Medical Staff Rules & Regulations

Allen Hospital
Waterloo, IA

Revised: July 2016
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ALLEN HOSPITAL
RULES AND REGULATIONS OF THE MEDICAL STAFF

ARTICLE I – ADMISSION

A. Allen Hospital shall accept patients suffering from all types of diseases/conditions, provided the care/services are available for the specific disease/condition.

B. When a patient who does not have a personal physician presents himself/herself to the Emergency Department and an admission is indicated, a Medical Staff member in the applicable specialty shall be requested to assume care for this patient. Physicians having “active” staff privileges are required to accept patients. By mutual agreement, a physician may designate another physician to accept his/her patients.

1. Each specialty shall provide the Emergency Department a schedule of the specialty physician “On call” for each day.
2. The physician on call shall respond to requests for emergency management and/or an emergency request from other medical facilities/physicians.
   a. The patient must be accepted when the services/capacity/staff are available at Allen.
   b. The patient may be transferred to Allen’s Emergency Department for medical screening before admission.

EMTALA law: CMS’s condition of participation requires that a “hospital that has specialized capabilities of facilities may not refuse to accept from a referring hospital... an appropriate transfer of an individual who requires specialized capabilities or facilities if the receiving hospital has the capacity to treat the individual.

C. Patients may be admitted only by a physician having admitting privileges at Allen Hospital.
   1. Another provider may refer a patient, but a physician or designee who has privileges to practice at Allen must agree to accept the patient and provide medical care for the patient.
   2. A patient admitted for dental, and/or podiatry services may be admitted by a practitioner who has privileges, but also must have a physician as the attending physician to manage the medical care. The physician shall be contacted by the dentist/podiatrist and request co-admission.
   3. Obstetrical patients may be managed and assessed by a Certified Nurse Midwife, but the sponsoring physician will be the physician of record for the admission.

Admission Criteria:

1. Patients may be admitted to acute care when requiring specialized professional services twenty-four hours a day and daily patient care.
2. Factors to be considered are:
   o the severity of the signs and symptoms exhibited by the patient.
   o the medical predictability of something adverse happening to the patient.
   o the need for diagnostic studies that cannot be done safely as an outpatient.
3. **Inpatient Rehabilitation**: Patients may be admitted to the Inpatient Rehabilitation Unit who meet criteria for comprehensive integrated interdisciplinary rehabilitative team services for whom
improvement in function is reasonably expected. The patients are medically stable and demonstrates interest and willingness to actively participate in the rehabilitation program. Only the rehab medical director or designee may admit patient to the inpatient rehabilitation unit.

4. **Mental Health Unit:** Only a psychiatrist may admit patients to the Mental Health Unit.

5. **ICU including PICU and NICU**
   a. Patients seen first in Allen’s Emergency Department and are admitted to the ICU shall be evaluated by the attending or consulting physician assuming care of this patient within 4 hours of admission or earlier, as appropriate based on the patient’s condition.
   b. Physicians who arrange a direct admission to the Intensive Care Units must be present at bedside at time of patient arrival, or immediately thereafter. Physicians may elect to have their supervised midlevel provider (MLP) initiate the intervention, provided the attending or consulting physician is in-house or immediately available to MLP and ICU staff.

D. Definitions:
   1. **Admitting physician:** The physician who is authorizing the admission of the patient is also the attending physician until he/she documents in the medical record transfer of care to another physician.
   2. **Attending Physician:** The physician who will be attending the patient during the hospitalization. It may/may not be the physician admitting the patient.
   3. **Provider:** Licensed Independent Practitioner or Physician Assistant privileged to provide inpatient care.

E. When a physician requests a bed for a patient, pre-admission information shall be provided, which shall include a provisional diagnosis.
   1. A general treatment consent form, signed by or on behalf of each patient admitted to the Hospital, must be obtained at the time of admission. The admitting physician should be notified whenever such consent has been refused.

F. The admitting/attending physician is required to provide documentation in the medical record of the need for admission and continued hospitalization.

G. The admitting practitioner shall be responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others.

H. The attending physician shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring physician and to relatives of the patient subject to the authorization of the patient. Whenever these responsibilities are transferred to another physician, a note describing the transfer of responsibility shall be entered on the order sheet of the medical record. Practitioners shall be guided in the care of patients by the written protocol of the Clinical Service Area or specialty in which they are a member. When a transfer is made to another physician the transferring physician is responsible to contact that physician for acceptance of the patient. (Article X Medical Staff Patient Hand-Off Report)

I. Each acute care patient shall be seen at least daily by his/her attending physician with documentation entered in the progress notes of the medical record.
1. Consultant physicians are expected to document their plan of care to cover each day of the hospitalization.
2. Rehabilitation patients shall be seen by a physician at least three times weekly, but more often contingent on the patient’s condition.
3. When a patient is admitted, orders shall be given for management of the patient until the physician’s visit. If the patient’s condition is serious or deteriorates, the physician shall be requested to come and evaluate the patient.
4. Stable newborns shall be seen within 24 hours of birth.
5. NICU patients may be managed and assessed by a Certified Neonatal Nurse Practitioner, but the sponsoring physician will be the physician of record for the admission.

J. When an insurance carrier denies admission or continued stay and the physician feels that in his/her judgment, hospitalization is necessary:
   1. The medical record shall contain reasons why the hospitalization is necessary in spite of the carrier’s denial.
   2. The physician shall request review by peers to substantiate his/her determination.
   3. The patient shall be allowed to remain hospitalized as long as deemed medically necessary, regardless of payment.
   4. An appeal will be lodged with the carrier, via letter, with appropriate documentation. Hospital representatives (Case Management staff) shall facilitate this.
   5. Alternate options, including self-pay basis, shall be reviewed and offered with the physician and patient/family.

K. Patients must be seen by designated provider within 30 minutes in the Emergency Department or the patient will need an examination by an Emergency Department physician.
ARTICLE II –DIRECT ADMIT POLICY

TRANSFER OF INPATIENTS:

1. All inpatients from other facilities will be made a direct admit to an Allen inpatient unit to the accepting Allen physician assuring appropriate bed availability as determined by the House Supervisor. The exceptions being:

   A. If the patient becomes unstable en route and needs to stop in the ED for stabilization or
   B. If the accepting/admitting physician requests the patient be evaluated in the ED to better determine proper floor placement. In this instance, the accepting/admitting physician may:
      1. See the patient in the ED in a timely fashion or
      2. Ask the ED provider to see the patient.

      a. In either case, the accepting/admitting physician will be responsible for contacting the ED provider to inform them of the pending patient arrival to the ED and the plan for care.

      b. If the accepting/admitting physician does not arrive in a timely fashion, the ED provider will assume care of the patient.

2. If the ED physician is contacted by the outlying inpatient physician, the ED physician will contact the house supervisor who will coordinate the transfer process.

3. The accepting Allen physician will be the admitting physician of record and will arrange for any necessary consults.

DIRECT ADMITS FROM HOME OR OFFICE:

1. All active medical staff at Allen may:

   A. Directly admit their own patients to Allen or
   B. Arrange for the patient to be directly admitted to another member of the active medical staff after direct communication with the staff member and acceptance by that staff member. The accepting physician will be the admitting physician of record and will arrange for any consults necessary.

TRANSFERS FROM OTHER EDS, NURSING HOMES, OR OUTLYING OFFICES:

1. All transfers of adult patients from another ED, a nursing home or an outlying office will come to Allen ED for appropriate treatment and determination of proper disposition of the patient.

   A. An exception may occur to the above statement for certain patients who, once evaluated by an outside provider, are determined to have an emergent STEMI. These patients may bypass the Allen ED and arrive directly in the cardiac catheterization lab with the approval of the cardiologist since every delay is potentially life-threatening.
B. An exception may also occur to the above statement for certain patients who, once evaluated by an outside provider, are determined to have an imminent delivery of a fetus. These patients may bypass the Allen ED and arrive directly in the obstetrics suite with the approval of the obstetrician since every delay increases the risk to both mother and child.

C. An exception may also occur to the above statement for certain patients who, once evaluated by an outside provider, are determined to have an emergent surgical condition. These patients may bypass the Allen ED and arrive directly in the operating suite with the approval of the surgeon since every delay is an unnecessary delay to definitive treatment.

2. Pediatric patients transferred from another ED or outlying office may be a direct admit to the accepting pediatrician or family practitioner. These pediatric patients would come to Allen ED if they become unstable or deteriorate en route.

3. When an Allen attending physician is contacted directly by the outlying ED, a nursing home or an outlying office, and he/she feels the transfer would be appropriate and is willing to accept care of this patient, the Allen attending physician has the following responsibilities:

   A. Contact the House Supervisor to facilitate the transfer process.

4. The accepting physician will be the admitting physician of record unless it is determined by the ED physician that another admitting service would be more appropriate for this patient’s care.

**ARTICLE III – INFUSION SERVICES**

1. Treatment in the infusion services area may be done via transcribed orders, clearly delineating specific therapies, medications (including dose, duration) and/or monitoring required.

2. Documentation describing the condition for which treatment is being provided is expected for defining the treatment of the patient.

3. The ordering physician is the attending physician of this episode of care, and questions regarding the patient condition are directed to him/her or their designee.

4. The ordering physician may not obligate another provider to assume care without direct provider-to-provider communication.

   5. In the event of an adverse reaction the MET team will be notified.
ARTICLE IV– CONSULTATION

A. Consultation shall be at the discretion of the individual physician, except as defined under specific Departmental policies (i.e., Surgery, Obstetrics and Neonatal).

B. A consultant must be well qualified in the field and if the consultant is not a member of the Medical Staff, privileges must be obtained.

C. The patient’s physician shall write the request for consultation in the patient’s record or give a verbal order that is also documented in the medical record. The specific physician or group he/she prefers and the type of opinion request shall be part of the consultation order.

D. Essentials of a consultation: A satisfactory consultation includes examination of the patient and the patient’s record. The consultant’s assessment and recommendation shall be documented and signed in the medical record. Physician may elect to have their supervised MLP initiate the consultation, provided the physician evaluates the patient within 24 hours of request for consultation. If the order for a consult is for assessment and recommendations only; this means that no orders are written by the consultant. The attending physician does have the option to order consult and follow patient; this means that the consultant can write orders which are to be carried out. If there is to be a transfer in responsibility of care (attending status), this must be mutually agreed upon and entered as an order in the medical record.

E. Consultations shall be completed and documented within twenty-four (24) hours of request, except when otherwise stated by the consultant and agreeable with the referring physician. When this does not occur, the attending physician shall be notified, and documented in the medical record.

F. The appropriateness of care and the need for consultation shall be monitored through the Performance Improvement process.

G. Opinions may be obtained from the physicians at other institutions, as the attending physician desires. In this case, the attending physician is responsible for calling and discussing the case with and writing recommendations in the medical record.

H. Required Consultations:
   1. Psychiatry – known or suspected suicidal patient.
   2. Intensivist
      a. Patients with the following conditions require an Intensivist consult:
         i. Cardiopulmonary System
            ▪ Any patient with hemodynamic instability more than 8-12 hours on vasopressor or inotropic support, or if rapidly deterioration, call immediately.
            ▪ Any acute respiratory failure patient requiring ventilatory or BIPAP support more than 24-16 hours.
            ▪ Any patient undergoing therapeutic hypothermia protocol
            ▪ Exception: CABG/valve surgical patients who routinely may be on vasopressors/inotropes.
         ii. Surgical or multi-trauma patients requiring ventilator or hemodynamic support as outlined in Section A
iii. Neurologic disorders
   - Acute stroke, status epilepticus patients requiring ventilator/hemodynamic support as outlined in Section A.
iv. Obstetric emergencies that require ventilatory support, correction of DIC, vasopressor support as outlined in Section A.
v. Anytime the multidisciplinary rounding team reasonably believes a medical condition warrants an Intensivist consult.
ARTICLE V – DISCHARGE

A. Any patient may leave the Hospital of his/her accord unless under custody of the law or court ordered commitment.

B. Patients shall be discharged only upon order of the attending physician, or resident or midlevel provider responsible for the management of the patient.

C. Should a patient leave the Hospital against the advice of the attending physician/practitioner responsible for the management of the patient.
   1. The physician shall be informed of the patient’s desire.
   2. Any patient who leaves the Hospital against the advice of the attending physician must sign the “Refusal of Exam/Treatment” form. Two Registered Nurses shall witness the completion of this form after having informed the patient and his/her relative of the terms of the release.
   3. In the event of patient’s (or relative’s) refusal to sign the release, the refusal must be documented in the patient’s record.
   4. The medical record must contain full documentation of the entire incident.

D. The attending physician may discharge the patient the next day by a order. The patient may then be discharged without being seen by the physician on the day of discharge as long as the patient’s condition has not changed from the time of the physician’s previous visit. Exception: Newborns shall be seen by the physician on the day of discharge.

