

**MercyOne Waterloo Medical Center
Medical Staff Rules and Regulations
August 4, 2022**

1.PURPOSE

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

2.ADMISSION, DISCHARGE, AND TRANSFER OF PATIENTS

- 2.1 The Hospital shall accept all patients for care and treatment.
- 2.2 A patient may be admitted to the Hospital only by a Physician member of the Medical Staff. All Practitioners shall be governed by the official admitting policy of the Hospital.
- 2.3 As required by the Medical Staff Bylaws, Practitioner's attending patients at the Hospital must designate a confirmed, qualified alternate(s) who will provide patient coverage/emergency coverage if the Practitioner is unavailable. Failure to provide patient coverage shall be considered a serious breach of these rules and may be a condition for corrective action up to and including suspension of privileges for a length of time dependent on MEC findings in an investigation.
- 2.4 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of any emergency, such statement shall be recorded as soon as possible. Emergency shall be defined as potential for loss of life and/or limb.
- 2.5 Within twenty-four (24 hours of admission) the Attending of Record is required to document a plan of care in the electronic medical record, which supports the medical necessity of admission and continued hospitalization. This documentation must contain:
 - A. an adequate record of the reason for admission and continued hospitalization
 - B. the clinical goals/outcomes and treatment plan
 - C. plans for post-hospital care
 - D. The estimated period of time the patient will remain in the hospital

Upon request of the Utilization Management Committee, the Attending of Record physician must provide written justification of the necessity for continued hospitalization, including an estimate of the number of additional days of stay and the reason therefore.

- 2.6 Intensive Care Unit Attending Physician. For patients admitted to the

Intensive Care Unit, an ICU Attending Physician will be identified to the Care Coordinator/Charge Nurse and will be responsible for all aspects of the patient's care. ICU Attending Physicians will be expected to provide coordinated ICU care at a high level. The elements of coordinated ICU care and their means of implementation are as follows:

- A. Clear identification of responsible physician: For each patient admitted to the ICU, an ICU attending physician/service will be identified before patient arrival in the unit. This information will be clearly identified on the patient's chart and care plan. When a colleague on call covers an ICU Attending Physician, the person on call assumes all the responsibilities of the ICU Attending Physician.
- B. All patient information flows through the ICU Attending Physician. The patient's care team will report all relevant clinical information to the ICU Attending Physician/Service.
- C. ICU Attending Physician manages and coordinates consultations. The ICU Attending Physician requests all consultations. Consultants do not seek additional consultations without the knowledge and permission of the ICU Attending Physician. Frequent discussion between consultants and the attending physician is expected.
- D. The ICU Attending Physician directly manages or specifically delegates all aspects of the patient's care. Where a portion of care has been delegated to a consultant, the consultant may write orders. Delegation of an aspect of the patient's care does NOT release the Attending Physician from responsibility for the overall care of the patient, nor from problems that may arise in the delegated care. If a consultant is unavailable, off call, or otherwise indisposed to handle problems, the ICU Attending Physician is expected to respond and is accountable for the care the patient receives.
- E. ICU Attending Physician leads the health care team. The ICU Attending Physician will be the leader for nurses, therapists, pharmacists, nutritionists, and social service workers who contribute to the patients care, and are expected to coordinate and focus their efforts.
- F. ICU Attending Physician manages the clinical and ethical direction of the case. The ICU Attending Physician will be responsible for providing patients and families with a daily update on the plan of care and a patient progress report. The ICU Attending Physician is responsible for ensuring that the patient's wishes regarding their healthcare are followed, including the discussions of resuscitation status, desire for life support, etc. In general, it is best if one member of the health care team provides all family discussion. If consultants are to visit with the family, it is preferred that the ICU Attending Physician be present.
- G. If there is any question as to the validity of admission to, or discharge from, the Intensive Care Unit, that decision is to be made through consultation with the appropriate Department Chairman.

- 2.7 Patient Transfers. No patient shall be transferred without such transfer being approved by the Attending physician. Documentation of physician-to-physician communication and acceptance of patient at receiving facility must be present prior to transport.
- 2.8 Discharge of Patients. Patients shall be discharged only with an order by the attending physician or his/her nurse practitioner, or physician assistant. Should a patient leave the Hospital against the advice of the attending, and without proper discharge procedure, a notation of the incident shall be made in the patient's medical record. Refer to the Discharge of Patient policy, or its current replacement policy, for additional information regarding the discharge process and for discharge against medical advice (AMA).

3. MEDICAL RECORDS

- 3.1 Documentation. All documentation in the medical record must be in electronic format. Practitioners are encouraged to use Pownotes/Dynamic Documentation or Dragon voice recognition. An exception to this rule occurs during system downtimes. Practitioners should follow downtime protocols during planned or unplanned periods of downtime.
- 3.2 Content of Medical Record. The appropriate member of the Medical Staff shall be responsible for the preparation of a complete and legible medical record for each inpatient. The record content shall be pertinent and current. At a minimum, the record shall include:
- A. Patient identification data
 - B. Chief complaint
 - C. History of present illness
 - D. Allergies
 - E. Current Medications
 - F. Complete personal history, social history, past medical/surgical history, and family history
 - G. Review of systems
 - H. Physical examination
 - I. Provisional diagnosis
 - J. Reports of consultations
 - K. Clinical laboratory, imaging and other diagnostic results
 - L. Any medical or surgical treatment
 - M. Operative report, if applicable
 - N. Pathological findings, if applicable
 - O. Progress notes
 - P. Final diagnosis
 - Q. Condition on discharge
 - R. Discharge note/clinical resume including:

- i. the reason for admission
- ii. pertinent findings
- iii. interventions relative to the findings
- iv. condition on discharge
- v. instructions to the patient and/or family, particularly in regard to activity, medication, diet, **and** post-hospitalization care
- vi. autopsy report, if performed

- 3.3 Attending of Record. The Attending of Record is the physician member of the Medical Staff who wrote the initial order to admit the patient. The Attending has the primary responsibility for the care of the patient for the entirety of their stay, for prompt completeness and accuracy of the medical record, for necessary special instructions, for authorizing transfer of the patient, and for transmitting reports on the condition of the patient to other appropriate Practitioners and relatives of the patient.

When a physician is taking call on behalf of another physician or is in the same call group, the on-call physician should indicate in the admitting orders who the Attending of Record will be. It is expected that the physician who wrote the initial admitting order will be responsible for the continued management of the patient until the documented Attending of Record, for whom they are covering, assumes care.

If it becomes necessary or desirable to change the Attending of Record during an episode of care (ie; surgeon to primary care), the Attending of Record must arrange for the transfer to a new Attending of Record who acknowledges and accepts the responsibility. This transfer must be documented in the chart before it is effective.

The Attending of Record may obtain consults from other physicians for advice or care. The Attending of Record may choose to delegate care to one or more Consultants, but ultimately retains the authority and responsibility for directing the care rendered to the patient. If a Consultant wishes to obtain additional Consultants or release an established Consultant during an episode of care, the request to make the change must be discussed with and accepted by the Attending of Record. Only in the case of immediate patient need, when the Attending of Record cannot be contacted, shall a Consultant request the involvement of a new Consultant without the agreement of the Attending of Record.

The Attending who writes the discharge order is responsible for completion of the discharge summary. The Attending who admitted the patient is responsible for the admission History and Physical.

