MEDICAL STAFF OF GENESIS HEALTH SYSTEM:

Rules and Regulations Manual

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APPROVALS: GMC Aledo MEC 6.13.17, GMC DeWitt MEC 6.06.17, GMC Davenport 6.09.17, Silvis MEC 6.12.17, MRC 6.22.17, GHS Board 7.13.17

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GENESIS HEALTH SYSTEM
RULES AND REGULATIONS

Preamble
In accordance with the Medical Staff Bylaws, the Medical Staff may adopt rules and regulations and policies as necessary to carry out its functions and meet its responsibilities under the Medical Staff Bylaws. Should a conflict exist between the provisions of the Medical Staff Bylaws and the Rules and Regulations, the Medical Staff Bylaws will govern. These Rules and Regulations apply to all Genesis Health System hospital locations unless otherwise specified in attached appendices.

I. PATIENT CARE:

A. Quality of Care

Quality of care is dependent upon the coordination and communication of the plan of care. It is expected of all health care practitioners to optimize resources and ensure patient safety. Practitioners are responsible to ensure that all patients receive care which is compatible with the GHS Mission Statement. Communication is the key to safe management of patient care.

B. Admission of Patients

1. Admission

A patient may be admitted to the hospital only by a member of the Medical Staff who is privileged to admit and care for patients. The admitting practitioner is the attending practitioner, unless otherwise designated by order in the medical record.

2. Responsibility of Admitting Practitioner

An appropriately credentialed practitioner shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to a referring practitioner and to relatives of the patient. Each practitioner shall name a qualified practitioner with admitting privileges to attend his/her patients when he/she is unavailable. If an alternate practitioner is not named, the President of the Medical Staff shall have the authority to call any appropriately credentialed practitioner to assume care, giving consideration to the wishes of the patient in the selection of substitute. Whenever these responsibilities are transferred to another practitioner, a note covering the transfer of care shall be entered in the Electronic Medical Record (EMR).

3. Responsibility of Emergency Department Practitioner for Admission

Emergency Department Practitioners may not admit patients to the hospital, initiate orders on patients admitted to the hospital through the Emergency Department or treat hospitalized patients except in cases of emergency unless also separately credentialed with admitting privileges.

4. Designation of Patient Status

The responsible practitioner shall order patient admission status as inpatient or outpatient observation per the GHS Electronic Medical Record and Documentation Requirements Policy.

5. Timing of Initial Patient Evaluation
Initial patient evaluation for patients admitted to the hospital shall be seen by the admitting practitioner or designated consultant on a timely basis as dictated by their clinical status.

6. Admissions to the Critical Care Unit (Refer to CCU (ICU) Admission/Discharge Criteria Policy)

   a. In facilities with a Critical Care Unit, if any questions as to the validity of admission to or discharge from the Unit should arise, consultation should be obtained from the Critical Care Unit Medical Director.
   b. Patients admitted to the Critical Care Unit should be seen by the practitioner at the time of admission and if not, within two hours or sooner if dictated by the clinical status.

7. Assessing and Managing Pain
All Practitioners are responsible for assessing and adequately managing pain on all patients under their care.

8. Practitioner Availability
Practitioners are required to arrange their practice and living arrangements in a manner which assures timely response to the Hospital in accordance with standards of practice and relevant state law (Governance and Organization Manual 1.7.f). If a practitioner is unable to satisfy this requirement, he/she then shall name an appropriately credentialed practitioner who is a resident in the area who may be called to attend his/her patients in an emergency, or until the patients practitioner is able to attend. In case of failure to name such associate, the Chief Medical Officer, President of the Medical Staff, Department Chair, Chief of Section or Vice President of Medical Affairs shall have authority to call any member of the Active Staff to assume care.

9. Responsibility for Transmission of Information
The admitting practitioner shall be held responsible for giving such information to the appropriate authorities as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatever.