E. Transfer of patients: Patients may be transferred to another facility in order to meet the indicated needs of the patient or to assist in the effective utilization of resources.
   1. The patient and/or family must agree to the transfer.
   2. The transferring physician or midlevel provider will contact the facility and obtain medical consent for acceptance of the patient.
   3. A copy of applicable records shall be sent with the patient.

F. The Emergency Examination and Transfer Policy – EMTALA shall be followed for emergency transfers.

G. Patients cannot go to a physician’s office for consultation, care/treatment. The physician must come and see the patient in the hospital.
ARTICLE VI - INFECTIOUS DISEASES

A. The Infection Control and Prevention Program - Statement of Purpose and Statement of Authority for Infection Control and Prevention Activities discuss the purposes and authority delegated to the Infection Control Officer(s).

B. Precautions for infectious diseases/conditions shall be according to the Centers for Disease Control (CDC) guidelines and Allen Hospital's Infection Control Program which are located in the Infection Control Policies.

C. Guidelines from the CDC shall be used when developing criteria for hospital acquired infections. Specific criteria may be modified by a specific service line, which is submitted to the Infection Prevention Committee for approval. The criteria are located in the Infection Control Manual.

D. Reporting of diseases/conditions, including certain occupational-related injuries and farm-related injuries/conditions shall be in compliance with the Rules and Regulations of the Iowa Department of Public Health.

E. The organization shall comply with all regulations of the Iowa Department of Public Health (IDPH).

F. Standard (Universal) Precautions, as required by the Centers for Disease Control and Prevention (CDC) and OSHA shall be used for contact with all body fluids, tissue, mucous membranes and non-intact skin. The policy/procedure is located in Control Plan for the Prevention of Occupational Exposure to Bloodborne Pathogens.

G. Rooms with negative pressure shall be used for patients with infections requiring airborne precautions.
ARTICLE VII – MEDICAL RECORDS

A. Original medical records are the property of the Hospital and shall not be removed from the building except by court order, subpoena or statute.

1. Copies of medical records, other records and/or radiology images may be removed from the building pursuant to policies, approved by Hospital Administration.
2. In case of readmission of a patient, all previous records shall be available for use of the attending physician/practitioner. This shall apply whether the patient is attended by the same practitioner or by another physician.
3. Unauthorized removal of charts from the hospital is grounds for precautionary suspension of the practitioner for a period to be determined by the Credentials committee of the Medical Staff.

B. The physician/practitioner caring for the patient shall be responsible for preparing complete and legible medical records.

The content of the record shall be organized to enable practitioners to provide continued care, permit consultants to render an opinion, allow another practitioner to assume patient care and allow for the retrieval of information for utilization review and performance improvement activities.

C. An admission note shall be recorded in the physician progress notes stating the reason for admission and pertinent findings.

D. Medical Records shall be completed within thirty (30) days of discharge of the patient in order to be in compliance with mandates from TJC regarding medical records completion including completion of chart for discharged patients within 30 days of discharge date. Failure to complete the dictated operative note within 24 hours of the procedure or completion of the discharge summary within 7 days of discharge will also result in a violation.

Six violations of this medical records policy within a six-month period (January 1 – June 30 or July 1–December 31) will:

1. Result in a $100 fine per week. The $100 fine will be reassessed each week until all delinquent records are complete. Additional $100 fines and will be assessed for each subsequent violation during the same six month period.
2. Monitoring of fines incurred as part of the recredentialing process.

Failure to timely pay the reapplication fee at the time of the new deadline will result in an incomplete application resulting in the voluntary relinquishment of all privileges and membership.

E. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Daily progress notes shall be written for all patients in the acute hospital with the exception of Acute Inpatient rehab that requires progress notes three (3) times per week. Hospitality and Hospice respite status do not require daily progress notes.
F. An operative/procedure report shall contain a pre-operative and post-operative diagnosis, a detailed account of the findings at surgery as well as the details of the surgical technique. The operative/procedure report shall be created immediately following surgery/procedure for all patients and the report promptly signed by the surgeon and made a part of the patient’s current medical record. A brief operative note shall be entered immediately after the procedure, in the case when the full operative note is not available.

G. All orders and clinical entries in the patient’s medical record, created during the patient’s hospitalization, must be complete, legible, accurately dated, timed and authenticated.

H. Symbols and abbreviations may be used only as defined in the adopted hospital reference for identifying appropriate abbreviations to be used by Allen Hospital (See Hospital Abbreviations Policy)

I. A discharge clinical summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours and be written or dictated within 7 days of discharge.
   a. Inpatients with a length of stay less than 48 hours and ambulatory or observation patients shall have either a dictated discharge summary
      OR
      A final progress note, which includes the outcome of hospitalization, case disposition, provisions for follow-up care and final diagnosis. The final diagnosis may also be noted on operative report or other physician documentation in the medical record.
   b. The Discharge Summary shall include reason for admission; significant findings; hospital course; condition on discharge; discharge instructions (diet, medications, physical activity and follow-up, procedure(s) performed, treatment rendered) and final diagnoses.
   c. For normal obstetrical deliveries and normal newborn infants, a final summation-type progress note shall be sufficient to justify the diagnosis and warrant the treatment and end result.
   d. All summaries shall be authenticated by the responsible practitioner.

J. Release of information from the patient medical record shall be governed by the hospital’s current release of information policies.

K. Access to the medical record is governed by the health information protection and information security policies signed as part of the application and re-application process to the medical staff. Medical research requires certified IRB approval. Requests made by former members of the medical staff for access to records shall be specified in writing for each individual case and authorized by the VP/Chief Quality Officer.

L. Allen Hospital has approved the use of electronic signatures. The misuse of the assigned electronic signature identified will result in actions outlined in the Unity Point Health Information Systems Access Policy.

M. Corrections and Addendum to Patient Medical Records:
   1. When an error in documentation is made within a paper patient medical record, the following steps must be taken:
      a. One straight line should be drawn through the entry. (At no time should the entry be scratched out, covered with correction fluid or obliterated to the point that it is illegible.)
b. Corrected reports, records shall be designated as such; the original shall be placed in the back of the record.
c. The word “error” should be written next to the entry.
d. The entry should be dated with “today’s date”.
e. The entry should be initialed by the documenter.

2. When an error is identified in the electronic record the Allen Hospital Chart Correction Team must be notified with indications of the error identified. The error will be investigated and appropriate actions taken if correction is necessary.

1. When an addendum to the patient medical record is made, the following steps should be taken:
   a. The entry should be headed “Addendum”
   b. The entry should be dated with the date of the entry.
   c. Referral should be made to the original dates that documentation is reflecting, but the entry date must always be indicated.
   d. The entry should be signed and dated by the author.

N. Pending Orders
   a. Any licensed healthcare professional can enter orders into the medical record for purposes of including the order in the numerator for the measure of the CPOE objective if they can enter the order per facility guidelines.
   b. The order must be entered by someone who could exercise clinical judgment in the case that the entry generates any alerts about possible interactions or other clinical decision support aides.
   c. This necessitates that CPOE occurs when the order first becomes part of the patient's medical record and before any action can be taken on the order.
   d. Each provider will have to evaluate on a case-by-case basis whether a given situation is entered allows for clinical judgment before the medication is given, and is the first time the order becomes part of the patient's medical record.
   e. The expectation is that a physician-designee would enter the orders in a planned/“hold” state, but the physician must log in, review, and sign them prior to them being initiated (implemented).
   f. While orders are in this “hold” state they cannot be seen or acted upon by staff.
   g. These orders differ from verbal significantly in that they are not processed until the physician reviews and signs them. They exist in a planned state until the physician logs on, opens them, reviews them and signs them.

O. When an autopsy is performed, the provisional anatomic diagnoses are recorded in the medical record within three (3) days and the complete report is made part of the record within sixty (60) days. Exception: Findings from an autopsy requested by the Medical Examiner will not be placed on the record, as these are the property of the Medical Examiner.
P. Filing of Incomplete Medical Records
No medical record shall be filed until it is complete and properly authenticated. In the event that a medical record remains incomplete by reason of death, resignation or other inability or unavailability of the responsible practitioner to complete the record, the Chief Medical Officer or designee shall consider the circumstances and may administratively close out the record and declare it complete.

Q. Co-signatures required

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ARTICLE VIII – VERBAL ORDERS

Purpose:
CPOE is an application that allows physicians to enter orders for medications, laboratory tests, procedures and imaging studies. The implementation of an EHR with CPOE has measureable benefit in reduction of medical errors and assuring the safety of patients. Physicians have an ethical obligation to assure the safety of patients. Verbal orders circumvent the benefit of CPOE, however the reality and logistics of clinical practice is that foreseen and unforeseen scenarios exist where verbal orders are the prudent and practical order entry vehicle. Clinical scenarios in which verbal orders will be consistently allowed to be a vehicle of order entry are provided. Clinical practice is not procrustean and it is acknowledged that prudent and practical scenarios exist or will arrive that are not provided at this juncture. This policy will indeed evolve and be refined over time influenced by demographics and technology.

Definitions:

1. CPOE- computerized provider (physician, NP or PA) order entry.

2. Verbal order (including a telephone order)- an order given by a provider, entered into the EHR by a non-physician. It is active upon entry; however, physician validation and signature are delayed.

3. All orders for treatment shall be entered into the electronic health record. The physician or other licensed practitioner is the optimal person to do this. However, verbal and telephone orders shall still be allowed at times when it is
impossible or impractical for the physician or other licensed practitioner to personally enter them into the electronic health record.

4. A verbal/telephone order shall be considered valid and actionable when dictated to a duly authorized person functioning within the person’s sphere of competence.

5. All orders shall include the date and time when the order was received.

6. The order will be read back to the practitioner for confirmation.

7. The person taking the order will electronically sign his or her own name and note the practitioner that dictated the order.

8. The responsible practitioner must authenticate such verbal/telephone order by electronically signing at the earliest, but no later than 30 days.

Clinical Scenarios of allowance for verbal orders:

1. Provider is actively involved in a procedure or an operative scenario that CPOE would involve unnecessary delay and/or breaking the sterile field.

2. Provider is directly involved in critical care; examples include but are not limited to directing CPR and Trauma stabilization.

3. Provider is unable to access a remote device; examples include but are not limited to traveling in a vehicle and off campus nocturnal coverage.

A verbal order shall be considered to be in writing if dictated to a person authorized to accept and record verbal orders and signed by the responsible practitioner.

All verbal orders shall be signed by the authorized person to whom dictated with the name of the practitioner (Medical Staff member) per his/her own name.

The responsible practitioner who gave the order shall sign such orders within thirty (30) days of discharge.

Another practitioner may not sign for the practitioner who gave the order.

Only registered Nurses, licensed Pharmacists, licensed Physical Therapists, Occupational Therapists, Speech Pathologists, Radiology Techs, certified Respiratory Therapy Technicians and Registered Dieticians are authorized to accept and record verbal order which relate to their respective specialty.

1. Radiology and Laboratory Secretaries/staff may accept a telephone order for an examination.

   The signed request form must be faxed or sent with the patient when the patient presents for the examination.
ARTICLE IX MEDICATION RECONCILIATION POLICY

Policy:

Reconcile the medication information the patient brought to the hospital with the medications ordered for the patient by the hospital in order to identify and resolve discrepancies. Medication reconciliation will occur with 24 hours of admission and at discharge.

Medication Reconciliation is not required for same day procedures for non-hospitalized patients not staying overnight.

Procedure:

I. The admitting personnel will obtain the list of home medications while performing the admission history and assessment.
   a. The medication history should include:
      i. Prescribed, over the counter medications, herbal or dietary supplements and vitamins.
      ii. Those taken at schedule times and those taken on an as needed basis.
      iii. All listed medications will include name, dosage, frequency, route, and date/time of last dose.

II. In cases where the current pre-hospital medication list is not available or the patient/family member are not considered to be a reliable source of information, the most recent medication list may be obtained from the following sources:
   a. Other family members.
   b. From the transferring or discharging facilities.
   c. The patient’s current pharmacy.
   d. The patient’s primary care physician.
   e. Recent hospital records, including most recent discharge instructions, and/or the discharge medication list followed by verification by either the patient’s current pharmacy or the patient’s primary care physician. A home medication wallet card can be used as an initial reference. However, it should be validated with one of the above sources.

III. The medications will be entered into the electronic record
   a. It is the responsibility of the physician, registered nurse and the clinical pharmacist to compare the home medications to the medications on the physicians’ admission orders. Medications with a corresponding order are considered reconciled.
   b. Interruptions and distractions must be minimized by the person reconciling medications.

IV. Discharge:
   a. Prior to discharge, the current hospital medications and prior to admission list will be reconciled and entered into EHR. The provider must complete the medication reconciliation prior to discharging the patient.
      i. If one or two non-reconciled medications remain on discharge medication reconciliation, see attached “Discharge Med Rec Process” map in addendum tab.
ii. A list of discharge medications will be provided to the patient/caregiver. The list should include name, dose, route and frequency.
b. Explain the importance of managing medication information to the patient/caregiver when he/she is discharged from the hospital.
c. Instruct patient to give a list to his/her primary care physician.
d. Instruct patient to update the information when medications are discontinued, doses are changed or new medications are added.
e. Instruct patient to carry medication information at all times in the event of emergency situations.