- 3.4 Consultant. The Consultant is the physician called by the Attending of Record to provide a professional opinion and/or treatment for a specified clinical concern. The Consultant may be a Nurse Practitioner or Physician Assistant. The Practitioner who requests the consult may require that

the consult be completed by a Physician. A Consultant may sign-off a case if asked to do so by the Attending of Record, or when the Consultant believes that his/her involvement in the case is no longer needed based on generally accepted standards of care.

See also section 5. Medical & Surgical Consultation

3.5 Progress Notes: Pertinent progress notes shall be recorded and properly authenticated with a signature, date and time, at the moment of observation or admission, sufficient to permit continuity of care and transfer ability. Whenever possible, each of the patient's clinical problems shall be clearly identified in the progress notes, including the results of tests and treatments. For all patients in the acute care hospital (exception Chemical Dependency Unit), a daily patient visit and progress note by the Attending of Record or his/her Nurse Practitioner or Physician Assistant shall be documented at least daily, or more frequently, if indicated, in critically ill patients, especially if there is difficulty in diagnosis or treatment.

3.6 Operative Reports: A full operative report must be completed immediately after an operative or other invasive procedure in order to manage the patient throughout the postoperative period and to facilitate patient hand-off to the next level of care. If the Practitioner performing the operation or high-risk procedure accompanies the patient from the operating room to the next unit or area of care, the report can be completed in the new unit or area of care.

1. If the full operative report is documented or dictated on the chart immediately after the procedure, there are no further expectations.
2. If the full operative report is not on the medical record immediately after the procedure, then a brief post op note must be entered into the patient's record before the patient can be moved to the next level of care. The brief post op note must contain the following:
 - Date of Surgery
 - Name(s) of primary surgeon and assistant(s),
 - Procedure(s) performed, description & findings
 - Type of Anesthesia
 - Estimated blood loss,
 - Specimen(s) removed,
 - Postoperative diagnosis.

Any full operative report not available within 24 hours of procedure completion will be considered delinquent and result in the practitioner being unable to schedule additional elective surgeries or procedures until such time as the deficiency is corrected.

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

- 3.7 Obstetrical Record: The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attending Practitioner's office record transferred to the Hospital before admission, but an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.
- 3.8 Authentication of Medical Record: All entries in the patient's record shall be legible, accurately timed, dated and authenticated by the Medical Staff member who authorized or made the entry. Medical Staff members may not authenticate entries in the patient's medical record for other members of the Medical Staff. A Medical Staff member may NOT use a rubber stamp signature to authenticate any entry in the patient's medical record. Exception: Behavioral health restraints may be authenticated by a physician in the same call group as the ordering physician. These restraints must be authenticated within 24-hours of the initial order.
- 3.9 Abbreviations: To avoid misinterpretation, use of abbreviations or symbols should be avoided in the medical record. Should it be necessary to use an abbreviation or symbol, only those found in the reference book, *Abbreviations, Acronyms, and Symbols*; Stedman's (current edition) will be acceptable. Unapproved symbols and abbreviations should not be used in the medical record.
- 3.10 Final Diagnosis: A final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and authenticated by the responsible Medical Staff member at the time of discharge of all patients. Final diagnoses must be recorded in the final progress notes or discharge summary. Medical Staff members shall work in cooperation with Health Information Management personnel to insure timely and accurate documentation and sequencing of final diagnoses and procedures.
- 3.11 Discharge Summary: A discharge summary shall be documented upon discharge for all inpatients, all psychiatric patients, and any observation patients who are in the hospital more than 48 hours. The discharge summary must be recorded within 48 hours from the time of patient discharge. Discharge instructions will be provided to the patient prior to discharge from the hospital.
- Discharge summaries will be considered overdue at 48 hours after discharge and delinquent at three (3) days post discharge. Delinquencies due to an incomplete discharge summary will result in an automatic suspension of admitting privileges as outlined in section 3.16, Completion of Medical Record.
- 3.12 Content of Discharge Summary: The discharge summary should summarize the reason for hospitalization, significant findings, procedures performed, treatment rendered, the outcome of hospitalization, the

condition of the patient on discharge, diagnostic tests, procedures and the results, specific instructions given to the patient and/or family, and provisions for follow-up care. The content of the summary shall be sufficient to justify the diagnosis and warrant the treatment and the end result.

- 3.13 Clinical Research. Free access to all medical records of all patients shall be afforded to Members of the Medical Staff for bona fide study, research, and review consistent with preserving the confidentiality of personal information concerning the individual patients. The President of the Medical Staff, the Vice President of Medical Affairs, and the Manager of Health Information Management shall approve all such projects.
- 3.14 When specific medical records are to be presented at a physician meeting (eg: Tumor Board), the Medical Staff member Attending of Record should be notified if any of his/her cases are to be discussed at the meeting, and if at all possible he/she should be present.
- 3.15 Release of Records: Former members of the Medical Staff shall be permitted access to the medical records of their patients. Requests for such access to records shall be specified in writing for each individual case and authorized by the Vice President of Medical Affairs, or designee, on the former member's request.

All medical records and x-ray films are the property of the Hospital and shall not be removed from the premises of MercyOne Waterloo Medical Center building except by court order, subpoena, or statute, or pursuant to policies approved by the Medical Staff and Hospital administration. In case of readmission of patient, all previous records shall be available for the use of the attending Medical Staff member. This shall apply whether the patient is attended by the same Medical Staff member or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the Medical Staff member for a period to be determined by the Executive Committee of the Medical Staff.

- 3.16 Completion of Medical Record: Quality patient care requires that all medical records be completed in a timely fashion, in accordance with applicable law, regulations and standards.
- A. Practitioners will be subject to the following procedure regarding delinquent medical records:
1. If a discharge summary is not completed within 48 hours after discharge, the practitioner's privileges will be automatically suspended if such records are not completed within two (2) days of the notification from Health Information Management.

2. Any full operative report not available within 24 hours of procedure completion will be considered delinquent and result in the practitioner being unable to schedule additional elective surgeries or procedures until such time as the deficiency is corrected. The physician will also receive letter in his/her quality file noting the suspension.
3. If the record(s) identified in the notice of delinquency are not completed within the timeframes specified above, a notice of automatic suspension will be sent to the Practitioner, suspending the Practitioner's clinical privileges until such time as the delinquent records have been completed. A copy of this notice will be placed in the Practitioner's Professional File. Such suspension shall be effective as of the date of mailing. A suspension for delinquent medical records does not require reporting to the National Practitioner Data Bank or entitle the affected Practitioner to any of the hearing and appeal rights otherwise afforded under the Medical Staff Bylaws. Reactivation of the suspended clinical privileges will require completion of the medical record(s).
4. A list of Practitioners with delinquent medical records may be distributed to the Vice President of Medical Affairs, the appropriate department chair, and the manager of the Health Information Management Department.
5. At the discretion of Hospital, flexibility may be provided for vacations of seven (7) days duration or longer, or for other extenuating circumstances. Physicians should provide seven (7) days' prior notification to the Health Information Management department of any such circumstances.

Physicians providing temporary or locum coverage must have records completed within the timeframes above and must have all records complete and signed before the end of their current assignment.

