RULES AND REGULATIONS
FOR
THE MEDICAL STAFF
OF
MERCY MEDICAL CENTER, CEDAR RAPIDS, IOWA

A. ADMISSION AND DISCHARGE OF THE PATIENT

1. All patients seeking care at the hospital are assigned according to this section.
2. A patient may be admitted to the hospital only by those holding admitting privileges. The attending or covering physician shall examine the patient within 24 hours of admission.
3. A physician who is a member of the medical staff or has the relevant temporary privileges shall be responsible for the medical care and treatment of each patient in the hospital; for completing the medical record promptly, completely, and accurately; for necessary instructions; and for transmitting reports of the patient to the referring clinician when appropriate. Whenever these responsibilities are transferred to another physician, a note covering the transfer of responsibilities shall be entered in the medical record.
4. Whenever a patient is accepted for care, the admitting provider must document that the level of care is appropriate. In the case of an emergency, such documentation shall be recorded as soon as reasonably possible.
5. Where no medical staff member is known to provide care to an emergency admission, an admitting clinician is selected for the patient from the appropriate on-call roster or Hospitalist Service.
6. All privilege holders must identify a back-up member of the active or associate staff who has appropriate clinical privileges as needed to care for his/her patients in the hospital. This back-up staff member with whom prior coverage arrangements have been made will be called when the primary member is not available to care for his/her patients. In unusual circumstances for a limited period of time, a clinician may request a waiver of this requirement in accordance with the Medical Staff policy "Back-Up Practitioner Coverage". Such a waiver may only be granted with the approval of the chair of the appropriate department of the medical staff, and the President of the Medical Staff. Every staff member providing back-up coverage must recognize and accept back-up responsibility and possess the expertise to provide in-patient care for or appropriately triage, if necessary, a patient presenting with the problems typical of the specialty involved. This assumes some commonality in education and professional experience.
   The President of the Medical Staff, or chairperson of the department concerned, or designee, shall have the authority to provide for care in emergency situations by calling an appropriate member of the staff if the practitioner's back-up is not available. Failure of a clinician to meet these requirements can subject a clinician to corrective action consistent with the Medical Staff Bylaws.
7. The admitting clinician shall provide what information he/she has that may be necessary for the protection of the patient from self-harm and the protection of others whenever patients might be a source of danger for any reason.
8. For the protection of patients and staff, suicidal patients and potentially violent patients shall be placed in an area where appropriate precautions may be implemented.
9. If a question of the validity of admission to or discharge from a critical care unit should arise, that decision is to be made in consultation with the appropriate medical director.
10. The appropriate physician shall personally visit or arrange for a qualified covering physician to visit his/her patient in acute care at least once daily.
11. The attending clinician is required to maintain progress notes in accordance with Rules and Regulations, Section B, Number 5. These notes must document the need for continued hospitalization.
12. The patient shall be discharged only on documented order of the attending clinician. Should the patient leave the hospital against the advice of the attending practitioner or without proper discharge, a report of the incident shall be made in the patient's medical record.

