WAYNE COUNTY HOSPITAL

MEDICAL STAFF RULES & REGULATIONS

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SECTION I: ADMISSION

1.1 ADMITTING

Except in an emergency, no patient will be admitted to the hospital without a valid order from a medical staff member with current admitting or co-admitting privileges, which order shall contain a provisional diagnosis or valid reason for admission. In the case of an emergency, this information shall be recorded as soon as possible. Members with co-admitting privileges are responsible when admitting a patient to arrange for a member with admitting privileges to examine the patient and approve the admission under his/her overall medical supervision. The member with admitting privileges should be notified by telephone prior to the admission, and examine the patient as promptly as possible consistent with the nature of the admission.

1.2 ADMISSION SUBJECT TO CAPABILITY OF HOSPITAL

Admission to the hospital is subject to the ability of the hospital to care for and treat the patient and its other patients. The hospital shall not receive patients requiring extraordinary security precautions or who present an unacceptable hazard to themselves or other patients, and shall with the assistance and cooperation of the attending physician; make arrangements for transfer of admitted patient who develop such status. Patients will not be admitted for the primary purpose of treatment of psychiatric illness or chemical dependency. If psychiatric treatment or consultation is requested or recommended, the medical record shall so state. The admitting practitioner shall be responsible to determine that the admission is consistent with these requirements.

1.3 ASSIGNED PHYSICIAN

If a patient does not have an attending physician on admission, the patient will be assigned to a member of the active staff on duty, or to the physician who is on call at that time.

1.4 PRACTITIONER RESPONSIBILITIES

The admitting and co-admitting practitioners shall be responsible for the medical care and treatment of the patient in the hospital; for the promptness, completeness and accuracy of the medical record; for necessary instructions to hospital employees and the patient; when appropriate, for reporting on the condition of the patient to relatives, the referring practitioner or appropriate others; and for giving such information as may be necessary to assure the protection of other patients or staff from those who are a source of danger from any cause or to assure protection to the patient from self-harm. Whenever these responsibilities are transferred to another practitioner, a note to that effect shall be entered on the order sheet of the medical record.

SECTION II: DISCHARGE AND TRANSFER

2.1 DISCHARGE ORDER

Patients shall be discharged or transferred only on order of the admitting member or his/her designee.

2.2 AGAINST MEDICAL ADVICE

Should a patient leave the hospital against medical advice or without proper discharge, a notation of the departure shall be made on the patient's medical record and the patient will be asked to sign a release for discharge against medical advice. If the patient refuses, a note of the request, the refusal, and the circumstances shall be made on the release and it shall be placed in the patient's medical record. Every effort will be made to have another hospital staff member witness and sign the note of refusal.

2.3 TEMPORARY LEAVE

Practitioners granting temporary leave to patients must record the leave in the patient's chart prior to the patient leaving the hospital. Time of return shall be stated.

2.4 PATIENTS ON RESPIRATOR/VENTILATOR

Any patient placed on a respirator/ventilator, who cannot be safely removed from the equipment within 72 hours, should have arrangements for transfer considered within the next 48 hours. This policy is adopted because of the limited number of experiences and resources available to the hospital for the treatment of respirator/ventilator patients.

SECTION III: TREATMENT – GENERAL

3.1 CONSENTS

An admission form containing general consent to admission and to the conditions of admission shall be signed by the patient or one authorized to consent for the patient at the time of admission. The admitting clerk shall notify the admitting or co-admitting practitioner whenever such consent has not been obtained. Except in an emergency, no procedures or treatment maybe be performed in the hospital without the signed admission form or other written consent of the patient or of one authorized to consent for the patient. In addition, if the patient is in a nursing home and cannot talk, no other procedure for which specific consent is required shall be performed until the patient's informed consent is properly obtained and documented in accordance with established policies of the hospital. All consents shall be documented on written forms to be prescribed by hospital administration in consultation with the medical staff, and shall be made a part of the patient's medical record.