10. Suicide Risk Assessment
For Suicide Risk Assessment, refer to Suicide Risk Assessment in the Emergency Department and Suicide Precautions Policies.

   a. Hospitals without Psychiatric Services Available
   In Hospitals without psychiatric services available, any patient known or suspected to have suicidal intent shall be referred to another institution where psychiatric facilities are available. If possible, tele-psychiatric services should be utilized. If immediate transfer is not possible, the patient may be admitted to the Hospital, and special surveillance provided. Specific procedures will be determined by the attending practitioner in consultation with the Nursing Service Manager and/or Administration. Such patients must be in an area where direct observation is always available.
   b. Use of Restraints
   The responsible practitioner will ensure that patients who require restraints have appropriate time limited orders (Refer to GHS Restraints Policy).

II. CONSULTATIONS:

A. Qualifications

Any qualified practitioner with clinical privileges in the hospital can be called for consultation within his/her area of expertise.

B. Responsibility of Requesting Practitioner

The attending physician is responsible for requesting consultation when indicated and for contacting a qualified consultant except in an emergency or if he/she is unable to do so. Except in the case of an emergency, he/she will provide authorization in the electronic medical record to permit another practitioner to attend or examine his/her patient.

C. Determination of Need for Consultation

In general it is the attending practitioner's responsibility to determine when a consultation is necessary. A consultation is appropriate anytime the diagnosis is obscure or in doubt. A consultation is required to validate brain death at all times. A consultation of the appropriate specialty shall be called anytime the diagnosis and/or treatment are not within the credentials of the attending practitioner. A consultation may be called at anytime when it is considered for the best interest of the patient. It will be the responsibility of the attending practitioner to discuss the case with the consultant. It is the responsibility of both practitioners to maintain communication during the treatment of the patient.

D. Consultation to Resolve Conflicts in Care

If, after discussion with the attending practitioner, a staff member 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, he/she shall bring this to the attention of the Department Chair/Section Chief. If the Department Chair/Section Chief is not available, the Medical Staff President or Vice President or Vice President of Medical Affairs or designee should be consulted.

E. Timeframe for Consultation

Upon receiving a request for a consultation, the consultant and the requesting practitioner will decide the urgency with which this consultation needs to be completed. The consultant should see the patient within this timeframe. If the consultation is deemed to be non-emergent but in the opinion of the requesting practitioner the patient needs to be seen by the consultant prior to discharge, it will be expected that the patient will be seen within 18 hours. The consultant will communicate back to the requesting practitioner regarding his/her recommendations.

F. Resident Practitioner Consultations (Refer to Resident Physician Scope of Activities Policy)

III. COORDINATION OF CARE:

Where more than one Practitioner is involved in the care of the patient, it is the responsibility of all those involved to ensure the coordination of care, treatment and services is provided.

IV. DISCHARGES/TRANSFERS:

A. Routine Discharges

Patients shall be discharged only by an order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, the patient shall be requested to sign a release from responsibility statement and a notation of the incident shall be made in the patient's medical record.

Ideally discharges should be completed by 11 am, but certainly no later than 1 pm. Where it is expected that the patient will be discharged the next day, the orders for discharge could be written the night before, and canceled or amended the next day as circumstances dictate. Medication Reconciliation must be part of the discharge orders.

B. Discharge from the Critical Care Unit

Discharge/transfer from the Critical Care Unit shall be initiated upon the order of the practitioner managing the patient's care. All orders shall be reviewed and updated at the time of discharge/transfer to assure appropriate continuous care.

C. EMTALA Requirement

A patient who presents to the hospital with an emergency condition must be stabilized in compliance with the hospital EMTALA policy or related guidance. If definitive treatment of the patients medical condition is beyond the scope of the professional staff or hospital resources, the patient must be stabilized prior to transfer to another medical facility that has agreed to accept the patient, in accordance with EMTALA regulations, unless the patient's condition, as determined by the attending practitioner, requires immediate transfer to a more appropriate treatment facility and satisfactory arrangements have been made with that facility and the receiving physician for transfer.