- B. During an automatic suspension for delinquent medical records, a Practitioner may continue with the medical care of:
(i) emergency and obstetric admissions; and (ii) any patients who were under his or her care in the hospital at the time of the suspension.
- C. If a Practitioner has been suspended for delinquent medical records three (3) occurrences in any 12 consecutive months, or if one (1) suspension for delinquent medical records lasts longer than ninety (90) days, reactivation of suspended

Medical Staff Clinical Privileges will be arranged and conducted during normal HIM business hours after:

1. Verification of completion of the delinquent medical record(s), and
2. The Practitioner appears before the Executive Committee and/or meets with the Medical Staff President, acting as designee for the Executive Committee until such time as the Executive Committee next meets, for consideration of additional disciplinary action, to include possible dismissal from the Medical Staff. If the Practitioner is dismissed from the Medical Staff on this basis, s/he must apply and be processed as a new applicant for initial membership and privileges in order to re-join the medical Staff.

- 3.17 Emergency Medical Record: An appropriate medical record shall be kept for every patient receiving emergency services and be incorporated in the patient's hospital record, if such exists. The record shall include:
- A. adequate patient identification;
 - B. information concerning the time of the patient's arrival and means of-arrival;
 - C. pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to this arrival at the hospital;
 - D. description of significant clinical, laboratory and radiology findings;
 - E. diagnosis;
 - F. treatment given;
 - G. condition of the patient on discharge or transfer;
 - H. Final disposition, including instruction given to the patient and/or his family, relative to necessary follow-up care.

- 3.18 Consultation Documentation: The consultant must enter brief information in the medical record at the time of consult so all caregivers in an emergency with the patient are aware of the recommendation of the consulting physician. A full report should be entered into the record soon after the consultation but within 24 hours and prior to an operative procedure.

See also section 5. Medical & Surgical Consultation

- 3.19 Patient Consents

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

Iowa law permits a minor to make personal applications for substance abuse treatment, and this fact may not be disclosed to

a parent or legal guardian without the minor's consent. The federal regulations provide that where a state has a law that authorizes drug or alcohol abuse treatments to minors without parental consent, then the consent of the minor is all that is needed for disclosure of information.

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

- B. Treatment Consent: A general treatment consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission, except in those situations wherein the patient's life or limb is in jeopardy and authorization cannot be obtained due to the condition of the patient. The reason for not obtaining the consent must be documented.
- C. Surgical Consent: Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life or limb is in jeopardy, or permanent injury will occur, and authorization cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from patient, guardian or next-of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

3.20 History and Physical Exams.

- A. H&P Exam: A medical history and physical exam must be completed no more than 30 days before or 24-hours after admission for each patient, but prior to surgery or a procedure requiring anesthesia (defined as general, regional for the purpose of anesthesia, MAC to include deep sedation/analgesia, and *conscious/moderate sedation/analgesia). Components of the H&P exam must include: chief complaint; history (detail) of present illness; past medical history (include current medications and allergies); family and social history (if relevant); physical exam to include general exam, vital signs, HEENT, heart, lungs, chest, abdomen, extremities, neurological, and any other exam deemed relevant; initial impression/reason for admission, and plan for treatment. *Exception: A history and physical is not required for mental health observation patient.*
- B. H&P Update Exam: When the medical history and physical exam are completed within 30 days before admission, an updated examination of the patient, including any changes in the patient's condition, must be placed in the patient's medical record within

24 hours after admission, but prior to surgery or a procedure requiring anesthesia. It is the responsibility of the anesthesiologist administering the anesthesia or the physician performing the procedure to complete the update exam.

Consistent with Centers for Medicare and Medicaid Services (“CMS”) and The Joint Commission requirements, H&Ps performed more than 30 days prior to admission or registration cannot be updated, they must be re-performed.

A physician is not required to document a formal H&P for patients undergoing procedures that pose minimal risk to the health and safety of the patient. (Examples: procedures performed outside the Operating Room under topical, local, minimal, or block anesthesia). However, the physician is required to document in the medical record the reason for the procedure performed and review any known allergies and current medications.

- C. *Condensed H&P Form: A physician may complete a condensed H&P for patients who are admitted for observation, or who are undergoing procedures that pose a moderate risk to the health and safety of the patient. (Examples: endoscopy, cardiac cath, or procedures involving conscious/moderate sedation/analgesia.) Components of the condensed H&P must include: the procedure to be performed, pre-operative diagnosis, history pertinent to procedure, and a physical assessment that must include heart and lung.
- D. A history and physical exam must be on the patient’s chart prior to surgery or procedures involving anesthesia, or the surgery or procedure shall be cancelled. *In an emergency*, when there is no time to record the complete history and physical examination, a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis must be recorded in the medical record before surgery.
- E. Completed by Appropriate Practitioner: History and Physical exams may be performed by Physicians (MD/DO), Physician Assistants, Nurse Practitioners, or Certified Nurse Midwives.
- F. Completed By Member of Medical/AHP Staff: If a Practitioner (see item E) who is not a member of the Medical/AHP Staff completes an H&P Exam, the license of the Practitioner shall be verified with the state licensing board to be Active.
- G. The History and Physical Exams of all Physician Assistants and who are members of the MercyOne Waterloo Medical center Allied Health Professional Staff must be cosigned by the supervising physician.

- 3.21 Orders: All orders for treatment shall be entered into the electronic medical record by the practitioner. An exception to this rule occurs during system downtimes. Practitioners should follow downtime protocols during planned or unplanned periods of downtime. *See also Medical Staff “Verbal & Telephone Orders” policy*
- Computerized practitioner order entry (CPOE) rate of compliance will be considered at reappointment.
- For all non-CPOE orders (Verbal/Telephone) the responsible Medical Staff Member (ordering practitioner) shall authenticate such orders within 30 days of patient discharge. An exception to this is restraint orders, which must be authenticated within 24 hours.
- 3.22 Routine Orders: A Medical Staff member’s routine orders must be entered by the ordering provider.
- 3.23 Verbal Orders: All verbal orders shall be entered by the person to whom dictated, with the name of the physician per his/her own name. *See also Medical Staff “Verbal & Telephone Orders” policy*
- 3.24 Telephone Orders: Telephone orders shall be considered and treated as verbal orders. Telephone orders from a physician’s office, which are transmitted by someone other than the physician, shall be construed and interpreted as coming from the physician. Hospital personnel accepting orders from physician’s office employees are to identify in the chart by name and title, the person from the office that is transmitting the order. A qualified Hospital employee can request to validate an order with the responsible physician. *See also Medical Staff “Verbal & Telephone Orders” policy*
- 3.25 Accept/Transcribe Telephone/Verbal Orders. A current list of staff approved to accept/transcribe telephone/verbal orders is located in the Patient Focus Policy and Procedure manual.
- 3.26 Chemotherapy Orders: Where Oncology CPOE is not available, orders will be written on paper by the provider and subsequently entered into the EHR’s Pharmacy System. Where oncology CPOE is available, providers will enter orders for each medication directly into the EHR. The chemotherapy order shall include name of medication, dosage, route of administration, and schedule of administration.
- 3.27. Medication Orders: The physician order for medication(s) is to outline the name of medication(s), dosage, route and schedule of administration, and interval for each medication. Orders for “continue home meds” and “meds as at home” will not be accepted.
- 3.28 Acute/Inpatient Orders: Inpatient orders will only be accepted by credentialed and appropriately privileged Members of the Medical Staff,

Physician Assistants, Advance Registered Nurse Practitioners, and/or Certified Nurse Midwives who have been approved by the Board of Directors.

