are limited to the specific area of professional expertise of the receiving individual. Orders dictated over the telephone shall be signed by those listed in the paragraph with name of the practitioner next to their name. Within 30 days, the practitioner shall authenticate with signature either on paper or electronically such orders (except for Oak Crest Manor where orders will be signed either on paper or electronically on the practitioner's next visit). Medication orders can only be given to a registered nurse or registered pharmacist.
- I. The practitioner's orders must be written clearly, legibly and completely, or entered electronically. Orders which are illegible or improperly written will not be carried out until rewritten or understood by staff delineated in Rule 9.
- J. Pre-printed routine standing orders shall not replace or cancel orders written for a specific patient. Pre-printed routine standing orders will be reviewed every year.
- K. The attending provider is required to document the need for continued hospitalization after specific periods of stay per disease categories as identified by the Utilization Review Committee of this Hospital and approved by the Executive Committee of the Medical Staff.
- L. The Pharmacy shall dispense generic drugs as approved by the Hospital Medical Staff through the Professional Activities Committee unless the prescribing physician identifies a therapeutic reason that an individual patient should not receive a specific trade name medication. In these cases the physician is to note "Dispense as Written" on the physician's order sheet or in the comment section of the electronic order. Any concerns regarding the bioequivalency of a specific generic drug dispensed by the pharmacy will be referred to the Hospital Medical Staff Professional Activities Committee.
- M. The Medical Staff will limit the duration of drug therapy in the absence of the prescriber's specific indication of duration of drug therapy through the use of criteria defined by the Hospital Medical Staff through the Professional Activities Committee. The prescribing practitioner may override the automatic stop date by specifying a particular duration for therapy. Automatic stop dates for the following drug categories are assigned as follows:
- Controlled substances and anti-infective agents – 30 days

- Other monitored drugs-as approved by the Medical Staff of Hospital and the Professional Activities Committee.

Renewal Notice: A notice of renewal will be posted with the progress notes twenty-four (24) hours before the automatic stop date takes effect. If not renewed, the prescribing physician will be contacted.

All medication orders are discontinued when the patient is transferred to a different level of care, i.e. for surgery, swing bed skilled care or nursing home.

- N. Any patient exhibiting behavior indicative of substance abuse or mental illness will have an assessment conducted by a substance abuse or mental health professional with hospital privileges or will be transferred to Mercy Medical Center, Dubuque or other appropriate health care facility for assessment.
- O. Any patient known or suspected to be suicidal shall be transferred to an appropriate facility for consultation by a member of behavioral health staff.
- P. Restraints (leather/soft) may be used on any nursing unit as outlined in the restraint policy in the patient care services policy manual. All orders for restraints/seclusion must include the type of restraint (leather/soft), time limit, and the reason for the specific episode. Orders must be signed, dated and timed by the practitioner writing or entering the order. PRN orders are not acceptable. Orders are time limited to 24 hours for adults and children for medical reasons.
- Q. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling a qualified consultant. He/she will provide either electronic or written authorization to permit another attending practitioner to attend or examine his/her patient except in an emergency. The consultant shall respond in a timely manner consistent with the patient's condition but in no case later than twenty-four (24) hours. The consultant will document the findings and recommendations in the medical record with twenty-four (24) hours.
- R. Each member of the Medical Staff, not a resident in the city or immediate vicinity, shall name a member of the Active Medical Staff who is a resident of the city, who may be called to attend his/her patient in an emergency. In the event that neither is available, the President of the Medical Staff or Director will have the authority to call any member of the Medical Staff to attend the patient.
- S. Written consent of the patient is required for release of medication information to persons not otherwise authorized to receive this information.
- T. At the time of discharge, the practitioner will complete the record, state final diagnosis and sign the record either on paper or electronically.

- U. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record and the patient shall be requested to sign the Refusal of Care form.
- V. The Medical Staff shall cooperate with the Hospital administration in the education of health care professionals by giving such personal supervision and educational programs as are necessary.
- W. Upon receiving staff privileges, the practitioner shall sign a statement acknowledging that the practitioner had read and understands the entire attestation paragraph, including the penalty notice, as required by Federal Regulations.
- X. A general consent form, signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission. It will be the practitioner's responsibility to obtain an informed consent which documents that benefits, risks and alternatives have been discussed with the patient or appropriate representative in the case of minors, or in the case of inability of the patient to comply, for all noninvasive and invasive procedures, and all other procedures as outlined in the Patient Care Manual. Additional specific consents required for both regional and general anesthesia as well as those instances when sedation is utilized. Consent is also required for blood or blood product transfusions. With the exception of life-threatening emergencies any and all required consents must be obtained prior to the procedure and documented on the appropriate form within the paper portion of the chart.
- Y. Do not resuscitate orders must be clearly documented and progress notes must indicate discussion was held with the patient and/or family regarding Do Not Resuscitate orders. When Advanced Directives and/or Living Will are present, the electronic or written documentation must include reference to these documents if decisions as to life support mechanisms or extraordinary medical care are necessary.
- Z. Whenever any minor patient is examined or treated and where there is suspicion of child abuse, the attending practitioner shall immediately complete a written report and notify the Department of Human Services.
- AA. Whenever any dependent adult is examined or treated and where there is a suspicion of dependent adult abuse, the attending physician shall immediately complete a written report and notify the Department of Human Services.

Section 2. Specific: Pertaining to Services

A. Obstetrical

Hospital does not routinely deliver babies at this facility. If a woman presents herself to the emergency room in labor, it is up to the discretion of the physician whether the delivery will be done at this institution. If at all possible, without endangering the life of either the mother or child, and in compliance with EMTALA regulations, the mother will be transferred to the nearest appropriate facility.

Should an infant be delivered in an emergency situation at the discretion of the physician, the mother and infant will be transferred to the nearest appropriate facility as soon as possible upon stabilization of both mother and infant.

B. Surgery

1. All previous orders are cancelled when patients go to surgery except those specifically indicated to begin after surgery.
2. Scheduling of Cases
 - a. Cases are scheduled in the operating room by the O.R. staff or Acute Nursing Staff after verifying anesthesia coverage. The schedule is controlled by the O.R. Patient Care Coordinator.
 - b. Scheduling is on a "first come, first served" basis.
3. Change of Schedule in Case of Emergency Surgery
 - a. In the event of an emergency, Patient Care Coordinator, in consultation with the anesthesiologist or anesthesiologist has the authority to rearrange the schedule to allow time for the case. It is the Patient Care Coordinator's responsibility to notify the appropriate surgeon. Any exceptional problems will be referred to the President of the Medical Staff.
4. Requirements Prior to Anesthesia and Operation
 - a. Anesthetic Risk and Evaluation
 1. A qualified practitioner must examine the patient immediately before surgery to evaluate the risk of the procedure to be performed.
 - a. Qualified Practitioner:

1. A doctor of medicine or osteopathy;
 2. A doctor of podiatric medicine.
 2. A qualified practitioner must examine each patient before surgery to evaluate the risk of anesthesia.
 - a. Qualified Practitioner:
 1. A doctor of medicine or osteopathy;
 2. A doctor of podiatric medicine;
 3. A certified registered nurse anesthetist (CRNA).
 3. Each patient, before discharge, must be evaluated for proper anesthesia recovery by a qualified practitioner, as specified in 2(a) and must include:
 - a. Cardiopulmonary status;
 - b. Level of consciousness;
 - c. Any follow-up care and/or observations; and
 - d. Any complications occurring during post-anesthesia recovery.
 - b. Moderate sedation must be administered by Medical Staff members with proper credentials according to guidelines outlined in the Moderate/Deep Sedation/Analgesia Policy which is included in the Patient Care Manual.
5. Minor Surgery Patients
- a. Patients being admitted for minor surgery on the day of the scheduled surgery shall be admitted two (2) hours prior to surgery to allow time for the necessary work-up. Whenever possible, pre-admission testing shall be used.
6. Preoperative Evaluation and Documentation
- a. The surgeon shall be held responsible for the preparation of the complete medical record prior to the surgery. This

includes identification data, complaint, personal history*, family history*, history of present illness*, physical examination*, special reports such as consultation, clinical laboratory, x-ray as well as provisional diagnosis and assessment of risks and benefits and need to administer blood or blood components. When the above information is not recorded before the time stated for the operation, the anesthesiologist or nurse anesthetist must ask the surgeon to document on the chart any medical problems. If the above is not accomplished, the operation may be cancelled by an anesthesiologist or anesthetist unless the attending surgeon states in writing that the delay would be detrimental to the patient.

*Not required for outpatients who receive only local anesthesia or I.V. Blocks, unless medical problems would require the history and/or physical.