V. Providers not performing medication reconciliation will be subject to disciplinary action deemed necessary by the credentials committee upon recommendation by clinical service chief.
Discharge Medication Reconciliation Process
For one or two unreconciled medications

Hospital Meds not to be continued--IV meds--Nurse to call the physician.

A new medication that is not a PTA med needs to be continued.

PTA med

Physician gives order to the nurse to discontinue the medication. The nurse discontinues the med through order management.

1) Nurse receives and order to continue the new medication.
2) Nurse gives physician the pharmacy number.
3) Physician calls in the new medication into the pharmacy.

Pharmacist call physician. Med rec is completed under physician's guidance.

Nurse hand writes the med on AVS and keeps a paper copy in the patient's chart.

Flows into AVS
ARTICLE X – INFORMED CONSENT

The healthcare provider performing the procedure is responsible for obtaining an informed consent prior to the procedure, except in those situations wherein a patient’s life is in jeopardy and authorizations cannot be obtained from either the patient, guardian, or next of kin due to the circumstances.

The following elements of informed consent are to be included in a discussion by the provider with the patient: the nature of the proposed procedure, risks, benefits, side effects, likelihood of achieving goals, and alternative treatments (including related risks, benefits, and side effects).

Informed consent in the electronic medical record can be documented by test template or electronically imported file or by scanned record. Healthcare provider documentation of informed consent must be in the medical record prior to the procedure.

In emergencies involving a minor or unconscious patient in which consent cannot be immediately obtained from durable power of attorney for healthcare decisions, parents, guardian, or next of kin, the circumstances shall be fully documented in the patient’s medical record and the House Supervisor shall be notified immediately.

(References: The Joint Commission Standard RI.01.03.01, Consent Policies)

ARTICLE XI – MEDICAL STAFF PATIENT HAND-OFF REPORTS

PURPOSE: 1. Patient care is routinely transferred between various providers during any given hospital stay and may include referral of complete responsibility, transfer of on-call responsibility and transfer of a patient to a separate unit.

2. Patient “hand-off” is the opportunity to convey critical information to the assuming provider.

POLICY: 1. Hand-off Reports are to
   a) be interactive
   b) may include critical information about patient’s diagnosis, condition, treatment plan, anticipated, needed follow-up, problem bases care plan and may include co morbidities, code status, consultations, pending labs, discharge plans, medication/treatment list.

2. Progress Notes, Orders, History and Physical and other documents should be complete and problem-oriented.

3. Computer generated, dictated, or other printed documents are encouraged to support verbal communication.
ARTICLE XII – ANESTHESIA SERVICES

A. All inhalation anesthesia administered in the Operating Suites, Birthing/Delivery Rooms or anywhere else in the Hospital must be administered by a qualified anesthesiologist who has anesthesia privileges at Allen Hospital or a Certified Nurse Anesthetist (CRNA), who has privileges to practice at Allen Hospital.

B. CRNAs shall function as independent anesthesia providers with anesthesiologists readily available.

C. The type of anesthesia may be suggested by the surgeon or consultant, but the final decision shall be made by the anesthesiologist or CRNA.

D. Patients or physicians shall have a choice, if available, as to which anesthesiologist/CRNA is assigned to the case.

E. In all surgical cases a member of the anesthesia team shall evaluate those patients expected to be anesthetized.
   1. The team member shall review the chart, interview the patient and perform any examination that would provide information that might assist in decision regarding risk and management.
   2. Necessary tests and medications should be ordered and indicated consultation obtained.
   3. Documentation of impressions in regard to the administration of the anesthesia to the patient should be in the progress notes or anesthetic record.
   4. In the event of a problem that would constitute an exceptional hazard to the patient or the anesthesiologist or CRNA feels there is sufficient medical reason to cancel a case for the proposed day of surgery, he/she may do so in consultation with the attending surgeon.
      a. In the event there is a disagreement concerning cancellation of the proposed surgery, the surgeon may seek consultation from another anesthesiologist, who should confer with the initial anesthesiologist regarding the reason for cancellation.
      b. Any such disagreement among conferring anesthesiologists is subject to review by the Anesthesiology Clinical service area. Documentation of reasons for cancellation or postponement shall be recorded in the medical record with the plan for subsequent anesthesia care.

F. In emergency cases, the member of the anesthesia team should be informed of the case by the operating surgeon so that both may consult in regard to the welfare and safety of the patient. The anesthesiologist should see and evaluate the patient and write pre-operative orders. If the urgency of the surgery makes this impossible, the patient shall be evaluated in the operating room prior to induction of anesthesia and the needed medication administered at this time.

G. Informed consent for the administration of anesthesia shall be obtained by the anesthesia provider and signed by the patient, durable power of attorney for healthcare decisions or guardian.

H. The administration of anesthesia shall not begin until the surgeon is in the facility.
I. Post-operative visits shall be conducted for inpatient surgeries. The anesthesiologist/CRNA who administered the anesthesia shall record his/her post anesthesia visit. An MD or DO anesthesia provider may delegate the responsibility of the post op visit to another anesthesia provider. At a minimum, the post anesthesia follow-up report documents cardiopulmonary status, level of consciousness, follow-up care and/or observations and complications occurring during post anesthesia recovery within 48 hours of the procedure.

J. Post-operative chart review shall be conducted for outpatient surgeries within 48 hours or next business day. The anesthesiologist/CRNA who administered the anesthesia shall complete the post-operative chart review. An MD or DO anesthesia provider may delegate the responsibility of the post op chart review to another anesthesia provider. At a minimum, the post anesthesia follow-up includes cardiopulmonary status, level of consciousness, follow-up care and/or observations and complications.

K. Except in extreme emergencies, no anesthesia shall be administered unless an adequate history and physical has been documented, proper consent has been obtained and appropriate tests and procedures have been performed and are available.

L. An anesthesiologist shall be available within 30 minutes to respond to emergency situations. Airway emergencies/codes will be responded to by Emergency Medicine Physicians.

M. Prior to beginning the administration of anesthesia, the patient shall be re-assessed and the anesthesiologist/anesthetist shall verify the readiness, availability, cleanliness and working condition of all equipment used in administration of anesthetic agents.

N. Following the procedure, in which anesthesia was administered; the anesthesiologist/anesthetist shall remain with the patient as long as necessary. Personnel responsible for post-anesthetic care shall be advised of any specific problems presented by the patient’s condition. Decisions relative to the discharge of patients from the Post Anesthesia Care Unit shall be made by the member of the anesthesia team or when set criteria are met for discharge.
ARTICLE XIII – AUTOPSY EXAMINATION

A. Each member of the Medical Staff shall be actively interested in securing autopsies whenever possible. None shall be performed without written consent of a responsible relative (as defined in the Consent for Autopsy Policy), except by order of the Medical Examiner. Autopsies shall be performed by Hospital Pathologists, state or local Medical Examiners or by a physician to whom the Medical Examiner may delegate the duty.

B. The physician should record in the death summary whether an autopsy was requested from the family. When they consent, the order shall be documented on the chart and the necessary consent signed. (Nursing will assist with this process.)

C. Criteria for Requesting an Autopsy: The purpose for such criteria is to assist in identifying those deaths in which there may be a significant question about the cause of death or about a co-existing condition, that post-mortem examination reasonable can be expected to answer.

Guidelines for such are as follows:

1. Consideration for requesting an autopsy should include, but not limited to the following situations:
   a. Unexpected death, especially obstetrical, full term infants, pediatric, and those following any dental, medical or surgical procedures, except when a terminal illness is identified.
   b. Lack of response or unusual reaction to therapy.
   c. Significant, unresolved discrepancy in pre-mortem diagnoses.
   d. Death involving an unexpected Hospital occurrence in treatment and/or care.
   e. When there are possible educational values to be gained.
   f. When requested by the family.
   g. Deaths of patients who have participated in clinical trial protocols approved by the institutional review board(s).
   h. Suspected cause of death to disease that may pose a threat to the patient’s family.
   i. Trauma victims who expire in the Emergency Department.

D. Deaths which are defined as "Medical Examiner cases" by State law, must be reported to the Medical Examiner, who may order an autopsy, which does not require consent of the deceased's relatives.

1. The determination of whether an autopsy will be done on patients whose deaths fall under the jurisdiction of the Medical Examiner will be made by the Medical Examiner.
2. Per Iowa Administrative Code 641-127.3 (1): A county medical examiner shall perform an autopsy or order that an autopsy be performed in the following cases:

   a. All cases of homicide or suspected homicide, irrespective of the period of survival following injury.
   b. All cases in which the manner of death is undetermined.
   c. All cases involving unidentified bodies.
   d. All deaths of children under the age of two when there is not a clear cause of death, including suspected cases of sudden infant death syndrome. A summary of the findings
of the autopsy shall be transmitted by the physician who performed the autopsy to the county medical examiner within two days of completion of the report. Autopsies performed on children under the age of two when the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death or the cause of death is not clearly explained by known medical history shall conform to Form ME-4.

e. All work- and farm-related deaths unless there is an obvious natural cause of death.

f. All drowning deaths.

g. All deaths of commercial vehicle drivers that occur during the performance of their job duties.

h. Deaths due to poisoning.

i. Deaths of airplane pilots who die as a result of an airplane crash. The National Transportation Safety Board and the Federal Aviation Administration should be contacted prior to the autopsy to request specimen kit(s).

j. Deaths due to a natural disaster, including tornadoes and floods

k. Deaths in a prison, jail or correctional institution or under police custody, where there is not a natural disease process that accounts for the death.

3. Per Iowa Administrative Code 641-127.3 (2): It is recommended that a county medical examiner should perform an autopsy or order that an autopsy be performed in the following cases:

a. Deaths of adolescents less than 18 years of age when there is not a natural cause of death.

b. All cases which involve a motor vehicle crash, unless it is a single motor vehicle accident with no potential for litigation and there is an obvious cause of death or the injuries have been clearly documented by hospitalization.

c. Deaths from suicide.

d. All pedestrian, bicycle, motorcycle, snowmobile, boating, watercraft, three- or four-wheeler or all-terrain vehicle fatalities.

e. Deaths due to failure of a consumer product.

f. Deaths due to a possible public health hazard.

   g. Deaths due to drug or alcohol abuse or overdose.

   h. Electrical- and lightning-related deaths.

   i. Deaths from burns or smoke or soot inhalation.

   j. All deaths related to exposure, such as hypothermia and hyperthermia.

   k. All sport-related deaths, including but not limited to deaths from auto racing and deaths resulting from injuries sustained in football, basketball, baseball, softball, soccer, or other games or sports.

E. The Medical Staff, especially the attending physician shall be notified when an autopsy is being performed and when results are available.

F. The pathologist shall identify discrepancies in diagnosis identified by autopsy which will be presented as part of the Mortality Review function for each service line.

G. Clinical Service Area review of mortalities will include, whether or not an autopsy was requested, when meeting one of the above criteria. This will be reported as part of the Clinical Service Area Clinical Outcome Indicators.
ARTICLE XIV - CARDIAC SERVICES

A. The Cardiovascular Service Line shall be responsible for the evaluation and analysis of the professional services rendered by the members of its service line. This evaluation shall be conducted through the performance of concurrent and retrospective review of patient care rendered by its members.

B. Percutaneous Cardiopulmonary Bypass (PCP):
   1. The cardiologists and/or cardiac surgeons shall initiate cannulation for the PCPs utilizing either Seldinger or Cutdown techniques in the Catheterization Laboratory, Emergency Department, ICU or Surgery. Supervision of the Cardiopulmonary Bypass will be the responsibility of the Cardiac Surgeons.
   2. A perfusionist shall be responsible for the operation of the Cardiopulmonary Support System.
   3. The Catheterization Laboratory call team and/or the open-heart team shall be called to assist with cannulation in the Catheterization Laboratory, Emergency Department or ICU.
   4. The Cardiopulmonary Support System shall be stored in the Perfusion Room with air tanks available in Catheterization Laboratory and Emergency Department.
   5. A consent for Special Diagnostic Procedures and Treatment shall be obtained prior to beginning of cardiopulmonary bypass.

C. Recommendations for Minimal Standards for Performance in the Cardiac Catheterization Laboratory:
   1. Physicians utilizing the Cardiac Catheterization Laboratory facilities shall adhere to guidelines designed to promote the efficient, safe and economical use of this area. Abuse of the schedule or equipment will result in review and recommendations by the Chief of the Cardiac Service Area and the Executive Committee of the Medical Staff.
   2. The physician in charge of the procedure shall be responsible for the general conduct of the procedure regarding insertion and position of the catheter, injection of contrast, physiology and stability of the patient and therapeutic responses during emergency situations.

