SECTION 1. ADMISSION OF PATIENTS

1.1 TYPES OF PATIENTS

Patients are admitted to Jackson County Regional Health Center without regard to race, creed, color, sex, national origin, age, disability, religious affiliation, sexual preference or source of payment. Admission of any patient is contingent on adequate facilities and personnel being available to care for the patient, as determined by the Chief Executive Officer (CEO) after consultation with the applicable Service Chief. Some patients may need to be transferred for treatment not available at Jackson County Regional Health Center.

1.2 ADMITTING PREROGATIVES

1.2-1 GENERALLY

Only a member in good standing of the Active, Courtesy, or Associate category of the medical staff may admit patients to the Hospital, subject to the conditions set forth below and to all other official admitting policies of the Hospital and the Medical Staff Bylaws as may be in effect from time to time. A member "in good standing" is one whose admitting privileges have not been restricted. Names of members not in good standing are provided to the admitting office by the CEO.

1.2-2 STAFF PRIORITIES WHEN RESOURCES ARE STRAINED

At times of full Hospital occupancy or of shortage of hospital beds or other facilities, as determined by the CEO, priorities among the members of the various staff categories for access to beds, services or facilities for patients of similar status are as follows:

1. Emergency (life threatening)
2. Urgent (serious, but not life threatening)
3. Elective

When two or more practitioners with the same priority status have made a reservation for an elective admission and all such reservations cannot be accommodated, priority is determined by the order in which the reservations were received.

1.2-3 LIMITATIONS FOR DENTISTS, PODIATRISTS AND PSYCHOLOGISTS

Members of the Associate Staff may admit patients to the Hospital, but an MD/DO member of the Medical Staff must sign the history and physical and assume full responsibility for the history and physical A nurse practitioner or a physician assistant may perform the History & Physical as allowed by Iowa Administrative Code.

1.3 TIME OF ADMISSION

Except in emergency cases, the attending practitioner shall arrange for a patient to be admitted during routine admission hours. In cases of outpatient or same admission day surgery, the attending practitioner must comply with Hospital policies concerning presurgical laboratory tests, documentation, and scheduling.

1.4 ADMISSION INFORMATION

Except in an emergency, a patient will not be admitted to the Hospital until a provisional diagnosis or valid reason for admission is provided by the practitioner requesting admission. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible. Other required documentation or information specific to the type of admission involved is detailed in Section 6. The admitting practitioner is also responsible for providing in the medical record the following information concerning a patient to be admitted: any source of communicable disease or significant infection; behavioral characteristics that would disturb or endanger others; and need for protecting the patient from self-harm.

1.5 EVALUATED BEFORE ADMISSION

All patients should be seen and evaluated by a practitioner prior to admission.

1.6 UNATTACHED PATIENTS

Active and Associate staff members will be assigned, commensurate with delineated clinical privileges, to attend unattached patients according to the on-call schedule, without regard to payment source.

SECTION 2. GENERAL RESPONSIBILITY FOR AND CONDUCT OF CARE

2.1 GENERALLY

A member of the medical staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completion and accuracy of those portions of the medical record for which he or she is responsible, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner, if any, and to relatives of the patient permitted to receive such reports. Primary practitioner responsibility for these matters belongs to the admitting practitioner except when transfer of responsibility is effected pursuant to Section 2.2.

2.2 TRANSFER OF RESPONSIBILITY

When primary responsibility for a patient's care is transferred from the admitting or current attending practitioner to another staff member, a note covering the transfer of responsibility and acceptance of the same must be entered on the order sheet and progress notes.

2.3 CONTINUOUS CARE

Each hospitalized acute care patient shall be seen by a practitioner every day. The practitioner must assure timely, adequate professional care for his or her patients in the Hospital by being personally available or designating a qualified alternate practitioner with whom prior arrangements have been made and who has the requisite clinical privileges at this Hospital to care for the patient. "Being personally available" means that the Practitioner resides and regularly engages in practice within thirty (30) minutes' travel time from the Hospital, or remains within thirty (30) minutes' travel time from the

Hospital for the duration of the patient's Hospital stay, and who is able to respond timely to contact by the Hospital.

Each member of the staff who will be out of town or unavailable in case of emergency will automatically be covered by the call physician for his/her clinic or his/her designee. If a designee is selected, the member of the staff who will be out of town or unavailable must indicate in writing on the order sheet the name of the practitioner who will be assuming responsibility for the care of the patient during his absence and how the practitioner may be contacted. Failure of an attending practitioner to meet the requirements of this section may result in loss of staff membership or such other disciplinary action as the Executive Committee or Governing Board deems appropriate. In the absence of a designated alternate practitioner, the CEO, the Chief of Staff, or the applicable Service Chief has the authority to call any member of the staff with the requisite clinical privileges.

2.4 , PSYCHOLOGISTS, AND ALLIED HEALTH PROFESSIONALS

Psychologists, and allied health professionals may treat patients under the conditions provided in Section 4.6 and Article V of the Medical Staff Bylaws and in Section 1.2-3 of these Rules and Regulations. Each psychologist and allied health professional is responsible for documenting in the medical record, in timely fashion, a complete and accurate description of the services he or she provided to the patient.

More specifically, psychologist and allied health members of the staff are responsible for the following:

a. A detailed history and description of the problem documenting the need for hospitalization and any surgery;
b. A detailed description of the examination of the patient and diagnosis, as appropriate;
c. Progress notes as are pertinent to the condition;
d. Pertinent instructions relative to the condition for the patient and / or significant other at the time of discharge; and

2.5 POLICY CONCERNING IMMEDIATE QUESTIONS OF CARE

If a nurse or other health care professional involved in the care of a patient has any reasons to doubt or question the care provided to that patient, or feels that appropriate consultation is needed and has not been obtained, the health care professional shall bring the matter to the attention of the attending physician. If the attending physician is not available, or if the doubt or question has not been resolved by the attending practitioner, the health care professional shall bring the matter to his or her supervisor who, in turn, may refer the matter to the department director or unit manager. If warranted, the department director or unit manager may bring the matter to the attention of the Chief of Service wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Service Chief may request a consultation. If the Service Chief

is not available, the matter should be brought to the attention of the Chief of the Medical Staff or his or her designee.

2.6 CONSULTATIONS

2.6-1 RESPONSIBILITY

The good conduct of medical practice includes the proper and timely use of consultation. The attending practitioner is primarily responsible for calling a consultation from a qualified staff member when indicated pursuant to the guidelines in Section 2.6-2 below. Judgment as to the serious nature of the illness and the question of doubt as to diagnosis and treatment generally rests with the attending practitioner.

When a consultation is indicated under these Rules or when the best interests of the patient will be served, any of the following may direct that a consultation be held and, if necessary, arrange for it: the applicable Service Chief; the physician director of a special unit; and Chief of the Medical Staff. If the attending practitioner disagrees with the necessity for consultation, the matter shall be brought immediately to the Chief of the Medical Staff or the applicable Service Chief for final decision and direction.

2.6-2 GUIDELINES FOR CALLING CONSULTATIONS

Unless the attending practitioner's expertise is in the area of the patient's problem, consultation with a qualified physician is indicated in the following cases:

a. Problems of critical illness in which any significant question exists of appropriate procedure or therapy.
b. When the patient is not a good risk for operation or treatment.
c. Cases of difficult or equivocal diagnosis or therapy.
d. When the needs of the patient exceed the privileges of the attending physician.
e. When required by State law
f. When requested by the patient or requested by the family if the patient is not competent.

2.6-4 COMMUNICATION AND DOCUMENTATION

a. Consultation Request: When requesting consultation, the attending practitioner shall contact the consultant and indicate the request in writing on the orders, and record the reason for the request
b. Consultant's Report: The consultant must make and sign a report of his findings, opinions and recommendations that reflect an actual examination of the patient and the medical record. In addition, the consultant shall communicate his recommendations directly to the ordering physician, either in writing or verbally in person or by telephone. The consultant's report shall become part of the patient's medical record. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in the emergency situation so verified on the patient's record.

2.7 STUDENTS, RESIDENTS AND INTERNS

Students who are currently enrolled in an accredited allopathic or osteopathic medical, dental or podiatric school, residency or internship program or an accredited physician assistant training program may be granted permission to observe, assess and/or treat patients in the Hospital under the direction and supervision of a member of the Medical Staff.

If a member of the Medical Staff receives a request from a student, resident or intern to observe and assess or treat patients in the Hospital, the Medical Staff member should instruct the student, resident, or intern to send to the CEO his or her curriculum vitae, the dates the individual plans to be in the facility, the name of the supervising Medical Staff member and a description activities he or she wishes to participate in.