3.2 ORDERS FOR TREATMENT

All orders for treatment shall be in writing. Verbal orders may be carried out only if given by the treating practitioner or other current medical staff member to a staff member who is authorized

by the hospital or department policy to carry out the order. The staff member taking the order will record the verbal order in the patient's record. The order shall be signed and date by the practitioner on his/her next visit to the hospital. Certified staff members may receive an order from the treating practitioner for modalities within the department. The staff member receiving the order will record the order in the patient's record. The order shall be promptly signed and dated by the practitioner.

3.3 LEGIBILITY OF ORDERS

All orders must be written clearly, legibly, and completely. Orders which do not comply with this rule may not be carried out until rewritten. The use of "renew", "repeat", and "continue" orders is not acceptable.

3.4 ORDERS CANCELLED ON SURGERY

All previous orders are cancelled when a patient goes to surgery.

3.5 DRUGS

1. Drugs used shall be those listed in the United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations or approved for use by the Food and Drug Administration. Exceptions to this rule must be approved by the Medical Staff, or in the case of investigational or research drugs, when properly approved by an institutional review board approved by the Board of Directors pursuant to the F.D.A. regulations.
2. The attending practitioner shall be available when starting administration of intravenous oxytocic drugs such as Pitocin to antepartum obstetrical patients, and shall thereafter be readily available in house. Close supervision is strongly suggested when oxytocic drugs are administered to antepartum patients by other routes.
3. Pharmaceuticals that are ordered without time limitation of dosage shall have a 30-day stop date and be reviewed with the attending practitioner for renewal, if indicated.
4. If a patient brings his/her own drugs into the hospital, these drugs shall not be administered with the following exception: If the patient's drugs are not available on the hospital formulary and cannot be obtained within a reasonable time frame, the patient's own supply will be used after proper identification and written order to administer these specific drugs is given by the attending practitioner. If the drugs that the patient brought to the hospital are NOT to be sued while he/she is hospitalized, they will be packaged, identified, sealed, and stored, to be returned to the patient at the time of discharge, if such action is approved by the attending practitioner. Medications not approved for return to the patient will be properly held for destruction by the pharmacist, with the permission of the patient or responsible family member. Medications unintentionally left by patients after dismissal will be properly discharged by the pharmacist 30 days following dismissal date.

3.6 LABORATORY WORK

No routine diagnostic tests are required at the time of admission. Each patient admitted to the hospital shall have lab and other diagnostic tests performed as lawfully ordered by the admitting

or co-admitting practitioners. Reports from laboratories outside the hospital are acceptable in lieu of tests performed in the hospital, only if the following safeguards are maintained.

1. Tests are done in a CLIA certified laboratory.
2. Tests are recent enough to be pertinent to the individual case.
3. The laboratory report is made a part of the medical record.
4. Laboratory tests for surgery must be performed as close to the time of surgery as deemed appropriate by the practitioner.

3.7 STANDING ORDERS

Standing orders shall be formulated by conference between members of the medical staff, the CEO, and the director of nursing service, and shall be reviewed annually. These orders shall be signed by the attending practitioner(s), but shall not replace or cancel orders written for a specific patient. Whenever standing orders are carried out with regard to a specific patient, that fact shall be detailed in the patient's medical record.

3.8 NURSE QUESTIONS ON ORDERS

If the nurse has any reason to doubt or question the care provided to a patient, the nurse shall bring the matter to the attention of the attending practitioner(s) and, if warranted, to the CNO or designee. If warranted, the CNO or designee may bring the matter to the attention of the Chief of Staff or to the CEO.

3.9 AVAILABILITY TO ATTEND TO PATIENTS

In order to promote timely, appropriate medical care of patients, each member of the medical staff shall at all times be reasonably available to attend his/her patients in the hospital or have secured the prior agreement of other members of the medical staff to be so available. It is the practitioner's responsibility to notify his/her patients of the absence and coverage arrangements. Members of the courtesy staff shall designate a member of the active staff who has agreed to be so available4 on a standing basis.

3.10 CARDIAC STRESS TESTS AND PROCEDURES USING CONTRAST MATERIAL

A qualified physician must be present during cardiac stress testing. Any procedure using contrast material be done only under the supervision of a physician and the physician will be in attendance until at least one-half hour after the injection.

