CENTRACARE – RICE MEMORIAL HOSPITAL

301 BECKER AVENUE SW
WILLMAR, MINNESOTA

MEDICAL STAFF RULES AND REGULATIONS

Adopted by Medical Staff: 3/05/2024

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Section A - General

A.1 Preamble

In recognition that the purpose of the Medical Staff of CentraCare - Rice Memorial Hospital is to both provide patient care and to evaluate and continually seek means to improve the quality of the care patients receive at CentraCare - Rice Memorial Hospital, these Rules and regulations have been established. These Rules and Regulations are intended to supplement and expand upon the Bylaws of the Medical Staff of CentraCare - Rice Memorial Hospital; however, if at any time there should appear to be a contradiction between the Rules and Regulations and the Bylaws, the latter shall have preference.

A.2 Definitions

Terms defined in the CentraCare - Rice Memorial Hospital Medical Staff Bylaws shall have the same meaning when used in these Rules and Regulations.

A.3 Effect

These rules and regulations shall be adopted and remain effective after action by the Medical Staff and Board of Directors as described in Medical Staff Bylaws Article 15.1.

Section B – Admission and Discharge of Patients

B.1 Admission

B.1.1 The Hospital may accept patients for admission with all types of diseases or conditions, subject to the limitations of the Hospital's facility, personnel and the medical services it provides.

B.1.2 A patient may be admitted to the Hospital only by a practitioner with appropriate admitting privileges.

A physician with appropriate clinical privileges shall be responsible for the continuous care and treatment of each patient in the Hospital as the attending physician. He/she shall see and evaluate or arrange for another qualified member of the Medical Staff, to see and evaluate the patient in a timely manner after admission, as appropriate to the nature and seriousness of the condition for which the patient was admitted, but in no event later than 24 hours after admission. The attending physician shall also be responsible for:

A. completing, or arranging for the completion of the history and physical in a timely manner as required by these Rules and Regulations.

B. the prompt completion and accuracy of the medical record.

C. the issuance of any necessary special instructions.

D. Seeing, or arranging for another practitioner to see the patient.

E. Completion of the 20-day Certification/Recertification of inpatient admissions.

B.1.3 Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. The admission order shall specify the patient status as inpatient, observation, or outpatient, based on the practitioner's evaluation of the patient's diagnosis, plan of care and expected length of stay. In the case of an emergency, such statement shall be recorded as soon as possible.

B.1.4 Patients presenting for care who have no identified primary provider shall be assigned to the appropriate Medical Staff member on call.

B.1.5 The Medical Staff shall define the criteria to be used to implement patient admission priorities and the proper review of those priorities. Such priorities shall include emergency admissions, preoperative admissions and routine admissions.

A. Emergency admissions: This includes all admissions classified as an emergency by the admitting physician. For the purpose of this section, "emergency" is defined as a condition in which serious permanent harm would result to the patient if treatment is delayed or in which the life of the patient is in immediate danger and any delay in administering treatment would add to that danger.

B.. Preoperative admissions: This includes all patients already scheduled for time-sensitive or urgent surgery who are not included in the above category.

C. Routine and other elective admissions: This includes all other routine or elective admissions that are not included in the above categories.

B.1.6 The admitting practitioner shall be responsible for sharing with appropriate Hospital staff information known to the practitioner that may be necessary to protect the patient from self-harm, and to protect others, whenever the patient might be a source of danger to self or others.

B.1.7 All patients admitted to the hospital shall have adequate diagnostic studies to support the admitting diagnosis and establish safety of any planned procedures.

B.1.8 Patients requiring admission to ICU must be seen by a physician immediately prior to or within 30 minutes of admission. Admitting diagnosis and orders are required as noted in B.1.3.

B.1.9 All dental patients shall receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the care of any medical problem that may be present at the time of admission or that may arise during hospitalization.

B.2 Discharge

B.2.1 Patients shall be discharged only by written order of the practitioner. The attending provider is encouraged to examine the record to ensure it is as complete as possible including the documentation of appropriate reports, final diagnosis and appropriate signature(s).