It shall be the supervising practitioner's responsibility to verify that the patient does not object to observation or participation in the patient's care by the student, resident or intern.

Trainees in graduate education programs and medical students who are practicing as part of their training program must be under the supervision of a licensed physician member of the Medical Staff who will oversee their care and review their documentation of patient care.
The management of each patient's care remains the responsibility of a member of the Medical Staff.

1. Graduate Education – Licensed physicians (MD/DO), dentists, optometrists, podiatrists, Advance Practice Nurses and Physician Assistant enrolled in a recognized training program who are at the facility for a portion of their training. These trainees are not members of the Medical Staff.
    a. The trainee must present a photo ID to the Medical Staff office
    b. The Chief of Service will serve as the facility designated liaison with the training program
    c. Trainees are not granted independent privileges while on duty at the facility as part of clinical training
    d. All clinical activities including orders, physical examinations, progress notes, histories, and discharge summaries will be supervised and counter signed by a credentialed and privileged member of the Medical Staff
        i. If the trainees holds a current valid license to practice orders and progress notes do not require countersignature
    e. Medical Staff members may reference trainee notes but must perform and document sufficient clinical activity themselves to support the level of billing coded for the clinical service
    f. Guidance for trainees is also provided by their graduate medical education program regarding expectations of the rotation, including supervision, expected outcomes and evaluation of the resident

g. Trainees must comply with any collaborative agreement between the facility and their training program/institution

2. Students – Students who have not yet graduated from a school for training physicians (MD/DO), dentists, podiatrists, and mid-level practitioners may complete rotation(s) at the facility. Students are not considered part of the Medical Staff.

a. The medical student must present a photo ID to the Medical Staff Office
b. The Chief of Service of the department will serve as the facility designated liaison with the medical education program.
c. Medical students may not treat patients independently and must be fully supervised by a member of the Medical Staff
d. Students may enter notes in patient records, but these notes must be cosigned and accompanied by a member of the Medical Staff. No documentation performed by students will be used for billing purposes or considered adequate documentation of a Medical Staff member's clinical activity.
e. All clinical encounters must be fully supervised by a Medical Staff member and all orders, progress notes, histories and physical exams must be countersigned by a member of the Medical Staff who will be responsible for their content.
f. Guidance for students is also provided by their medical education program regarding expectations of the rotation, including supervision, expected outcomes and evaluation of the student.
g. Students must also comply with any collaborative agreement between the facility and their training program/institution.

2.9 MEDICAL COVERAGE OF THE EMERGENCY ROOM

Medical Coverage of the Emergency Room is provided in the following manner:

a. Members of the Emergency Medical staff are scheduled to rotate call. The call schedule will be posted in the Emergency Room. The Emergency Physician will be contacted for all patients who present to the Emergency Room, unless the patient specifically requests a particular physician and that physician is available to treat the patient in the Emergency Room within a reasonable period of time.
b. The Emergency Physician, if not available in person, will telephone contact the emergency room within five (5) minutes after having been paged. The Emergency Physician will respond to the Emergency Room in person within five (5) minutes or as soon as practically possible after notification for a life threatening situation. The Emergency Physician will respond to the Emergency Room within fifteen (15) minutes after notification of the completion of ancillary tests/examinations for a non-life threatening situation. In any event, a Practitioner with training and experience in emergency care shall be on-call and immediately available by telephone or page, and shall be available on site at the Hospital within thirty (30) minutes, 24 hours a day.
c. Federal law requires that all persons presenting to the Emergency Room must be screened by qualified medical personnel (physician, physician assistant, or nurse

practitioner) to determine whether they have an emergency medical condition. The initial medical screening must be performed at the hospital; it is not legally permissible for the hospital to honor a physician's request that the patient be sent to the physician's private office or clinic for the initial medical screening examination. Accordingly, at JCRHC a physician shall provide a medical screening examination of all patients presenting to the Emergency Room. Federal law further mandates that if the patient is medically assessed as having an emergency medical condition, then all appropriate ancillary services and resources of the hospital must be utilized in treating the emergency condition, unless the patient requests transfer to another health care facility.

2.10 PERFORMANCE OF ABORTIONS

Chapter 146 of the Code of Iowa provides that public hospitals may not prohibit the performance of abortions in their facilities. Chapter 146 further provides that no individual shall be required against their religious beliefs or moral convictions to perform, assist, or participate in an abortion procedure. For the purposes of Chapter 146, "abortion" means the termination of a human pregnancy with the intent other than to produce a live birth or to remove a dead fetus.

In accordance with Iowa law, legal abortions may be performed by members of the medical staff who are qualified and privileged to perform such procedures. However, no employee or medical staff member shall be required to perform, participate or assist in such a procedure against their religious beliefs or moral convictions. As required by law, no individual shall be discriminated against in any way, including but not limited to employment, promotion, advancement, transfer, licensing, education, training, or the granting of Hospital privileges or staff appointments, because of the individual's participation or refusal to participate in the performance of a legal abortion procedure.

2.11 DISASTER PLAN

In the event of civil disaster, all available physicians shall report to the Hospital immediately and shall carry out assignments made by the physician in charge. The Chief of Staff and the CEO will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Hospital to another or evacuation from Hospital premises, they will authorize the movement of patients. All policies concerning patient care will be a joint responsibility of these individuals and, in their absence, of the administrative and medical staff members next in line of authority. All physicians on the medical staff of the Hospital specifically agree to relinquish direction of the professional care of their patients to these individuals in cases of such emergency. The plan for the care of mass casualties should be rehearsed by key Hospital personnel at least semi-annually.

SECTION 3. TRANSFER OF PATIENTS

3.1 INTERNAL TRANSFER

Internal patient transfer priorities are as follows:

a. Emergency patient to an available and appropriate inpatient bed

b. From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for the patient.

3.2 TRANSFER TO ANOTHER FACILITY

3.3-1 GENERAL REQUIREMENTS

A stabilized patient shall be transferred to another health care facility

a. Only upon the order of the a physician
b. After the patient/patient's representative has provided informed written consent
c. After arrangements have been made for transfer with a physician/designee of the other facility, including its consent to receive the patient, and documentation of the facility's acceptance of the patient;
d. After the patient is considered sufficiently stabilized for transport

An unstabilized patient shall be transferred to another facility

a. The patient/patient's representative after being informed of the risks and the hospital's obligations requests a transfer,
b. A physician has signed the certification that the benefits of the transfer of the patient to another facility outweigh the risks or
c. Provide treatment to minimize the risks of transfer;
d. Send all pertinent records to the receiving hospital;
e. Obtain the consent of the receiving hospital to accept the transfer,
f. Ensure that the transfer of an unstabilized individual is effected through qualified personnel and transportation equipment, including the use of medically appropriate life support measures

For both the stable and unstable patient all pertinent medical information necessary to insure continuity of care must accompany the patient at the time of transfer.

3.3 ADMISSION ORDERS

Contract ER physicians may write admission orders.

SECTION 4. DISCHARGE OF PATIENTS

4.1 REQUIRED ORDER

A patient may be discharged only on the written order of the attending practitioner or designee, who shall also be a practitioner with the requisite privileges. The attending practitioner is responsible for documenting or dictating the principal diagnosis, secondary diagnoses, co-morbidities, complications, principal procedures, and additional procedures, discharge or clinical summary within 15 days of discharge.

4.2 LEAVING AGAINST MEDICAL ADVICE (AMA)

If a patient desires to leave the Hospital against the advice of the attending practitioner or without proper discharge, the attending practitioner shall be notified and the patient will be requested to sign the appropriate release form, attested by the patient or his/her legal

representative and witnessed by a competent third party. If a patient leaves the Hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident must be made in the patient's medical record, including documentation addressing benefits, risks and alternatives to treatment.

4.3 DISCHARGE OF MINOR PATIENT

Any individual who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing, and the statement must be made a part of the patient's medical record.

SECTION 5. ORDERS

5.1 GENERAL REQUIREMENTS

All orders for treatment or diagnostic tests must be written or electronic clearly, legibly and completely and signed by the practitioner responsible for them. Orders which are illegible or improperly written will not be carried out until rewritten or clarified and understood by the person who is to execute the order. Orders to "renew", "repeat", and "continue orders" are not acceptable. Orders using the words "STAT", "now" and "soon" shall be defined as follows: "STAT" means initiation of order within 1-2 minutes; "now" means initiation within 15 minutes; and "soon" or all new orders mean within one hour. Orders for diagnostic tests which necessitate the administration of test substances of medications will be considered to include the order for administration. All medication orders shall specify the route of administration.