- 3.29 Resident Orders: Hospital approved Residents are authorized to initiate orders on patients admitted to their group and/or supervising physician's care. While each order need not be countersigned prior to being processed, there shall be sufficient documentation to demonstrate the supervision of the patient's care by a licensed independent Practitioner. Exception: Orders in the NICU must be countersigned by a licensed independent Practitioner with NICU privileges prior to the order being processed.
- 3.30 Cancellation of Orders When in Surgery: All previous orders are cancelled when patients go to surgery, except when diagnostic or minor procedures are done under local anesthesia or moderate/conscious sedation.

4. EMERGENCY DEPARTMENT

- 4.1 Assignment of Patients.
- A. Assignment of patients who have an established relationship with a Member of the Medical Staff will be based on the primary admitting diagnosis, age of patient, and co-morbid conditions (see section 4.2).
 - B. Patients who do not have a physician, whose physician is not a Member of the Medical Staff, or who cannot definitively state whether or not an established relationship exists with a Member of the Medical Staff will be considered a "No-Doc" patient.
 - C. No-Doc patients will be assigned an Attending of Record based on primary admitting diagnosis, age of patient, and co-morbid conditions (see 4.2).
 - D. If the Emergency Medicine physician determines that the appropriate Attending of Record should be a primary care physician, (pediatrician, internist, or family physician), the patient will be assigned to the next physician on the rotating list of primary care physicians. The rotating list is comprised of primary care physicians who belong to the Active Staff category. That primary care physician is designated to serve as the Attending of Record for that case. If that person is not on call, then the covering physician for that call group, who is on call, becomes the designated Attending of Record. (Note: Obstetrical No-Doc patients are handled through a rotation within the Department of OB/GYN.)
 - E. A transaction log will be kept by the Emergency Department that

details the name of the patient, the date and time of the assignment, as well as the specific physician assigned to that case. The assigned physician is not permitted to refuse service for that patient. The Emergency Medicine physician is empowered to enforce this requirement. Should the assigned physician refuse to fulfill this medical staff responsibility, the Emergency Medicine physician will assign the patient to the next physician on the rotating list.

- G. The physician that refused to accept the patient assignment will be sent written notification by the Medical Staff President, or designee, either by certified mail, return receipt requested, or hand delivery to the addressee. The written notice will require that physician to provide a written response within 10 days from the date of the letter explaining why that physician refused to comply with medical staff rules and regulations. The Medical Staff President and Medical Executive Committee (MEC) will then decide on further disciplinary steps that may include, but are not limited to, appearance before the full MEC, suspension of medical staff privileges, and/or revocation of staff membership and privileges with mandatory reporting to the Iowa Board of Medicine. All transactions will be documented and placed in that physician's professional practice trending file for review.

4.2 Determination of Appropriate Attending of Record:

- A. Age: anyone 65 and over should be admitted to a primary care physician/service(exception trauma).
- B. Trauma: Any Level 1 trauma patient will be admitted to the trauma surgeon on-call.
- C. Primary diagnosis: If the diagnosis is a primary medical disease, the patient should be admitted to a primary care physician. Examples include but are not limited to: abdomen pain, chest pain, pneumonia, COPD, CHF, cellulites, CVA, alcohol detoxification, diabetic complications, uncomplicated small bowel obstructions, etc.
- D. A clear surgical/specialty diagnosis should be admitted to that appropriate service. Examples include but are not limited to: recent post operative complications, surgical orthopedic problems, appendicitis, acute cholecystitis, surgical ENT problems, oncology patients, nephrolithiasis that will need intervention or is under treatment by a urologist, etc.
- E. Co-morbid conditions: Any patient presenting with a

surgical/specialty diagnosis that has two (2) or more co-morbid problems should be admitted to a primary care physician. These include:

1. Uncontrolled HTN
2. Moderate COPD
3. Diabetes
4. Severe coronary artery or peripheral vascular disease
5. Significant renal insufficiency
6. Congestive heart failure
7. Any other co-morbid condition that would place the patient at a significant risk

F. Emergency Department Discretion: Obviously not all cases can be clearly written and clarified in an algorithm and there are plenty of “gray areas”. Ultimately, the Emergency Department physician will have the authority to determine who should be the Attending of Record for the patient.

4.3 Refusal to See Patient. If the attending physician refuses to come to the Emergency Department to see and evaluate the patient, the Emergency Department physician shall:

- A. Notify the House Supervisor of the situation;
- B. Forward the patient chart and all relevant information, by the end of his/her shift, to the appropriate Department Chair for review the following day.
- C. For No-Doc patients, the Emergency Department physician will go to the next physician on the No-Doc call list.

4.4 EMTALA Compliance.

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

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

- B. An individual is considered to have “come to the emergency department” if the individual has:
- A. Presented at the hospital’s dedicated emergency department or on hospital property and requests examination or treatment for a potential emergency medical condition, or has such a request made on his or her behalf. In the absence of such a request, a request on behalf of the individual will be considered to exist if a prudent layperson would believe, on the basis of the individual’s appearance or behavior, that the individual needs examination or treatment for a medical condition;
 2. Is in a hospital-owned ambulance for the purpose of examination and treatment for a medical condition at the hospital’s dedicated emergency department. In the case of an infant birth, the federal Born-Alive Infants Protection Act of 2002 protects and extends protections under EMTALA to any infant born alive at any stage of development.
- C. Any patient who comes to the Hospital’s dedicated emergency department and requests or has a request made on his or her behalf for emergency examination and treatment or who a prudent layperson would believe, on the basis of the individual’s appearance or behavior, requires examination or treatment for a medical condition, will be provided an appropriate medical screening examination within the capabilities of the Hospital to determine whether an emergency medical condition exists regardless of their ability to pay for medical care.
- D. When the medical screening examination reveals that the person has an emergency medical condition, the Hospital will provide further medical examination and stabilizing treatment as required to stabilize the medical condition or will transfer the patient in accordance with its **EMTALA: Patient Transfer to Another Acute Care Facility Policy**.
- E. The Hospital will maintain a list of on-call physicians who can provide further evaluation and/or treatment necessary to stabilize an individual with an emergency medical condition.
- F. When on the Emergency Department on-call schedule, the only acceptable reasons for failure to respond to a request for consultation by the Emergency Department is sudden illness, unavoidable detainment such as attending to another emergency, or other event that physically prohibits the on-call physician from appearing in the hospital.

- G. Failure to respond to a request for consultation by the Emergency Department when on the Emergency Department on-call schedule, may constitute a violation of the EMTALA guidelines, may result in a personal fine assessed by CMS, and may result in corrective action by the Medical Staff.
- H. A medical screening exam may be performed by a physician or “qualified medical person.” A “qualified medical person” is defined as an individual, in addition to a licensed physician, who is licensed or certified in the State of Iowa and who has demonstrated current competence in the performance of medical screening examinations. Qualified Medical Person(s) include:
 - I. Emergency Department: Physicians, Physician Assistants, Advance Registered Nurse Practitioners, and the Psychiatric Nurse Case Manager in the Emergency Department.
 - J. In the event the Emergency Department Physician, Physician Assistant, or Advance Registered Nurse Practitioner is unavailable, an Emergency Department registered nurse is designated as the alternative qualified medical provider.
 - K. Certified Nurse Midwives
 - L. Labor and delivery registered nurses who have at least one year of experience, have completed charge nurse competency, and have completed external fetal monitoring certification.
 - M. Paramedics in the pre-hospital setting, within the scope of their license to practice
 - N. Cardiac rehabilitation registered nurses (off-campus/outpatient facilities)
 - O. Dialysis registered nurses (off-campus/outpatient facilities)
 - P. Physicians, Physician’s Assistants and Advanced Registered Nurse Practitioners (off-campus/outpatient facilities)
 - Q. In the event that the designated physician, physician’s assistant, or nurse Practitioner in an off-campus outpatient setting is unavailable, a registered nurse or licensed practical nurse on-site is designated as the alternative qualified medical provider.