D. Outpatient Test Ordered at Discharge for Follow-up by Another Provider

For any outpatient test ordered at the time of discharge within a GHS Facility which needs follow up by another provider, the ordering provider should communicate directly with the follow up provider to ensure proper action on critical test results.

Providers should not order tests with instructions to call results to another provider unless this has been communicated.

V. CALL RESPONSIBILITIES:

A. Call Coverage Responsibility

1. Active Staff

   All active members of the medical staff with admitting privileges shall be required to participate in an emergency call schedule as defined in the Bylaws Article I, Section 1.8 of the Governance Manual.

2. Courtesy Staff

   Courtesy staff members may be required to take part in the call schedule if in the judgment of the Department Chair/Section Chief (with the agreement of the Medical Executive Committee) such participation is necessary to maintain adequate emergency patient services.

3. Affiliate Staff

   Affiliate staff do not have to be on call for the patients that require admission to the hospital, but need to provide Medical Affairs with a practitioner call list. They will be required to satisfy the follow-up requirements outlined in item V.C. below.

4. Patient without a Practitioner

   Patients requiring admission who do not have a private practitioner in the area shall be referred to the appropriate practitioner who is on the call panel for that particular specialty. The Department of Medical Affairs will maintain a roster of applicable on call practitioners which will be available in the electronic call schedule located on the hospital's internal webpage.

   It is the responsibility of all practitioners to ensure that their call responsibilities are covered in the event that they are away. All such absences shall be communicated to the Department of Medical Affairs or the Regional Referral Center. In general, it is the responsibility of each specialty group to submit their call schedule to the Department of Medical Affairs by entering it into the Genesis electronic call schedule. For those groups i.e. Trauma at GMC Silvis where the call schedule is made up by the Department of Medical Affairs, it is essential that communication of absences is given in enough time in advance so that the call schedule can be covered. It is also desirable that no more than one of the Trauma Services Practitioners is gone at the same time.

5. Consequences of Non-Compliance

   Failure to participate in the call schedule or failure to meet established guidelines for emergency call may subject the practitioner to disciplinary action by the Department.

6. Exceptions
   a. Limited Practitioner in Specialty – call may be waived or modified where there are few practitioners in that specialty on the medical staff.
   b. Age - although serving on the call roster is not required over the age of 60, such practitioners may continue to serve on a voluntary basis.
   c. Call at multiple locations - a practitioner may be on call at more than one institution at a time (this excludes Trauma call) and may conduct his/her regular practice while on call. However, an on call practitioner should arrange a designated back up in case he/she were to be unavailable during the on call duty period and inform the institution of the name of the covering practitioner.
   d. Failure to respond - it is not acceptable for the practitioner to fail to respond unless he/she is dealing with an emergent patient or is involved in a procedure that cannot be interrupted. Under EMTALA regulations, it is not acceptable for the on call practitioner to request that a patient with an emergent medical condition be transferred to his/her location for care.

B. Response Time

Members shall in general, respond to pages within 15 minutes of the page being received and when necessary must be able to be present in 30 minutes. Trauma Surgeons shall respond as per protocol, State Rules, and Administrative Code. Variances regarding call response shall be reviewed through the peer review process.

C. Follow-up Requirements

For a patient without a designated practitioner, the on-call practitioner of the day at time of discharge from the Emergency Department/Hospital, regardless of specialty, is obligated to provide a one-time follow-up office visit which is limited to the follow up care that, in the opinion of the Emergency Department practitioner/hospitalist, is required for the adequate medical care of the condition diagnosed in the Emergency Department/Hospital. Following this mandated visit, it is the responsibility of the on call practitioner to decide whether he/she will provide ongoing medical care for that patient, or whether the patient will be responsible for finding a practitioner for ongoing care. The Emergency Department practitioner/hospitalist will notify the on-call practitioner prior to the follow-up visit. If the patient does not follow-up within 30 days of discharge, the on-call practitioner is no longer obligated.