5.2 STANDING ORDERS

Standing orders for any Service may be formulated by the Service Chief in consultation with the nursing service and appropriate representatives of administration. Additional standing orders may be formulated by a member of the medical staff, subject to the approval of the applicable Service Chief. All standing orders shall be listed on an "Orders" sheet that must be included in the patient's medical record and signed, timed and dated by the attending practitioner. Standing orders shall be considered as a specific order by the attending practitioner for that patient and shall be followed in the absence of other specific orders by the attending practitioner, insofar as the proper treatment of the patient will allow. All standing orders must be reviewed at least annually and revised as necessary.

5.3 VERBAL ORDERS

5.3-1 BY WHOM AND CIRCUMSTANCE

Telephone or other verbal orders may be taken only by a registered nurse, except that the following personnel may take verbal orders for medication, treatment and/or procedures within their respective areas of practice and which they will prepare, deliver or perform: certified registered nurse anesthetist, licensed practical nurse, registered pharmacist, registered dietician, registered respiratory therapist, licensed physical therapist, registered x-ray technologist, registered laboratory technologist, medical

student, emergency medical technician, licensed speech pathologist, registered occupational therapist, registered polysomnographic technologist (RPSGT) and registered neurodiagnostic technologist. Such verbal orders must be appropriate to the scope of practice of the person accepting the order. Verbal orders shall be documented in the patient's record by the person who took the order, and shall be signed by the practitioner who dictated the order. Telephone or verbal orders will be accepted only from the responsible practitioner and only when it is not practical for the order to be given in writing.

The above-named personnel may accept verbal orders personally given by the ordering practitioner, or transmitted by an authorized agent of the practitioner, who is acting under the direct supervision of the practitioner and for whom the practitioner assumes legal responsibility. (EXCEPTION: Verbal DNR orders may be given only by the ordering practitioner, as set forth in Section 5.8-2 of these Rules and Regulations.)

5.3-2 DOCUMENTATION OF VERBAL ORDERS

All verbal orders must be read back and confirmed to the ordering practitioner by the individual receiving the verbal order. All verbal orders shall be transcribed in the proper place in the medical record, shall include the date, time, name and signature of the person receiving the order and the name of the practitioner giving the order. All Medical Staff orders, including medication orders, verbal and standing orders, must be authenticated (signed, dated and timed) by the ordering Medical staff within a period not to exceed 30 days following a patient's discharge [per Iowa Administrative Code 481 – 51.14(3) (135B)].

5.3 PHYSICAL AND PHARMACOLOGICAL RESTRAINTS AND SECLUSION

A practitioner order is necessary for the use of a physical restraint device or seclusion. The order must specify the clinical justification and time limit, which shall not exceed the limits set forth in approved Hospital policies. A chemical restraint is defined as a psycho pharmacological drug that is used for discipline or convenience and not required to treat medical symptoms. Use of chemical restraints as defined above will not be permitted at Jackson County Regional Health Center.

When the practitioner responsible for a patient's care is not immediately available to assess the patient and determine the need for restraint or seclusion for behavior management purposes, specifically trained staff (a registered nurse practitioner, physician assistant, registered nurse) may initiate the intervention pursuant to an adopted protocol, but a practitioner must see and evaluated the need for restrain and seclusion within one *1) hour after the initiation of the intervention. See restraints and seclusions policy for exceptions in the event of an emergency. Although the Hospital does not provide behavioral management services, patients may present to the facility with psychiatric conditions. Treatment in those cases shall be limited to management of the patient's medical need, and there will be no counseling, group therapy or recreational therapy. If the patient requires ongoing behavioral management, the patient shall be transferred to an appropriate psychiatric facility. In the event the patient cannot be transferred to an

appropriate psychiatric facility. Hospital policies for the use of restraints or seclusion for behavioral management shall be followed.

5.5 ORDERS BY ALLIED HEALTH PROFESSIONALS

An allied health professional (AHP) may write orders only to the extent, if any, specified in the position description developed for that category of AHP's and consistent with the scope of services for which he/she has privileges.

5.6 AUTOMATIC CANCELLATION OF ORDERS

All previous orders are automatically cancelled, unless a specific order is written otherwise, when the patient goes to surgery or is transferred to another service or another level of service.

5.7 5.7-1 DRUGS/TREATMENTS COVERED AND MAXIMUM DURATION

When feasible and in order to assure that the proper and complete therapeutic regimen intended by the prescribing practitioner is carried out, the exact total dosage or total period of time for the drugs or treatments listed shall be specified.

Drug/Treatment Category	Maximum Duration
All Medication Orders	93 days

5.8 BLOOD TRANSFUSIONS AND INTRAVENOUS INFUSIONS

Blood transfusions and intravenous infusions must be started by the attending practitioner or by a registered nurse who has the requisite training and has been credentialed to do so in the Hospital. The order must specifically state the rate of infusion.

5.9 SPECIAL ORDERS

5.9-1 PATIENTS OWN DRUGS AND SELF-ADMINISTRATION

Drugs brought into the Hospital by a patient may not be administered unless the drugs have been identified by the hospital pharmacist or registered nurse and there is a written order from the attending practitioner to administer the drugs. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing practitioner and in accordance with established Hospital policy.

5.9-2 DO NOT RESUSCITATE (DNR) ORDERS

a. After the DNR decision has been made, this directive must be written as an order by the attending physician on the order sheet.
b. All facts, considerations and consents pertinent to this decision should be documented by the physician in the progress notes.
c. Verbal orders for DNR status generally are not appropriate or acceptable, however, verbal DNR orders may be used under circumstances where the patient is currently under the care of the physician from whom the order is sought and the physician has personal knowledge of the patient's terminal condition and the wishes of the patient and/or family. Under these circumstances, a verbal telephone order from the physician may be received by a registered nurse and witnessed by one other

registered nurse or one other patient care personnel who must also hear the order and co-sign the order written on the chart. Telephone orders must be countersigned by the ordering physician and appropriate documentation made in the progress notes within 24 hours of issuance. If the order is not countersigned within the 24-hour period, it is invalid.

d. DNR orders should be reviewed on a regular basis and may be rescinded at any time.
e.

SECTION 6. MEDICAL RECORDS

1. General Requirements
   a. Documentation includes hard copy written form or in the electronic health record
   b. All entries must be dated and timed
   c. All entries must authenticated and can be verified through electronic signatures, written signatures or initials, rubber-stamp signatures, or computer key
   d. All entries, including dictated reports, must be authenticated by and include the professional degree level of the author
   e. Entries made by students or unlicensed trainees must be countersigned by their supervising provider
   f. Completion of the medical record does not exceed 30 days after the patient discharge
   g. For patients receiving ongoing ambulatory care, a summary list is initiated by the third visit that includes
      i. Significant medical diagnoses and conditions
      ii. Significant operative and invasive procedures
      iii. Adverse or allergic drug reactions
      iv. Current medications, over-the-counter medications, and herbal preparations
   h. Patients are discharged only on written order of the responsible physician or designee
      i. At the time of discharge the attending physician or designee takes appropriate action to resolve all active orders, see that the record is complete, state the final diagnosis, and sign the record
   i. Provider use of standing orders and protocols limited to those approved by the Medical Staff
2. Admission Note - Inpatient
   a. An admission note must be written in the progress notes when the medical history and physical examination report is not available and in the medical record. This admit note must include pertinent history and physical examination findings and the initial impressions or indication for surgery or admission.
3. History and Physical Examination
   a. Inpatient
      i. A medical history and physical examination is completed no more than thirty (30) days before or no later than twenty-four (24) hours after admission to the hospital, but prior to surgery or a procedure requiring anesthesia services.

ii. The medical history and physical examination must be completed and documented by a physician, surgeon dentist, podiatrist, physician assistant or nurse practitioner. A MD/DO must sign the history and physical examination

iii. A copy of history and physical completed 30 days prior to admission may be placed in the patient's current inpatient record with a note by the attending physician as to any change in patient condition. This note must be dated, timed and signed by the attending physician.