- 5.1 Qualifications: A consultant must be qualified, based on his/her individual training, experience, and competency, in the field in which the opinion is sought.
- 5.2 Essentials of a Consultation: A consultation includes examination of the patient and the patient's medical record. A documented opinion signed by the consultant must be included in the medical record.
- 5.3 Indications for Consultation: Except in an emergency, consultation should be considered in the following situations:
- A. When the patient is not a good risk for operation or treatment;
 - B. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
 - C. Any procedure for which the Attending of Record does not have privileges;
 - D. Where there is doubt as to the choices of therapeutic measures to be utilized;
 - E. In unusually complicated situations where specific skills of other Practitioners may be needed;
 - F. In instances in which the patient exhibits behavior suggesting harm to self or others;
 - G. When requested by the patient or patient's family;
- 5.4 Requesting Consultation: The requesting practitioner should not rely solely on the electronic medical record for communicating the request for consultation. Two types of consultations exist by definition. These are STAT and Routine. The reason for the consultation must be documented at the time of consultation.
- A. STAT consultations require direct peer-to-peer communication at the time of the consultation request and again after the consultant has seen the patient to provide his/her recommendations. This facilitates optimal care and any necessary immediate interventions. (Exception: Family Birth Center admissions to the NICU)
 - B. Routine consultations require evaluation by the consultant within twenty-four (24) hours of the consultation request.
 - C. All orders for consultations must specify the name of the group and/or physician being requested to do the consult.
See also "Provider to Provider Communication" Policy

6. ANESTHESIA SERVICES

- 6.1 The provision of Anesthesia Services in the hospital is coordinated through the Department of Anesthesia. Anesthesia Services are defined as follows:
- A. Anesthesia: General, regional for the purpose of sedation, monitored anesthesia care (MAC) to include

deep sedation, and moderate (conscious) sedation.

- B. Analgisia: Topical, local anesthesia, minimal sedation (e.g. oral medication to decrease anxiety prior to a MRI or CT), and regional for the sole purpose of analgesia (e.g. during labor and delivery)

6.2 A non-anesthesiologist qualified medical doctor, doctor of osteopathic medicine, dentist, oral surgeon, or CRNA, requesting permission to administer anesthesia or sedation, must meet the credentialing criteria, established by the Department of Anesthesia and approved by the Board of Directors, and must be privileged to administer moderate/conscious sedation and MAC, to include deep sedation.

6.3 Anesthesia Pre-Operative Visits: In all surgical case(s)/procedures the licensed anesthesiologist or certified registered nurse anesthetist shall evaluate those patients expected to be anesthetized within 48 hours prior to all cases. This provider shall review the chart, interview the patient, and perform any examination that would provide information that might assist in decision regarding risk and management. Necessary tests and medications should be ordered and any requested consultation obtained. If the provider feels there is a sufficient medical reason to cancel a case/procedure for the proposed day of surgery, he or she may do so in consultation with the attending surgeon. In the event there is a disagreement concerning the cancellation of the proposed surgery/procedure, the surgeon may seek consultation from another anesthesiologist.

For emergency cases in the operating room, the anesthesiologist should be informed of the case by the operating surgeon so that both may consult in regard to the welfare and safety of the patient. The anesthesiologist should see and evaluate the patient and write pre-operative orders. If the urgency of the surgery makes this impossible, the patient will be evaluated in the operating room prior to induction of anesthesia and needed medication given then.

6.4 Anesthesia Record: The anesthesiologist or certified registered nurse anesthetist, administering the anesthesia agent, shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation.

6.5 Pre-Operative Tests Under Topical Analgesia, Local Anesthesia/Sedation, or Minimal Anesthesia/Sedation: The ordering of any pre-operative tests for patients undergoing procedures involving these types of analgesia or sedation are the responsibility of the physician performing the procedure under the following conditions:

- A. The above analgesia or sedation is administered by the non-anesthesiologist physician performing the procedure;
- B. There is no participation by a member of the Department of

Anesthesia in the procedure, including anesthesia standby.

- 6.6 Cardiorespiratory monitoring is required on all patients undergoing procedures performed in the surgical suite.
- 6.7 Anesthesia Selection. The type of anesthesia should not be designated by the surgeon, but should be left to the discretion of the anesthesiologist.
- 6.8 The following are the types of anesthesia services delivered outside of the operating room and where they may be performed:
 1. Ambulatory Surgery Unit
 1. Locals
 2. Moderate/Conscious Sedation
 3. Epidural Blocks
 4. Sympathetic Nerve Block
 5. Spinals
 6. Regional Blocks
 2. Outpatient Clinic
 1. Locals
 2. Moderate/Conscious Sedation
 3. Epidural Blocks
 4. Sympathetic Nerve Block
 5. Spinal Blocks
 6. Regional Blocks
 7. Deep Sedation
 3. Emergency Department
 1. Locals
 2. Moderate/Conscious Sedation
 3. Deep Sedation
 4. Regional Blocks
 4. Radiology/MRI
 1. Locals
 2. Moderate/Conscious Sedation
 3. Generals
 4. Spinals
 5. Epidurals
 6. Deep sedation
 5. Family Birth Center
 1. Locals
 2. Moderate/Conscious Sedation
 3. Epidurals
 4. Paracervical
 5. Spinal Narcotics
 6. Pudendal's
 7. Generals
 8. Deep Sedation
 6. PACU
 1. Generals
 2. Moderate/Conscious Sedation

3. Epidurals
4. Deep Sedation
5. Locals
7. ICU
 1. Generals
 2. Moderate/Conscious Sedation
 3. Epidurals
 4. Spinal Narcotics
 5. Deep Sedation
 6. Locals
8. Cardiac Catheterization and Electrophysiology Laboratory
 1. Moderate/Conscious Sedation
 2. Deep Sedation
 3. Locals
9. NICU
 1. Locals, Moderate, and Deep Sedation
10. Inpatient Unit
 1. Locals and Epidurals
11. Inpatient Unit:

6.9 Locals and Epidurals Pre, Intra, and Post-anesthesia visits and notes must be completed whenever anesthesia is performed. The patient must be reevaluated immediately before administering moderate or deep sedation or anesthesia. The post-anesthesia evaluation must be completed only when the patient has recovered sufficiently from the anesthesia to appropriately participate in the assessment.

6.10 An anesthesiologist shall be on call, and available within a reasonable period of time, to respond to emergency situations as they arise.

7.SURGERY

- 7.1 Description of Operations. All surgical procedures performed shall be fully described by the appropriate physician.
- 7.2. Surgery maintains a procedure file summary listing, by procedure code, for procedures done in the operating room.
- 7.3 Surgically Removed Tissue to Pathologist. All specimens removed during a surgical procedure shall be sent to the Hospital's pathologist, who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis. Administrative policy OR282, or its current replacement policy, lists any exemptions to this requirement. All specimens remain the property of the Hospital.
- 7.4 Documentation on Chart Prior to Surgical Procedure.