VI. AUTOPSIES/PRONOUNCEMENT OF DEATH:

A. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee. Policies with respect to release of the deceased shall conform to the laws of the city, county and/or the State of Illinois/Iowa.

B. All staff members shall order autopsies whenever indicated according to the Autopsy policy/procedure.

VII. HEALTH INFORMATION MANAGEMENT (Refer to GHS Electronic Medical Record and Documentation Requirements Policy)

VIII. GENERAL CONDUCT OF CARE:

A. Consent for Admission/Treatment

A Condition of Admission/Consent for Treatment form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission, except in an emergency when consent cannot be obtained. Under those circumstances, a consent shall be obtained as soon as practical after admission. Additional consents may be required for specific procedures such as surgical procedures and blood transfusions. (Refer to entity specific Consent Policy and also see Appendix Surgical Care)

B. Orders (Refer to GHS Electronic Medical Record and Documentation Requirements Policy)

1. Medications

All Medication Management policies and procedures will be defined and approved by the Genesis Health System Pharmacy and Therapeutics Committee.

GHS Pharmacy and Therapeutics Committee Purpose Statement:

The Pharmacy and Therapeutics Committee is responsible for managing the safe and effective use of medications within the Health System Medical Centers. The Committee is responsible to the Medical Staff as a whole, and its policy recommendations are subject to approval by the Medical Executive Committee as well as to the normal administrative approval process. The Pharmacy and Therapeutics Committee assists in the formulation of broad professional policies relating to drugs in the hospital, including their evaluation, selection, procurement, storage, distribution, administration, and use.

Specific Responsibilities:

- Formulary management
- Medication use evaluations and outcomes
- Develop and maintain policies and procedures related to medication use including investigational drug related studies
- Medication error reporting and prevention
- Advise and collaborate with various Committees to meet the needs of the professional staff (physicians, pharmacist, nurses and other healthcare professionals) for complete knowledge to enhance the safety of medication therapy, and improving therapeutic outcomes
- Adverse drug event monitoring and reporting
- Collaborate in the development of clinical care plans, guidelines, and physician standing orders
- Oversee medication shortages and recalls
- Evaluate program effectiveness annually

2. Medication Reconciliation after Surgery
   Medication Reconciliation after surgery will occur as dictated by the Medication Reconciliation Policy.

3. Postoperative orders
   Postoperative orders must be created on all patients before the patient leaves the recovery area.

C. Emergency Responsiveness

1. Responsibility of Practitioner in Emergency
   It is the responsibility of any member of the medical staff to provide a mechanism whereby he/she can be reached in case of an emergency.

2. Code Blue
   When a Code Blue is called, qualified practitioners in-house should respond if possible.

3. Notification of Attending Practitioner in Case of Emergency
   If it is determined that the patient needs emergency treatment, the attending and/or covering practitioner(s) will be contacted, if they are not available, the following medical staff members are contacted in the order listed: 1) Department Chair/Section Chief, 2) Medical Staff President, 3) Vice President Medical Affairs.

D. Communication with Patients and Relatives
It is the practitioner's responsibility to communicate to the patients, and when appropriate their families about the outcomes of care, including unanticipated outcomes and document this in the patient record.

E. Procedure Cancelation and/or Delay: Patient Communication
When a procedure has to be canceled suddenly on the day it was supposed to occur on a patient in a Genesis Medical Center facility who has been or who is about to be prepared for the procedure or there is a significant delay, it is the responsibility of the proceduralist, whenever possible, to discuss the situation directly with the patient or caregivers, reassure them that the delay will not cause any harm, and if necessary will be rebooked at the earliest available opportunity.

IX. DISASTER PLAN:

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 the hospital's Emergency Management Committee in coordination with the Emergency Department Medical Director/Chief. See entity specific Disaster Plans.