iv. A complete history and physical examination shall include
   (1.) Chief Complaint
   (2.) Present Illness
   (3.) Personal Past Medical/Surgical History
   (4.) Medications
   (5.) Family Medical History
   (6.) Social History
   (7.) Review of all pertinent body systems
   (8.) Physical Examination
   (9.) Initial Impression or diagnosis(es)
   (10.) Plan
   (11.) Signature
   (12.) Date

b. Same Day or Outpatient Surgery
   i. A medical history and physical examination is completed no more than thirty (30) days before but prior to surgery or a procedure requiring anesthesia services. Use of an approved short form History and Physical is allowed.
   ii. Patients undergoing outpatient invasive procedures with or without use of sedation shall have an appropriate focused medical history and pertinent physical examination which includes
      (1.) Present illness
      (2.) Pertinent past medical history
      (3.) Family history
      (4.) Social history
      (5.) Pertinent physical examination (which must include heart and lungs)
      (6.) Pertinent lab and x-ray results
      (7.) Impression
      (8.) Plan
      (9.) Signature
      (10.) Date

c. History and Physical Update
   i. An update must be done for any history and physical that is 24 hours to 30 days old

ii. The original history and physical must be available in the patient record and the update attached to or written on the original. For EHR, the original history and physical the update must be referenced

iii. The update exam must be conducted, and documented, to include

(1.) Vital signs
(2.) Heart and lungs
(3.) Procedure-specific exam
(4.) Impression
(5.) Plan
(6.) Signature
(7.) Date

iv. The update exam must be performed by a member of the Medical Staff or delegated to an independent practitioner acting within the scope of their hospital privileges and must be authenticated by the Medical Staff member

4. Discharge Summary - Inpatient
   a. Is required for all inpatients discharged from the hospital
      i. For patients with a length of stay of less than 48 hours a final progress note may be substituted for the discharge summary. The note contains the outcome of hospitalization, disposition of the case, and provisions for follow-up care
   b. Contains a concise summary that includes the following
      i. Reason for hospitalization
      ii. Significant findings
      iii. Procedures performed
      iv. Care, treatment, and services provided
      v. Patient's condition and disposition at discharge
      vi. Instructions relating to physical activity, medication, diet and follow up care
      vii. Summaries shall be authenticated by the responsible provider
5. Progress Notes - Inpatient
   a. Pertinent progress notes are recorded, timed and dated at the time of the observation
   b. The note are sufficient to permit continuity of care
   c. The patient's clinical problems are clearly identified and correlated with specific orders, tests and treatments
6. Completion of Medical Record - Inpatient
   a. The attending provider is held responsible for the preparation of a complete medical record for each patient
   b. No medical record is closed until all required entries and reports have been entered and authenticated
   c. A record is deemed delinquent 30 days post discharge
      i. Providers who have delinquent medical records are notified by the Medical Record Department

7. Operative or other high-risk procedures and use of moderate or deep sedation or anesthesia
   a. A licensed independent practitioner involved in the patient's care documents the provisional diagnosis in the medical record before an operative or other high-risk procedure is performed
   b. The provider performing the procedure writes or dictates an operative or high risk procedure report on completion of the procedure and before the patient is transferred to the next level of care
   c. The operative or other high-risk procedure report includes the following
      i. Name(s) of the licensed independent practitioner(s) who performed the procedure and any assistant(s)
      ii. Name of procedure performed
      iii. Description of the procedure
      iv. Findings of the procedure
      v. Estimated blood loss
      vi. Specimen(s) removed
      vii. Postoperative diagnosis
   d. The provider performing a procedure will document a progress note in the medical record before the patient is transferred to the next level of care and includes
      i. Name(s) of the primary surgeon(s) and assistant(s)
      ii. Procedure performed
      iii. Description of each procedure finding
      iv. Estimated blood loss
      v. Specimens removed
      vi. Postoperative diagnosis
8. Postoperative recovery
   a. Staff monitoring the patient post procedure documents
      i. Vital signs and level of consciousness
      ii. Any medications, including intravenous fluids and any administered blood, blood products, and blood components
      iii. Any unanticipated events or complications (including blood transfusion reactions) and the management of those events
      iv. Patients are discharged either by licensed independent practitioner responsible for care or according to discharge criteria approved by the Medical Staff
         (1.) PACU nursing staff are responsible to document patient progress and achievement of criteria indicating readiness for discharge

6.3-2 PREOPERATIVE ANESTHESIA EVALUATION

The anesthesiologist/anesthetist must conduct and document in the record a pre-anesthesia evaluation of the patient including pertinent information relative to the choice

of anesthesia and the procedure anticipated, pertinent previous drug history, other pertinent anesthetic experience, any potential anesthetic problems, ASA patient status classification, and orders for pre-op medication. Except in cases of emergency, this evaluation should be recorded prior to the patient's transfer to the operating area and before preoperative medication has been administered." (CoP485.639(e)(1), Federal Register (66 FR 56762-56769), CMS 42 CFR Part 416, 482, and 485.

6.4 PROGRESS NOTES

Pertinent progress notes must be recorded at the time of observation and must be sufficient to permit continuity of care and transferability of the patient. Final responsibility for an accurate description in the medical record of the patient's progress rests with the attending practitioner. Whenever possible, each of the patient's clinical problems must be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes by the attending practitioner must be written or documented in the EHR at least daily, and more frequently if condition warrants.

6.5 OPERATIVE, SPECIAL PROCEDURE AND TISSUE REPORTS

6.5-1 OPERATIVE AND SPECIAL CARE REPORTS

Operative and special procedure reports must contain, as applicable, a detailed account of the findings, the technical procedures used, the specimens removed, the postoperative diagnosis, and the name of the primary performing practitioner and any assistants. If the report is dictated and not immediately transcribed or not written in the record immediately, after the procedure, the practitioner must enter a comprehensive operative progress note in the medical record immediately after the procedure providing sufficient and pertinent information for use any practitioner who is required to attend the patient. The complete report must be written or dictated immediately following the procedure, filed in the medical record as soon after the procedure as possible, and promptly signed by the primary performing practitioner.

The anesthesiologist/anesthetist must conduct and document in the record a post-anesthesia evaluation of the patient including date and time of evaluation and notation of any anesthesia complications.

6.5-2 TISSUE EXAMINATION AND REPORTS to be reviewed by Path

All tissues, foreign bodies, artifacts and prostheses removed during a procedure, except those specifically excluded by policy of the Surgical Service, shall be properly labeled, and packaged in preservative as designated, identified as to patient and source in the operating room or suite at the time of removal, and sent to the pathologist. The pathologist shall document receipt and make such examination as is necessary to arrive at a pathological diagnosis. Each specimen must be accompanied by pertinent clinical information and, to the degree known, the preoperative and postoperative diagnoses. An authenticated report of the pathologist's examination shall be made a part of the medical record.

Macroscopic (gross) only examination of tissues removed shall be considered adequate for the following unless microscopic examination is deemed necessary by the physician and/or pathologist:

a. Accessory digits.
b. Bunions and hammertoes
c. Extraocular muscle from corrective procedures (for example, strabismus repair)
d. Inguinal hernia sac in adults (age 15 or older)
e. Nasal bone and cartilage from rhinoplasty or septoplasty
f. Prosthetic breast implants
g. Tonsils and adenoids from children (age 15 or younger)
h. Torn meniscus
i. Umbilical hernia sac in children (age 15 or younger)
j. Varicose veins
k. Traumatic amputation
l. Tissue removed at arthroscopy for mechanical joint derangements, such as torn meniscus
m. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics
n. Unchanged skin from plastic procedures

All other tissue removed shall require both macroscopic and microscopic examination unless otherwise deemed unnecessary and so documented by the physician and/or pathologist.

The following specimens may be excluded from routine submission to the Pathology Department:

a. Bone donated to the blood bank
b. Bone segments removed as part of corrective or reconstructive orthopedic procedure (example: rotator cuff repair, synostosis repair, spinal fusion)
c. Cataract removed by phacoemulsification
d. Dental appliances
e. Fat removed by liposuction
f. Foreign bodies, such as bullets, or other medicolegal evidence that are given directly to law enforcement personnel
g. Foreskin from circumcision of a newborn
h. Intrauterine contraceptive devices without attached soft tissue
i. Medical devices, such as gastrostomy tubes, myringotomy tubes, stents, and sutures that have not contributed to patient illness, injury, or death
j. Middle ear ossicles
k. Orthopedic hardware and other radiopaque mechanical devices, provided there is an alternative policy for documentation
l. Placentas that are excluded by the pathologist because they do not meet approved criteria for examination.
m. Rib segments or other tissues removed only for the purpose of gaining surgical access from patients who do not have a history of malignancy.

n. Skin or other normal tissues removed during a cosmetic or reconstructive procedure (for example, blepharoplasty, cleft palate repair, abdominoplasty, rhytidectomy, or syndactyly repair) that is not contiguous with a lesion and that is taken from patient who does not have a history of malignancy.
o. Teeth without attached soft tissue
p. Therapeutic radioactive sources
q. Toenails and fingernails that are grossly unremarkable