The following is a list of additional forms, reports, and documentation which must be in the record prior to the beginning of the surgical

1. For patients receiving services of an anesthesiologist:
 - A. History and physical – pre-operative diagnosis; to be available 24 hours prior to scheduled procedure for all AM admissions and ambulatory surgeries;
 - B. Completed physician Pre-Operative orders (PMM 87445 or its current replacement). This document lists the current pre-operative requirements.
 - C. Operative permit signed by patient, if of legal age, or a responsible relative or guardian;
 - D. Signed and witnessed patient forms as dictated by procedure:
 1. General (surgical/procedure) consent form (PMM 463123, its language alternatives, or its current replacement)
 2. Request for sterilization – in addition to the Hospital form, those patients covered by Medicaid must have that form signed 30 days prior to procedure;
 3. Anesthesia consent form
 4. Consent for transfusion of blood (PMM 463124, or its current replacement policy)
 5. Patients with underlying medical conditions may require additional laboratory or other diagnostic tests. Questions should be directed to Anesthesia.
2. For patients receiving moderate/conscious sedation by non-anesthesiologist providers:
 - A. Pre-operative diagnosis;
 - B. History and physical
 - C. General/surgical consent
 - D. Pre and Post Anesthesia Evaluation
3. For patients receiving deep sedation by non-anesthesiologist provider.
 - A. Pre-operative diagnosis
 - B. History and physical
 - C. General/surgical consent
 - D. Anesthesia consent
 - E. Pre, Intra, and Post Anesthesia Evaluation
4. No Pre-op labs required for cataracts performed under monitored anesthesia care (MAC).

- 7.5 High Risk Surgical Case/Qualified Assistant. An appropriate trained and credentialed assistant will be provided by the hospital, at the surgeon's discretion, for high-risk surgical procedures.
- 7.6 A history and physical must be on the chart prior to the beginning of the following procedures, with or without anesthesia:
- A. Arteriograms/angiograms;
 - B. Myelograms;
 - C. Percutaneous drainage procedures;
 - D. Percutaneous biopsies that would cause an interruption of a visceral space. (i.e. kidney biopsies, retroperitoneal, pancreas etc.). Breast Biopsies, Thyroid Biopsies, Inguinal Lymph node biopsies do not require a history and physical exam prior to the performance of the procedure.
 - E. Transesophageal Echo

8.OBSTETRICS/GYNECOLOGY

- 8.1 Obstetrical Consultation. Requesting and providing obstetrical consultation is a formal process that should be accomplished according to the general guidelines stated in other sections of the Rules and Regulations. Informal opinions do not fulfill the requirements of consultation. When the complexity of an illness, complications or procedure exceeds the scope of practice of an attending physician, obstetrical consultation is required. The following are situations where obstetrical consultation is required, unless a provider has special credentialing to provide these cares;
- A. Cesarean section, if a repeat Cesarean is planned then recommended consultation in the third trimester (ideally 26-30 weeks) to facilitate scheduling;
 - B. Preeclampsia, pregnancy-induced hypertension, eclampsia, and chronic hypertension. Consultation is recommended at the time the diagnosis is made for planning delivery. For chronic hypertension, consider consultation in the first or second trimester;
 - C. Prolapsed cord with a living fetus;
 - D. External version;
 - E. Operative vaginal deliveries. Those privileged to do operative vaginal deliveries should notify OB on-call so they can be prepared in the event of a failed operative delivery;
 - F. Dührssen's incisions;
 - G. Breech delivery;
 - H. Elective induction with a Bishop's score of less than 8 or induction <39 weeks;
 - I. Labor less than 36 weeks gestation;
 - J. Medication controlled diabetes. Consultation is recommended when medication therapy is initiated;
 - K. Prolonged labor as defined by arrest of dilation for greater than four (4) hours with adequate contractions as evidenced by an

- IUPC or arrest of descent as evidenced by greater than two (2) hours of active pushing in a multiparous patient or greater than three (3) hours of active pushing in a primiparous patient;
 - L. Multiple pregnancies. Consultation is recommended when diagnosis is made but it is reasonable to have shared care during the pregnancy;
 - M. Third trimester bleeding;
 - N. Placenta previa, placenta accreta, vasa previa or low lying placenta (within 2 cm of internal os) at greater than 20 weeks gestation;
 - O. Post-partum hemorrhage that does not respond to bedside interventions;
 - P. Trial of labor after Cesarean delivery/Vaginal Birth after Cesarean. Consultation in the second or early third trimester is recommended to discuss risks and benefits;
 - Q. Non-reassuring fetal heart rate - category 3 tracing or category 2 tracing that is not responding to interventions to improve;
 - R. Thrombophilia or history of DVT/PE. Consultation is recommended when diagnosis is made but it is reasonable to have shared care during the pregnancy;
 - S. Fourth degree perineal laceration;
 - T. Consultation may be requested at the discretion of the attending physician at any time there are concerns not otherwise specified above.
- 8.2 Use of Pitocin. When IV Pitocin is being used in an undelivered patient, the attending physician must be readily available.
- 8.3 Vaginal Birth After Cesarean Section (VBAC) Labor.
1. When a patient who has had a previous cesarean section, and who is planning a vaginal birth after cesarean section is in active labor, the patient's physician must be on campus.
 2. Active labor is defined as regular contractions with an effacing or dilating cervix and/or descending presenting part.
 3. The patient's physician must see the patient while she is in labor.
 4. The attending physician must be an obstetrician
 5. The anesthesiologist should be available within 15 minutes of the call request for VBAC labor.

9. NEONATOLOGY/INTENSIVE CARE NURSERY

- 9.1 Supplemental Oxygen. A neonatologist will care for all infants requiring continuous positive airway pressure, by any route, or assisted ventilation. Such management will be complete and will begin, where possible, before the decision to institute such therapy and will continue at least

until the infant is off oxygen and intravenous therapy, unless the neonatologist elects to turn the care over to the pediatrician.

- 9.2 Delivery Attendance. A neonatologist will be consulted to attend high-risk deliveries at the discretion of the pediatrician and/or obstetrician. A neonatologist shall be consulted to attend the delivery and then assume complete care of infants less than 32 weeks gestational age. A neonatologist may be asked to attend the delivery of an infant who has specific problem that is expected not to be a problem once the baby has been safely delivered. The neonatologist would fully anticipate that such infant would be cared for by the primary pediatrician, unless the infant had difficulty after delivery.
- 9.3 Neonatal Consultation. Neonatal consultation shall be obtained:
- A. When the diagnosis is in doubt;
 - B. When it is requested by the family;
 - C. When there is significant deterioration in the infant's condition;
 - D. If the infant is unstable
- 9.4 Conditions requiring a neonatal consultation include, but are not limited to, the following conditions:
- A. significant respiratory disease;
 - B. hypertension; jaundice needing possible exchange;
 - C. sepsis in which the infant is unstable;
 - D. Seizures and similar conditions.
- 9.5 Return of Care to the Patient's Physician. If the neonatologist has assumed complete management of an infant, care will be returned to the primary physician when the infant is stable and/or discharged.
- 9.6 Neonatology Backup. If a high-risk mother is admitted it would be appropriate for the obstetrician, after talking to the mother and the family physician or pediatrician, to involve the neonatologist in the care of the infant at the time of delivery.

The neonatologist is to make every effort to be available when the infant is delivered. However, if the neonatologist were not available to attend the delivery, then the pediatrician on call would care for the infant.