- b. Patients admitted for elective surgical procedures should utilize the pre-admission testing program which includes patient education.
 - c. The medical record shall include a pre-op assessment which shall be done either by the anesthesiologist, nurse anesthetist and/or qualified practitioner.
7. Laboratory procedures to be completed prior to surgery involving general or regional anesthesia are outlined in the Patient Care Manual. These procedures will be done within (7) days prior to surgery.
8. Informed Consent Forms
- a. Surgical. It will be responsibility of the attending practitioner to inform the patient about the expected benefits of the proposed surgical procedure as well as alternatives and the risks associated with having or not having the procedure. After the patient has received this information, it will be the responsibility of the attending practitioner or the registered nurse to secure the signature of the patient on the Consent for Surgical Treatment form. In the event that the patient is a minor unable to consent because of the medical condition, consent will be obtained from the legal representative.
 - b. It will be the responsibility of the anesthesiologist or the nurse practitioner to inform the patient about the expected

benefits of the proposed anesthetic method as well as the alternatives and the risks of anesthesia. After the patient has received the information, it will be the responsibility of the anesthesiologist the nurse anesthetist, or the registered nurse to secure the signature of the patient on the Consent for Anesthesia form. In the event that the patient is a minor or unable to consent because of medical condition, consent will be obtained from the legal representative.

- c. No operation shall be performed, nor general or spinal anesthetic administered without the informed written consent of the patient or his/her legal representative. In the case where one of the foregoing procedures is deemed urgent because of life-threatening conditions and informed consent cannot be obtained either because of a minor patient, an irresponsible or unresponsive patient, a written or electronic statement on the chart should be made by the attending practitioner concerning the patient's condition and imminent need of the recommended procedure. In addition, a consultation should be obtained with corroborative statements by the consultant indicating that the procedure is indicated in view of the imminent, life-threatening situation
9. Outpatient procedures requiring general anesthesia shall only be done in the Operating Room, according to the same standards as inpatient procedures.
 10. Care and Transport of Patients
 - a. Patients shall be transferred from the surgical suite to the recovery room by the anesthesiologist or nurse anesthetist who administered the anesthesia and O.R. staff members.
 - b. Anesthesiologist or the nurse anesthetist who administered the anesthesia on a particular patient shall remain in Post Anesthesia Recovery until he/she is sure the patient is in satisfactory condition.
 - c. Patients transferred from PACU or OR to the nursing unit are accompanied by a registered nurse with the exception that those patients that have a cumulative score of 8-10 on Modified Aldrite Scoring System or all categories the same as baseline may be transported by a nursing assistant.

11. Post Anesthesia Recovery

- a. Post Anesthesia Recovery shall be under the medical direction of an anesthesiologist or nurse anesthetist and attending physician.
- b. All patients who have undergone the following anesthetics shall be admitted to Post Anesthesia Recovery.
 - i. general
 - ii. spinal
 - iii. caudal
 - iv. local, if indicated
 - v. nerve blocks
 - vi. patients receiving conscious sedation in the operating room that do not meet discharge criteria
- c. The anesthesiologist or nurse anesthetists shall determine when a patient is ready to be transferred from Post Anesthesia Recovery.

12. Efficient Utilization of Operating Rooms

- a. The assignment of cases to the specific operating room shall be made by the Patient Care Coordinator.
- b. In emergency cases, which are not life threatening, one (1) hour notification to the operating room and anesthesia is desirable.
- c. Universal Precautions will be followed for all cases.

13. Consultation

- a. Except in emergency, consultation with another member of the Active Medical Staff is suggested in all major cases in which the patient is considered a high risk. The consultant shall always complete and sign a record of findings and recommendations.

14. Operative Report

Operative reports shall be dictated or written in the medical record immediately after surgery and shall contain a description of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the

primary surgeon and any assistants. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. A comprehensive operative progress note shall be entered in the medical record immediately after surgery to provide pertinent information for use by any practitioner who is required to attend the patient.

15. Tissue Examination

- a. All tissue removed during surgery shall be sent to the Hospital laboratory for examination by the pathologist. However, the following may be exempted from this requirement.
 - i. specimens that by their nature or condition do not permit productive examination, such as cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;
 - ii. foreign bodies (for example, bullets) that for legal reasons are given directly in the chain of custody to law enforcement representatives.
 - iii. teeth, provided the number, including fragments, is recorded in the medical record; and old scars.
- b. Report is to be made and recorded on the patient's record of all tissue removed and whether it has been forwarded for examination. All tissues remain the property of the Hospital.
- c. All specimens submitted for Pathology examination must be processed through the Hospital pathology department including those specimens being referred to another institution for special studies.
- d. Certain types of specimens will require only gross examination by the pathologist. These include, but are not limited to the following:
 - i. tonsils and/or adenoids under age 15
 - ii. hernia sac and other hernia tissue
 - iii. varicose veins

- iv. foreign body
- v. prosthetic material
- vi. teeth
- vii. bone and/or soft tissue removed for reconstructive purposes only
- viii. traumatic amputations and/or post traumatic amputated or debrided tissue.
- ix. calculi (biliary, urinary, other)
- x. blood clot from hematoma

Occasionally other types of specimens may require only gross examination. This determination will be left to the judgment of the pathologist and may include consultation with the surgeon. After gross examination of the above types of specimens, the pathologist may proceed with microscopic exam if deemed indicated in the particular case. Also, the surgeon or other involved physicians may request microscopic exam for appropriate indication.

- 16. Rules governing advisability for having surgical assistants at a surgical procedure are as follows:
 - a. In any procedure with unusual hazard to life there must be a qualified physician present and scrubbed as first assistant.
 - b. A qualified assistant is defined as a physician designated by the Board.

17. Conductivity and Environmental Control

The Director of Plant Engineering shall see that the necessary safety inspection and checks in regard to environmental control are accomplished. It is the Supervisor's responsibility to see that the necessary records are kept of these checks and filed. One copy shall be furnished to the OR Patient Care Coordinator.

18. Radiation Safety

- a. Surgical Rooms – Conventional portable x-ray machines:
When a surgical procedure requires x-ray services, all

surgical personnel should leave the room during the x-ray exposure. The surgeon, anesthesiologist, anesthetist and x-ray technologist remaining in the room during the x-ray exposure will wear lead protective aprons.

Section 3. Medical Records

- A. All records and films shall be the property of Hospital. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court subpoena or statute. In case of a readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the practitioner.
- B. Pre-printed routine standing orders shall be formulated by conference between the Medical Staff and the Director or designee. All pre-printed routine standing orders shall be reviewed every year, revised as necessary, and signed by the practitioner(s).
- C. The attending practitioner shall be held responsible for the preparation of a complete medical record for the Hospital file. This includes: identification data, complaint, personal history, family history, history of present illness, physical examination, special reports such as consultation, clinical laboratory, x-ray and others; provisional diagnosis; medical or surgical treatment, operative report, condition on discharge; progress notes; autopsy or tissue report when available, and final diagnosis. In addition, instructions for follow-up given to the patients should be delineated in either the final progress notes or dictated discharge summary.
- D. All reports completed by Allied Health Professionals who are the responsibility of a member of the Medical Staff shall be authenticated by him/her. For example, when specified professional personnel have been approved or such duties as taking medical histories and some aspects of a physical examination, such information shall be authenticated by the responsible Medical Staff member.
- E. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever 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.
- F. Consultation shall show evidence of a review of the patient's record by the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as, "I concur," does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note, except in emergency situations so verified on the record

shall be recorded prior to the operation.

- G. Copies of reports of clinical lab, x-ray, and other tests performed in the practitioner's office shall be incorporated into the medical record pertinent to that patient's hospitalization.
- H. All clinical entries in the patient's medical record shall be accurately dated and authenticated.
- I. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Record Department.
- J. Final diagnosis shall be recorded in full, without use of symbols or abbreviations, and dated and signed either on paper or electronically by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important at the actual discharge order.
- K. A discharge clinical resume (summary) shall be written or dictated on all medical records of patients hospitalized over 48 hours. In all instances, the content of the medical record must be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.
- L. Access to all medical records of all patients shall be afforded to members of the Medical Staff and other authorized parties for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Director, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in Hospital.
- M. A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Executive Committee.
- N. The patient's medical record shall be completed at the time of discharge, including progress notes, final diagnoses and dictated clinical resume. When this is not possible, the patient's record will be available in the Medical Record Department after discharge. Medical Records will be considered delinquent when they are 15 days past-due following discharge. On Tuesdays of each week a letter is sent to each Medical Staff member who has four or more records overdue or when any records are 30 days overdue. That letter contains the number of records over ten days old or older and the number of suspensions the Medical Staff member has received within this twelve-month period. On Friday, a reminder telephone call is made to the office if those records remain incomplete.