For those items listed above, the medical record must contain documentation that the specimen or device was removed and disposed by the physician and confirmed by the registered nurse. This is very important for any failed medical device that may have contributed to the patient injury, any failed device for which litigation is pending or likely, and for devices subject to tracking under the Safe Medical Devices Act of 1990 as listed below;

a. Permanently implantable devices:
    1. Vascular grafts prosthesis
    2. Vascular bypass (assist) devices
    3. Implantable pacemaker pulse generator
    4. Cardiovascular permanent pacemaker electrode
    5. Annuloplasty ring
    6. Replacement heart valve
    7. Automatic implantable cardioverter/defibrillator
    8. Tracheal prosthesis
    9. Implanted cerebellar stimulator
    10. Implanted diaphragmatic/phrenic nerve stimulator
    11. Implanted infusion device
b. Life-sustaining or life support devices:
    1. Breathing frequency monitors (apnea monitors)
    2. Continuous ventilators
    3. CD-defibrillator and paddles
    4. FDA-designated devices:
    5. Silicone inflatable breast prosthesis
    6. Silicone gel-filled breast prosthesis
    7. Silicone gel-filled testicular prosthesis
    8. Silicone gel-filled chin prosthesis
    9. Silicone gel-filled angel chick reflux valve
    10. Electromechanical infusion pump

6.5-3 PRE-PROCEDURE REVIEW OF EXTERNAL HISTO-PATHOLOGIC DIAGNOSIS

When a patient enters this Hospital to undergo a definitive therapeutic procedure based on histopathologic diagnosis made elsewhere, the attending practitioner must present diagnostic slides and reports to this Hospital's pathology staff for review and confirmation of the diagnosis. Exceptions may be made in cases in which a staff pathologist is willing to carry responsibility for accepting the outside diagnosis without

personal review of the diagnostic material in question. The pathologist will accept the responsibility of notifying the attending practitioner regarding the findings of the review.

6.6 ENTRIES AT CONCLUSION OF HOSPITALIZATION

6.6-1 FACE SHEET

The face sheet will contain the following information:

a. Demographic: To be submitted by Business/Admitting Office.
b. Advance Directives: To be submitted by Business/Admitting Office or Nursing Service.
c. Diagnosis Codes: To be submitted by Medical Records.

6.8-2 DISCHARGE SUMMARY

a. In General: A discharge summary must be recorded for all patients. The summary must recapitulate concisely the reason for hospitalization, the significant findings, including complications, the procedures performed and treatment rendered, and the condition of the patient on discharge, stated in a manner allowing specific comparison with the condition on admission.
b. Exceptions: A final progress note may be substituted for the discharge summary in the case of the following categories of patients those whose problems of a minor nature require less than 48 hours of hospitalization;
c. Discharge summaries shall be completed within fifteen (15) days after discharge from the Hospital. Admitting privileges shall be suspended for any physician who is delinquent to the following extent:
    1. More than three discharge summaries not completed within fifteen (15) days after the patient's discharge from the Hospital.
    2. One or more discharge summaries not completed within fifteen (15) days after discharge or receipt in physician's dictation box.
d. Whenever a physician becomes delinquent to such an extent that admitting privileges are to be suspended, the Hospital CEO shall immediately notify the physician in writing that admitting privileges are suspended pursuant to Section 8.3-5 of the Medical Staff Bylaws.
e. Any physician whose admission privileges are suspended more than six times in one calendar year under this section shall have his or her medical staff privileges terminated upon written notification by the Administrator. The physician's right to hearing and appellate review shall be limited as set forth in Section 8.3-7 of the Medical Staff Bylaws; provided however, that the privileges of a physician not then under suspension pursuant to Section 8.3-5 of the Bylaws shall not be terminated for repeated violations under this subsection until the procedural review has been completed.
f. The principal diagnosis, any secondary diagnoses, co-morbidities, complications, principal procedure and any additional procedures must be dictated in full, and must be dated and signed by the attending practitioner within 15 days of the patient's discharge. Medical Records will sequence the diagnoses and appropriate code and return for the physician's approval. The following definitions are applicable to the terms used herein:

1. Principal Diagnosis: The condition established, after study, to be chiefly responsible for occasioning the admission of the patient to the Hospital for care.
2. Secondary Diagnosis (if applicable): A diagnosis, other than the principal diagnosis, that describes a condition for which a patient receives treatment or which the attending practitioner considers of sufficient significance to warrant inclusion for investigative medical studies.
3. Co-morbidities (if applicable): A condition that coexisted at admission with a specific principal diagnosis, and is thought to increase the length of stay by at least one day (for about 75% of the patients).
4. Complications (if applicable): An additional diagnosis that describes a condition arising after the beginning of Hospital observation and treatment and modifying the course of the patient's illness or the medical care required, and is thought to increase the length of stay by at least one day.
5. Principal Procedure (if applicable): The procedure most related to the principal diagnosis or the one which was performed for definitive treatment rather than performed for diagnostic or exploratory purposes or was necessary to take care of a complication.
6. Additional Procedures (if applicable): Any other procedures, other than principal procedure, pertinent to the individual stay.

6.8-3 INSTRUCTIONS TO PATIENTS

The discharge summary or final progress note must indicate any specific instructions given to the patient and/or significant other relating to physical activity, medication, diet and follow-up care. If no instructions were required, a record entry must be made to that effect.

6.7 AUTHENTICATION

All medical record entries must be legible, complete, dated, timed and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. (CoP 485.635 (a)(4)(iv), CoP 485.631(b)(1)(iv), CoP 485.631(c)(1)(ii), CoP 485.641(b)(3)

The following areas of the medical record require the responsible practitioner's signature:

a. Admission orders
b. History and physical examination *(If performed by AHP, this must be reviewed and countersigned by the responsible supervising/collaborating practitioner)
c. Progress notes
d. Orders
e. Immediate pre-operative and post-operative progress notes
f. All operative or special procedure reports
g. Discharge summary *(If performed by AHP, this must be reviewed and countersigned by the responsible supervising/collaborating practitioner)
h. Narcotic orders and all other clinical entries, diagnoses, orders, reports, and progress notes personally give or written by him.

6.8 USE OF SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used only when they have been approved by the medical staff. An official record of approved symbols and abbreviations and of unapproved abbreviations is available at each nursing station and in the medical records department.

6.9 FILING

No medical record shall be filed or electronically closed until it is complete and properly signed. In the event that a chart remains incomplete by reason of the death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the medical executive committee shall consider the circumstances and may enter such reasons in the record and order it filed.

6.9-1 OWNERSHIP AND REMOVAL OF RECORDS

All original patient medical records, including imaging studies, pathological specimens and slides, are the property of the Hospital and may be removed only in accordance with a court order, subpoena or statute, or with the permission of the CEO. Copies of records, films, slides, etc. may be released for follow-up patient care only upon presentation of appropriate authorization and fees for duplication. Unauthorized removal of a medical record or any portion thereof from the Hospital is grounds for such disciplinary action, including immediate suspension and permanent revocation of staff appointment and clinical privileges, as determined by the appropriate authorities of the Medical Staff and Governing Board.

6.10 ACCESS TO RECORDS

6.10-1 BY PATIENT

A patient may, upon written request to the CEO or Medical Records, have access to all information contained in his medical record, unless access is specifically restricted by the attending practitioner for medical reasons or is prohibited by law.

6.10-2 FOR STATISTICAL PURPOSES AND REQUIRED ACTIVITIES

Patient medical records shall also be made available to authorized Hospital personnel, medical staff members or others with an official, Hospital-approved interest for the following purposes:

a. Automated data processing of designated information
b. Activities concerned with assessing the quality, appropriateness and efficiency of patient care
c. Clinical unit support service review of work performance
d. Official surveys for hospital compliance with accreditation, regulatory and licensing standards
e. Approved educational programs and research studies.

Use of a patient record for any of these purposes shall be such as to protect the patient, insofar as possible, from identification, and confidential personal information extraneous to the purposes for which the data is sought shall not be used.

6.10-3 ON READMISSION
In the case of readmission of a patient, all previous records shall be available for use of the current attending practitioner.

6.10-4 TO FORMER MEDICAL STAFF MEMBERS
Subject to the discretion of the CEO, former members of the medical staff shall be permitted access to information from the medical records of their patients for all periods during which they attended such patients in the Hospital.

6.10-5 PATIENT CONSENT REQUIRED UNDER CIRCUMSTANCES
Written consent of the patient or the patient's legally qualified representative is required for release of medical information to persons not otherwise authorized under this Section 6.10 or by law to receive this information.

6.10-6 SPECIAL DISCLOSURE CONSENT
Special written disclosure consents and prohibitions against re-disclosure are required for release of patient information pertaining to diagnosis or treatment of mental health, substance abuse, and HIV/AIDS conditions.