10. GENERAL RULES OF THE MEDICAL STAFF

- 10.1 On Call Proximity to the Hospital. While on call, members of the Medical Staff must be available within 30 minutes to the Hospital, or sooner as may be established by the department and/or required by the type of call responsibilities. Each on call member of the Medical Staff who is not available within 30 minutes shall name a member of the Medical Staff who is a resident in the area who may be called to attend his/her patients in an emergency, or until he/she arrives. In case of failure to

name such as an associate, the President of the Hospital, President of the Medical Staff, or Chairman of the Department concerned, shall have authority to call any member of the active staff in such an event.

- 10.2 Practitioners will make arrangements for an appropriate backup physician(s) to take call and provide emergency coverage in his/her absence

10.3 **Autopsies and Hospital Deaths**

- A. Autopsies. It shall be the duty of all Medical Staff members to secure autopsies whenever possible and as indicated in Administrative Policy. Unless assigned to the Medical Examiner's Office, an autopsy may be performed only with a written consent, signed in accordance with state law. Autopsies shall be performed by the Hospital's pathologist, or by a qualified designee. Provisional anatomic diagnoses shall be made available to the attending physician and placed in the medical record within three (3) working days and the complete protocol shall be made a part of the medical record within six (6) weeks.

Autopsies will not automatically be performed in situations where the deceased does not meet the indicators, the attending physician does not make a request, and/or the deceased meets the criteria for becoming a Medical Examiner's Case. Cases meeting the criteria for becoming a Medical Examiner's Case will be assigned to the Medical Examiner.

Efforts to obtain permission to perform an autopsy for deaths that meet the indications in Administrative Policy and for which the family or guardian refuses to grant permission should be documented in the medical record (in Practitioner and/or nursing notes).

- B. Hospital Deaths. In the event of a death in the hospital, the deceased shall be pronounced dead by the attending physician or his/her physician designee within a reasonable period of time.

In the event of death in the Emergency Department the physician's responsibilities include:

- A. Determination of time of death by stopping resuscitation efforts.
- B. Determination of probable cause of death.
- C. Establishing the need for an autopsy and obtainment of consent, if not a Medical Examiner Case.
- D. Notification of death to deceased's physician
- E. Communication with and support to family

Patients in the Emergency Department are not classified as "dead

on arrival”. A patient may be pronounced dead by the physician after examination and resuscitation effort.

Reporting of deaths to the Medical Examiner’s Office shall be carried out when required by and in conformance with state and local law.

- 10.4 Organ Removal. Prior to organ transplantation procedures involving brain wave death donors, a written consent form must be obtained from next-of-kin and a statement of death should be in the medical record before actual organ removal begins.

10.5 Formulary: All drugs and medications administered to patients shall be those listed in the latest edition of the Centers for Medicare and Medicaid Services (CMS) Compendia. Drugs for Bona fide clinical investigation may be exceptions. These shall be used in full accordance with the approval of the MercyOne Waterloo Medical Center Institutional Review Board (IRB)

- 10.6 Human Subjects Research: Medical Staff Members will follow the MercyOne Waterloo Medical Center policy on clinical investigation when conducting or participating in research involving human subjects. Research involving human subjects must be reviewed and approved by the MercyOne Waterloo Medical Center Institutional Review Board (IRB).

There shall be adequate provisions in the research protocol to protect the privacy of subjects and to maintain the confidentiality of data. All clinical investigation projects shall comply with the Ethical and Religious Directives. The “Human Subjects Research” policy explains the process to follow in detail.

- 10.7 Infectious Disease. Each Practitioner shall participate in measures to reduce the risk of infections in patients and health care providers. Practitioners shall be required to follow the recommendations of the Infection Control Committee as approved by the Executive Committee of the Medical Staff. Recommendations and policies shall be based on information from the Centers for Disease Control, and state and federal regulations. All Members of the Medical Staff shall observe recognized infection control protocols, including, but not limited to, standard precautions, hand washing, and wearing of appropriate protective apparel.

- 10.8 Automatic Stop Order Policy for Drugs. Automatic stop orders for certain classes of medications have been approved by the Medical Staff.. Details regarding automatic stop orders and reinstatement of such orders are located in the MercyOne Waterloo Medical Center Medication Administration Policy.

- 10.9 External Acceptable Sources For Laboratory Tests. Laboratory tests will

be accepted from any laboratory accredited by the College of American Pathologists, The Joint Commission, or COLA.

10.10 External Chest X-Ray Acceptable Sources. Only pre-operative chest x-rays interpreted by a licensed radiologist will be accepted.

10.11 External EKG Acceptable Sources. Only pre-operative EKG impressions interpreted by a licensed physician, and within the scope of training and licensure shall be accepted.

10.12 Requests for New Procedures. All requests for new procedures (those not already approved by the Board of Directors) must first be validated and recommended by the Credentials Committee and the Medical Executive Committee, with approval by the Board of Directors. Consideration of hospital resources, personnel, supplies and equipment, medical necessity and clinical outcomes, and physician training/education/competence are types of components of the validation process. Consistent with the Medical Staff Bylaws, requests for new or increased privileges will be processed in the same manner as an application for initial Clinical Privileges.

10.13 Ventilator Monitoring. Adult acute ventilator support may only be provided in the Intensive Care Unit (ICU). The Neonate Intensive Care Unit (NICU) may be used to vent appropriately aged patients. In the case of chronic ventilator support, the Rehabilitation Department may be considered, with consultation of the Medical Director of Rehab.

10.14 Restraint and Seclusion. Providers are to comply with the MercyOne Waterloo Medical Center Restraint/Seclusion policy and procedure.

10.15 Fee-Splitting Prohibition. In the conduct of professional practice of all Members of the Medical Staff, there shall be no fee splitting. Fee splitting is defined as: giving or receiving, directly or indirectly, to or from any person, firm or corporation any fee, commission, rebate or other form of compensation or anything of value for sending, referring or otherwise inducing a person to communicate with a member of the Medical Staff in a professional capacity, or for any professional services not actually provided personally or at his or her discretion. It includes those cases in which the term “assistant” is used to obtain a part of the fee which otherwise could not be rightfully claimed. Practitioners and surgeons shall bill separately for services provided. Bills provided to the patients shall reflect actual services provided.

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

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

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

11. Trauma Services

The Medical Staff of MercyOne Waterloo Medical Center supports the trauma services and commits to providing specialty care as required for current level of verification to support optimal care of trauma patients.

11.1 **Trauma Alert Policy:** The Trauma Alert Policy is developed, reviewed and revised by the Trauma Services Committee. It encompasses all necessary elements to comply with the Iowa State Department of Public Health Bureau of EMS Standards. The Trauma Alert Policy and may be found on the MercyOne intranet.

11.2 **Medical Director and Trauma Committee:** The President of the Medical Staff shall designate a qualified general surgeon as the Trauma Services Medical Director. The Medical Staff Bylaws define the roles and responsibilities of the Trauma Services Medical Director, and the composition and duties of the Trauma Services Committee.

The Trauma Services Medical Director is the Chair of the Trauma Services Committee. The Trauma Services Medical Director reports to the Medical Staff Executive Committee. The Trauma Services Medical Director reviews and communicates recommendations concerning requests for trauma privileges to the Chair of the Surgery Department. The Trauma Services Medical Director has oversight authority for the care of trauma patients in all departments, including the Intensive Care Unit.

11.3 The Trauma Service is covered twenty-four hours a day, seven days a week by the general surgeons who are credentialed and privileged at MercyOne Waterloo Medical Center.