3.11 BLOOD

Blood will be given only at the direction of a practitioner.

SECTION IV: MEDICAL RECORDS

4.1 ENTRIES

Medical record entries may be made only by medical staff members and others who are properly qualified through training, licensure, and hospital policy to make such entries. All

entries shall be accurately dated and signed by the author, even if signed also by the responsible physician or other supervising practitioner.

4.2 ATTENDING PRACTITIONER DUTIES

The attending practitioner shall be responsible for the preparation of a complete medical record for each patient. This record shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultation, clinical laboratory, x-ray and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; discharge instructions; summary; and autopsy report when available. No medical record shall be considered complete until all signatures have been obtained except on order of the Executive Committee. Provisional diagnosis shall be stated as soon after admission as possible, and generally no later than 24 hours after admission.

4.3 HISTORY AND PHYSICAL

For inpatients, a complete history and physical shall be written or dictated up to thirty (30) days prior to admission or no later than 48 hours after admission of the patient. Any change in physical condition in the interim will be noted in the progress notes. *(See 4.3-1 for information specific to cataract patients.)* When a patient is readmitted within 30 days for the same or a related problem, an interval history and physical reflecting any subsequent changes may be used if the original information is readily available. Patients hospitalized for outpatient surgery will require a history and physical and a discharge note to include the patient's disposition and condition upon discharge. Patients hospitalized as medical outpatients will require a history and physical only. A history and physical will not be required for outpatient services determined to be outpatient diagnostic procedures.

4.3-1 No subsequent history and physical will be required for patients who return for a second cataract surgery within sixty (60) days of the original history and physical.

4.4 CONSULTATIONS

Clinical consultation reports shall show review of the patient's medical record, pertinent findings on examination of the patient, and the consultant's opinion and recommendations.

4.5 SURGERY

Surgical reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Surgical reports shall be dictated or written within 24 hours following the surgery and shall be promptly signed and made a part of the medical record.

4.6 PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, the patient's clinic problems shall be identified in the progress notes and correlated with specific orders as well as the results of tests

and treatment. Progress notes shall be recorded at least daily on critically ill patients and on patients where there is difficulty in diagnosis or management of the clinical problem.

4.7 ANESTHETIC RECORD

The anesthetist shall be responsible for maintain a complete and timely anesthesia record, including pre-anesthetic evaluation; all events during induction, maintenance, and emergence; and post-anesthetic follow-up. Pre-anesthetic evaluation must, except in case of extreme emergency, be recorded prior to the patient's transfer to the operating area and before preoperative medication is administered.

4.8 OBSTETRICAL RECORD

The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the attention practitioner's office record, transferred to the hospital. An interval admitting note mu be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

4.9 DISCHARGE

Final diagnosis shall be recorded by the responsible practitioner(s) at the time of discharge of all patients.

A discharge summary shall be written or dictated on all medical records of patients, except that a final summation-type progress note shall be sufficient for those hospitalized less than 48 hours, for normal obstetrical delivers, for normal newborn infants, and for certain selected patients with problems of a minor nature. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. All summaries shall be authenticated by the responsible practitioner.

The discharge summary shall contain the following:

1. Why did the patient enter the hospital?
2. What were the pertinent laboratory, x-ray and physical findings?
3. What was the medical and/or surgical treatment?
4. What was the patient's condition on discharge, with instructions for continuing care?
5. What was the final diagnosis?

4.10 SYMBOLS AND ABBREVIATIONS

Symbols and abbreviations may be used only when and to the extent they have been approved by the medical staff. A list of approved symbols and abbreviations shall be kept at each nurse's station and in the Health Information Management department.

4.11 SIGNATURES

All medical record signatures, including those of physicians, shall be electronic or hand-written. Use of a rubber signature stamp is not allowed.

4.12 DELINQUENT CHARTS

The entire medical record shall be completed within thirty (30) days following the patient's discharge. Charts remaining open after this time are considered delinquent as defined in Section 8.3-5 of the Medical Staff Bylaws.