On Monday at 12:00 Noon, if those records (now at least 15 days overdue) are still incomplete, the Medical Staff member's admitting and surgery scheduling privileges are suspended until the records are completed. If the Medical Staff member is on vacation during the time 10 day records are identified and he/she has notified the Medical Record Department before leaving, he/she is not place on the delinquent list. If the Medical Staff member is on the list before a vacation, he/she is kept on the list until the records are completed. As soon as the records are completed and a Medical Records person is notified, the Medical Staff member is removed from the list.

It at any time a medical record is not available for a Medical Staff member, the age of the record is set back to zero and will not count against the Medical Staff member.

The Medical Staff member with five temporary suspensions in any twelve-month period will be required to meet personally with the Executive Committee to explain his position and agree to comply with the policy. Suspensions following the meeting with the Executive Committee will automatically trigger the following:

1. The sixth suspension within a twelve-month period will result in a one-week suspension of all admitting and scheduling privileges.
2. The seventh suspension within a twelve-month period will result in a two-week suspension of all admitting and scheduling privileges.
3. The eighth suspension within a twelve-month period will result in a four-week suspension of all admitting and scheduling privileges.
4. Any further suspension will automatically trigger permanent suspension requiring reapplication to the medical staff.

Letters of incomplete medical records sent to Medical Staff members with five or more suspensions will be sent by certified mail with return receipt requested, which will require the Medical Staff member's signature.

- O. When an autopsy is performed, provisional anatomic diagnosis should be recorded in the medical record within three days and complete protocol should be made part of the record within sixty (60) days.

Section 4. Hospital Deaths

- A. In the event of a hospital death, the deceased shall be pronounced dead by the practitioner or his designee within a reasonable time. In the event of a patient whose death is anticipated, a licensed physician assistant or registered nurse may make the pronouncement of death within a reasonable time. The body shall not be released until an entry has been made and signed, either on paper or electronically, in the medical record of the deceased by a member of the Medical Staff. Exceptions shall be made in those instances of incontrovertible terminal disease wherein the patient's course has been adequately documented.
- B. Every member of the Medical Staff shall be actively interested in securing autopsies that shall be performed by the Hospital pathologist, or by a physician to whom delegated. Medical Staff members will be notified of autopsies about to be performed in the hospital utilizing the paging system and are encouraged to attend.
- C. Autopsy should be considered in the following cases of death:
1. Deaths in which an autopsy may help explain unknown and unanticipated medical complications.
 2. Deaths in which the cause is not known with certainty on clinical grounds.
 3. Cases in which an autopsy may help allay concerns of the family and/or the public regarding the death and provide reassurance to them regarding same.
 4. Unexpected or unexplained deaths occurring during or following any dental, medical or surgical diagnostic procedures and/or therapies.
 5. Deaths occurring in patients who have participated in clinical trials (protocols) approved by institutional review boards.
 6. Sudden, unexpected and unexplained deaths which are apparently natural and not subject to a forensic medical jurisdiction
 7. Deaths in which the patient sustained or apparently sustained an injury while hospitalized.
 8. Deaths at any age in which it is felt that autopsy would disclose a known or suspected illness which may also have a bearing on survivors or recipients of transplant organs.

9. Deaths known or suspected to have resulted from environmental or occupational hazards.
- D. When death occurs suddenly, directly, or indirectly due to an accident or under suspicious circumstances, a report must be made within twenty-four (24) hours by the supervisor in charge at the time of death to the Medical Examiner whose permission must be secured before the body may be removed from the Hospital. This regulation also applies to surgical deaths that occur in the operating and recovery rooms.

Section 5. Infection and Environmental Control.

A. Infection Surveillance:

Infection Surveillance will be the responsibility of the epidemiologist under the direction of the Infection Control Officer. The epidemiologist will perform the following duties:

1. supervise the surveillance program;
2. attempt to determine the source of infection;
3. bring to the attention of the Professional Activities Committee problems detected through the surveillance system; and
4. report specified communicable diseases to the local public health department.

B. A Sanitary Environment:

Hospital departments concerned with a sanitary environment (e.g. nutrition, environmental services, plant engineering, etc.) are to establish and carry out infection control policies pertinent to the operation of their departments. These are to be periodically reviewed and updated by the Professional Activities Committee.

Environmental culturing is the responsibility of the epidemiologist or designated laboratory personnel. Limited environmental culturing may be carried out through the Professional Activities Committee for the following objectives:

- a. investigation of hospital acquired infections;
- b. education of hospital personnel; and
- c. monitoring of microbial flora in areas, objects and equipment specified by the Professional Activities Committee.

C. Procedures for the Isolation of Infected Patients.

The procedure for the isolation of infected patients will be determined by the Professional Activities Committee and will be periodically reviewed and revised to conform to current standards of practice. Problems with isolation techniques are brought to the attention of the Professional Activities Committee by the Director of Patient Care Services and/or epidemiologist.

D. Programs for the Education of Personnel in the Control of Nosocomial Infection:

The epidemiologist will be responsible for coordinating the orientation of all new employees and for the inservice and continuing education of all departments relative to prevention and control of infection. The epidemiologist will periodically report these activities to the committee for their evaluation and recommendations.

E. Departmental Policies and Procedures Designed to Prevent Infection:

There shall be specific written infection control policies and procedures for all services in the Hospital. These policies will be subject to the approval of the Professional Activities Committee and will be periodically reviewed for reapproval or revision.

F. Authority of the Professional Activities Committee:

1. Recommendations of the committee affecting Hospital departments shall be forwarded to the appropriate department for approval. In those instances where the recommendations are not approved by the department involved, they will be referred to Hospital administration.
2. Recommendations of the committee affecting clinical departments shall be forwarded to the appropriate department(s) for approval. Recommendations affecting all clinical departments shall be brought before all departments for approval. On those instances where the recommendations are not approved, they will be referred to the Executive Committee for review and action.

G. Authority of the Infection Control Officer:

In the interest of uniform application of isolation regulations and protection of all patients and personnel, the Infection Control Officer and or/epidemiologist will have the authority to order appropriate cultures and/or isolation of a patient and personnel. A consultation will be obtained with the attending physician when such action is deemed necessary. In situations where there occurs an epidemic,

threatened epidemic, or unusual cluster of infectious disease, the Infection Control Officer will have the authority to order appropriate control measures including isolation, investigational procedures and closure of a unit. The Infection Control Office shall also have the authority to prohibit those persons suspected to be carriers or in the communicable phase of an infectious disease process from working in areas of direct patient contact until appropriate measures have been taken to reduce the possibility of cross infection. In the event that an Infection Control Officer is not available, another physician from the Hospital's Infection and Environmental Control Committee shall be contacted and will have full authority for making necessary decisions.

Section 6. Healthcare Professionals' Responsibility in Patient Care

- A. If a healthcare professional has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, the health professional shall call the situation to the attention of the nurse in charge of the floor at that time, and also provide the nurse a written statement regarding the situation. The nurse in charge will then contact the attending practitioner and invite comment. If the problem is not solved by this means the nurse in charge shall refer the matter to the Director of Patient Care Services. The Director of Patient Care Services shall, if warranted, bring the matter to the attention of the President of the Medical Staff. Where circumstances are such that it presents an immediate problem for the patient, the President of the Medical Staff shall request a consultation, consisting of an immediate review of the medical record with the attending practitioner.
- B. If any other healthcare professional has any reason to doubt or question the care provided, or the interpretation of an order, that healthcare professional will contact the attending practitioner, and also verbally inform the nurse in charge of the floor at the time of this action. If the matter is not resolved between the attending practitioner and the healthcare professional, the healthcare professional will provide the nurse in charge a written statement regarding the situation, who will in turn, refer the matter to the Director of Patient Care Services, and the steps outlined from this point in the above paragraph will be followed.

Section 7. Long Term Care

- A. Skilled Nursing Unit/Skilled Swing Beds
 - 1. The Medical Director of the Skilled Nursing Unit/Skilled Swing Beds shall have the authority and responsibility for the conduct of all activity in the Skilled Nursing Unit with regard to the maintenance of proper standards of quality and safety and with regard to the implementation and enforcement of administrative policies and procedures pertinent to that unit.