B. MEDICAL RECORDS

1. The attending clinician shall be responsible for the preparation of a complete and accurate medical record for each patient using the electronic health record (EHR) selected by the hospital. This record shall include, as appropriate, identification data; chief complaint; personal history; family history, history of present illness; medications; allergies; physical examination; special reports such as consultations, clinical laboratory and radiology services, and other; admitting provisional diagnosis and plan of treatment; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; clinical resume; and autopsy report when performed. Other data may be required based on applicable Medical Staff policy.
2. A complete admissions history and physical shall be recorded by a qualified physician member of the medical staff and placed in the medical record within twenty-four hours of admission. This report should include all pertinent findings resulting from an assessment of all the systems of the body. If a complete history has been recorded and the physical examination performed within 30 days prior to the patient's admission to the hospital, the data from the assessment may be used in the hospital medical record in lieu of the admission history and report of the physical examination. In such instances, an interval admission note that documents the current status of the patient and any changes that may have occurred in the history and physical examination must be recorded in the medical record at the time of admission.
3. A history and physical examination must be performed prior to surgery and prior to procedures requiring anesthesia services, regardless of whether care is being provided on an inpatient or outpatient basis. When the history and physical examination are not recorded and placed on the medical record before surgery or procedures requiring anesthesia services, the procedure shall be canceled, unless the attending clinician states in writing that such delay would be detrimental to the patient.
   All ambulatory surgical patients treated in the facility must have appropriate pre-operative and post-operative evaluations.
4. The responsible physician shall countersign any notes recorded by a practitioner who does not have appropriate privileges.
5. Pertinent progress notes shall be recorded in a timely fashion sufficient to permit continuity of care and transfer if necessary. Each of the patient's clinical problems shall be clearly identified in the medical record. Progress notes shall be recorded at least daily on all acute care patients.
6. Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports should be recorded immediately following surgery for outpatients as well as inpatients, and the report shall be signed promptly by the surgeon and made a part of the patient's medical record. If the complete operative note is not immediately available, a brief summary of the surgical procedure must be completed immediately.
7. Consultation reports shall document a review of the patient's medical record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record.
8. The current obstetrical record shall include a record of prenatal care for the current pregnancy. The prenatal record shall be transferred to the hospital at, or before admission. An interval admission note must include pertinent additions to the history and any subsequent changes in the physical findings.
9. All records are the property of the hospital. Records may be accessed according to hospital policy in compliance with state and federal law.
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10. Free access to all medical records of all patients shall be afforded to members of the medical staff for bona fide study and research consistent with preserving the confidentiality of information concerning the individual patient. All such research projects shall be approved by the appropriate Institutional Review Committee before such records can be studied. Also, subject to the discretion of the CEO or designee, former members of the medical staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.
11. The patient's medical record shall be completed by the attending clinician at the time of discharge, including progress notes, data relevant to the management of the case including pending tests,

preliminary diagnosis, discharge summary and necessary validations. When the record has not been completed within 30 days of discharge, it will be considered delinquent.

12. The CEO or designee shall notify the practitioner that his or her privileges to admit, consult or perform procedures shall be suspended until the records have been completed.

C. GENERAL CONDUCT OF CARE

1. A general consent to treatment, authenticated by or on behalf of every patient presenting to the hospital for treatment, must be obtained. Except in emergency situations, informed consent for specific treatment or procedures that entail significant risk must be obtained and documented by the responsible clinician or their designee before the patient is treated in the hospital.
2. All orders for treatment shall be entered or verified in the EHR by the ordering clinician. All verbal/telephone/faxed orders shall be signed by the person to whom they are dictated with the name of the clinician providing the order. The order shall be verified by the responsible clinician.
3. All previous orders, including DNR, are canceled when patients go to surgery. Patients who will be receiving a general anesthetic will have their oral medications held prior to the procedure as specified in the anesthesia guidelines, unless otherwise specified by the responsible clinician.
4. All medications for inclusion in the hospital formulary must be approved by the Medication Management Committee which reports to the Medical Executive Committee.
5. Requests for medical, surgical or psychiatric consultation shall be made by the attending clinician to a clinician with relevant privileges.
    a. The attending clinician shall obtain consultation in the following situations:
        i. When the patient requires diagnostic testing and/or treatment for which the attending clinician does not have privileges.
        ii. When required by Medical Staff policy, e.g., to determine the presence of brain death for organ donation purposes.
        iii. When the patient or his/her legal representative requests a second opinion.
    b. It is recommended that the attending clinician obtain consultation in the following situations:
        i. When the diagnosis is obscure after ordinary diagnostic procedures have been completed.
        ii. When there is uncertainty as to the choice of therapeutic measures to be utilized.

    Except in an emergency, the attending clinician shall provide written authorization to permit another clinician to attend or examine his/her patient. Any qualified clinician can be asked to consult within the scope of his/her clinical privileges.
6. If a nurse has reasonable doubt or concerns about the care provided to any patient or reasonably believes that appropriate consultation is needed and has not been obtained, the nurse shall call this to the attention of the supervisor/nurse manager. The supervisor/nurse manager shall bring substantiated concerns to the attention of the attending physician. If there is not reasonable resolution, the supervisor/nurse manager shall bring the concern to the chairperson of the appropriate clinical department, or his/her designee, for appropriate action.
7. When the patient's need for care requires transfer to another facility, a clinician with admitting privileges in the receiving organization must agree to assume responsibility for the patient's care.
8. The transferring clinician is required to follow appropriate state and federal regulations regarding transfers.