A. Establishment of Command Center
An Incident Command Center will be established to oversee all the aspects of the emergency.

B. Practitioner Responsibility
All Practitioners that are requested to participate in the Disaster Management Plan will be contacted and should report as soon as possible to the Emergency Department and will be assigned to areas of treatment.

C. Participation in Disaster Drills
Preferably twice per year but at a minimum yearly, the disaster plan should be rehearsed as part of a coordinated drill in which other community emergency service agencies participate. It is the responsibility of the Medical Staff to participate in the drills if asked to do so.

X. MEDICAL STAFF MEETINGS: (Refer to Article VI Meetings of the Medical Staff in the Governance and Organization Manual)

A. All members of the Medical Staff should attend all meetings of the General Medical Staff.

B. All Members of the Medical Staff are encouraged to attend all meetings of the Department to which they have been assigned.

C. Meeting frequency will be held as decided by the individual Departments/Sections but should occur at least biannually.

XI. MEDICAL STAFF ANNUAL DUES:

Medical Staff members where applicable shall be assessed dues in the amount determined by the Medical Executive Committee. These dues, together with any outstanding fines, shall become due and payable January 1 and delinquent March 1 after which time the practitioner may lose their clinical privileges. (Refer to applicable Entity Specific Medical Staff Dues Policy, Governance and Organization Manual Article I, and Corrective Action & Fair Hearing Plan Article I)

XII. MEDICAL STAFF COMMUNICATION:

E-mail will be used as the primary source of communication with the medical staff.

Members of the medical staff will provide Medical Affairs with a working personal, password protected e-mail and cell phone number.

XIII. FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)/ONGOING PROFESSIONAL PRACTICE EVALUATION (OPPE)/PEER REVIEW/PROCTORING:

In compliance with The Joint Commission requirements, Genesis Health System has a FPPE and OPPE Policy to ensure Practitioners ability to provide safe and high quality care on an ongoing basis. (Refer to FPPE and OPPE Policies and Governance and Organization Manual Article III)

Peer review is an unbiased activity performed by the medical staff to measure, assess and where necessary, improve clinical performance. The process will be consistently followed by all entities performing Peer Review (Refer to Peer Review Policy).

IX. EDUCATIONAL REQUIREMENTS:

All regulatory and department educational requirements will be met.

APPENDIX

Anesthesia

A. Responsibilities
1. Anesthesia Services must be under the direction of one individual who is a qualified Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.)
2. Standards of Care: Anesthesia providers should adhere to the standards of care adopted by the American Society of Anesthesiologists.
3. Equipment Required: The Service Director recommends to the administration and medical staff the type and amount of equipment necessary for administering anesthesia and for related resuscitative effort, ensuring through at least annual review that such equipment is available.
4. Response Time: Anesthesia providers shall in general respond in 15 minutes of being paged and when necessary must be able to be present within 30 minutes.
5. Follow the Medical Staff Bylaws.

B. Delivery of Anesthesia Care
1. Anesthesia shall be administered by:
   a. Members of the Department of Anesthesia.
   b. Where applicable, credentialed, qualified certified registered nurse anesthetists under supervision of the supervising practitioner who is present in the hospital for the diagnosis and treatment of emergencies.
2. Recognizing the serious consequences of leaving an anesthetized patient unattended, the members of the Anesthesia Department hereby agree to abide by the ASA standards and guidelines.
3. The responsible Anesthesia Provider shall accompany the patient to the Recovery Room (PACU) upon completion of a procedure and remain with the patient as long as required by the patient's condition relative to the anesthesia status and until responsibility for proper patient care has been assumed by Recovery personnel.
4. The decision to discharge a patient from the Recovery Room (PACU) shall be made by a Medical Practitioner. The Medical Practitioner need not be physically present to give this order.