D. Complications resulting in death, disability or dismemberment shall be reviewed as soon after the event as possible by all persons involved in the patient's care and a report submitted to the Service Line Leader/Medical Director for conclusions, recommendations, actions and follow-up. The review and discussion shall be performed under the "Peer Review Process", with all discussions held in confidence.

E. Pacemaker Procedures
   1. Permanent pacemaker implantation that requires fluoroscopic control (transvenous pacemaker) shall be performed in either the Cardiac Catheterization Laboratory, or the Operating Room.
   2. Pacemaker battery changes may be performed in either the Catheterization Laboratory or the Operating Room.
   3. An open thoracic approach for a permanent pacemaker implantation shall be performed in the Operating Room by Cardiovascular surgeons.
F. All patients with a diagnosis of myocardial infarction, open heart surgery, PTCA, roto blade and/or stenting are automatically referred to Phase I Cardiac Rehab, as this is the standard of care. A Physician must specifically write an order for no cardiac rehab and document the contraindications if a particular patient should not receive the standard of care. Patients are to be allowed to exercise their right of choosing a Cardiac Phase II program as part of their discharge plan.

G. The Cardiovascular Service Line Leader/Medical Director will also serve as the Chest Pain Center Medical Director.

**ARTICLE XV - EMERGENCY MEDICAL SERVICES**

A. Emergency Department (ED) physicians provide primary coverage on a twenty-four (24)-hour basis.

1. Patients presenting to the Emergency Department will receive a medical screening examination by a physician to determine if an emergency medical condition exists.
   a. The evaluation, and treatment rendered to all patients who present to the Emergency Department with an emergency medical condition is the responsibility of the Emergency physician.
   b. If the personal physician assumes responsibility for the evaluation and treatment of a patient in the ED it is their responsibility to determine a final disposition and discharge the patient from the emergency department.
   c. Patients who have been directly admitted by their personal physician and come through the ED ambulance entrance will not be evaluated by an ED physician, unless an emergency developed en route to the Hospital.

2. Patients greater than 20 weeks gestation presenting to the Hospital/Emergency Department who appear to be in labor shall immediately be transferred to the Obstetrical Labor/delivery suite. The obstetrical registered nurse shall perform an assessment and immediately thereafter notify the patient's physician/nurse midwife of the findings.
   a. Pregnant patients with complaints unrelated to pregnancy and who do not appear to be in labor shall receive medical screening and treatment in the Emergency Department.
   b. Obstetric Patients presenting to the Emergency Department including those in a trauma situation shall be triaged according to EMTALA polices.

3. If, after examining a patient, the Emergency physician determines that the patient is a candidate for admission or observation, he/she shall notify the attending physician and inform him/her of pertinent medical information regarding the patient's condition.

4. If the attending physician does not concur with the Emergency Department physician's recommendations to admit, the Emergency Department physician should:
   a. Objectively summarize to the attending physician his/her reasons for recommending the admission to assure there is no misunderstanding;
   b. The attending physician, must come to the Emergency Department and evaluate the patient.
   c. The attending physician assumes care of the patient if the disagreement cannot be resolved.
d. The Emergency Department Director may contact the Chief of the specific service if a resolution concerning patient disposition is not reached.

B. Selecting a physician for a patient who doesn't have a personal physician (or the physician does not have privileges to practice at Allen and the patient desires to stay at Allen):

   1. A patient requiring admission, who does not have a personal physician, will be referred to the physician "on call" in the applicable service. The "on call" physician must accept the patient for care of the current illness or injury. When requested by the Emergency Physician for emergency care of the patient, the "on call" physician will respond within **30 minutes**. A rotating list is available for patients requiring admission. A physician may opt to have another physician take his/her patients, with a mutual agreement.

C. A roster is posted in the Emergency Department designating the Emergency Physician/Physicians on duty and list of specialty consultants available for duty that day. The roster is updated daily.

D. The Emergency Department Physician responds to all "Code Blues" and "Code Pinks" in the Hospital, except when critical, unstable patients are in the Emergency Department; then the House Supervisor shall be immediately notified. Hospitalists also respond to Code Blues.

E. The Emergency Department physician responds to Labor and Delivery for precipitous and "imminent delivery" in the absence of the primary physician.

F. The Emergency Department Physician will provide guidance to the EMS Providers in the field via radio communication.
   1. The Emergency Department Physician may deviate from established pre-hospital protocol.
   2. Pre-hospital protocol may guide the action of the pre-hospital caregiver.
   3. The Emergency Department Physician will give orders for the care provided in the field. Conflicting opinions should be addressed immediately in a positive and educational manner in a private setting.

G. The Emergency Management Plan is a guide for the care of mass casualties at the time of a major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It will be developed by the Emergency Management Committee which includes members of the Medical Staff and a representative of Nursing Administration. The plan will be approved by the President of the Medical Staff and the President/CEO of the Hospital.

H. Screening, Treatment and Transfer of Emergency Patients:
   1. See Hospital Examination and Transfer Policy- EMTALA.

   2. Pertinent information must accompany the patient to the receiving facility. This information includes:
      a. Copies of medical record which includes a summary of all pertinent events, actions, diagnoses and treatment;
      b. Copies of the transfer forms;
      c. Copies of pertinent diagnostic studies to include lab, x-rays, CT scans, etc.
3. The physician may not be penalized for refusing to authorize the transfer of an individual with an emergency medical condition that has not been stabilized.

4. If the patient is accompanied by an RN during transport, the nurse shall record observations and treatment occurring during the transfer and present a report to the transferring facility.

5. A "Refusal of Transfer" form is available if the patient refuses to be transferred. The benefits and risks shall be clearly documented.

**ARTICLE XVI - LABORATORY/PATHOLOGY SERVICES**

A. The physician or designee requesting "Stat studies" must be available to receive the results.

B. The physician may authorize laboratory procedure results for patients who have had studies performed at another facility/laboratory to be used at Allen Hospital if that laboratory is approved by the College of American Pathologists or The Joint Commission (TJC).

C. Reference laboratories must be accredited by the College of American Pathologists (CAP) or The Joint Commission (TJC) and agree to adhere to applicable standards. A listing of reference laboratories shall be submitted to the Medical Staff Executive Committee for recommendation to the Board of Directors.

D. The usage of Blood and Blood Products will be monitored through the medical staff performance improvement process.

E. The laboratory secretaries may accept a telephone order for outpatient laboratory studies. The signed order shall be faxed or it may be brought with the patient.

F. Requests for laboratory services shall contain reasonable information from the requesting practitioner, identifying diagnosis and the reason for the examination.

G. Autopsies will be performed by a credentialed and privileged provider. The result of the autopsy will be part of the clinical outcomes report for the relevant department(s).
ARTICLE XVII - NEONATAL/PEDIATRIC SERVICES

A. The Neonatal/Pediatric Services will function under the direction of the Chief of Pediatrics Clinical Service Area.

B. In the following cases, mandatory consultations with a pediatrician or neonatologist are required for other physicians who have newborn privileges:

1. All high risk deliveries as indicated by maternal/fetal presentation.
2. Infants in the intensive care nursery.
3. A pediatrician shall be called for a Cesarean section consultation as indicated by the maternal/fetal presentation.
4. Newborns of less than thirty-six (36) weeks or birth weight less than two thousand (2,000) grams.
5. Respiratory distress and/or cyanosis lasting longer than two (2) hours or requiring ambient oxygen in excess of thirty-five percent (35%) for more than two (2) hours.
6. Infant of infected mother and the baby is symptomatic.
7. Neonatal seizures or other major CNS problems (e.g. intracranial bleed or other serious infection), subgaleal bleed
8. Suspected neonatal sepsis and/or meningitis.
10. Gastro-intestinal distress as exemplified by:
    a. Abdominal distension (moderate to severe).
    b. Other serious condition
    c. Bloody diarrhea (moderate to severe).
11. Infant of diabetic mother (if clinically significant) if persistent hypoglycemia, etc.
12. Infant of addicted mother - any baby who tests positive for drugs, when clinically significant.
14. Suspected Asphyxia
15. Apnea.
16. Hyperbilirubinemia- when the cord bilirubin is greater than 5mg/dl.
17. All critical or seriously ill pediatric patients.
18. Clinically significant or symptomatic hypoglycemia

C. Circumcision procedures may be performed by a physician with appropriate privileges after obtaining written consent from the parent(s). Analgesia/anesthesia will be used when performing circumcision according to American Academy of Pediatrics Circumcision Policy Statement.

D. Readmission to the Nursery
1. Infants born outside of the Hospital shall be assessed for possible contagious conditions before placement in the Nursery. When there is a possibility of an infectious disease, the infant shall not be in the Nursery, but room-in with the mother. If continuous nursing observation is required, the infant shall be placed in the NICU Pod 1-3.
2. Neonates transferred from another institution will be acceptable for admission to the nursery or the Neonatal Intensive Care Unit (NICU) when a physician who is a member of Allen Medical Staff agrees to accept admission, receives a report and the infant does not have a
Communicable (an infection which may be transferred from one person to another) infection. The referring physician shall contact the physician directly.

3. Neonates who have discharges to home from the hospital may be readmitted to the nursery or NICU when it is determined that they do not have a contagious infection and intensive care is required.

E. Cord blood from every infant will be sent to the Laboratory to determine fetal Coombs, ABO and Rh. If a positive Coombs is found, a serum bilirubin will be determined by the Laboratory and results sent to the Nursery as soon as possible.

F. Every newborn will have blood drawn prior to discharge to send to the Iowa State Department of Hygiene Laboratory for screening for neonatal metabolic screening. It shall be repeated if drawn previous to 24 hours of age.

G. The Level II Intensive Care Nursery is for infants who require a higher intensity of care than a normal newborn.
   a. The following infant conditions shall not be managed in this nursery and require transfer to a facility which provides such care unless the neonatologist is willing to care for the patient here:
      1. Anomalies of the heart, bowel, spine, etc., which require surgical intervention.
      2. Infants with gestational age below thirty (30) weeks.
      3. Other conditions, at the discretion of the neonatologist.
   b. All infants who require care in the Level II Intensive Care Nursery will be cared for by a pediatrician or neonatologist. The primary care physician may continue to see the infant and visit with the parents regarding the infant's condition.

H. When granted privileges a Certified Nurse Midwife (CNM) may perform a routine newborn assessment and intubation for meconium.
ARTICLE XVIII - OBSTETRICAL SERVICES

A. The Obstetrical service will function under the direction of the Maternal/Fetal service line leader/medical director who has privileges to care for Obstetrical and Gynecological patients at Allen Hospital.

B. Patients presenting to the Hospital/Emergency Department who appear to be in labor* or if more than 20 weeks gestation with a chief complaint of abdominal pain, cramping, contractions, fluid leak of vaginal bleeding shall immediately be transferred to the Obstetrical Labor/Delivery Suite. The registered nurse shall perform an assessment and immediately thereafter notify the patient's physician or nurse midwife, or the "On call" obstetrical physician of the findings.
1. The patient shall be monitored for 1-2 hours in triage. When it appears that the patient is not in active labor, a report shall be given to the physician/midwife, who may authorize the patient's discharge.
2. The discharge process in EPIC shall be followed and signed by the physician/midwife who gave permission for discharge with the date of signature.
3. Pregnant patients with complaints unrelated to pregnancy and who do not appear to be in labor shall receive medical screening and/or treatment in the Emergency Department.
4. Pregnant patients with trauma injuries shall first receive medical screening/treatment for the injuries in the Emergency Department. If the patient appears to be in labor, the ER physician shall determine the priority for treatment.
5. All pregnant patients who were involved in a trauma situation shall have an obstetrical assessment by an Obstetrical Registered Nurse, and/or midwife, and/or physician. The nurse shall report findings from the assessment to the patient's physician/midwife managing the obstetrical care. When it is determined that the patient is not in labor, the physician/midwife may authorize the patient's return to the Emergency Department or discharge from the Labor/delivery area. The disposition shall be based upon injuries and treatment.
6. A Nurse Midwife must consult a physician before transferring a patient to another facility

*"Labor" as defined by CMS in the EMTALA law: "The process of childbirth beginning with the latent or early phase of labor and continuing through the delivery of the placenta. A woman is in true labor unless a physician or nurse midwife that after a reasonable time of observation, the woman is in false labor" (A-406- Interpretative Guidelines)

C. Pathological Specimens:
1. All placentas shall be grossly examined, number of vessels and length of cords measured and documented in the medical record by the Delivery/Birthing Room staff.
2. Placentas meeting the following conditions will automatically be sent to Pathology.
   a. Maternal:
      i. Diabetes mellitus
      ii. Pregnancy-induced hypertension
      iii. Premature rupture of membranes
      iv. Post-term delivery (forty-two (42) weeks or beyond)
      v. Pre-term delivery (prior to thirty-six (36) weeks)
      vi. Unexplained fever
      vii. Poor previous obstetrical history
b. Fetal/Newborn:
   i. Stillborn
   ii. Neonatal death
   iii. Multiple gestation
   iv. Intrauterine growth retardation
   v. Congenital anomalies
   vi. Erythroblastosis Fetalis
   vii. Transfer to Intensive Care Unit
   viii. Ominous heart tracing
   ix. Presence of meconium
   x. Apgar score of five (5) at one (1) minute or below seven (7) at five (5) minutes

c. Placental/Umbilical Cord:
   i. Infarction
   ii. Placenta Abruptio
   iii. Vasa previa
   iv. Placenta previa
   v. Abnormal calcification
   vi. Abnormal appearance of placenta or cord

D. Video/audio taping is prohibited until the completion of delivery and with the approval of the physician/midwife.

E. When conducting trial labor for vaginal birth after a previous Cesarean Section (VBAC), appropriate facilities and personnel including an obstetrician, anesthesia and nursing shall be immediately available to perform and emergency Cesarean Section. (Approved by Department of Obstetrics 1/8/02, Medical Executive Committee 2/5/02)
ARTICLE XIX - PHARMACY SERVICES

A. All medications require a minimum review for renewal every 30 days. Medications that are considered higher risk or that have been determined to need more frequent review will be determined by the Pharmacy and Therapeutics Committee.