2. There must be a written or electronically entered order for admission. The order is written on the transfer form or physician order form, and signed by the attending practitioner. All patients admitted to the Skilled Nursing Unit/swing bed for skilled care shall have orders which include transfer information, medication, treatment, diet, activity, specific diagnosis, rehabilitative services required, rehabilitative potential (programs) of patient, plans for continuing care and estimated average length of stay.
3. All orders shall be in writing or electronic form. An order shall be considered to be in writing if dictated to a registered nurse, registered therapist, registered pharmacist, x-ray technician, registered lab technician, registered or licensed dietician or x-ray secretary (only noninvasive studies) employed by the Hospital and signed either on paper or electronically by the attending practitioner. Orders dictated over the telephone shall be signed either on paper or electronically by the practitioner on the practitioner's next visit. Medication orders can only be dictated to a registered nurse.
4. Each resident shall be admitted or transferred by a member of the Medical Staff and placed under continuing supervision of that practitioner. No patient shall be admitted to the Skilled Nursing Unit/swing bed skilled care until the provisional diagnosis or valid reason for admission has been recorded. Admission criteria provided by the Professional Review Organization (PRO) will be utilized as guidelines for skilled level of care.
5. An individual with mental illness or mental retardation may not be admitted unless the individual requires the level of service provided by the facility. Determination must be made if the mentally ill/mentally retarded person needs active treatment. All patients will be pre-screened prior to admission to determine mental retardation and/or mental illness. If a patient is taking antipsychotic medications, the practitioner must certify the person's need for a specific condition. A person may be admitted to nursing facilities for a period of up to 30 days without a Level II screening for medically necessary recovery following acute hospitalization if they are not a danger to themselves or others.
6. A transfer form must be completed prior to admission and signed by the physician. The history and physical, discharge summary from acute care, consultations, laboratory, x-ray and physical medicine reports must accompany the patient upon transfer.
7. A complete history and physical shall be done no more than seven (7) days before or 48 hours after an admission for each patient by a doctor of medicine or osteopathy. This report shall include all pertinent findings resulting from an assessment of all of the

systems of the body. If a complete history has been recorded and a physical examination performed 30 days prior to the patient's admission to the hospital, a reasonably durable, legible copy of these reports may be used in the patient's hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the medical staff. In such instances, an interval admission note that includes all additions to the history and any subsequent changes in the physical findings must always be recorded within 48 hours.

8. Annual examination of the patient is required to be done by the attending physician and findings recorded in the medical record.
9. Any patient with an anticipated length of stay in excess of 30 days requires a visit within 30 days. All patients in a swing bed for skilled care require a visit by the attending practitioner every thirty (30) days for the next sixty (60) days. The patient will be seen every sixty (60) days thereafter. A progress note must be written indicating the patient's plan of care. The attending practitioner will be notified prior to each required visit.
10. A consultant must be qualified to give an opinion in the area in which his opinion is being sought. The areas in which a physician is qualified to consult shall be determined by the delineation of said consultant's "clinical privileges."
11. A discharge summary must be completed on each patient discharged from a skilled or swing bed. The summary must be completed even if the patient was not visited by the attending practitioner. The summary should indicate results of continued skilled care, any additional diagnosis, and condition upon discharge.
12. Those patients receiving skilled care in a swing bed or the Skilled Nursing Unit who die shall be pronounced dead by the attending physician or, in his absence, another licensed physician, licensed physician assistant, or registered nurse within a reasonable time.
13. A two-step TB test will be performed on all patients expected to have a length of stay in excess of (90) days.

B. Oak Crest Manor

1. There must be a written order for admission. The order is written on the Physician Order Form and signed by the attending practitioner. All patients admitted to Oak Crest Manor shall have orders which include

transfer information, medication, treatment, diet, activity, specific diagnosis, rehabilitative services required, rehabilitative potential (programs) of the patient, and plans for continuing care.

2. A member of the active staff shall be responsible for the medical care and treatment of each patient in the nursing home. In planning the medical care of this patient, prior to or upon admission, the physicians should make a medical evaluation of the patient's immediate and long term care needs. The attending physician shall perform a physical examination of the patient and provide the facility with an admitting diagnosis, statement about the patient's functional status, diet orders, medications, treatments, rehabilitation potential undertaken by the patient and plans for continuing care and when appropriate, planning for discharge.
3. Each member of the Medical Staff who does not reside in the immediate vicinity shall designate an alternate physician who may be called to see his patients for regular or emergency care when the attending physician is not available. In the event that neither the attending physician nor the designated alternate physician is available to examine and treat a patient requiring immediate attention, the Medical Director of Oak Crest Manor shall have the authority to call another physician to treat the patient.
4. The admitting practitioner shall be held responsible for giving such information necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patient might be a source of danger from any cause whatever.
5. For the protection of the nursing home patients and the medical and nursing staff, potentially suicidal patients shall be referred to another facility.
6. Each attending physician shall be aware of the availability of social, psychological, and other non-medical aspects of care for his patient so that he may assure himself that such care is compatible with the medical condition of the patient.
7. The attending physician shall consult with the Medical Director of Oak Crest Manor and/or Director of Patient Care when, in the judgment of either, there is a question as to the appropriate placement or the advisability of transfer of any patient originally admitted by the attending physician.
8. Where possible, the attending physician shall reserve the right to seek consultation. As part of the treatment plan, this should be discussed with the patient. The facility's administrative personnel, Medical Director of Oak Crest Manor, and other involved personnel can independently request

a consultation without prior approval of the attending physician. The attending physician will be informed of the treatment changes.

9. Laboratory and x-rays will be ordered as medically necessary. If a patient is admitted directly from a hospital, or admitted within 30 days of previous hospitalization, a copy of the CBC, UA and chest x-ray may be made a part of the record in lieu of additional laboratory and x-ray work. A two- step TB test will be performed on admission on all patients. A PPD skin test will be performed every three years on all patients.
10. All orders for treatment shall be in writing. An order shall be considered to be in writing if dictated to an authorized licensed nurse, registered pharmacist, registered or licensed dietician, registered therapist, x-ray technician or laboratory technician employed by the hospital. The order must be signed and dated by the person to whom the order is dictated and countersigned by the physician.
11. The physician's order must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse.
12. The Medical Staff will limit the duration of drug therapy in the absence of the prescriber's specific indication of duration of drug therapy through the use of criteria defined by the Professional Activities Committee. The prescribing practitioner may override the automatic stop date by specifying a particular duration for therapy. Automatic stop dates for the following drug categories are assigned as follows.
 - Controlled substances and anti-infective agents – 30 days
 - Other monitored drugs – as approved by the Professional Activities Committee.

Renewal Notice: A notice of renewal will be posted with the progress notes twenty-four (24) hours before the automatic stop date takes effect. If not renewed, the prescribing physician will be contacted.

All medication orders are discontinued when the patient is transferred to another level of care.

13. No medication will be discontinued until the attending physician is notified, preferably between 7:00 a.m. and 3:00 p.m. on the day the order expires.
14. Annual re-examination of the patient is required to be done by the attending physician and findings recorded in the medical record.

15. The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter. If a resident believes a physician visit is not necessary, or does not want a physician to visit, a resident has the right to refuse the visit. Explanation must be given to the resident of the result of such a refusal and alternatives that may be available. If a seriously ill resident continues to refuse treatment such that the refusal effects a significant change in the resident's condition, the facility should reassess the resident and institute care planning changes in the context of the resident's directions regarding treatment.
16. Patients shall be discharged only on written order of the attending physician. Should a patient leave the nursing home against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
17. Those patients who die in the nursing home shall be pronounced dead by the attending physician or, in his absence, another licensed physician, licensed physician assistant, or registered nurse within a reasonable time. The body shall not be released until an entry has been made and signed, either on paper or electronically, in the medical record of the deceased by the attending physician or the physician's designee.
18. Patients with an infection needing isolation technique shall be treated with appropriate precautions within the nursing home.
19. A patient discharged from the nursing home shall have his/her medical record closed.
20. When death occurs suddenly, directly or indirectly, due to an accident or under suspicious circumstances, a report must be made by the Director and/or the Director of Patient Care Services, to the Medical Examiner and his permission must be secured before the body may be removed from the nursing home.
21. Each attending physician shall participate in a quality assurance program. Such participation may extend to medical care evaluation of patient care.
22. For utilization review purposes, the attending practitioner is required to document the need for continued intermediate long term care placement after a specific period of stay as designated by the Long Term Care Standards, PSRO and document plans for post nursing homes care where applicable.
23. The attending physician shall be held responsible for the preparation of a complete and accurate medical record for each patient. Its content shall be

pertinent and current. This record shall include the identification data, medical history, physical examination, annual re-examination, treatment plan and rehabilitation potential, admitting diagnosis, physician orders and progress notes, nursing notes, medication and treatment record, laboratory and x-ray reports, consultation reports, dental reports, physical therapy and occupational therapy records; podiatry records, rehabilitation records, social service histories and summaries, patient referral forms, final diagnosis, dispositions of patient and final discharge.