4.13 PROPERTY OF HOSPITAL

All medical records are the property of the hospital and the originals shall not be removed from hospital control and custody except pursuant to a statutory requirement, court order, or express permission of the CEO of the hospital. In the case of readmission of a patient, all previous records shall be available for the use of the attending practitioner(s), whether the patient is attended by the same or another. Unauthorized removal of charts from the hospital is strictly prohibited and will constitute grounds for automatic suspension if such records are not returned within one (1) day after notice, and may be the basis of further corrective action as well.

4.14 ACCESS TO MEDICAL RECORDS

Written consent of the patient or one authorized to consent on the patient's behalf is required for release of medical information unless otherwise permitted by law. All members of the medical staff shall have access to the medical records of all patients under their care, and to the medical records of all patients for bona fide study and research, and to carry out peer review as provided in the Medical Staff Bylaws or Rules and Regulations, provided that the confidentiality of personal information concerning individual patients is preserved. Former members of the medical staff requiring access to medical records of former hospital patients attended by them shall first obtain the approval of the CEO. All access shall be in compliance with HIPAA requirements.

SECTION V: CONSULTATIONS

5.1 CONSULTATIONS

The attending practitioner is primarily responsible for requesting consultations when indicated and for calling in a qualified consultant. A satisfactory consultation includes examination of the patient and the medical record, and preparation of a written opinion and recommendation signed by the consultant and included in the medical record. When operative procedures are involved, and except in an emergency, the consultation note shall be recorded prior to the operation. Consultations are required, except in emergencies, on first Caesarian Sections.

SECTION VI: STERILIZATION PROCEDURES

6.1 CONSENT

In all cases of procedures for primary sterilization, the physician shall obtain the appropriate informed consent of the patient for the procedure.

SECTION VII: DEATH

7.1 DETERMINATION

In the event of a death, the deceased shall be pronounced dead by the attending practitioner within a reasonable time. The certificate of death shall be completed and signed within 24 hours. The body shall not be released until the practitioner has declared the patient dead and ordered release. The practitioner's declaration and order shall be recorded in the medical record, and signed by the practitioner as soon as possible. Policies with respect to release of dead bodies shall conform to state and local law.

7.2 AUTOPSIES

It shall be the duty of all staff members to secure meaningful autopsies whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist or by a practitioner delegated with this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 72 hours and the complete protocol, including report, shall be made a part of the record as soon thereafter as possible.

7.3 MEDICAL EXAMINER

The county medical examiner shall be called to assume responsibility for the determination and certification of death, and authorization to remove the body, when the death occurred due to:

- Violent deaths, including homicidal, suicidal, or accidental deaths;
- Deaths caused by thermal, chemical, electrical, or radiation injury
- Deaths caused by criminal abortion including those self-induced or by sexual abuse;
- Deaths that have occurred unexpectedly, or from unexplained causes;
- Deaths of persons confined in any prison, jail, or correctional institution;
- Death of a person if a physician was not in attendance within thirty-six hours preceding death, excluding pre-diagnosed terminal or bed-fast cases for which the time period is extended to 30 days, and excluding terminally ill patient who was admitted to and had received services from a hospice program, if a physician or registered nurse employed by the program was in attendance within thirty days preceding death;
- Death of a person if the body is not claimed by a relative or friend;
- Death of a person if the identity of the deceased is unknown;
- 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;
- Death related to disease thought to be virulent or contagious which may constitute a public hazard.

SECTION VIII: EMERGENCY CARE

8.1 ON-CALL ROTATION FOR EMERGENCY CARE

The active staff and CEO or designee shall establish procedures for rotation/coverage of the emergency room. All members of the active staff are required to accept on-call duties for emergencies, unless such requirement has been waived by the CEO and the active staff or other arrangements have been made by the hospital.

Being in a rural community, the medical staff does not have the availability of specialists. Therefore, there will be no separate on-call schedule for specialty services. The doctor who is on-call will respond to a request for his/her presence in the emergency department within the time frames set up by the hospital's EMTALA policy and procedure, regardless of any attempts by hospital staff to contact the patient's primary care provider. Every patient coming to the emergency department shall be treated in accordance with the hospital's EMTALA policies and procedures to determine if an emergency condition exists and there will be no delay in screening, stabilizing, and treating the patient due to attempts to locate the patient's primary care provider.