SECTION 7. CONSENTS

7.1 GENERAL CONSENT
Each patient's medical record must contain evidence of the general consent of the patient or the patient's legal representative for treatment during hospitalization.

7.2 INFORMED CONSENT
7.2-1 WHEN REQUIRED
The performing practitioner is responsible for obtaining informed consent for the procedures and treatments listed below. Hospital personnel may obtain signatures on consent forms, but under Iowa law the responsibility for informing the patient of the proposed procedure and its risks and benefits, and obtaining the informed consent of the patient, remains the sole responsibility of the practitioner. The consent form simply documents that the informed consent process between the practitioner and the patient took place.

a. Anesthesia;
b. Surgical and other invasive and special procedures;
c. Use of experimental drugs/devices/research studies;
d. Organ donation;
e. Autopsy;
f. Photography, where the patient is identifiable; and
g. Transfusions.
h. Observing a procedure or treatment in progress by an individual who is not a member of the treatment team, except for educational purposes as specified on the general admission form.

7.2-2 DOCUMENTATION REQUIRED

The informed consent must be documented in the patient's medical record or on a form appended to the record and must include at least the following information:

a. Name of patient and when appropriate, patient's legal guardian.
b. Name of the facility, Jackson County Regional Health Center
c. Name of procedure.
d. Name of practitioner performing the procedure or important aspects of the procedure as well as the name and specific significant surgical tasks that will be conducted by practitioners other than the primary surgeon. These significant task include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissues.
e. Discussion of risks, benefits of alternatives including the possible results of not receiving care, treatment and services.
f. Authorization for anesthesia.
g. Statement that patient has been given the opportunity to ask questions and their questions have been answered to the patient's satisfaction.
h. Authorization for disposition of body parts.
i. Signature of patient or legal guardian.
j. Date and time consent obtained
k. Statement that the procedure was explained to patient or guardian
l. Signature of professional person witnessing the consent.

7.2-3 SIGNATURES

An informed consent must be signed by the patient (or on the patient's behalf by the patient's authorized representative), and the signature witnessed by a professional person.

7.2-4 EMERGENCIES

If emergency circumstances arise where it is deemed medically advisable to proceed with a procedure or treatment specified in Section 7.2-1 without first obtaining the informed consent required therein, such circumstances must be explained in the patient's medical record. In order for informed consent to be implied in emergency cases, the patient must be incapable of giving informed consent and the patient's health will suffer serious harm if the procedure or treatment is not undertaken immediately. Where possible, two physicians shall document the medical advisability of proceeding without expressed informed consent.

SECTION 8. SPECIAL SERVICES, UNITS AND PROGRAMS

8.1 DESIGNATION

Special services units and programs include, but are not limited to, the following:

a. Medical-SurgicalEmergency Room
b. Operating Room
c. Recovery Room
d. Ambulatory Care
e. Outpatient Department

Appropriate officers, committees, and representatives of the medical staff will develop, in coordination with applicable Hospital services, departments and units, specific policies for the special services units and programs, covering, when applicable such subjects as the responsibility for care of patients in the unit/program, criteria for patient admission to the unit/program, consultation requirements, admission/discharge/transfer protocols, direction/organization of the unit/program, authority of the physician direction of the unit/program, special record-keeping requirements, scheduling of patients, etc. The policies of the various units and programs will be coordinated and approved by the Medical Executive Committee and the Chief Executive Officer.

SECTION 9. AUTOPSIES AND HOSPITAL DEATHS

9.1 ORGAN PROCUREMENT NOTIFICATION

In accordance with written Hospital protocols, the Iowa Donor Network shall be notified in a timely manner of individuals who death is imminent or who have died in the Hospital, and the Hospital shall collaborate with the IDN in informing the family of each potential donor of their options to donate organs, tissues or eyes, or to decline to donate.

9.1-3 DEATH CERTIFICATE

The death certificate must be signed by the attending physician unless the death is a Medical Examiner's case, in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the attending physician issues the death certificate.

9. 1-4 RELEASE OF BODY

The body may not be released until an entry has been made and signed in the deceased's medical record by a physician member of the medical staff or a physician member of the medical staff has ordered release of the body. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to State Law.

9.2 AUTOPSIES

Members of the Medical Staff are encouraged to secure autopsies whenever possible. Proper consent for an autopsy shall be in accordance with applicable State law.

If the physician recommends an autopsy to the family, and the family refuses, the recommendation and refusal should be included in the documentation.

9.3 HOSPITAL DEATHS

9.3-1 PRONOUNCEMENT

Death is defined by Iowa Code 702.8 as a condition determined by the following standards: A person will be considered dead if in the announced opinion of a physician

licensed pursuant to chapter 148, a physician assistant licensed pursuant to chapter 148C, or a registered nurse or a licensed practical nurse licensed pursuant to chapter 152, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of two physicians, based on ordinary standards of medical practice, that person has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

9.3-2 REPORTABLE DEATHS

To the County Medical Examiner. Reporting of deaths affecting the public interest to the County Medical Examiner's Office shall be carried out when required by and in conformance with State law. Deaths affecting the public interest include, but are not limited to, any of the following:

a. Violent death, including homicidal, suicidal, or accidental death.
b. Death caused by thermal, chemical, electrical or radiation injury.
c. Death caused by criminal abortion including self-induced, or by sexual abuse.
d. Death related to disease thought to be virulent or contagious which may constitute a public hazard.
e. Death that has occurred unexpectedly or from an unexplained cause.
f. Death of a person confined in a prison, jail or correctional institution.
g. Death of a person if a physician was not in attendance within 36 hours preceding death, excluding prediagnosed terminal or bedfast cases for which the time period is extended to 30 days and excluding terminally ill patient who were admitted to and had received services from a hospice program, if a physician or a registered nurse employed by the program was in attendance within 30 days preceding death.
h. Death of a person if the body is not claimed by a relative or a friend.
i. Death of a person if the identity of the deceased is unknown.
j. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

Reporting to CMS

a. Death of a person that occurs while in restraint.

SECTION 10. INFECTION CONTROL

10.1 CULTURES

All suspected clinically significant infections of the skin or surgical incisions shall be cultured. Suspected infection of other organs by communicable organisms shall be cultured when practical. Cultures shall be ordered by the physician in charge of the case. The infection control coordinator shall call suspected cases of infection to the attention of the attending physician. If the attending physician refuses to order a culture in such cases, this information shall be given to the chairperson of the infection control committee who shall then consult with the attending physician and make the final decision concerning ordering a culture.

10.2 PATIENTS WITH INFECTIOUS/COMMUNICABLE DISEASES

Any patient with a suspected infectious or communicable disease will be treated using appropriate techniques, as ordered by the attending physician and consistent with the principles outlined in the infection control manual of Jackson County Regional Health Center. The infection control coordinator may call cases which may need isolation to the attention of the attending physician. If the attending physician refuses to order isolation, this information shall be given to the chairperson of the infection control committee who will consult with the chairperson of the department involved. The department chairperson shall consult with the attending physician and make the final decision concerning isolation of the case for the protection of Hospital employees and other patients.

10.3 REPORTING OF INFECTIONS/COMMUNICABLE DISEASES

All cases of infections and communicable disease must be reported to the infection control committee. Those found in special services units must also be reported to the physician in charge of the unit. Those found in other areas of the Hospital should be reported to the applicable department chairperson. Every staff member should also report promptly to the infection control committee, infections which develop after discharge and which may be Hospital-acquired.

10.4 GENERAL AUTHORITY

The infection control committee has authority to institute any appropriate control measure or study when there is reasonably felt to be a danger to patients or personnel from an infectious source.

SECTION 11. CHEMICALLY IMPAIRED PRACTITIONERS

11.1 CHEMICALLY IMPAIRED PRACTITIONERS

The State regulations governing the practice of medicine in Iowa provide that habitual intoxication, drug addiction, or the excessive use of alcohol, drugs, narcotics, chemicals, or other types of materials which may impair a practitioner's ability to practice his or her profession with reasonable skill and safety, are practices that are harmful or detrimental to the public. Accordingly, the Medical Staff has determined that the best interests of patient care require that appropriate steps be taken to assure that no practitioner is permitted to provide patient care at the Hospital while he or she is under the influence of alcohol, drugs or other chemical substances.