24. The attending physician or licensed independent practitioner performs each resident's medical assessment, including a medical history and physical examination, within required time frames. This timeframe must not exceed 24 hours before admission or within 72 hours after admission. Durable, legible originals or reproductions of a medical history and physical examination, obtained from the attending physician or licensed independent practitioner and completed within 30 days before admission or readmission, are acceptable provided that:
- There is a summary of the resident's condition and course of care during the interim period; and
 - the summary also includes the current physical/psychosocial status of the resident.

This summary is completed within 24 hours before admission or within 72 hours after admission. If the physician or licensed independent practitioner other than the attending physician performed the assessment that is being transferred and that assessment was performed within 30 days before admission, or within 24 hours before admission, or within 72 hours after admission, the attending physician or attending licensed independent practitioner must:

- review the physical examination;
- conduct a second assessment to confirm the information and findings;
- update any information and findings as necessary including a summary of the resident's condition and course of care during the interim period and the current physical/psychosocial status
- sign and date the additional information as an attestation to it being current.

Any previous medical history does not have to be completely redone. It can be updated with information about the most recent illness and hospitalization.

25. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Record Department.

26. The patient's medical record will be completed upon discharge according to Article I, Section 3-N.
27. A physician's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, be dated and signed by the attending physician.
28. All current and completed records are the property of the Hospital and shall be removed from the facility's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute, and nursing home policy.
29. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive such information.
30. Free access to all medical records of nursing home patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with applicable state and federal law while preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be studied. Subject to the discretion of the Director or designee, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all of the period during which they attended such patients in the nursing home.

Section 9. Students

- A. All students shall be sponsored by a member of the Active Medical Staff or Associate Staff.
- B. A request to have a medical student accompany a practitioner must be submitted to the Hospital's Medical Staff Office at least one (1) month prior to the student's expected arrival date. The length of time the student will be at Hospital shall also be made known at this time.
- C. The request shall provide, at a minimum, information regarding:
 - Name of student
 - Address
 - University attending
 - Year in school
 - Expected outcomes of the experience; that is, hands on experience or just observation, etc.

- D. The student and sponsoring Medical Staff member shall complete an application form which is available from the Hospital's Medical Staff Office.
- E. The sponsoring Medical Staff member shall submit a statement assuming full responsibility for the student and an agreement to hold harmless the hospital for any and all claims, costs, etc. as a result of any claim or less that would involve the student.
- F. All students shall sign a confidentiality statement prior to any involvement with patients.
- G. All students shall submit written proof of his/her own professional liability insurance with at least minimal limits of \$200,000/\$600,000 if it is intended that the student have any "hands on" patient care.
- H. Students shall be allowed to perform "hands on" care based on their year in school and training. This decision to allow students to perform "hands on" care and what that will be, shall be determined and made known to Hospital by the sponsoring physician. In the case of surgery activities shall not exceed the following:
 - Hemostasis by clamping, sponging, tying suture and electro-coagulation
 - Retracting
 - Skin closure by suturing or stapling
 - Irrigation and suctioning.
- I. The appropriate hospital staff shall be notified when the student is approved.
- J. Students shall wear a name tag identifying them as a student and shall perform and dress in an appropriate manner.

Section 10:

- A. Emergency Services
 - 1. The Medical Staff shall see to it and decide among themselves that there is adequate coverage at the nurse's station and in ER. The on call provider will present to the hospital within 30 minutes of notification.
 - 2. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed as a cooperative effort of the Medical Staff, nursing service and Hospital administration.

3. It is the policy of Hospital to appropriately screen, stabilize and transfer patients who present to the hospital requesting examination or treatment in accordance with federal laws including EMTALA. A physician is responsible for the medial screening to determine if an emergency exists.
4. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee which includes members of the Medical Staff, the director of nursing services or his/her designee, and a representative from Hospital administration.

B. Disaster Plan:

1. The disaster plan should make provision within the Hospital for:
 - a) Availability of adequate basic utilities and supplies, including gas, water, food and essential medical and supportive materials.
 - b) An efficient system of notifying and assigning personnel.
 - c) Unified medical command under the direction of a designated physician.
 - d) Conversion of all usable space into clearly defined areas for efficient triage, for patient observation and for immediate care.
 - e) Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.
 - f) A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he/she is moved.
 - g) Maintaining security in order to keep relatives and curious person out of the triage area.
 - h) Pre-establishment of a public information center and assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.
2. All physicians shall be assigned to posts and it is their responsibility to report to their assigned stations. The ER Medical Director in the Hospital and the Director of the Hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one

section of the Hospital to another or evacuation from Hospital premises, the chief of the staff during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the ER Medical Director and the Director/Director of Patient Care Services of the Hospital. In their absence, another Medical Staff member or the Charge Nurse are next in line of authority respectively.

3. The disaster plan should be rehearsed at least biannually, preferably as part of a coordinated drill in which other community emergency services agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patients during drills is optional. A written report and evaluation of all drills shall be made.

March 14, 2005

MERCY MEDICAL CENTER
DYERSVILLE, IOWA
CREDENTIALING MANUAL
RELATED DOCUMENTS

ADOPTED by Mercy Medical Center - Dyersville
Medical Staff,

APPROVED by Mercy Medical Center - Dyersville
Community Health Care Board

Original Printing in 2005

ARTICLE 1: PURPOSE

The Credentialing and Privileging Manual outlines the process and procedures in the handling of Hospital's credentialing program. It is the intent of Hospital to comply with state and federal regulations, including the Healthcare Quality Improvement Act.

ARTICLE II: APPOINTMENT AND REAPPOINTMENT

Section 1. Initial Application

- A. Prior to the submission of an initial application, an individual shall be provided with a copy of the Medical Staff Bylaws. An individual making initial application for Medical Staff membership shall submit a written application on a prescribed form to the Medical Staff Services Office. By virtue of submitting an application the applicant:
1. accepts the obligation of providing all information requested in support of the applicant's application;
 2. authorizes Hospital and Mercy Medical Center - Dubuque to consult with appointees of medical staffs, hospital administrations, and other professional contacts with whom the applicant has been previously associated; and
 3. consents to the Hospital's inspection of all records and documents such as medical school diplomas, state licenses, specialty board certificates and certificates of membership in professional societies and organizations.
- B. The application shall include, at a minimum, the following information:
1. professional education and training;
 2. professional experience;
 3. other professional qualifications, including specialty board membership or active candidate status;
 4. written evidence of current Iowa license, and federal and state DEA (Drug Enforcement Administration) numbers if applicable;
 5. letters of reference from at least three practitioners who are currently knowledgeable about the applicant's professional competence and ethical character;
 6. if applicable, a letter of reference and information on the number and type of cases performed from the chief of the clinical service or

department of a hospital where the practitioner has or has had clinical privileges;

7. any instance in which the applicant has been subject to legal action based upon an allegation of medical malpractice, including a summary of the allegation, the names of the person or persons making such allegation, and the disposition of the allegation against the practitioner;
 8. any instance in which the practitioner's license has ever been suspended or challenged by a state or provincial licensing board in any jurisdiction;
 9. whether the applicant has ever been refused admission, renewal or suffered a revocation, suspension, or reduction of staff privileges at any other institution;
 10. a specific request for particular staff assignments and delineated clinical privileges;
 11. certification that the amount of professional liability insurance maintained in force by the applicant is equal to or greater than the minimal amount required by Trinity Health Services;
 12. information relating to the applicant's current physical and mental health, including information relative to communicable diseases;
 13. agreement to abide by the Ethical and Religious Directives for Catholic Health Care Services;
 14. agreement to abide by the Notice of Privacy Practices;
 15. agreement to provide for the continuous care of the applicant's patients while they are undergoing treatment at Hospital;
 16. acknowledgment of the immunity from liability provisions of Article XI of the Medical Staff Bylaws; and
 17. agreement to abide by those regulations imposed on the hospital by regulatory agencies and law.
- C. A practitioner making application shall be required to have a personal interview with the President of the Medical Staff.