D. GENERAL RULES REGARDING SURGICAL CARE

1. Except in emergencies, the history and physical exam, the pre-operative diagnosis and any pertinent laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled.
2. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation, intra-operative evaluation, and relevant post-anesthetic follow-up.
3. Specimens removed at the time of surgery or procedure shall be sent to Pathology in accordance with Medical Staff policy.
4. Surgeons and Anesthesiologists shall be available to commence operation at the time scheduled.
5. A patient admitted for dental care is a dual responsibility of the dentist/oral and maxillofacial surgeon and a clinician with admitting privileges.

a. The dentist/oral and maxillofacial surgeon is responsible for:
   - A detailed dental history justifying hospital admission
   - A detailed description of the examination of the oral cavity and pre-operative diagnosis
   - A complete operative report, describing the findings and technique. In cases of extraction of teeth the dentist/oral and maxillofacial surgeon should clearly state the number of teeth and fragments removed. Tissue, including teeth and fragments shall be sent to the hospital pathologist for examination in accordance with Medical Staff policy
   - Progress notes as are pertinent to the oral condition
   - Requesting laboratory and radiology procedures pertinent to the condition

b. The admitting clinician is responsible for:
   - The medical history pertinent to the patient's general health
   - A physical examination to determine the patient's condition prior to anesthesia and surgery
   - Supervision of the patient's general health status while hospitalized

c. The discharge of the patient shall be on written order of the dentist/oral and maxillofacial surgeon.

6. A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a clinician with admitting privileges.
   a. The podiatrist is responsible for:
      - A detailed podiatric history justifying hospital admission
      - A detailed description of the podiatric examination and a pre-operative diagnosis
      - A complete operative report describing the findings and technique
      - Progress notes as are pertinent to the podiatric condition
      - Requesting laboratory and radiology procedures pertinent to the condition
   b. The physician is responsible for:
      - The medical history pertinent to the patient's general health
      - A physical examination to determine the patient's condition prior to anesthesia and surgery
      - Supervision of the patient's general health status while hospitalized
   c. The discharge of the patient shall be on written order of the podiatrist.

E. EMERGENCY SERVICES

1. A patient presenting to the hospital with a possible emergent condition shall have an appropriate medical screening examination to determine if an emergency medical condition exists. This will be performed in accordance with the hospital's policies and procedures. Such examination will be performed by a health care provider with appropriate privileges. Examination of patients with obstetrical concerns will be performed by a physician with appropriate privileges, or a qualified nurse in consultation with a physician.

F. INVESTIGATIONAL DRUGS

An "Investigational Drug" for the purpose of this rule shall refer to all drugs which have not been approved by the Federal Food and Drug Administration. A physician wishing to administer, or have administered, an investigational drug to a patient in the hospital must:

a. have the investigational study approved by the Institutional Review Committee,
b. secure a written consent from the patient or the patient's representative, and
c. write an order for the medication.

If the principal investigator is not the attending practitioner, the attending practitioner must concur with the order. The principal investigator or designee shall provide all necessary information to pharmacy and the nursing staff prior to administration of the drug(s) and certify on the patient chart that such a release has been obtained when his/her orders the administration of the drug.

Members of the nursing and house staff will not be allowed to administer such drugs until adequate information concerning the drug is made available, including pharmacology, toxicology, monitoring parameters and treatment of adverse reactions.

G. AUTOPSY

It shall be the duty of all clinicians to consider the need for an autopsy as appropriate, such as in cases of unanticipated and/or unexplained death, unknown diagnosis or death following dental, medical, or surgical diagnostic procedures and/or therapies. In all deaths, except as required by state law, an autopsy may be performed only with written consent, signed in accordance with state law. All autopsies shall be performed by a pathologist with autopsy privileges. Provisional anatomical diagnoses shall be recorded on the medical record within seventy-two hours, and the complete report shall be made a part of the record within two months.