11.4 **Level 1 and Level 2 Trauma:**

Once a patient is identified as a Level 1 trauma patient, the on-call trauma surgeon is notified immediately and is expected to be in the Emergency Department upon arrival of the patient. For all Level 1 Trauma

alerts, the trauma surgeon will fulfill the functions as listed in the Trauma Alert policy. All Level 1 trauma patients must first be seen by a physician in the Emergency Department before being admitted.

All Level 1 traumas are admitted to a trauma surgeon who will become the designated attending of record for the patient for a term not to be less than twenty-four (24) hours. During this time period, the trauma surgeon contacts hospitals and physicians to accept patient transfers, when applicable, and completes documentation on the transfer forms. After initial twenty-four (24) hours, the status of attending of record and related duties, for the single body system trauma patients, will be assumed by the appropriate specialist to care for the patient. If it is determined by the trauma surgeon that there is no likely risk of a surgical problem as a result of the trauma, that surgeon must discharge the patient if appropriate, or find an accepting attending for transfer of care (document of acceptance must be in the medical record)

All Level 2 trauma patients are seen and treated by the Emergency Medicine physician. For Level 2 traumas, the trauma surgeon will respond to Emergency Department Physician consult after initial evaluation. The trauma surgeon will become the designated attending of record for the patient for a term not to be less than twenty-four (24) hours

12 HEALTH INSURANCE AND PORTABILITY ACT (HIPAA)

- A. The Health Insurance portability Act of 1996 and its implementing regulations (“HIPAA”), among other thing, regulate how providers can use and disclose individually identifiable protected health information (“PHI”) with one another.
- B. HIPAA also requires a provider with a direct treatment relationship with an individual (including, among others, hospitals, providers and allied health professionals) to provide the individual with a notice of its privacy practices. The notice must afford the individual with adequate notice of the provider’s uses and disclosures of PHI, the individual’s rights and the provider’s responsibilities with respect to PHI. The notice of privacy practices must be furnished to the individual upon the first service delivery, except in emergency situations, in which case it may be provided as soon as reasonably practicable.
- C. HIPAA further requires a provider with a direct treatment relationship with an individual to make a good faith effort to obtain a written acknowledgement of the individual’s receipt of the provider’s notice of its privacy practices. If the acknowledgement cannot be obtained, the provider must document in good faith its efforts to obtain such acknowledgment and the reason why the acknowledgement was not obtained.
- D. Under HIPAA, if two or more providers (including a hospital and its medical staff) are part of the same “Organized Health Care Arrangement” (“OHCA”), they may issue a joint notice of their privacy practices and

obtain a joint acknowledgement from the individual. Accordingly, for patients treated through the OHCA, only one notice and one acknowledgement are required for all of the providers in the OHCA.

- E. Notwithstanding, under HIPAA, if a provider is a member of an OHCA, and that same provider also has his or her own private practice, and his or her privacy practices in his private office are different than that of the OHCA, for patients that provider treats outside of the OHCA, the provider must still deliver his/her own notice of privacy practices and obtain his/her own acknowledgement.

12.1 Hospital and Medical Staff are OHCA. The Hospital and its Medical and Allied Health Staff Members (referred to for purposes of this Article XV as “Members”) operate as OHCA in that they provide direct patient care services through clinically integrated settings (e.g., inpatient or outpatient hospital settings and/or other hospital-based clinical settings).

12.2 Joint Acknowledgement and Joint Notice of Privacy Practices

- A. Members treating patients at any of the clinically integrated settings of the Hospital’s OHCA shall use a joint acknowledgment and joint notice of privacy practices, as described herein.
- B. The joint acknowledgement and joint notice of privacy practices shall be in such forms as are designated by the Hospital and such joint acknowledgement and joint notice of privacy practices shall meet the requirements of HIPAA.
- C. Each Member shall abide by the terms of the joint notice of privacy practices with respect to PHI created or received by such Member as part of its participation in the Hospital’s OHCA.
- D. Each Member shall take reasonable steps to ensure the privacy and security of all PHI, including PHI created, used, transmitted or maintained as part of the Hospital’s OHCA. Such reasonable steps should be in place for all PHI, in all forms, including verbal, written and/or electronic.

12.3 Corrective Action. Failure of any Practitioner or Allied Health Professional to comply with the requirements of this section may be subject for corrective action as provided in the Medical Staff Bylaws.

12.4 Disclaimer of Liability. Notwithstanding the foregoing OHCA relationship described in this article, the hospital hereby explicitly disclaims any and all liability to members and/or any third parties, whether under theories of apparent agency or any other theory of liability, for the acts and omissions of its members.

13. BEHAVIOR AND CONDUCT

13.1. All Medical Staff members must treat others with respect, courtesy, and dignity and conduct themselves in a professional and cooperative manner.

13.2 In dealing with all incidents of inappropriate conduct, the protection of patients, employees, physicians, and others in the Hospital and the

orderly operation of the Medical Staff and Hospital are paramount concerns. Complying with the law and providing an environment free from sexual harassment are also critical.

13.3 Definitions and Examples of Inappropriate Conduct: To aid in both the collegial education of Medical Staff members and in the enforcement policy, examples of "inappropriate conduct" include, but are not limited to:

- a. threatening or abusive language directed at patients, nurses, Hospital personnel, or other physicians (e.g., belittling, berating, and/or threatening another individual);
- b. degrading or demeaning comments regarding patients, families, nurses, physicians, Hospital personnel, or the Hospital;
- c. profanity or similarly offensive language while in the Hospital and/or while speaking with nurses or other Hospital personnel;
- d. inappropriate physical contact with another individual that is threatening or intimidating;
- e. nonconstructive criticism addressed to a person in such a way as to intimidate, threaten verbally or physically or disrupt Hospital operations.
- f. derogatory comments about the quality of care being provided by the Hospital, another Medical Staff member, or any other individual or otherwise critical of the Hospital, another Medical Staff Member, or any other individual that are made outside of appropriate Medical Staff and/or administrative channels;
- g. entries in patient medical records or other official documents that denigrate the quality of care being provided by the Hospital or any other individual or are otherwise critical of Hospital policies, or attack other Medical Staff members or personnel;
- h. refusal to abide by Medical Staff requirements as delineated in the Medical Staff Bylaws and Rules and Regulations (including, but not limited to, emergency call issues, response times, medical record keeping, and other patient care responsibilities, failure to participate on assigned committees, and an unwillingness to work cooperatively and harmoniously with other members of the Medical and Hospital Staffs); and/or
- i. "sexual harassment," which is defined as any verbal and/or physical conduct of a sexual nature that is unwelcome and offensive to those individuals who are subjected to it or who witness it. Examples include, but are not limited to, the following:
 - (1) Verbal: innuendoes, epithets, derogatory slurs, off-color jokes, propositions, graphic commentaries, threats, and/or suggestive or

- (2) Visual/Non-Verbal: derogatory posters, cartoons, or drawings; suggestive objects or pictures; leering; and/or obscene gestures;
 - (3) Physical: unwanted physical contact, including touching, interference with an individual's normal work movement, and/or assault; and
 - (4) Other: making or threatening retaliation as a result of an individual's negative response to harassing conduct.
- j. any other behavior that creates a "hostile work environment," disrupts the efficient and effective operation of the hospital or jeopardizes patient care.

14. ADOPTION AND AMENDMENT

These Rules and Regulations, together with the Medical Staff Bylaws, shall be effective upon approval by the Board of Directors. The process for adoption and amendment is detailed in the Medical Staff Bylaws.

Medical Executive Committee Adopted Date: July 20, 2022

Board of Directors Adopted Date: August 4, 2022