B. A Hospital Formulary System shall exist which is the mechanism by which the Pharmacy and Therapeutics Committee and Quality and Performance Improvement Committee provide a broad array of drugs for meeting clinical needs while avoiding duplication of therapeutic efforts.

1. Hospital Formulary document: A document shall be developed, consisting of a list of currently available drugs and a compilation of formulary policies adopted by the Medical Staff.
2. Addition of drugs to the formulary: A request to add a product not currently available to the formulary can be made by any physician or pharmacist by completing a "Formulary Drug Request" and submitting it to the Pharmacy and Therapeutics Committee for initial review and recommendation.
3. Quality and Performance Improvement Committee shall approve therapeutic substitutions, dosing adjustments therapeutic interventions and formulary recommendations proposed by the Pharmacy and Therapeutics Committee.

C. "Meds as at home", "Resume meds" and other blanket orders are not valid orders. An order for a medication that is to be given in the hospital must include: Date, time, drug name, dose, route, frequency, special instructions for PRN medications and a physician’s signature.

D. Home medication orders on admission are to be verified and approved by a physician or midlevel provider before they are to be filled and dispensed for administration to the patient. Discharge medication orders are to be listed out to provide the patient with an exact list of the medications they are to be taking at home after discharge. The medication reconciliation policy is to be followed for all phases of care through the hospital inpatient and outpatient setting. (Pharmacy Inpatient Policy and Procedure Medication Reconciliation)

E. The Hospital Policy for Moderate/Deep (Conscious) Sedation shall be observed.

F. The Patient Care Policy Intravenous Administration of Medications and Patient Care Policy Intravenous Administration of Medications for Pediatrics shall be observed by members of the Medical Staff.

G. In specific cases, a few medications may be administered one time without a physician order. These medications are listed in the Patient Care Policy Medication Policies. These medications are considered standing orders and do require a physician signature either prior to discharge or within 30 days post discharge.

H. Placebos shall not be administered. (Patient Care Policy Placebo Use)
ARTICLE XX - PSYCHIATRY SERVICES

A. Patients with acute psychiatric conditions, including substance abuse and/or when the patient may be assessed to have a potential for causing harm to self or others, may be admitted to the applicable nursing unit including the Medical Health Unit directly, dependent upon the patient's condition.

1. Patients with a primary substance abuse/intoxication problem may be admitted to the Intensive Care Unit, to a general medical or surgical unit, or the Mental Health Unit depending upon the patient's condition and the treatment plan of the attending and/or consulting physician.

2. Patients may be admitted to the Mental Health Unit only by a psychiatrist who has privileges to practice at Allen Hospital. The psychiatrist may consult another medical staff member to provide medical management for the patient.

3. Because there is not specific space allocated for children, children under the age of 15 shall not be admitted to the Mental Health Unit.

B. Multidisciplinary team psychiatric/substance abuse patient care conferences are held weekly and more often as needed for the purpose of identifying patient problems, setting goals, planning actions and therapeutic approaches and planning for discharge. A psychiatrist is involved in and approves the multidisciplinary treatment plan.

C. Patients requiring involuntary commitment shall be managed according to the Iowa Code.

D. Psychosurgery or other surgical procedures to alter or intervene in an emotional, mental or behavior disorder shall not be performed at Allen Hospital.

E. Behavior modification procedures that use aversive conditioning shall not be performed at Allen Hospital.

F. Restraints and Seclusion: The Hospital policy Restraint and Seclusion shall be followed.

G. Electroconvulsive Therapy:

1. Electroconvulsive therapy must be ordered and administered by a psychiatrist. Prior to administering a series of electroconvulsive therapy, the following work-up will be completed:

   a. Medical history and physical by a physician, documentation in the patient's medical record, his/her concurrence with the decision to administer such therapy when patient's physical condition warrants;
   b. Chest X-rays;
   c. Dorsal and lumbar spine;
   d. Electrocardiogram;
   e. Laboratory - CBC, sodium, potassium (within seventy-two {72} hours);
   f. Consent from patient/close relative. If patient signs consent, additional consents from close relative is preferable; and,
   g. Teaching documentation.
2. A member of the anesthesia team shall evaluate the patient prior to each electroconvulsive treatment and document the assessment on the medical record.

3. Electroconvulsive therapy is administered in the Post Anesthesia Care Unit (PACU). An anesthesia team member, psychiatrist, PACU nurse and are in attendance. The intravenous medications are administered by the anesthesia team member.

4. Electroconvulsive therapy shall not be administered to children or adolescents (under age fifteen {15}) at Allen Hospital.

ARTICLE XXI- RADIOLOGY/NUCLEAR MEDICINE SERVICES

A. The Chief of the Radiology/Nuclear Medicine Clinical Service Area shall be responsible for the enforcement of the Clinical Service Areas Rules and Regulations.

B. Requests for radiological services shall contain specific information from the requesting practitioner identifying diagnosis and the reason for the examination in order to assist the radiologist in interpretation of the images.

- All radiological examinations shall have an interpretation by a radiologist, except in the incidence of those specialized procedures, including fluoroscopy, performed by other physicians who are granted privileges for those specific procedures.

C. The Emergency Department will be notified of all discrepancies with the initial ER physician interpretations.

D. A radiologist is "on call" 24 hours a day, 7 days a week.

E. A telephone order for an outpatient procedure(s) may be given to the Radiology receptionist, with a copy of the order faxed to the department, or it may be brought with the patient.
ARTICLE XXII – SURGICAL SERVICES

A. The anesthesiologist and/or surgeon will order specific laboratory and other studies as indicated by the patient’s physical status.

B. Reports from Radiology and other procedures taken outside of the Hospital, before admission, or in previous hospitalizations, pertinent to the condition of the patient should be incorporated in the chart before the time of surgery.

C. An operative/procedure report, fully describing the surgical procedure, pre-procedure and post-procedure diagnoses shall be prepared by the physician who performed the procedure within 24 hours after the procedure had been completed. A post op progress note shall be entered in the Physician Progress Notes of the patient’s chart immediately after completion of the procedure.

D. Surgical Specimens
   a. Any specimen that physician requests be sent to Pathology shall be sent.
   b. In order to comply with laws regarding biohazardous and chemically hazardous materials, pathological specimens shall not be given to patients and families. They shall remain the property of Allen Health System Inc. and shall be disposed following hospital policy and federal/state laws.
   c. All specimens removed during a surgical procedure (except those designated for bone bank and those listed below) shall be sent to the Hospital Pathology Department, where such examination shall be made as considered necessary for a pathological diagnosis.
   d. The following specimens do not require submission, unless requested by the surgeon:
      • Orthopedic Appliance
      • Bone Fragments from foot surgery
      • Bone chips, disc from laminectomies
      • Cartilage removed during arthroscopies
      • Cataracts
      • Adipose tissue from plastic surgery
      • Vaginal mucosa from vaginal plastic surgery
      • Fragments from fractures (except pathological fractures)
      • Foreskin under 20 years of age
      • Hernia Sacs
      • Intrauterine contraceptive devices
      • Nasal bones and cartilage
      • Teeth
      • Prosthesis (breast, joint, nasal)
      • Pacemakers
      • Radioactive source
      • Toe nails
      • Items considered evidence such as bullets and other foreign substances see hospital policy Receipt and Release of Evidence.
      • Ribs incidental to thoracic procedure
      • Plaque form vascular procedure
      • Tonsils and/or adenoids
- Total knee and total hip tissue
- Exostosis (tori)
- Bone and soft tissue during routine alveoplasty or perio-osseous reconstruction
- Carious tissue
- Bone removed from Le Forte or sagittal split osteotomies for treatment of malocclusion
- Hyperplastic gingiva induced by drugs i.e. dilantin
- Varicose veins
- Vagina from a/p repair
- Foreign bodies

F. The operative site and procedure shall be identified following the Patient Care Policy/Procedure Correct Site, Correct Procedure, Correct Person – Invasive Procedures.

G. Only authorized personnel shall be permitted in the operating and delivery rooms, unless specifically approved by the surgeon or obstetrician in charge of the case and the patient. The Surgery Department policy describes the protocols for observers in the operating room.

H. All previous orders are placed on hold when patients go to surgery. Orders may then be resumed, modified, or cancelled postoperatively by the surgeon or midlevel provider.

I. A mandatory OB consult with patients obstetric provider or designee for any pregnant patients greater than 20 (twenty) weeks gestation having non-OB related surgery, elective or emergent. Post-op monitoring will be decided by the consultant on an individual basis depending on the patient and the procedure.
ARTICLE XXIII - TRAUMA SERVICES

A. The Trauma Service shall be under the direction of a physician designated by the Hospital President/CEO and approved by the President of the Medical Staff.

B. The Qualifications/responsibilities of the Trauma Service Director are:
   - A Board Certified general surgeon, licensed to practice medicine in the State of Iowa.
   - Conducts or coordinates and documents trauma case reviews. Coordinates the review records of all trauma patients who are transferred.
   - Coordinates the peer review process of trauma cases.
   - Reviews all trauma deaths to determine if management was appropriate and/or if the death was preventable, potentially preventable or non-preventable.
   - Participates in the development of action plans based on Performance Improvement findings, re-evaluates the trauma implementation plans of action.
   - Actively participates in the development of standards of care for the trauma patient.
   - Involved in community education related to trauma or prevention as requested.
   - Recommends educational programs for the Medical Staff.
   - Meets all qualifications for trauma surgeons as identified in E.

C. The Director, by virtue of his/her position shall be a voting member of the Executive Committee of the Medical Staff.

D. The Trauma Services Committee shall meet at least quarterly to review trauma cases, protocols and/or present educational programs. The responsibilities and membership of this Committee are discussed in the Medical Staff Bylaws. (Article 17.5)

E. Members of the trauma team must obtain 24 hours of continuing trauma education every 4 years to include:
   1. 8 hours formal (ATLS refresher course required),
   2. 16 hours informal as determined and approved by a trauma care facility from any of the following:
      a. Multidisciplinary trauma case reviews;
      b. Multidisciplinary trauma conferences;
      c. Multidisciplinary trauma mortality and morbidity reviews;
      d. Multidisciplinary trauma committee meetings;
      e. Trauma peer review meetings;
      f. Any trauma care facility committee meeting with a focus on trauma care evaluation; and
      g. Critical care education such as ACLS course, PALS course, NRP course, or equipment services.

F. A general surgeon shall attend patients who are admitted with multiple-system/major trauma for at least the first twenty-four (24) hours. Further follow-up is dependent upon the nature of the injuries sustained by the patient. Other specialty physicians (i.e. neurosurgery, orthopedic surgery) may be consulted by the general surgeon to provide care for the trauma patient and may assume primary care of the patient once the general surgeon has determined that no further general surgery intervention is required.
G. The patient's primary care provider shall be notified and may be called as a consultant to manage the patient's medical conditions. If the patient is stable and the general surgeon has determined that further general surgical intervention is not required, the management of the patient may be turned over to the primary care provider providing there is mutual agreement between physicians.

H. A physician with obstetrical privileges shall be consulted for pregnant patients of greater than 20 weeks gestation who have sustained trauma.

I. The Emergency Physician shall determine when a "trauma alert" shall be called. In the event of multiple victims, the Hospital’s Emergency Management Plan shall be initiated as determined by the officer in charge of the Hospital.

J. When indicated, an autopsy should be requested for all trauma deaths occurring in the Emergency Department, even though it may not be ordered by the Medical Examiner

**ARTICLE XXIV - CARDIO-PULMONARY RESUSCITATION REQUIREMENTS**

Requirements and completion of courses online are specific by specialty and must be met within 6 months of becoming a member of the medical staff or being granted privilege(s). Recertification as required by each program is required.