C. Safety Regulations
1. Apparel appropriate for the operating room as designated by proper authority will be the only clothing permitted in the operating room area.
2. Anesthesia apparatus wholly owned by the hospital will be maintained in a safe condition by the hospital.
3. Anesthetic apparatus must be inspected and tested by the anesthetists before use. If a leak or any other defect is observed, the equipment must not be used until the fault is repaired.
4. Only non-explosive agents shall be used for anesthesia. Only prep solutions approved by the operating room director and the department of surgery shall be used in the operating suite.
5. Anesthesia personnel shall familiarize themselves with the rate, volume, and mechanism of air exchange within the surgical and obstetrical suites, as well as with humidity control.

D. Administrative
1. It is expected that each member of the Anesthesia Department inform the Operating Room of times when he/she may be delayed in starting scheduled cases at their specified times.
2. If a surgical emergency arises which requires the interruption of scheduled cases, the Anesthesiologist (i.e., cardiovascular, obstetric, etc.) who is most immediately available will offer his/her services for the Emergency. (See also Department of Surgery)

EMERGENCY SERVICES

A. Emergency Department Staffing and Qualifications

The Emergency Department in the State where it is located shall be staffed on a full-time basis, twenty-four (24) hours per day, seven (7) days per week.

B. Medical Staff Status and Privileges

Members of the Emergency Department, in full-time practice, shall be members of the Active Medical Staff. They shall have all the rights, privileges and responsibilities except admission and consultation privileges on inpatients except under certain circumstances.

C. Certifications

Emergency Department physicians shall maintain current ATLS, ACLS, and PALS certifications according to State Regulations and Contractual Agreements. It is highly recommended that all practitioners involved in the care of children be certified in PALS.

D. Provision of Coverage

The Emergency Department Medical Director/Chief is responsible for ensuring coverage will be available twenty-four (24) hours per day, seven (7) days per week, and such other duties as established by the Administration of the institution.

E. Primary Responsibility

The primary responsibility of Emergency Department practitioners shall be to provide emergency services within the Department and to render whenever possible emergency service required elsewhere in the hospital. All patients requesting emergency treatment shall be examined by a practitioner prior to discharge from treatment. Practitioners at certain Critical Access Hospitals may also be expected to care for patients admitted to the hospital.

F. Emergency Department Physicians will Routinely Examine and Treat

Any patient who presents to the Emergency Department for treatment.

G. Communication with Administration

The Emergency Department Medical Director/Chief will advise the Chief Executive Officer or designee on matters pertaining to the availability of nursing staff, clerical help, supplies, equipment, and working space. Nursing staff and clerical help remain the employees of the hospital, and supplies, equipment and space remain the property of the hospital.

EMERGENCY SERVICES - PEDIATRIC
(Silvis Campus Only)

A. See the following policies for further information:

1. E.D. Physician Coverage and Continuing Medical Education
2. On Call Physician Response
3. Physician Back-Up Panel
4. Mid-Level Provider Coverage, Qualifications and Continuing Medical Education

EMERGENCY SERVICES – TRAUMA

A. The Trauma Service incorporates multiple components necessary to provide a comprehensive integrated system of trauma care delivery that extends across the patient care continuum and allows each Genesis facility to function at their designated Trauma Level in both the States of Iowa and Illinois Trauma Systems.

   Because of differences in State regulations and availability of different specialties, Trauma oversight is handled differently in Iowa and Illinois.

   Surgeons providing trauma call coverage shall maintain current ATLS certification.

B. Duties
   1. Coordinate Trauma Service development, implementation, and monitoring.
   2. Establish program policies and procedures.
   3. Ensure compliance with appropriate Level Trauma Care Facility criteria.
   4. Prepare the medical center for verification site visit.
   5. Provide input and assist in the development of programs related to trauma education, outreach, out-of-hospital care, and trauma prevention activities.
   6. Forward identified problems to appropriate oversight body.

C. Reporting Relationships
   The committee provides communication to and receives input from the Surgery Department and Emergency Medicine Department.