For purposes of the Medical Staff Rules and Regulations, "under the influence" means that the practitioner's behavior, appearance or speech is affected by a drug, alcohol or other chemical substance in any detectable manner, whereby the safety of the practitioner, his or her colleagues, Hospital employees, patients, or members of the public, or the practitioner's clinical performance or the safe and efficient operation of the Hospital or its property are threatened or impaired. A practitioner who emits the odor of alcohol, drugs or other chemical substances shall be considered to be "under the influence" until determined otherwise. If there is a question of the existence of odor or of

fitness to proceed, a second supervisory professional staff member will be called to validate the interpretation.

If a practitioner appears to be under the influence of any chemical substance, it shall be the obligation of the professional staff of the Hospital and the practitioner's fellow practitioners to intervene immediately, whether prior to or during a procedure. The procedure shall not begin or continue until a determination of the practitioner's fitness to proceed has been made by the Chief of Staff or his or her designee.

If it is determined that the practitioner is under the influence, patient care shall not be rendered by the practitioner in question, and alternate coverage must be arranged. The practitioner on appropriate call for coverage, or the Service Chief, will be called to provide backup coverage as is clinically indicated and as may be chosen by the family or patient when the practitioner is removed from the case.

Following the intervention and interruption of care, the affected practitioner will be asked and expected to leave the Hospital premises. Transportation will be provided as determined appropriate by the persons making the intervention. If the practitioner requests a chemical substance test at the time of intervention, the test should be provided. All such incidents shall be reported promptly to the Chief of the Medical Staff and the Hospital CEO for immediate referral to the Executive Committee. The Executive Committee, acting in its peer review capacity, will meet promptly to review the matter with the intervening staff members and the practitioner and determine the appropriate follow-up. Peer review activities and records of the Executive

Committee are privileged and confidential under law; persons at all other levels of involvement are expected to exercise the utmost discretion to protect the privacy rights of all parties involved. It shall be the policy of the Medical Staff to attempt to address and resolve issues of chemical impairment through informal processes short of corrective action. Informal actions taken outside the corrective action process that do not involve a restriction of privileges are not reportable to the National Practitioner Data Bank.

The Executive Committee may encourage a chemically impaired practitioner to take a voluntary leave of absence for the purpose of treatment and rehabilitation, in accordance with the provisions of Section 3.9 of the Medical Staff Bylaws. After the practitioner has completed his or her rehabilitation, he or she will be required to meet with the Executive Committee prior to resuming practice, for the purpose of ascertaining the practitioner's current health status and whether any restrictions or conditions on the individual's resumption of practice are indicated. The procedure for seeking resumption of privileges is specified in Section 3.9-2 of the Bylaws.

It shall be the responsibility of all practitioners who observe or have knowledge of another practitioner in a chemically impaired condition within the medical setting which affects the practitioner's ability to practice his or her profession with reasonable skill and safety, or who poses a hazard to the safety or welfare of others, or is otherwise in violation of this section, to promptly report that fact to the Chief of the Medical Staff and

the Hospital CEO. In addition, licensed practitioners in Iowa have a continuing legal duty to report such acts or omissions of a fellow licensee to their professional licensing boards, and are subject to discipline by their licensing board for their willful failure to make the report.

SECTION 12. MISCELLANEOUS PROVISIONS

12.1 AMENDMENT

12.1-1 PROCESSES

These General Rules and Regulations of the Medical Staff may be amended or repealed, in whole or in part, by the following processes:

a. Suggestions or proposals for amendments to these Rules and Regulations may be made by any member of the Active Medical Staff to the Medical Executive Committee for the Committee's review and recommendation to the full Medical Staff. If the Committee fails to make a recommendation to the full Medical Staff within sixty days of receipt of the proposed amendment, the proposed amendment may be presented to the full Medical Staff without a Committee recommendation.

b. Adoption of an amendment to these Rules and Regulations shall require the affirmative vote of a majority of the Active Medical Staff members in good standing present at a regular or special staff meeting at which a quorum is present, provided that a copy of the proposed amendment was sent to each staff member entitled to vote thereon at least two weeks in advance of the meeting. The Medical Staff's adopted amendment shall be forwarded to the Governing Body for its action. Amendments adopted by the Medical Staff shall become effective following approval by the Governing Body.

c. If these Rules and Regulations are not in compliance with requirements imposed by law, regulation, order of court of law, accreditation, or for tax purposes, or are otherwise necessary to avoid adverse action or sanction against the Hospital, or are inconsistent with the Bylaws of the Medical Staff or the Hospital, the Governing Body may request appropriate amendment. The Medical Staff shall take action on the proposed amendment at its next regular meeting, provided that a copy of the proposed amendment is sent to each staff member eligible to vote thereon at least two weeks in advance of the meeting, unless adverse action will be taken or sanction will be imposed upon the Hospital in the absence of amendment prior to the next regular meeting, in which case a special meeting of the Medical Staff shall be called within a reasonable time to act thereon. Such amendment as is proposed by the Governing Body that is necessary to comply with law, regulation, court order, accreditation requirement, or tax purposes, or is otherwise necessary to avoid adverse action or sanction, shall be deemed adopted by the Medical Staff unless the Medical Staff takes action to amend these Rules and Regulations to conform to such requirements.

12.2 PROFESSIONAL LIABILITY INSURANCE

Each practitioner granted clinical privileges at the Hospital shall maintain in force professional liability insurance coverage with an insurance carrier licensed or approved to do business in the State of Iowa, in an amount not less than that determined by the Hospital Board of Trustees. A plan of self-insurance, appropriately secured and

supplemented as necessary by an excess liability insurance policy with an approved insurer, may be acceptable, but must be submitted to and approved in writing by the CEO. Each practitioner shall give evidence in writing of his or her insurance coverage or self-funded plan to the Medical Executive Committee and/or the CEO/designee as a precondition to acceptance as a member of the Medical Staff and annually thereafter. The written evidence shall be a certificate of coverage issued by the insurance carrier indicating the amount of coverage, or details of the self-insurance plan with documentation of security and excess liability insurance coverage as appropriate. Each member shall report to the Medical Executive Committee and/or the CEO/designee any reduction, restriction, cancellation, or termination of the required professional liability insurance coverage or change in insurance carrier or self-insurance plan within ten (10) days of receipt of notification or decision regarding such action from the insurance carrier or plan administrator.

SECTION 13. HARASSMENT AND COMPLAINT PROCEDURE

13.1 PURPOSE

The Hospital is strongly opposed to unlawful harassment of any kind in the workplace, and such harassment will not be tolerated in any form. The purpose of this policy is to identify complaint procedures available to employees and staff members, and disciplinary actions that may be taken, for harassment on the basis of sex, age, race, color, religion, disability or national origin. It is the intent of the Hospital that no employee or staff member will be expected to work in an environment that is intimidating, hostile or offensive because of unlawful harassment.

13.2 POLICY

a. The Hospital will not tolerate any harassment of or by employees or staff members on the basis of sex, age, race, color, religion, disability or national origin. All employees and staff members, including nonsupervisory personnel, supervisors, managers, and members of the Medical Staff and AIIP Staff will be subject to discipline, up to and including immediate discharge or termination of privileges, for harassing behavior.

b. Unwelcome sexual advances. requests for sexual favors, and other verbal or physical conduct of a sexual nature constitutes sexual harassment when:
   1. Submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment or privileges:
   2. Submission to or rejection of such conduct by an individual is used as the basis for an adverse decisions affecting the individual's employment or privileges;
   3. Such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile or offensive work environment.

c. No employee or member of the Medical Staff or AHP Staff shall threaten or suggest that another employee's or staff member's refusal to submit to sexual advances will adversely affect that individual's employment, wages, advancement, assigned duties,

shifts, other conditions of employment, or their Medical/AHP Staff membership or privileges. Other types of prohibited conduct that constitutes sexual harassment include innuendoes, suggestive comments, sexual humor, unwelcome flirtations or sexual propositions, verbal abuse of a sexual nature, unwelcome touching, suggestive gestures and comments, graphic verbal descriptions of an individual's body. the display in the workplace of sexually suggestive objects, pictures, photographs or drawings, persistent unwelcome social invitations, or harassment that is not of a sexual nature but is directed against an individual because of his or her sex.

13.3 REPORTING HARASSMENT

Any employee who believes he or she is being harassed on the basis of sex, age, race, color. Religion, disability or national origin is strongly encouraged to report the incident promptly (within 48 hours of the incident, if possible) to his or her supervisor or to Human Resources. If the employee's supervisor is unavailable or is the source of the alleged harassment, the employee should report the problem to the supervisor's superior, to Human Resources, or to the CEO. When a supervisor or manager receives a harassment report. Human Resources or the CEO must be notified immediately.