1. Midlevel providers shall follow the same cardio-pulmonary resuscitation requirements as their sponsoring physician.

2. Locum tenen providers shall be subject to the same cardio-pulmonary resuscitation requirements as members of the medical staff.

ACLS - Acute Cardiac Life Support
ATLS - Acute Trauma Life Support
BLS - Basic Life Support

NRP - Neonatal Resuscitation Program
NRP - Neonatal Resuscitation Program
PALS - Pediatric Advanced Life Support
ARTICLE XXV – RED RULES

Red rules are rules that cannot be broken. In highly reliable industries, red rules are few in number, easy to remember, and associated only with processes that can cause serious harm to employees, customers, or the product line. The red rule must be followed exactly as specified. Every staff member, regardless of rank or experience in the hospital, is expected to stop the task or procedure if the red rule is violated. This is the most important aspect of a red rule: to empower any employee to speak up when the rule is not being followed and to stop the line. All violations of a red rule are mediated through a Just Culture approach in which the hospital employee or medical staff member’s behavioral choice—in this case, breaking a red rule—is evaluated to determine if it was caused by human error, at-risk behavior, or reckless behavior, regardless of staff member's rank, popularity, and importance to the hospital. Red Rules at Allen Hospital are applicable and enforceable for all Allen employees and Medical Staff Members

Purpose: To outline the Allen Hospital Red Rules and the steps taken when one of the rules is violated.

Policy:
Allen Hospital has five Red Rules:
1. Mutually Respectful Behavior: Every person at Allen Hospital will be treated with respect.
   
   A Medical Staff Member exhibiting respectful behavior:
   - Remains approachable at all times
   - Treats team members with respect
   - Conveys criticism in a constructive, professional, and respectful manner and in good faith with the aim of improving patient care and safety
   - Handles difficult team members effectively
   - Is open to suggestions
   - Responds to conflict by working out solutions
   - Adapts to changing policies, procedures, and priorities

   Disruptive behavior violating Red Rule Number One includes but is not limited to:
   - Displaying anger inappropriately, including throwing instruments, charts, or other objects
   - Using verbal or written foul language, racial and ethnic slurs, sexual comments or other abusive language.
   - Humiliating, intimidating, or degrading another individual
   - Engaging in unwelcome or inappropriate physical contact
   - Physical abuse directed at patients or staff

2. Respond When Called: It is never appropriate for a provider at the bedside to observe unexpected patient deterioration and be unable to get help or reassurance. If you are called to provide that help or reassurance, you must do so, being certain the concerns of the provider seeking help have been addressed. During this process, if the provider’s concerns are not resolved and you are asked to come personally to bedside, you must do so, unless doing so would jeopardize the health or safety of another patient. If you are unable to immediately provide assistance, it is required that you offer other available options pending your availability.
3. **Time Out**: Every procedure is preceded by verification of patient identification, procedure, and site of procedure.

4. **Missing in O.R.**: Any question of a missing object in the O.R. requires site appropriate radiographic imaging prior to patient departure from O.R.

5. **Two IDs for Blood**: Infusion of any blood product requires identification of the patient and blood product by two independent observers.

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**Procedure**

1. Nurses, staff, patients, and other physicians may report a violation of the Red Rules to the Risk Manager or to the unit department head to forward to the Risk Manager.

2. When an occurrence report is received by Risk Management and involves a Member of the Medical Staff, the Risk Manager will proceed as follows:

   - Draft a summary and forward this to the VP/Chief Quality Officer or designee. The VP/Chief Quality Officer or designee will conduct an informal investigation process, including staff interviews with assistance from Risk Management if necessary. During the inquiry, the VP/Chief Quality Officer or designee ascertains the complaint’s level of severity and validity.
   - If validated, the VP/Chief Quality Officer or designee will contact the alleged offender to review the summary with him/her, provide him/her a copy of the occurrence report and invite him/her to submit a written or verbal report addressing the occurrence report;
   - The alleged offender will be required to sign a non-retaliation clause against the reporting person or individuals involved in the informal investigation. Failure to sign or honor the non-retaliation clause will incur disciplinary action.
   - During this informal mediation, the VP/Chief Quality Officer or designee may expect an acknowledgement of the facts of the event and an action plan toward remediation, with documentation of the corrective action. Resolution may involve a mediated meeting, formal apology, or other educational or behavioral interventions per the VP/Chief Quality Officer or designee judgment. Corrective actions of the first and second offense may be closed with tracking and trending via a providers performance improvement file for review at the next recredentialing cycle. The President of the Medical Staff shall be informed of such remediation, and may escalate the process further to Grievance Committee.

3. Periodic update of the status of the investigation to be given to the parties involved at a minimum of bi-weekly intervals. If the VP/Chief Quality Officer or designee cannot broker resolution the complaint is passed to the grievance committee.

4. The Grievance Committee will be made up of the following voting membership:
   - Medical Staff President or designee, who will serve as chair
   - Chairperson of the appropriate clinical department or designee
   - CEO or designee
   - Chief Medical Officer (VP/Chief Quality Officer)
   - Additional Medical Staff Members as needed to achieve a gender balance of no less than 40% of each gender, if appropriate for the specific incident.
• The Unit Director on which the incident occurred is invited to attend the meeting to present the occurrence report and answer questions. S/He is excused prior to the committee's deliberations.
• Allen Health System Board Member

5. The grievance committee must meet within 10 business days of the date the complaint is passed on to the committee.

6. The committee may request that a more formalized investigatory process commences by the VP/Chief Quality Officer including speaking to the person bringing the complaint and the alleged offender.

7. The committee then decides whether or not the complaint has merit based upon the investigation. Among the key factors considered will be witnesses able to substantiate the claim.

8. Any individuals filing a false report with the intention of injuring or defaming the reputation of a physician will face disciplinary action as laid out in Discipline Action policy.

9. If the complaint is found to be valid, the committee will debrief with the offender and recommend corrective action described below.

10. Corrective Action:
• First Offense – Collegial discussion by Chief of Service, President of Medical Staff, and/or VP/Chief Quality Officer regarding the infraction, Red Rules and consequences.
• Second Offense – Written warning from the President of Medical Staff or VP/Chief Quality Officer requiring signature acknowledging Red Rules and consequences.
• Third Offense – Suspension of privileges for two weeks and attend anger/behavior management or other appropriate education recommended by medical staff leaders and administration. Initial assessment for anger/behavior programs and any interventions deemed appropriate as a result will be performed at the expense of the Medical Staff member. Failure by the medical staff member to attend and complete recommended counseling or educational programs will result in an additional two week suspension of medical staff privileges.
• Fourth Offense – Revocation of medical staff privileges. (Reportable)

Based upon the severity of the infraction, the VP/Chief Quality Officer, President of the Medical Staff, and/or the Grievance Committee may recommend a disciplinary action above the standard step process.

This corrective action procedure is strictly for infraction of Red Rules and does not alter or replace the corrective action policy as laid out in the Medical Staff By-laws. Corrective action taken will also not alter or replace any potential legal actions that may be taken against a Medical Staff Member as a result of a violation.

11. The involvement of the Grievance Committee is required for third or fourth offense level disciplinary action.
12. The findings of the VP/Chief Quality Officer, Medical Staff President and/or Grievance Committee will be placed in the performance improvement file separate from the credentials file for review by the Hospital Credentials Committee at reappointment.

13. All information relating to the incident, the findings of the committee and information regarding the resolution of the problem are to be kept confidential and only available to those parties involved in investigating and resolving the problems.

14. Once a resolution is achieved either through informal mediation with the VP/Chief Quality Officer or the grievance committee, the VP/Chief Quality Officer follows up with the complainant to give a general debriefing of the resolution.

15. Medical Staff members will revert back one disciplinary level every two years from the date of the last violation as long as no additional Red Rules violations occur during that period.

16. The Red Rules will also be applicable to Medical Staff Residents at Allen Hospital, however, the VP/Chief Quality Officer will report founded allegations of violations to the residency program which will be responsible for disciplinary actions.

Effective Date – August 17, 2009, Revised November 23, 2010

**ARTICLE XXVI – DELINEATION OF SERVICE LINES AND ASSIGNMENT TO SERVICE LINES**

The Medical Staff shall be divided into the following service lines Cardiovascular, Medicine, Critical Care, Emergency Department, Behavioral Health, Mother/Child and Surgery.

**ASSIGNMENT TO SERVICE LINES**

Members are assigned to a specific service line according to their specialty

The following specialties are members of the Medicine Service Line:
- Endocrinology
- Family Medicine
- Gastroenterology
- Hematology
- Infectious Diseases
- Internal Medicine
- Nephrology
- Neurology
- Oncology
- Palliative Care
- Physical Medicine/Rehabilitation

The following specialties are members of the Surgery Clinical Service Area:
- Dentistry
- General Surgery
- Ophthalmology
- Otolaryngology
- Plastic Surgery
- Urology
- Orthopedic Surgery
- Podiatry
- Neurosurgery
- Anesthesia
- Radiology
- Wound Care
- Pain Management
- Pathology
The following specialties are members for the Behavioral Health Service Line
   Psychiatry

The following specialties are members for the Mother/Child Service Line
   Obstetrics
   Gynecology
   Pediatrics
   Neonatology

The following specialties are members of the Cardiovascular Service Line:
   Cardiology
   Cardiac Surgery
   Thoracic Surgery
   Vascular Surgery
   Interventional Radiology

The following specialties are members for the Emergency Department Service Line
   Emergency Medicine
   Occupational Medicine

The following specialties are members for the Critical Care Service Line
   Critical Care
   Pulmonology

**ARTICLE XVII – MALPRACTICE INSURANCE**

Proof of current malpractice liability insurance is required for membership in amounts jointly agreed upon by the Medical Executive Committee and the Board of Directors.

A minimum of $1,000,000/3,000,000 will be required in order to maintain membership on the medical staff.

**ARTICLE XXVIII – CALL COVERAGE REQUIREMENTS**

- 1 provider in a specialty 7 days per month including 1 weekend
- 2 providers in a specialty 18 days per month, including 2 weekends
- 3 providers in a specialty full coverage
ARTICLE XXIX – OTHER APPOINTMENTS

Medical Directors of Clinical Services

1. A physician may be requested by Hospital Administration to be a medical director for specific clinical services. The physician services are contractually between the hospital and the physician.

2. Responsibilities of the medical director are delineated in their contract.

ARTICLE XXX – PEER REVIEW PROCESS/IMMUNITY

Section 1- Interpretation

It is the intention of this article to define the term “peer review” or “review by peers” in the broadest terms and to secure to those who engage in any aspect of review in, at, for, or on the behalf of the hospital and its medical staff, the broadest possible privilege and immunity from liability. This Article will be interpreted to effectuate this objective. The privileges and immunities set forth in this Article shall be cumulative of other protections provided by law.

"Peer" is defined as a person who has equal standing with another person, or other persons, as in education, age, training, rank or status. In quality of care reviews, peers are defined as professionals in the same specialty of professional practice or a related specialty.

Section 2- Authorization and Release

The following shall be express conditions on the application for, or the holding or exercise of, membership or privileges at the Hospital. Each applicant hereby expressly:

1. Authorizes the hospital and its authorized representatives to request, receive, furnish, discuss, consider, and act upon relevant information bearing upon such practitioner’s qualifications and performance.

2. Releases from Liability to the fullest extent permitted by law, the hospital and its authorized representatives for requesting, receiving, considering, discussing, furnishing or acting upon information as authorized above in connection with the peer review functions of the Hospital and its medical staff.

3. Authorizes and directs any other hospital, institution, organization, or individual to furnish information and releases from liability any of the above for furnishing such information, when reasonably believed to relate to the peer review responsibilities of the Hospital and its Medical Staff.

4. Agrees to be bound by the provisions of this Article in connection with application and corrective action proceedings.

5. Agrees to furnish all information in his or her possession regarding any other practitioner in connection with, and to participate according to assigned responsibilities in the peer review functions of this Hospital and its medical staff.

6. Pledges to maintain the confidentiality of the minutes, records and work product of the Hospital and its medical staff related to peer review. This provision will not be construed to prohibit mandatory disclosures to government, professional organizations or other providers made in the context of peer review at this Hospital or elsewhere.
As used in this Section, the term “this hospital and it authorized representatives” include the members of the Board of Directors and their appointed representatives, the President/CEO and his/her designee(s), any hearing officer, presiding officer, service line leaders/medical directors, members of any hearing committee, consultants to the Hospital, the hospital’s attorney(s) and his/her staff and partners and all members of the Medical Staff. The term also includes allied health practitioners and Hospital employees who have responsibility for obtaining, giving, evaluating, or acting upon information in the peer review context or who otherwise participate or provide information.