Section 2. Action on Initial Appointment

- A. Upon receipt of an application for Medical Staff membership and clinical privileges, the Medical Staff Services Office shall review the application for completeness. An incomplete application shall be returned to the applicant for completion and resubmission. Upon determining that an application is complete, the Medical Staff Services Office shall transmit the completed application to the President of the Medical Staff. No applicant will be appointed to the Medical Staff or granted specific clinical privileges unless the applicant's credentials file contains verified information and supporting data demonstrating current clinical competence. In addition, an inquiry shall be made to the National Practitioner Data Bank for each applicant. The President of the Medical Staff shall forward recommendations to the Executive Committee.
- B. Upon receipt of a completed application, the President of the Medical Staff, in conjunction with the Medical Staff Services Office will:
1. review and investigate the character, health, qualifications and professional competence of the applicant;
 2. verify the accuracy of the information contained in the application;
- C. Unless the applicant consents to a longer period of time, within one hundred and twenty (120) days of receipt of the completed application President of the Medical Staff shall make a written report of his/her review to the Executive Committee. Such report shall include a recommendation that the applicant be:
1. appointed to the Medical Staff;
 2. be deferred for further consideration; or
 3. rejected for Medical Staff membership.

Section 3. Executive Committee Action on Initial Appointment

- A. At the next regular Executive Committee meeting, the Executive Committee will determine the recommendation to be made to the Board.
- B. If the recommendation of the Executive Committee is that the applicant should be appointed to the Medical Staff, the Executive Committee shall also specifically recommend the clinical privileges to be granted, including any limitations to be imposed upon such clinical privileges.
- C. If the recommendation of the Executive Committee is to defer action on the application for further consideration, the Executive Committee must specify the specific procedures and the limits that will be used to make a subsequent

recommendation on the applicant's acceptance, rejection, or limitation of privileges.

- D. If the Executive Committee's recommendation is that the applicant should be rejected for Medical Staff membership, or that the clinical privileges should be less than requested by the applicant, the Director shall promptly notify the applicant by certified mail, return receipt requested, of the Executive Committee's recommendation. No such adverse recommendation shall be transmitted to the Board until the applicant has exercised or has been deemed to waive rights of appeal pursuant to Article X of the Bylaws and the Fair Hearing Procedures.

Section 4. Action of the Board on Initial Application

- A. If the application in question is not subject to an appeal pursuant to Article X of these Bylaws, at the next regularly scheduled meeting of the Board after the Executive Committee has forwarded its recommendation, the Board shall act upon the application. If the decision of the Board is contrary to the recommendation of the Executive Committee, the Board shall submit the matter to a Special Committee appointed by the chairperson of the Board as provided in Section 2, Article V of the Board's Bylaws, for its review and recommendation and shall consider such recommendation before making its final decision.
- B. If the recommendation of the Executive Committee has been appealed pursuant to Article X of these Bylaws, but the applicant has not requested appellate review by the Board of the Hearing Committee's decision, at the next regularly scheduled meeting of the Board after the Hearing Committee has forwarded its decision, the Board will consider the Hearing Committee's decision and the recommendation of the Executive Committee and act upon the application. If the decision of the Board is contrary to the original recommendation of the Executive Committee, the Board shall submit the matter to the Special Committee referred to in Section 4(A) above for its review and recommendations and shall consider such recommendations before making its final decision.
- C. If the recommendation of the Executive Committee has been appealed pursuant to Article X of these Bylaws, and the applicant has requested appellate review of the Hearing Committee's decision by the Board, the decision of the Board on Appellate review pursuant to Article X of these Bylaws shall be the Board's action on the initial application.
- D. When the Board's decision is final, it shall send notice of such decision through the Director to the President of the Medical Staff, and by certified mail, return receipt requested, to the applicant. If the Executive Committee's recommendation was favorable to the practitioner, and the Board's decision is adverse to the practitioner, such notice will include a right of appeal in Accordance with Article X of these Bylaws.

Section 5. Term of Appointment

- A. The Board will make all appointments to the Medical Staff. The initial appointment shall be in the provisional status for a period not to exceed one (1) year. Thereafter, the member will be subject to reappointment as set forth in Section 6.
- B. Notwithstanding the provisions of this Section 5, the clinical privileges and Medical Staff membership of any practitioner may be suspended or revoked at any time pursuant to Article X of these Bylaws, and the applicable provisions of the governing documents of Hospital.

Section 6. Reappraisal and Reappointment

- A. Reappointment by the Board shall be for two years, based upon a recommendation of the Executive Committee.
1. At least ninety (90) days prior to the expiration of reappointment, Medical Executive Committee shall begin review of all pertinent information available on each member whose term expires for the purposes of making a recommendation to the Board on the member's reappointment and for granting of clinical privileges during the term of such reappointment.
- B. The Executive Committee will initiate its review by requesting, in writing, at least the following information from the member:
1. any change from the information provided by the member in the initial application;
 2. any change in the privileges requested by the member;
 3. the basis for any request for a change in privileges;
 4. the extent of the member's continuing education efforts, as required by law, since the last appointment or reappointment;
 5. the practitioner's malpractice insurance coverage; and
 6. information relating to the applicant's current physical and mental health, including information relative to communicable diseases.
- C. Simultaneously, the Executive Committee will obtain, at a minimum, the following information from the President of the Medical Staff:
1. a peer evaluation of the member's performance, judgment, and,

and when appropriate, technical skill;

2. whether the member has any physical or mental impairments that interfere with the member's ability to care for patients in Hospital;
 3. the member's attendance at required department and Medical Staff meetings;
 3. the member's service on Hospital and Medical Staff committees when requested;
 4. whether the member maintains timely, accurate and complete medical records;
 5. the member's patterns of care, as demonstrated by reviews and evaluations conducted by committees (such as utilization review, infection control, etc.);
 6. the member's ability to work with other members of the Medical Staff and with Hospital personnel;
 8. quality assurance and risk management information; and
 9. any other relevant factors.
- E. The President of the Medical Staff shall transmit his/her recommendation in writing to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff shall make written recommendations to the Board concerning the reappointment, nonreappointment, and/or revision of clinical privileges of each practitioner then scheduled for periodic appraisal. In each step above when nonreappointment or a change in the clinical privileges is recommended, the reason for such recommendation shall be stated and documented.
- F. Changes in staff category and advances in clinical privileges at reappointment time are for a provisional period as with initial appointment and privilege delineation. As with initial appointment, decision at reappointment shall specify medical staff category and assignment of specific clinical privileges.

Thereafter, the procedure provided in Article II relating to the recommendations on applications for initial appointment shall be followed:

ARTICLE III: CLINICAL PRIVILEGES

Section 1. Limitation of Clinical Privileges

- A. Every Medical Staff member permitted by law and by Hospital to provide patient care services independently in the hospital, shall have delineated clinical privileges specifically granted by the Board.
- B. Privileges granted to members of the Medical Staff shall be based on their training, experience, and demonstrated competence. The scope and extent of procedures shall be specifically delineated.
- C. A physician member of the Active Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or present itself during the period of hospitalization.
- D. Practitioners who are subject to Medicare or Medicaid exclusion shall not be eligible to exercise clinical privileges at the Hospital.

Section 2. Delineation of Clinical Privileges

- A. All clinical privileges granted to practitioners shall be delineated with sufficient specificity to insure that a practitioner does not treat a patient in Hospital outside the practitioner's area of demonstrated competence.
- B. Podiatrists are recommended for privileges by the President of the Medical Staff and are under the overall supervision of the President of the Medical Staff.
- C. Psychologists are recommended for privileges by the President of the Medical Staff and are under the overall supervision of the President of the Medical Staff.

Section 3. Determination of Privileges

- A. Each practitioner shall have the responsibility of establishing his or her qualifications and competency for the clinical privileges requested..
- B. Determination of initial privileges is based upon the applicant's education, training, experience, demonstrated current competence, references, current physical and mental health, and any other relevant information.
- C. Determination of the retention or extension of clinical privileges to members of the Medical Staff is based upon the member's education, training, experience, demonstrated current competence, continuing education effort, current physical and mental health, the observation of the Medical Staff, and any other relevant information.

D. Granting of clinical privileges shall be for a period of two years after a practitioner has satisfied his/her provisional period.

Section 4. Temporary Privileges

A. Upon receipt of any application for Medical Staff membership from an appropriately licensed practitioner, and for the period of time required to process the application, but not to exceed one hundred and twenty days (120), the Director upon the basis of information then available which may reasonably be relied upon as to the competence and ethical standing of the applicant, and with the written concurrence of the President of the Medical Staff, may grant temporary privileges to the applicant. In exercising such privileges, the applicant shall act under the supervision of the President of the Medical Staff.