Refer to the Wayne County Hospital Medical Screening, Treatment and Transfers (EMTALA) policy for further information. (Attachment A)

Women presenting with an emergent non-obstetrical problem will be handled by the emergency room provider or the provider on-call. If it is uncertain as to whether the problem is obstetrical or not, the provider on-call will proceed as above and make appropriate consults as needed.

8.2 TRAINING

All personnel providing patient care in the emergency service shall participate in training programs on a periodic basis. All active medical staff with rotation/coverage of the emergency room will be ATLS certified. Courtesy staff that are providing ER coverage must, at a minimum, be certified in ACLS and BLS. Anyone working in the ER who is not ATLS certified must call the primary on-call provider in the event of a trauma or trauma alert. Practitioners with OB privilege should be certified in NRP.

8.3 PROCEDURES

The policies and procedures for examination and transfer of patients presenting for emergency care are set forth in a separate Medical Screening, Treatment and Transfers (EMTALA) Policy and Procedure which is attached to these Rules and Regulations as Attachment A, and is hereby expressly adopted and approved as part of these Medical Staff Rules and Regulations.

8.4 EMERGENCY ROOM PEER REVIEWS

Periodic reviews of non-physician practitioner patient records will be performed by Emergency Services Medical Director on a quarterly basis.

SECTION IX: RULES PERTAINING TO THE EXERCISE OF PRIVILGES IN SURGERY

9.1 TISSUES FOR PATHOLOGY

All tissues removed in surgery will be sent to pathology for appropriate gross and microscopic examination with the exception of the following list of specimens, which may be exempted by the physician. These tissues may have a macroscopic examination done by the physician or be sent to pathology as directed by the physician. When tissue is not submitted to pathology, the tissue disposal must be authorized by the physician on the medical record. The physician should also record in the operative report that a macroscopic examination was done and any pertinent findings noted.

- Bone bits and chips
- Cartilage chips
- Cauterized fallopian tubes via laparoscope
- Fingernails and toenails
- Foreign bodies
- Newborn foreskin
- Orthopedic hardware
- Pacemakers
- Superfluous skin and skin scars
- Teeth
- Tissue from arthroscopy
- Tissue from carpal tunnel
- Tonsils and adenoids (patients age 15 and under)
- Calculi
- Hernia sacs
- Traumatic amputations
- Ureteral stents
- Cataract nucleus

9.2 ASSISTANTS

The surgeon shall utilize such assistants at surgery as he/she deems appropriate and such assistants may include any practitioner, AHP, nurse, aide or technician who is properly trained, qualified and privileged. The medical staff may establish a list from time to time of procedures which require a physician as surgical assistant.

9.3 REQUIREMENTS BEFORE SURGERY

Except in an emergency, history and physical examination must be dictated and preoperative diagnosis must be recorded on the patient's chart before any anesthesia is administered or

operative procedure begun. The surgeon must be in the operating room and ready to commence the operation at the time scheduled.

9.4 ANESTHESIA

Anesthesia services shall be provided under the direction of a member of the medical staff. Pre-anesthesia evaluation shall include appraisal of the patient's current condition, preparation of an intraoperative anesthesia record and discharge criteria. A qualified physician or anesthetist shall, prior to the administration of anesthesia, check all equipment for readiness, availability, cleanliness, and working condition.

SECTION X: OBSTETRICAL SERVICES

10.1 PLACENTA/UMBILICAL CORD PATHOLOGY

The placenta and umbilical cord should be retained and could be submitted for pathological examination when ordered by the provider, or when any of the following conditions exist:

10.1-1 CONDITION OF MOTHER

Diabetes mellitus; pregnancy induced hypertension; prematurely ruptured membrane; pre-term delivery (less than 34 weeks); unexplained fever; or unusual intrauterine procedure.