Section 3
Multidisciplinary Peer Review

A. **PRC Constitution:**
A peer review committee (PRC) will be comprised of multiple disciplines from the medical staff including but not limited to a representative (chief of service, if possible) from internal medicine, surgery department, emergency department, family medicine, nephrology, cardiology, and critical care medicine. This could be composed of the service line dyad physicians. Additional members will include the president of the medical staff and chairs of the credentials committee and Quality and Performance Improvement Committee. Additional appropriate members may be requested to participate. PRC will be chaired by President of the Medical Staff. A quorum of 5 members will be required. Physician of interest in case being reviewed is required to attend.

B. **Information Privileged:**
All statements, disclosures, reports, recommendations, and other communications made in connection with peer review activities of the Hospital shall, to the fullest extent permitted by law, be confidential and privileged from further disclosure, except as otherwise provided in this document.

C. **Indications for Peer Review**
1. Each case in which there is suspected deviation from standard of care or professional practice, an adverse outcome or failing to meet the established criteria for management, or a patient or provider complaint shall be reviewed.
2. Each service line and the QI Department shall determine which clinical outcome indicator(s) require peer review.
3. All unexpected mortalities occurring during hospitalization or immediately after discharge (when known) shall be reviewed. Initial screening criteria may be implemented to determine when physician peer review is required.

D. **Peer Review Process**
1. Information shall be abstracted from the medical record by a Quality Improvement staff member. The appropriate chief of service or his/her delegate (if chief of service has a conflict of interest or is not available), or VP/Chief Quality Officer or delegate will review the abstract and medical record. After the review, the physician shall record the findings on the Peer Review form. The reviewing physician or VP/Chief Quality Officer may determine if appropriate to forward case to multidisciplinary peer review committee (PRC). The chair of PRC will refer the case to appropriate members of the committee who will review the case prior to the meeting and come prepared to present and discuss the case. The chair will also ask a reviewing member to present the case at PRC. The physician(s) will be notified that the case has been referred to PRC.
and the nature of the concern that prompted the referral, at least 15 days prior to the meeting of PRC. (The physician(s) will be allowed to attend and participate in the PRC discussion.) The review must be completed within 45 days after being requested.

2. When a concern has been validated by the PRC.
   a. The chair shall determine the action(s) to be taken:
      i. A letter sent to the physician indicating closure of the case without further investigation or action.
      ii. Collegial discussion between the physician and the Chair.
      iii. A letter sent to the physician addressing identified concerns and requesting a written response.
      iv. Submission of case for external review.
      v. Case referred to Credentials Committee for review and action.
   b. Non-physician attendees, except the Director of Quality Improvement and an Administrative Representative, shall be excused from the meeting following initial presentation and information gathering. The exception is when hospital staff are requested to participate in the discussion. All discussions at the meeting shall be maintained as confidential, and not discussed outside of the meeting.

3. Peer review conclusions are recorded and monitored over time with evaluation of the findings used during the re-appointment process. When necessary, an interim evaluation of the physician’s performance may be conducted at any time.

E. Reporting of Peer Review Findings:
   All documents containing recommendations and actions shall be placed in the practitioner’s performance improvement file.

   All cases discussed at meetings shall be recorded in the minutes with findings, conclusions, recommendations and actions. The patient’s name and medical record number, as well as the practitioner’s name shall not be recorded.

Revised 07-16-10

ARTICLE XXXI – PRIVACY RULES APPLICABLE TO PRACTITIONERS

The hospital has adopted a formal Compliance Plan to address its responsibilities under the privacy and security standards of the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”). Parts of the Compliance Plan are made applicable to practitioners at the Hospital by this Rule.

A. Definitions
   “Practitioner” means an individual granted clinical privileges at the Hospital.

   “Covered Practitioner” means a Practitioner who is directly regulated as a Covered Health Care Provider under HIPAA.

   “Non-Covered Practitioner” means a Practitioner who is not directly regulated by HIPAA.
“Protected Health Information” means individually identifiable health information about an individual, regardless of whether it is gathered, stored or transmitted in written, electronic, or even oral form.

“Health Care Operations” means those activities with Practitioners engage in on behalf of the Hospital, such as Hospital and Medical Staff quality improvement, utilization management, peer review and similar functions, which involve access to Protected Health Information. Medical Staff committee and service line activities are typically Health Care Operations.

“Patient” means the individual whose information is protected under HIPAA (usually a registered inpatient or outpatient). The term includes personal representatives entitled to make health care decisions on behalf of individuals.

“Workforce” means for this Rule, Practitioners who are employed by the Hospital or provide services under the direct control of the Hospital.

B. Coverage: All Practitioners are covered by this Rule. Practitioners who are Covered Practitioners are also subject to subsection C and automatically participate with the Hospital in an organized health care arrangement as described below, unless they are members of the Hospital’s Workforce. Practitioners who are Non-Covered Practitioners are subject to subsection D and must provide the Hospital with a signed business associate agreement. All Practitioners are subject to the rules governing information practices in subsection E.

C. Organized Health Care Arrangement. The Hospital is a clinically integrated care setting in which individuals typically receive health care from Hospital personnel and Practitioners. As permitted under HIPAA, all Covered Practitioners will participate with the Hospital in an organized health care arrangement or “OHCA” with the following characteristics”

1. **Description.** The OHCA is an arrangement among the Hospital and Covered Practitioners under which
   i. They satisfy their separate notice and acknowledgement requirements under HIPAA by posting and delivery a joint Notice of Privacy Practices and obtaining or documenting efforts to obtain a single acknowledgement of receipt of the Notice of Privacy Practices:
   
   ii. They individually agree to follow the information practices described in the joint Notice of Privacy Practices; and
   
   iii. Covered Practitioners may access and use Protected Health Information from Hospital records in order to perform Health Care Operations.

2. **Subject Matter.** The arrangement covers only information practices related to:
   
   i. Inpatient and outpatient encounters at the Hospital involving Hospital patients; and
   
   ii. Health Care Operations of the Hospital.

Records and designated record sets covered by the arrangement consist of existing Hospital records and designated record sets identified in Hospital policies and procedures.
3. **Excluded Subjects.** This arrangement expressly does not cover:

   i. Information practices, Protected Health Information, records and designated record sets of Practitioners and their practice groups relating to their private office practices or their other (non-Hospital) practice sites – for example, their separate office clinical and billing records or their records or practices at other hospitals and facilities.

   ii. Activities other than information practices - for example, this arrangement does not pertain to the actual care or services provided by the Practitioners. Under no circumstances shall this Rule or the organized health care arrangement imply joint and several responsibility for clinical services or alter in any way the independent status of the Practitioners in the OHCA to one another.

4. **Service Delivery Sites.** The arrangement covers services delivered at all service delivery sites owned and operated by the Hospital.

5. **Joint Notice of Privacy Practices.** The Hospital’s Notice of Privacy Practices will be drafted to describe the organized health care arrangement and its participants and to serve as the joint Notice of Privacy Practices. The Notice will:

   i. Describe service delivery sites covered by the Notice of Privacy Practices;

   ii. Describe the participants in the organized health care arrangement; and

   iii. State that the joint Notice of Privacy Practices covers only Hospital sites and records and does not cover the information practices of Practitioners in their offices or at other sites.

6. **Acknowledgement.** The Hospital, following its established policies and procedures, will be responsible to obtain or document reasonable efforts to obtain the patient’s signed acknowledgement of receipt of the Notice of Privacy Practices.

7. **Agreement.** Requesting, holding or exercising privileges at the Hospital constitutes agreement on the part of each Covered Practitioner to participate in the organized health care arrangement with the Hospital.

D. **Business Associate Agreements.** Non-Covered Practitioners, in order to participate fully in health care operations, must execute and return a business associate agreement on Hospital’s standard form and thereafter comply with the terms and assurances therein.

E. **General Terms.** The following terms apply to all Practitioners:

1. **Notice of Privacy Practices.** The Hospital’s Notice of Privacy Practices governs access to and use and disclosure of Protected Health Information by all Practitioners when using Hospital Protected Health Information or engaging in activities at the Hospital.

2. **Disclosures for Treatment and Payment Purposes of Practitioners.** As a convenience to Practitioners, the Hospital may furnish Protected Health Information to Practitioners, and Practitioners may request, use and disclose Protected Health Information from the Hospital, for the treatment and payment purposes of such practitioners, without consent, authorization or other special permission, provided that the following conditions are met:
i. The requesting Practitioner must have or be about to have a treatment relationship with the Patient supporting the need for the information.

ii. The Practitioner (and those for whom the Practitioner is responsible) must use and disclose information furnished by the Hospital solely for treatment or payment purposes.

iii. The manner of furnishing Protected Health Information to Practitioners for their treatment and payment purposes will be per guidelines or arrangements established by the Hospital.

iv. Each Practitioner who is subject to this Rule will be presumed to meet the conditions for disclosure, unless the Hospital has information of a pattern or practice by such Practitioner (or his or her group) constituting a material breach of this Rule.

3. Voluntary Restrictions. From time to time, Patients may request that the Hospital voluntarily accept restrictions or limitations on how it uses or discloses Protected Health Information about the individual. The Hospital has designated the Hospital’s Privacy Officer to receive and act on such requests. No individual Practitioner may agree to or accept voluntary conditions or restrictions requested by the Patient, if the effect could be binding on the Hospital or other Practitioners. All requests for acceptance of voluntary conditions or restrictions must be referred to the Hospital for consideration and processing.

4. Reporting and Mitigation. Practitioners must promptly report to the Hospital’s Privacy Officer any improper use or disclosure of Protected Health Information constituting a material breach of this Rule of which they have first-hand knowledge in order that the Hospital may determine whether any harmful effects may be mitigated. This reporting requirement includes improper use and disclosure by the reporting Practitioner, members of his or her office staff (with respect to Hospital Protected Health Information covered by this Rule), other Practitioners and members of the Hospital’s Workforce.

Each Practitioner must cooperate in efforts to mitigate the harmful effects of any improper use or disclosure attributable to such Practitioner or people for whom such Practitioner is responsible, such as member of his or her office staff.

5. Access Controls. Practitioners are responsible, in addition to the requirements in this Rule, to follow all access controls established at the Hospital. Where policies permit access by members of a Practitioner’s office staff, Practitioners will be responsible for the compliance of their office staff.

6. Investigations and Sanctions: Unrestricted access to the medical records system is the means to provide patient care within the hospital system. As such, the Medical Staff retains control of that access through its usual credentialing and privileging responsibility. Any concerns regarding possible improper or inappropriate access to the medical record system by a member of the medical staff will be investigated within 30 days by the Chief Medical Officer, Chief Medical Information Officer, or the President of the Medical Staff. After investigation, if a serious concern remains, the member will be invited to give a written response for the next scheduled credentials committee meeting. The Member may be invited to appear directly. The Credentials Committee will then preliminarily decide on an action plan for the provider, and give their recommendation to the Medical Executive Committee. Sanctions could include a
verbal or written warning, temporary suspension of privileges for a period of up to 29 days, or a longer than 30 days restriction or permanent revocation of privileges. The Medical Executive Committee will review the Credentials Committee report and give a final recommendation for action to the Board of Directors for final determination. A restriction longer than 30 days or a permanent revocation of privileges will trigger rights for the fair hearing process as outlined elsewhere.

7. **Other Policies Applicable to Medical Staff.** Practitioners are also subject to other Hospital and Medical Staff Bylaws, Rules and Regulations, and policies and procedures which by their terms are applicable to Practitioners and members of the Medical Staff.

**ARTICLE XXXII - QUESTIONS RE: MEDICAL MANAGEMENT**

If a staff nurse has reason to question the medical care provided to a patient, his/her immediate supervisor shall be notified.

The immediate supervisor shall notify the Clinical Director or House Supervisor.

The Clinical Director or House Supervisor shall either direct the nurse to contact the physician or contact the physician directly.

If following the discussion with the physician, questions still persists, the Clinical Director or House Supervisor shall call the Medical Director or Medical Advisor or Clinical Service Chief of the unit/area concerned.

If unable to contact the Medical Director or Medical Advisor or Clinical Service Chief, or if questions still persist, administration shall be notified and will decide whether or not the President of Medical Staff should be contacted.

If administration is unable to contact the President of Medical Staff, or the issue is not resolved, the President of the Hospital will be contacted.

**ARTICLE XXXIII – THE JOINT COMMISSION (TJC) NATIONAL PATIENT SAFETY GOALS**

Physicians shall adhere to the requirements of The Joint Commission (TJC) national patient safety goals as appropriate to services provided.

**ARTICLE XXXIV – CENTERS FOR MEDICARE & MEDICAID SERVICES (CMS) EVIDENCE BASED BEST PRACTICES**

Physicians shall adhere to the requirements of Centers for Medicare & Medicaid Services (CMS) Evidence Based Best Practices as appropriate to services provided. (I.e. AMI, CHF, SCIP, PN and others as approved)
ARTICLE XXXV – FOCUSED PROFESSIONAL PRACTICE EVALUATION (FPPE)

I. PURPOSE:

To establish a systematic process to ensure that there is sufficient information available to confirm the current competency of practitioners initially granted privileges at Allen Hospital. This process, termed Focused Professional Practice Evaluation (FPPE) will provide the basis for obtaining organization-specific information of current competence for these practitioners.