B. Temporary clinical privileges may also be granted by the Director upon the recommendation of the President of the Medical Staff when an important patient care need requires immediate authorization to practice for a limited period of time while the practitioner's full credentials are verified. Temporary clinical privileges may be granted at reappointment only after the important patient care need that supports such a decision has been documented. An important patient care need includes the following:

1. A circumstance in which one or more patients experience care that does not adequately meet their needs if the hospital does not grant the temporary privileges under consideration.
2. A circumstance in which the hospital risks not adequately meeting the needs of patients if it does not grant the temporary privileges under consideration.
3. A circumstance in which a group of patients in the community face the risk of not receiving care they need if the hospital does not grant the temporary privileges under consideration.

The practitioner under consideration for temporary privileges shall provide a signed acknowledgement of having received and read copies of the Medical Staff's Bylaws, Rules and Regulations and agreeing to be bound by the terms thereof in all matters relating to temporary clinical privileges. Such privileges shall be restricted to the period of time when the important patient care need exists, after which such practitioner shall be required to apply for staff membership on the Medical Staff before being allowed to attend additional patients.

C. Locum tenens may be granted by the Director on an appropriately licensed practitioner at the request of a member of the Medical Staff. A practitioner receiving locum tenens may attend patients without applying for membership on the Medical Staff for a period not to exceed sixty (60) days, providing all credentials have first been approved by the President of the Medical Staff.

- D. Special requirements of supervision and reporting may be imposed by the President of the Medical Staff regarding any practitioner granted temporary privileges. Temporary privilege shall be immediately terminated by the Director upon notice of any failure by the practitioner to comply with such special conditions.
- E. The Director, at any time, upon the recommendation of the President of the Medical Staff may terminate a practitioner's temporary privileges effective as of the discharge from the Hospital of the practitioner's patient(s) being cared for in the Hospital. However, where it is determined that the life or health of such patient(s) would be endangered by continued treatment by the practitioner, the termination may be imposed by any person entitled to impose a summary suspension pursuant to Section 1 of Article X of these Bylaws, and the same shall be immediately effective. The President of the Medical Staff shall assign a member of the Medical Staff to assume responsibility for the care of such terminated practitioner's patients(s) until they are discharged from the hospital. The wishes of the patient(s) shall be considered where feasible in selection of a substitute practitioner. The termination of temporary privileges shall not entitle a practitioner to the appeal rights set forth in Article X of the Bylaws or the Fair Hearing Procedures.

Section 5. Emergency Privileges

- A. For the purpose of this section, a "clinical emergency" is defined as a condition in which serious permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administered treatment would add to that danger.
- B. In the case of a clinical emergency, any practitioner, to the degree permitted by the practitioner's license, shall be permitted and assisted to do everything possible to treat a patient, using any necessary facilities of Hospital and including the calling of any consultation necessary or desirable.
- C. When a clinical emergency situation no longer exists, the practitioner must request the privileges necessary to continue to treat the patient. In the event such privileges are denied or the practitioner does not desire to request privileges, the patient shall be assigned to an appropriate member of the Medical Staff.
- D. During disasters in which the emergency management plan has been activated, the Director or President of the Medical Staff or their designee has the option to grant emergency privileges upon presentation of any of the following:
 - 1. a current photo hospital ID card;
 - 2. a current license to practice and a valid photo ID card issued by a state, federal, or regulatory agency;
 - 3. identification indicating that the individual is a member of a Disaster Medical Assistance Team;

4. identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity;
5. presentation by current hospital or medical staff members with personal knowledge regarding the practitioner's identity.

Verification of the practitioner's information should be done as soon as possible by the Medical Staff Services Office.

Section 6. Medical Residents

Medical Residents who are enrolled in an approved medical or osteopathic residency may apply for privileges if they:

- A. are licensed in the State of Iowa;
- B. complete an application for privileges as required for locum tenens physicians;
- C. are sponsored by an active staff member;
- D. agree to be directly supervised by that staff member or his or her designee; and
- E. agree to exercise only those specific privileges authorized for their experience level.

Medical Residents are not considered members of the Medical Staff and, as such, are not entitled to the rights and privileges of Medical Staff membership.

Section 7. Medical Students

Students enrolled in a medical or osteopathic school may function under limited circumstances if:

- A. a written application from an active staff member is submitted outlining the specific requested responsibilities;
- B. the request is approved by the appropriate chairperson; and
- C. the sponsoring physician is physically present when the student performs his or her responsibilities.

Section 8. New or Newly Learned Technical Procedures

Each medical staff member requesting new privileges for a procedure will be considered on an individual basis by the President of the Medical Staff. The review process will be the same for appointment and reappointment following these parameters:

- A. A formal fellowship, or residency training in the related field with certification by that training program's director will be the standard for granting specific privileges.
- B. An alternative to this will allow privileging by the completion of an approved educational course in the procedure which will include an understanding of the physiology, anatomy and pathology as well as indications, contraindications and possible complications of the procedure and the appropriate handling of the complications. This should include practical experience in the procedure and a letter of certification by the approved facility which states that the practitioner has received instructions and has shown competence in performing the procedure.
- C. A minimal experience in performing the procedure prior to obtaining privileges at Hospital must be demonstrated. The number of cases should include those observed, as well as those performed under supervision or independently prior to obtaining the privileges requested. This number will be established independently by the Medical Staff for each procedure as requested.

ARTICLE IV: ALLIED HEALTH PROFESSIONALS/MEDICAL STAFF ASSISTANTS

Section 1: General

- A. An Allied Health Professional is an individual who possesses a license, certificate or other legal credential required by Iowa law to provide patient care services in a hospital setting, as approved by the Board, and who is not an employee of the Hospital.
- B. Medical Staff Assistants are individuals who are qualified by academic or special training to function in a Medical Staff directed role. They do not possess a license, certificate or other legal document required by Iowa law.
- C. Allied Health Professionals and Medical Staff Assistants are not members of the Medical Staff and are not eligible for admitting privileges.
- D. Allied Health Professionals and Medical Staff Assistants may apply for specific privileges commensurate with documented license, certification, other legal credentials, training and experience.

E. Allied Health Professionals and Medical Staff Assistants must:

1. provide patients with care at the generally recognized professional level of quality and efficiency;
2. abide by the relevant sections of the Medical Staff Bylaws and by all other lawful standards, policies and rules of Hospital;
3. discharge such staff, department, committee and hospital functions for which s(he) is responsible by staff category assignment, appointment, election or otherwise;
4. prepare and complete in a timely fashion any documentation relevant to patient care provided;
5. abide by the ethical and moral principles of the relevant profession;
6. read and agree to abide by the Ethical and Religious Directives for Catholic Health Care Services.

F. Allied Health Professionals and Medical Staff Assistants:

1. may provide specified patient care services upon direct order and under the sponsorship, supervision and direction of a member of the Medical Staff of the Hospital;
2. the Allied Health Professional may write or enter computerized orders, but not beyond the scope of the Allied Health Professional's license, certificate or other credentials and provided the order is countersigned by the sponsoring medical staff physician;
3. shall serve on staff and hospital committees as requested;
4. shall attend meetings of committees as requested;
5. may exercise such other prerogatives as shall be, by resolution or written policy, duly adopted and approved by the Executive Committee and the Board.

Section 2. Appointment and Reappointment

- A. An Allied Health Professional and Medical Staff Assistant making initial application shall submit a written application on a prescribed form to the Medical Staff Services Office. By virtue of submitting an application, the applicant:
1. accepts the obligation of providing all information requested in support of the applicant's application.
 2. authorizes Hospital to consult with appointees of medical staffs, hospital administrations, and other professional contacts with whom the applicant has been previously associated.
 3. consent to the Hospital's inspection of all records and documents such as school diplomas, state licenses, and certificates of membership in professional societies and organizations.

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- B. The application shall include, at a minimum, the following information:
1. professional education and training;
 2. professional experience;
 3. other professional qualifications;
 4. written evidence of current Iowa license, certificate or other legal credentials required by Iowa law;
 5. letters of reference from at least three practitioners who are currently knowledgeable about the applicant's professional competence and ethical character.
 6. any instance in which the applicant has been subject to legal action based upon an allegation of medical malpractice, including a summary of the allegation, the names of the person or persons making such allegation, and the disposition of the allegation against the Allied Health Professional or Medical Staff assistant.
 7. any instance in which the Allied Health Professional's license, certificate or other legal credential has ever been suspended or challenged by a state licensing board in any jurisdiction;
 8. whether the applicant has ever been refused admission, renewal or suffered a revocation, suspension, or reduction of practice privileges at any other institution;

9. a specific request for particular hospital assignments and delineated practice privileges;
10. certification that the amount of professional liability insurance maintained in force by the applicant is equal to or greater than the minimal amount required by Trinity Health Services.
11. information relating to the applicant's current physical and mental health;
12. agreement to observe all of the profession's ethical principles.
13. agreement to observe and abide by the Ethical and Religious Directives of Catholic Health Care Services.
14. agreement to abide by the Notice of Privacy Practices;
15. acknowledgment of the immunity from liability provisions of Article XIV of these Bylaws; and
16. agreement to abide by those regulations imposed on the Hospital by regulatory agencies and law.