D. Responsibilities
   The Trauma Service oversees quality assessment and improvement activities across the patient care continuum. Issues in need of peer review and system issues are referred to the appropriate Medical staff and hospital departments.
   1. Identifies systems/processes needing performance improvement and develop a plan to achieve desired results.
   2. Ensures implementation of a comprehensive performance improvement plan, which addresses patient care issues across the continuum (out-of hospital, acute care phase, rehabilitation).
   3. Recommends data sources, indicators and types of monitoring for the Trauma Service.
   4. Collects, analyzes and trends selected data.
   5. Identifies individual performance and system issues in need of review and forwards them to the appropriate medical staff committees or individual departments.
   6. System issues in need of review are forwarded to the appropriate Medical Staff committees or hospital departments.
   7. Identifies appropriate education for members of the Trauma Service.

   The Committee receives regular reports from hospital departments involved in trauma-related quality monitoring.

E. Appointment of Physician Membership
   Physician members are appointed by the Trauma Program Medical Director and approved by the Department of Surgery Chairperson at Davenport and Silvis.

F. Trauma Program Performance Committee (Davenport): The oversight committee responsible for Trauma Service development, implementation, and monitoring.

Trauma Program Membership (Davenport):

1. Bi-Monthly Attendance
    a. Trauma Program Medical Director
    b. CMO/VPMA/Director of Quality
    c. Trauma Coordinator
    d. Trauma Surgeons
    e. Neurosurgeons
    f. Orthopedic Surgeons
    g. Radiologists
    h. Emergency Department Medical Director
    i. Anesthesiologist
    j. Medical Examiner
    k. ICU Medical Director
    l. Physiatrist
    m. Vice-President of Medical Affairs
    n. Vice-President of Patient Services

2. Triennial Attendance
    a. Vice President Medical Affairs
    b. Pediatrician
    c. Manager, ICU
    d. Manager(s), Emergency Department
    e. Manager, O.R. Clinical
    f. Manager, Radiology
    g. Manager, Laboratory (or designee)
    h. Director, Physician Medicine and Rehabilitation
    i. MEDIC EMS, Education Director
    j. MED-FORCE Executive Director
    k. Scott County EMS Coordinator
    l. Emergency Physician

Trauma Services Committee (Silvis): The oversight committee responsible for Trauma Service development, implementation, and monitoring.

Trauma Services Committee Membership (Silvis):

1. Quarterly Attendance
    a. Trauma Program Medical Director
    b. Trauma Coordinator
    c. Trauma Surgeons
    d. Neurosurgeons
    e. Orthopedic Surgeons
    f. Emergency Department Medical Director
    g. Vice-President of Medical Affairs
    h. Chief Nursing Officer
    i. Silvis Campus President
    j. Quality Department Specialist (or designee)
    k. Manager, Critical Care Services (ED & ICU)
    l. Manager, Genesis Ambulance Service
    m. Manager, Operating Room
    n. Manager, Radiology (or designee)
    o. Manager, Pharmacy (or designee)
    p. Manager, Laboratory (or designee)
    q. Manager, Cardiopulmonary (or designee)
    r. EMS Coordinator

Trauma Services Committee (DeWitt): The oversight committee responsible for Trauma Service development, implementation, and monitoring meets every other month in conjunction with Emergency Department Services meeting.

Committee Membership (DeWitt):

1. Every Other Month Attendance
    a. Trauma Program Medical Director
    b. Trauma Program Coordinator
    c. Manager, Emergency Services
    d. Chief Nursing Officer

FAMILY PRACTICE

A. No Doctor Emergency Department Call
All Genesis Family Practice physicians with an active clinical practice, regardless of medical staff status (active, or courtesy no admitting, affiliate), and those under age 60, will participate in the no doctor call schedule.

The need for follow up care is determined by the Emergency Department providers. The responsibility of the physician on call for no doctor call includes but is not limited to providing a one-time follow up office visit.