II. PROCEDURE:

A. Medical Staff Oversight:

The credentials committee is charged with the responsibility of monitoring compliance with this policy and procedure. It accomplishes this oversight by receiving regular status reports related to the progress of all practitioners required to be proctored as well as any issues or problems involved in implementing this policy and procedure. The service line leader/medical director shall be responsible for overseeing the proctoring process for all applicants assigned to their department.

Information collected for Ongoing Professional Practice Evaluation (OPPE) will also be collected for these new practitioners or privileges and will be sent to the credentials committee as appropriate during the FPPE period.

III. SCOPE OF THE PROCTORING PROGRAM

- Definition of proctoring
  - For purposes of this policy, proctoring is a focused evaluation (FPPE) to confirm an individual practitioner’s current competence at the time when he or she requests new privileges, either at initial appointment or as a current member of the medical staff. In addition to specialty-specific issues, proctoring also will address the six general competencies of physician performance:
    - Medical/Clinical knowledge
    - Technical and Clinical skills
    - Communication skills
    - Interpersonal skills
    - Professionalism
    - Clinical judgment
  - Practitioners requesting membership but not exercising specific privileges do not need to be proctored. FPPE for medical staff members for existing privileges based on trends or patterns of performance identified by FPPE or because of infrequent use of a specific privilege are outside the scope of this policy.

- Proctoring methods
  - Proctoring may be performed using prospective, concurrent, or retrospective approaches. Specialists who most often provide cognitive care, as opposed to procedural care, are usually evaluated prospectively or retrospectively. Prospective and concurrent proctoring are the preferred methods of evaluating practitioners who request privileges to perform various procedures.

- Duration of proctoring period
  - Proctoring shall begin at the time an applicant is granted privileges and continue until the plan is completed. The proctoring period may be extended for a period not to exceed 2
years either if initial concerns are raised that require further evaluation or if there is insufficient activity during the initial period.

- Medical staff’s ethical position on proctoring
  - The proctor’s role is typically that of an evaluator, not of a consultant or mentor. A practitioners serving solely as a proctor, for the purpose of assessing and reporting on the competence of another practitioner, is an agent of the hospital. The proctor shall receive no compensation directly or indirectly from any patient for this service, and be or shall have no duty to the patient to intervene if the care provided by the proctored practitioner is deficient or appears to be deficient. The proctor or any other practitioner, however, may nonetheless render emergency medical care to the patient for medical complications arising from the care provided by the proctored practitioner. The hospital will defend and indemnify any practitioner who is subjected to a claim or suit arising from his or her acts or omissions in the role of proctor.

IV. RESPONSIBILITIES
Proctors must be members in good standing of the active medical staff of Allen Hospital and must have unrestricted privileges to perform any procedure(s) to be concurrently observed.

A. The proctor shall do the following:

1. Directly observe the procedure being performed or concurrently observe medical management for the medical admission and complete appropriate sections of the proctoring form

   AND/OR

2. retrospectively review the completed medical record following discharge and complete appropriate sections of the proctoring form

   AND/OR

3. Monitor the practitioner being proctored from admission through discharge, including:
   a. History and physical
   b. Diagnosis and justification
   c. Proposed treatment or procedure and its indications
   d. Continuity of care provided to the patients
   e. Appropriateness of procedures, tests, and medications prescribed
   f. Appropriate use of consultants
   g. Appropriateness of length of stay
   h. Adequacy of progress notes
   i. Adequacy of operative notes
   j. Discharge summary
   k. Timely completion of medical records
   l. Appropriately signed consents
   m. Technical skills/knowledge (as appropriate)
   n. Use of blood and blood components
   o. Punctuality and conduct in OR (as appropriate)
   p. Pre- and postoperative care
   q. Management of complications
r. Adherence to Red Rules

4. Ensure the confidentiality of the proctoring results and forms. The proctor will deliver the completed proctoring forms to the medical staff office.

5. If at any time during the proctoring period the proctor has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s), the proctor shall promptly notify the service line leader/medical director and may recommend that one of the following occur:
   a. The service line leader/medical director/chair intervenes and adjudicates the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient.
   b. The service line leader/medical director/chair reviews the case for possible peer review at the next department meeting or for possible external review.
   c. Additional or revised proctoring requirements be imposed upon the practitioner until the proctor can make an informed judgment and recommendation regarding the clinical performance of the individual being proctored.
   d. The appointee’s continued appointment and clinical privileges be referred to the MEC.

B. Responsibilities of practitioners being proctored:

The practitioner being proctored shall do the following:

1. Notify the proctor of each case in which care is to be evaluated and, when required, do so in sufficient time to enable the proctor to observe or review the case concurrently. For elective surgical or invasive procedures where direct observation is required, the practitioner must secure agreement from the proctor to attend the procedure. In an emergency, the practitioners may admit and treat the patient and must notify the proctor as soon as is reasonably possible of the emergency.

2. Provide the proctor with information about the patient’s clinical history; pertinent physical findings; pertinent lab and x-ray results; the planned course of treatment or management; and direct delivery of a copy of all histories and physicals, operative reports, consultations, and discharge summaries documented by the proctored physician to the proctor.

3. Shall have the prerogative of requesting from the service line leader/medical director a change of proctor if disagreements with the current proctor may adversely affect his or her ability to complete the proctorship satisfactorily. The service line leader/medical director will make recommendation on this matter to the MEC for final action.

4. Inform the proctor of any unusual incident(s) associated with his or her patients.

5. Ensure documentation of the satisfactory completion of his or her proctorship, including the completion and delivery of proctorship forms and the summary proctor report to the medical staff office. The proctoring period will automatically extend for up to three months if the summary proctor report is not completed and submitted at the end of the initial proctoring period. If the summary proctor report is not completed and submitted to the medical staff office at the end of a proctoring period extended under this subparagraph five, the privileges of a provisional appointee subject to proctoring, or the additional or new privileges that are the subject of proctoring for any other member of the medical staff shall be automatically suspended. Failure to obtain submission of a completed summary proctor report before the time for submission of the physician’s next reappointment application shall be treated as a voluntary relinquishment of the privileges that were subject to proctoring.

C. Responsibilities of service line leader/medical director designees
Each medical staff service line leader/medical director designees or their designee shall be responsible for the following:

1. Assigning proctors as noted above
2. Helping establish a minimum number of cases or procedures to be proctored and determining the times when the proctor must be present. When there are inter-departmental privileges, the credentials committee shall determine the minimum number of cases or procedures to be reviewed.
3. Identifying the names of medical staff members eligible to serve as proctors as noted above.
4. Reviewing the medical records of the patient(s) treated by the practitioner being proctored if, at any time during the proctoring period, the proctor notifies the service line leader/medical director that he or she has concerns about the practitioner’s competency to perform specific clinical privileges or care related to a specific patient(s), based on the recommendations of the proctor. The service line leader/medical director shall then do one of the following:
   a. Intervene and adjudicate the conflict if the proctor and the practitioner disagree as to what constitutes appropriate care for a patient.
   b. Refer the case(s) to the next department meeting for peer review
   c. Recommend to the Credentials Committee that one of the following occur:
      i. Additional or revised proctoring requirements be imposed on the practitioner;
      ii. Corrective action be undertaken pursuant to the corrective action plan.

D. Responsibilities of the medical staff office/quality department

The medical staff office/quality department shall do the following:

1. Send a letter to the practitioner being proctored and to the assigned proctor containing the following information:
   a. A copy of the privilege form of the practitioner being proctored
   b. The name, address, and telephone numbers of both the practitioner being proctored and the proctor
   c. A copy of the proctoring policy and procedure
   d. Proctoring forms to be completed by the proctor
2. Develop a mechanism for tracking all admissions or procedures performed by the practitioner being proctored
3. Contact both the practitioner being proctored, and the proctor, on a monthly basis to ensure that proctoring and chart reviews are being conducted as required
4. Periodically submit a report to the Credentials Committee of proctorship activity for all practitioners being proctored
5. At the conclusion of the proctoring period, submit a summary proctor report to the credentials committee and the MEC via the Credentials Committee minutes.

Responsibilities of the credentials committee
The credentials committee is charged with monitoring compliance with the proctoring policy and procedures. It will receive regular status reports related to the progress of all practitioners required to be proctored, as well as any issues or problems involved in implementing the policy and procedure.

V. METHODS
A. **Proctoring methods available to each specialty:**

Proctoring may use a combination of the following methods to obtain the best understanding of the care provided by the practitioner:

Prospective proctoring: Presentation of cases with planned treatment outlined for treatment concurrence or review of case documentation for treatment concurrence.

Concurrent proctoring: Real-time observation of a procedure or patient’s history and physical and review of treatment orders.

Retrospective evaluation: Review of case record after care has been completed. May also involve interviews of personnel directly involved in the patient’s care.

B. **Sources of data:**

Proctoring data can be obtained for all dimensions of practitioner competence from multiple data sources. Data may be individual (i.e. case specific) or aggregate “rate” data from multiple cases. Data may be derived from information specifically obtained for FPPE or for OPPE.

FPPE data may include the following:

- Personal interaction with the practitioner by the proctor
- Detailed medical record review by the proctor
- Interview of hospital staff interacting with the practitioner
- Surveys of hospital staff interacting with the practitioner
- Chart audits by non-medical staff personnel based on medical staff-defined criteria for initial appointees

The data obtained by the proctor will be recorded in a proctoring form that has been approved by each specialty in an effort to structure the proctoring data for consistency and interrater reliability.

OPPE data may include the following:

- Routine chart audits by non-medical staff personnel for important clinical functions
- Data abstracted for external comparative databases used to evaluate current medical staff members
- Incident reports
- Findings of cases identified for review by medical staff peer review committees
- Electronic claims data used to evaluate current medical staff members
- Patient satisfaction surveys

C. **Data analysis**

The proctor will review both the case-specific and aggregate data and will provide the credentials committee with an interpretation about whether the practitioner’s performance was acceptable, whether the proctor needs additional data to complete the evaluation, or whether the practitioner’s performance was unacceptable. For aggregate rate data, the medical staff will determine the acceptable target.
D. Selection of methods for each specialty

Each specialty will define the appropriate methods to determine what constitutes practitioner’s current competency. The specialty will describe these methods in a brief proctoring plan submitted to the credentials committee for approval. The plan will be reviewed and updated annually and will include the types of proctoring to be used, the data sources and collection methods employed, and method of evaluating the data.

**ARTICLE XXXVI – FIRST REPORT OF INJURY**

Members of the medical staff who are not UnityPoint Health employees are expected to report work-related injury, illness or exposure in the same manner as employed associates, for the purpose of hospital tracking and trending. This does not preclude the medical staff member from reporting such events to their own employer. The hospital will protect such reported information as protected health information.

I. Reporting Injury, Illness, or Exposure
   A. The associate shall report to his/her supervisor any work-related injury/illness and/or exposure sustained while performing his/her duty or on the premises of Allen Health System while on duty or coming/leaving duty. This shall be done at the time of the injury/illness/exposure or as soon as the injury/illness/exposure is suspected. The medical staff member shall report to the VP/Chief Quality Officer or medical staff office any work-related injury/illness and/or exposure sustained while performing medical services on the premises of the UnityPoint Health – Allen facilities. This shall be done at the time of the incident, or as soon as the injury/illness or exposure is suspected.

II. Documentation of Injury, Illness, or Exposure
   B. The medical staff member shall complete the form First Report of Injury, found on the company intranet under the HR tab. It should be completed at the time of injury/illness/exposure. It must have the shift supervisor/charge person (if an employee) or VP/Chief Quality Officer complete and sign before seeking evaluation/treatment in Occupational Health or, after hours, in the Emergency Department. If treatment is needed/required, the First Report of Injury is required in order for Occupational Health or the Emergency Department to complete an evaluation/treatment.

If urgent medical treatment is needed and the employee cannot complete the form due to their injury, the form will need to be completed immediately after treatment and faxed to Occupational Health (fax number on bottom of report form).

   C. The First Report of Injury form is used as the claim form to file a Worker's Compensation claim and must be signed by the associate and by the shift supervisor/charge person it is reported to. If the medical staff member authorizes, the First Report of Injury form may be forwarded to his/her employer as part of a worker’s compensation process.
ARTICLE XXXVII - REVIEW AND REVISIONS

A. The Rules and Regulations shall be reviewed by the respective Medical Staff Service Line or Committee every two years so that they comply with current medical standards of practice. Revisions may be recommended at any time. Revisions shall be accepted by a majority vote of eligible members present.

B. The Medical Staff Rules and Regulations can be amended following the procedure(s) outlined in the Medical Staff Bylaws

Reapproved with revisions by Medical Staff Executive Committee on 7/11/2016
Reapproved with revisions by Hospital Board of Directors on 7/26/2016