Section 3. Action on Initial Appointment

- A. Upon receipt of an application from an Allied Health Professional or Medical Staff Assistant, the Medical Staff Services Office shall review the application for completeness. An incomplete application shall be returned to the applicant for completion and resubmission. Upon determining that an application is complete, the Medical Staff Services Office shall transmit the completed application to the President of the Medical Staff. The President of the Medical Staff shall forward recommendations to the Executive Committee of the Medical Staff.
- B. Upon receipt of a completed application, the President of the Medical Staff, in conjunction with the Medical Staff Services Office will:
 1. review and investigate the character, health, qualifications and professional competence of the applicant;
 2. verify the accuracy of the information contained in the application;
- C. Unless the applicant consents to a longer period of time, within one hundred and twenty (120) days of receipt of the completed application the President of the Medical Staff shall make a written report of review to the Executive Committee. Such report shall include a recommendation that the applicant be:

1. appointed as an Allied Health Professional or Medical Staff Assistant;
2. deferred for further consideration; or
3. rejected as an Allied Health Professional or Medical Staff Assistant.

Section 4. Executive Committee Action on Initial Appointment

- A. At the next regular Executive Committee meeting, the Executive Committee will consider the report from the President of the Medical Staff and determine the recommendation to be made to the Board.
- B. If the recommendation of the Executive Committee is that the applicant should be appointed, the Executive Committee shall also specifically recommend the practice privileges to be granted, including any limitations to be imposed upon such practice privileges.
- C. If the recommendation of the Executive Committee is to defer action on the application for further consideration, the Executive Committee must specify the specific procedures and time limits that will be used to make a subsequent recommendation on the applicant's acceptance, rejection, or limitation of practice privileges.
- D. If the Executive Committee's recommendation is that the application should be rejected or that the practice privileges granted to the applicant should be less than requested by the applicant, the Director shall promptly notify the applicant by certified mail, return receipt requested, of the Executive Committee's recommendation. No such adverse recommendation shall be transmitted to the Board until the applicant has exercised or has been deemed to waive his or her rights for departmental review under Section 9 of this Article.

Section 5. Term of Appointment

- A. Allied Health Professionals and Medical Staff Assistants will serve in a provisional status for a minimum of twelve (12) months to allow sufficient time for evaluation. During this provisional period their professional competence, ethical and moral conduct shall be observed President of the Medical Staff or designee. At the end of the twelve month provisional period, the President of the Medical Staff will submit a written report to the Executive Committee indicating whether the Allied Health Professional is recommended for full appointment or whether the provisional period should be extended, indicating the recommended period of time.
- B. The Board will make all Allied Health Professional and Medical Staff Assistant appointments. The initial appointment will be made until the end of the next medical staff year. Thereafter, the member will be subject to reappointments set forth in Section 6.

- C. All Allied Health Professionals and Medical Staff Assistants shall be supervised by the President of the Medical Staff unless state or federal regulations require assignment of those professionals to an individual physician.

Notwithstanding the provisions of this Section 5, the privileges and membership of any Allied Health Professional and Medical Staff Assistant may be suspended or revoked at any time pursuant to Sections 7 and 8 if this Article, and the applicable provisions of the governing documents of Hospital.

Section 6. Reappraisal and Reappointment

- A. Reappointments by the Board shall be for two years, based upon a recommendation of the Executive Committee.
- B. At least ninety (90) days prior to the expiration of reappointment, the Medical Staff Executive Committee shall begin review of all pertinent information available on Allied Health Professionals and Medical Assistants whose term expires for the purpose of making a recommendation on the Allied Health Professional's and Medical Staff Assistant's reappointment and for the granting of practice privileges during the term of such reappointment.
- C. The Executive Committee will initiate its review by requesting, in writing, at least the following information from the Allied Health Professional and Medical Staff Assistant:
 - 1. any change from the information provided by the Allied Health Professional or Medical Staff Assistant in the initial application;
 - 2. any change in the practice privileges requested by the Allied Health Professional or Medical Staff Assistant;
 - 3. the basis for any request for a change in practice privileges.
 - 4. the extent of the Allied Health Professional's or Medical Staff Assistant's continuing education efforts since last appointment or reappointment;
 - 5. Allied Health Professional's or Medical Staff Assistant's malpractice insurance coverage.
- D. Simultaneously, the Executive Committee will obtain, at a minimum, the following information from the President of the Medical Staff:
 - 1. whether the Allied Health Professional or Medical Staff Assistant has any physical or mental impairments that interfere with his/her ability to provide health care services within the Hospital;

2. the Allied Health Professional's or Medical Staff Assistant's attendance at required meetings.
 3. whether the member maintains timely, accurate and complete records;
 4. performance patterns as demonstrated by reviews and evaluations;
 5. a written evaluation by the sponsoring physician documenting the extent and quality of the work performed by the Allied Health Professional or Medical Staff Assistant during the preceding credentialing period as well as continued qualifications for the requested privileges;
 6. the Allied Health Professional's or Medical Staff Assistant's ability to work with members of the Medical Staff and Hospital personnel;
 7. quality assurance and risk management information; and
 8. any other relevant factors.
- E. The President of the Medical Staff shall transmit his/her recommendation in writing to the Executive Committee of the Medical Staff. The Executive Committee of the Medical Staff shall make written recommendations to the Board concerning the reappointment, non-reappointment, and/or revision of practice privileges of each Allied Health Professional and Medical Staff Assistant then scheduled for periodic appraisal. In each step above when non-reappointment or a change in the practice privileges is recommended, the reason for such recommendation shall be stated and documented.
- F. Changes in practice privileges at reappointment time are for a provisional period of one year as with initial appointment and practice privilege delineation.

Section 7. Summary suspension

- A. The Director, at any time believing that it is in the best interest of patient care, may summarily suspend all or a portion of the practice privileges as an Allied Health Professional or Medical Staff Assistant on the recommendation or with a concurrence of:
1. the President of the staff; or
 2. the Board.

The Director shall notify the Allied Health Professional or Medical Staff Assistant, department chairperson, and Executive Committee of the Medical Staff of such summary suspension.

Section 8. Automatic Suspension

- A. Any Allied Health Professional or Medical Staff Assistant whose license or certificate is revoked or suspended shall automatically have all practice privileges at Hospital revoked.

Section 9. Medical Staff Executive Committee Review

- A. Nothing contained in these Bylaws should be interpreted to entitle an Allied Health Professional or Medical Staff Assistant to review, hearing or appeal as identified in the Fair Hearing Procedure Manual.
- B. When any Allied Health Professional or Medical Staff Assistant receives written notice from the President of the Medical Staff, Executive Committee of the Medical Staff, or Director that will adversely affect that Allied Health Professional's or Medical Staff Assistant's initial appointment and delineation of practice privileges, the Allied Health Professional's or Medical Staff Assistant's status as an Allied Health Professional or Medical Staff Assistant or the Allied Health Professional's or Medical Staff Assistant's exercise of practice privileges, that individual shall be entitled to file a written grievance with the President of the Medical Staff. Such written grievance must be submitted within 15 days of receiving notice or the right is waived.
- C. Upon receipt of such grievance, the President of the Medical Staff shall appoint a Committee to review the proposed action. The Committee shall include, if available, an Allied Health Professional/Medical Staff Assistant or Allied Health Professionals/Medical Staff Assistants having the same or similar license or certification as the affected Allied Health Professional/Medical Staff Assistant.
- D. The Committee shall initiate an investigation and the Allied Health Professional or Medical Staff Assistant shall be afforded the opportunity for an interview before the Committee within 45 days of receipt of the grievance. At the interview, the Allied Health Professional/Medical Staff Assistant may provide information relevant to the circumstances giving rise as to the proposed action.
- E. A record of the findings of such interview shall be made and a report of the finding and recommendations of the Committee shall be made to the Executive Committee.
- F. The decision of the Executive Committee shall be final.

Section 10. Allied Health Professionals' and Medical Staff Assistants' Release from Liability

Any person seeking appointment as an Allied Health Professional or Medical Staff Assistant, and each Allied Health Professional or Medical Staff Assistant, hereby agrees to release and give full immunity from civil liability and to execute any requested releases, in the same manner and to the same extent as is provided in Section 1 of Article IV.

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