Members of the Medical Staff or AHP Staff should report harassing behavior to the Chief of the Service to which the individual is assigned or to the Chief of the Medical Staff, who shall immediately report the conduct to the Hospital CEO for initiation of appropriate follow-up.

THE EMPLOYEE OR STAFF MEMBER MUST REPORT HIS OR HER COMPLAINT OF HARASSMENT TO ONE OF THE PERSONS LISTED ABOVE. It is NOT sufficient to report a complaint of harassment to any person other than one of these persons.

13.4 INVESTIGATION

The alleged harassment will be investigated promptly, impartially, and discreetly, with due regard for the sensitive personal nature of the complaint and the reputations of the individuals involved. All employees and staff members are expected to cooperate with any such investigation.

13.5 PROTECTION AGAINST RETALIATION

The Hospital will not retaliate or permit retaliation against any individual who in good faith makes a report of unlawful harassment or cooperates in an investigation. Retaliation is considered a very serious violation of this policy and should be reported immediately to one of the persons identified in Section 12.3 of this policy, who will cause an investigation to be conducted promptly. Any individual found to have retaliated against any employee or staff member who in good faith makes a report or cooperates in the investigation of a complaint of unlawful harassment will be subject to appropriate disciplinary action, up to and including termination of employment or privileges.

Disciplinary action, up to and including termination of employment or privileges, will be taken against individuals who make false complaints or who make false statements during an investigation.

13.6 SANCTIONS FOR UNLAWFUL HARASSMENT

If the fact-finding investigation shows that this policy has been violated, the Hospital will take prompt remedial measures to end the offending conduct, and will take or initiate appropriate disciplinary action against the offender. Individuals found to have engaged in unlawful harassment shall be subject to sanctions up to and including termination of employment or privileges, depending upon the seriousness or recurring nature of the offense.

13.7 CONSENSUAL RELATIONSHIPS

The Hospital strongly discourages consenting romantic or sexual relationships between individuals when there is any direct or indirect reporting relationship between them. Practitioners, AHPs, managers and employees acting in a supervisory capacity who enter into such relationships with subordinates do so at their own risk and may jeopardize their continued employment or privileges.

SECTION 14. DISRUPTIVE PRACTITIONERS

14.1 PURPOSE

It is the policy of this Hospital that all individuals within its facilities will be treated courteously, respectfully, and with dignity. To that end, the Hospital requires all employees and practitioners to conduct themselves in a professional and cooperative manner in the Hospital. All such individuals shall refrain from disruptive, abusive, or otherwise inappropriate conduct toward Hospital patients, employees, practitioners, and visitors.

If an employee fails to conduct himself or herself as required above, the matter shall be addressed in accordance with Hospital employment policies.

If a physician or other practitioner fails to conduct himself or herself appropriately, the matter shall be addressed in accordance with this Disruptive Practitioners policy, the Hospital's policy on Harassment, its Chemically Impaired Practitioners policy, or the Corrective Action provisions of the Medical Staff Bylaws, whichever is appropriate.

14.2 DEFINITION OF DISRUPTIVE CONDUCT

Disruptive behavior is a descriptive term, which encompasses a variety of inappropriate behavior which is intentionally offensive, destructive, or abusive, or disruptive to generally accepted Hospital operations. Such conduct harms rather than promotes the philosophy of respect to members of the community and collegiality among health care professionals.

A. Disallowed disruptive behaviors include but are not limited to the following acts directed toward a patient, family, or legal guardian; another medical staff member; facility staff or contractor; or an outside agency staff conducting business at the facility

1. Inappropriate verbal outbursts or physical threats

2. Condescending language or voice intonations

3. Inappropriate communications via telephone, in writing or via electronic media (e-mail, text, posting on social media)

4. Racial or ethnic slurs

5. Threatening, intimidating, belittling or abusive language

6. Degrading or demeaning comments

7. The use of profanity or similarly offensive language

8. Threatening or intimidating verbal attack or physical contact with another individual

9. Verbal or physical conduct of a sexual nature, sexual innuendoes or harassment which creates an intimidating, hostile, or offensive work environment

10. Uncontrolled expressions of anger involving the throwing and/or damaging of supplies and equipment

11. Public derogatory comments about the quality of care being provided by other staff

12. Inappropriate medical record entries concerning the quality of care being provided by the organization or other members of the medical staff or members of the healthcare team

13. Lack of cooperation or purposeful unavailability to other practitioners for exchange of pertinent care information or resolution of patient care information, such as reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions

14. Any behavior intended to suppress input by other members of the healthcare team

15. Other behaviors deemed inappropriate by the medical staff

B. Reports to Medical Staff Leadership alleging disruptive behavior on the part of a the medical staff member will be evaluated and acted on in an objective and consistent manner

C. The Medical staff will address the remediation of proven disruptive behavior in a consistent and objective manner

D. If the alleged disruptive behavior is reported against the Chief of Staff, the CEO will assign a member of the medical staff to assume the role of the Chief of Staff in the investigation and corrective action

14.3 REPORTING AND DOCUMENTING DISRUPTIVE BEHAVIOR

a. Any employee, practitioner, AHP, patient, or visitor who observes behavior by a practitioner that disrupts the smooth operation of the Hospital or jeopardizes patient care shall immediately report the incident verbally to the immediate supervisor, with a follow-up written report within the shift of the incident, if possible. If the immediate supervisor is unavailable, report to the nursing supervisor, the CNO, or the CEO.
b. Documentation of disruptive conduct is critical since it is often a pattern of conduct that justifies disciplinary action, rather than a single incident. The documentation should include:
    1. the date and time of the questionable behavior;
    2. if the behavior was in the presence of a patient or affected or involved a patient in any way, the name of the patient;
    3. the circumstances which precipitated the situation;
    4. a description of the questionable behavior, limited to factual, objective language as much as possible;
    5. the consequences, if any, of the disruptive behavior as it relates to patient care or personnel or hospital operations:
    6. the names of witnesses, if any: and
    7. any action taken including date, time, place, action, and name(s) of those intervening.
c. The report shall be submitted to the CEO, who shall present a copy to the Chief of Staff. In the absence of the CEO, submit the report to the CNO.
d. Reports of disruptive behavior will be investigated by the CEO and Chief of Staff, or their designees. Reports which are not founded may be dismissed, and the person initiating the report so apprised. Reports that are confirmed will be addressed as follows.

14.4 MEETING WITH PRACTITIONER

a. A single confirmed incident warrants a discussion with the practitioner. The CEO, the Chief of Staff, or other appropriate person shall meet with the practitioner and emphasize that such conduct is inappropriate. The practitioner shall be given a copy of this policy and advised to take immediate steps to end the behavior.
b. If it appears to the CEO and/or the Chief of Staff that a pattern of disruptive behavior is developing, one or both of these individuals shall discuss the matter with the practitioner, emphasizing that if the behavior continues, formal action will be taken to stop it. It is neither necessary nor appropriate to await several incidents before making this determination. Smooth operation of the Hospital and protection of patients, employees or others within the Hospital from mistreatment and abuse is a paramount concern. A letter to the practitioner shall follow up the meeting, stating the

inappropriate conduct and the requirement that the practitioner behave professionally and cooperatively.

c. All meetings with the practitioners shall be documented.
d. Informal meetings with the practitioner do not constitute a "hearing" subject to the procedural requirements of the Medical Staff Bylaws: however, the practitioner may submit a rebuttal to the complaint.
e. After each meeting with the practitioner, with the exception of the first, a letter shall be sent to the practitioner confirming the discussion with the practitioner and restating that the practitioner is required to behave professionally and cooperatively, or that formal action will be taken.
f. If the practitioner's disruptive behavior continues, or if the CEO or the Chief of Staff determines it to be necessary, the CEO, Chief of Staff and Board Chairperson, or an individual acting on the Chairperson's behalf shall meet with and advise the practitioner that such conduct must stop. This meeting constitutes the practitioner's final warning. It shall be followed with a letter reiterating the final warning. That letter becomes a part of the practitioner's permanent file. This letter shall articulate in detail, as specific as possible, what behavior is unacceptable and shall state that the consequences of unacceptable behavior will include suspension or termination of privileges in accordance with the Medical Staff Bylaws.
g. While this policy outlines several warnings and meetings with a practitioner, the conduct at issue may be so egregious as to make these multiple opportunities inappropriate. Based on the misconduct at issue, corrective action under the Medical Staff Bylaws may be pursued immediately.

ADOPTED by the Medical Staff of Jackson County Regional Health Center:

Date: 07/15/14

Chief of Staff

Secretary

APPROVED by the Board of Trustees of Jackson County Regional Health Center:

Date: 07/22/14

Chairperson

Secretary