B. No Doctor Follow-up Post Discharge
The physician on no doctor call on the day the patient is **discharged** will be responsible for outpatient follow-up care.

HOSPITALIST

A. Membership in the department shall mainly consist of Internal medicine and Family practice providers.

B. A provider with subspecialty training can be a part of the department when their practice is relevant to the hospitalist department.

C. Main scope of practice is medical management of patients admitted to the hospital including in Acute Rehab and Psychiatric unit.

INTERNAL MEDICINE

A. The Department of Internal Medicine consists of the following medical specialties:
   1. Allergy/Immunology
   2. Cardiovascular Disease
   3. Critical Care Medicine
   4. Electrophysiology
   5. Endocrinology/Metabolism
   6. Gastroenterology
   7. Geriatrics
   8. Hematology
   9. Infections Disease
   10. Medical Oncology
   11. Nephrology
   12. Pulmonary Disease
   13. Rheumatology
   14. Dermatology
   15. Physical Medicine/Rehabilitation
   16. Physical Medicine/Rehabilitation Pain Management
   17. Neurology

OBSTETRICS AND GYNECOLOGY

If a patient is to be admitted to the hospital, the admitting (sponsoring) practitioner must be notified.

A. Vaginal Birth After Cesarean Section (VBAC)
A practitioner with credentials to perform cesarean sections must be aware of all patients attempting VBAC. The attending practitioner MUST consult with a properly credentialed practitioner and make note in the patient's medical record. Follow individual institution policies.

B. Neonatal Resuscitation Provider (NRP)
A Neonatal Resuscitation Provider (NRP) must be present at all C-sections to coordinate the resuscitation efforts of the newborn if necessary.

C. Delivery of Non Viable Fetus
For management of situations where the delivery of a non viable fetus appears inevitable, see GMC specific policies.

D. Call Responsibility
In addition to the general rules and regulations call responsibilities, in order to assure accessibility to the hospital and continuity of patient care, in the event of an emergency, the members of the department shall respond to a page or telephone call within 10 minutes and be present within 20 minutes of being contacted.

PSYCHIATRY

A. Special Treatment Procedures
   1. Use of Seclusion/Restraint: Shall follow unit standards/guidelines
   2. The Department of Psychiatry does not utilize Psychosurgery or Aversive Therapy. Policies regarding these treatments will be developed should any proposals be initiated.
   3. Treatment Planning:
      a. Policy Statement/Purpose: The psychiatrist in conjunction with a designated coordinating nurse shall develop a Master Treatment Plan within seventy-two (72) hours of admission. The Treatment Plan will be used to implement treatment objectives. The purpose of this policy statement is to provide guidelines to all professional staff regarding treatment planning for psychiatric patients.
      b. Guidelines/Special Instructions:
         1. Nursing will meet regularly with the various interdisciplinary mental health professionals and will coordinate care and documentation.
         2. The psychiatrists will review, approve and countersign all additions and modifications to the Treatment Plan.

SURGICAL CARE

A. Information Required to Schedule Surgery
Refer to the Operating Room Scheduling policy.

B. Requirement prior to Anesthetic and Operation
Refer to the GHS Universal/Time Out Policy and Electronic Medical Record and Documentation Requirements Policy.

C. Consents
Refer to the Consent, General Information specific to the Genesis Medical Center entities.

D. Availability of Surgeon
1. It is expected that each member of the Surgery Department inform the Operating Room of times when he/she may be delayed in starting scheduled cases at their specified times.
2. After 15 minutes the surgery schedule will be reviewed to facilitate efficiencies.

E. Handling of Tissues Removed in Surgery
All tissues removed at the operation shall be managed per guidelines Surgical Specimen Handling.

AMENDMENTS TO THE RULES AND REGULATONS

Effective Date	Section	Change
October 15, 2017	Page 10, B. Orders, 2. Medication Reconciliation After Surgery	Changed Medication Reconciliation and Discharge Medications Policy to Medication Reconciliation Policy