10.1-2 CONDITION OF FETUS OR INFANT

Stillborn/newborn deaths/transfers to neonatal ICU; multiple pregnancy; intrauterine growth retardation; ominous fetal heart tracing; thick meconium; low Apgar score; or resuscitation of newborn.

10.1-3 CONDITION OF PLACENTA

Abruptio placenta; infarction; ruptured vass previa; giant chorioangioma (unexplained mass); or abnormal appearing umbilical cord or knotted cord.

10.1-4 UNSCHEDULED CESAREAN SECTION

SECTION XI: PHYSICIAN ASSISTANTS

11.1 APPLICATION AND APPROVAL

Physician Assistants ("PA") must be specifically credentialed and approved in advance to render services at the hospital. Approval and credentialing will be determined through the credentialing process adopted by the active staff. If the PA is an employee of one or more active or courtesy staff members, the employing member(s) shall also sign the application for credentialing. The supervising physician(s) must be a member of the hospital's active or courtesy staff with all clinical privileges necessary to fully supervise the PA. The PA shall be responsible to immediately notify the CEO and the Chief of Staff whenever there is a revocation, reduction, suspension, limitation, or any other change of any type in the PA's state approval, or a change in supervising physicians.

11.2 SUPERVISION

The supervising physicians are responsible to assure that the PA complies fully with all restrictions imposed by the state or by the hospital, and to assure that the PA is supervised in compliance with the laws and regulations of the State of Iowa. "Supervision" shall mean, at a minimum, the supervising physician is readily available for consultation and direction of the activities of the PA as required by state law.

11.3 Limitations

The PA shall only perform tasks and procedures for which the PA is specifically credentialed for by the hospital, and subject to any restrictions or limitations imposed by either scope of practice or the hospital.

11.4 CHARTING

All notes, written entries or orders made by a PA shall be counter-signed by the supervising physician.

11.5 IDENTIFICATION

PA's must clearly identify themselves when performing services or duties in the hospital, by wearing a name badge with his/her name and the designation "Physician Assistant".

SECTION XII: ADVANCED PRACTICE NURSES

12.1 APPLICATION AND APPROVAL

Advanced Practice Nurses ("APN") to include Advanced Registered Nurse Practitioner, Certified Nurse Midwife, and Certified Registered Nurse Anesthetist, must be specifically credentialed and approved in advance to render services at the hospital. Approval and credentialing will be done by the active staff pursuant to the Medical Staff Bylaws. An APN may choose to have a collaborating physician. All physicians collaborating with the APN at the hospital must be members of the hospital's active or courtesy staff with all clinical privileges appropriate to collaborate with the APN in his/her specialty, if applicable. The ANP shall be responsible to immediately notify CEO and Chief of Staff whenever there is a revocation, reduction, suspension, limitation, or other change of any type in the APN's licensure.

12.2 SUPERVISION

APNs are directly responsible to the hospital for full compliance with all scope of practice limitations applicable to the APN. A physician shall be readily available for consultation and direction of the activities of the APN within the APN's defined scope of practice, if needed.

12.3 LIMITATIONS

The APN shall only perform tasks and procedures within his/her scope of practice and for which he/she is credentialed by the active medical staff, and subject to any restrictions or limitations imposed by either the state or the hospital.

12.4 CHARTING

Notes, written entries and orders may be independently made and signed by an APN.

12.5 IDENTIFICATION

APNs must clearly identify themselves when performing services or duties in the hospital, by wearing a name badge with his/her name and the designation specific to the provider (i.e., ARNP, CNM, CRNA, etc.).

SECTION XIII POLICIES

13.1 These Rules and Regulations shall not be exclusive of other hospital and medical staff policies and procedures, such as (without limitation) policies on transfer of emergency patients, DNR orders and the like, and such as the quality assurance, utilization review, and disaster plans. All adopted policies and procedures shall be binding according to their terms on the medical staff members, AHPs, and others when rendering care or engaging in other activities at the hospital, whether or not included in these Rules and Regulations.

Wayne County Hospital Medical Staff Rules and Regulations
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Joel Baker, DO
Chief of Staff/Chief Medical Officer