B.2.2 If a patient indicates intent to leave the Hospital before the completion of treatment or contrary to the advice of the patient's attending practitioner, the nursing staff shall contact the patient's attending practitioner or designee to arrange for the patient to discuss his/her plan with the attending practitioner or designee before the patient leaves. The attending practitioner or designee shall discuss with the patient the implications or leaving the Hospital against medical advice, including the risks involved and the benefits of remaining for treatment, as necessary to meet the standard of informed refusal of treatment.

B.2.3 Patients who insist on leaving the hospital against the advice of their attending provider shall have this status (AMA) documented in their medical record. These patients shall be requested to sign a release acknowledging that they are leaving against medical advice and their understanding of the medical risks and possible consequences of refusing continued treatment at the Hospital. If the patient cannot be located or refuses to sign this form, refusal shall be documented on the form and signed by two witnesses. Details shall also be documented in the Nurse's Notes.

B.2.4 A patient who leaves the Hospital without notifying any healthcare worker prior to departure is considered to have eloped. In the Emergency Department, this applies to any patient who has been seen by the Triage Registered Nurse, had a triage assessment initiated and/or been placed in a treatment area but left prior to completion of an evaluation in the Emergency Department. Documentation of the circumstances, time and date of the incident shall be documented by the nurse in the medical record.

B.3 Death

B.3.1 In the event of a death, the deceased shall be pronounced dead by the attending practitioner or other practitioner as determined by Hospital policy. Policies with respect to the release of deceased patients shall conform to local law.

A. It shall be the responsibility of all Medical Staff members to secure autopsies whenever they are required by law or deemed appropriate according to the Rules delineated in Section J – Guidelines on Requesting an Autopsy.

Section C – Orders and Consents

C.1 Orders

All orders for treatment shall be documented by the ordering provider. All orders must be signed, dated and timed. Outpatient orders must include diagnosis or reason for the therapy and/or test.

C.1.1 Verbal Orders

Under certain circumstances, an order may be given to an authorized licensed professional who will record it as a verbal or telephone order. Verbal orders or Telephone orders may be given when a provider does not have immediate access to a computer for order entry or in emergent situations. Verbal or telephone orders may be signed by any physician participating in the care of the patient. A practitioner who countersigns a verbal order for another practitioner in such a situation assumes responsibility for the order as being complete, accurate and final.

A. Verbal/telephone orders for restraint and/or seclusion shall be authenticated at the time of reassessment as noted in policy Restraint.

C.1.2 Physician co-signatures

Physician co-signatures are not required on orders given by Advanced Practice Registered Nurses and Physician Assistants

C.1.3 Do Not Resuscitate or No Code orders

Unless previously documented in the medical record or in Advanced Directives, Do Not Resuscitate (DNR), “No Code” or other orders to withhold or withdraw life-sustaining treatment must be entered into the patient record and accompanied by appropriate documentation describing the patient’s medical condition and the discussions with the patient and/or patient’s family on which the order is based.

C.1.4 Outpatient Orders

A. Orders for outpatient therapeutic or diagnostic services will be accepted from any physician, Advanced Practice Registered Nurse (APRN) or Physician Assistant who is a member of the Medical Staff/APP Staff or has been granted privileges at CentraCare - Rice Memorial Hospital. Orders will also be accepted from Allied Health Staff members who have been granted privileges to order outpatient services.

B. Physicians**,** Podiatrists, or Advanced Practice Registered Nurses (APRNs) that are not members of the Medical Staff/Advanced Practice Practitioner Provider Staff may order outpatient diagnostic, therapeutic (excluding Observation and Outpatient Surgical), rehabilitative or Hospice services via authenticated order; providing they are:
   1. Responsible for the care of the patient
   2. Licensed to practice in the state where he or she provides care to the patient

3. Acting within his/her scope of practice under state law Licensure will be verified by Medical Staff Services. Orders require detail as noted in E.8.3.

C. Physician Assistants that are licensed to practice in Minnesota may order outpatient diagnostic and rehabilitative services within their scope of practice. Orders require detail as noted in E.8.3.

D. Chiropractors that are licensed to practice in Minnesota may order outpatient diagnostic services as permitted by policy Use of Diagnostic Imaging Services by Chiropractors. Orders must meet the specifications noted in E.8.3.

C.2 Consents

C.2.1 General Consent

A. A general consent for medical treatment, diagnostic testing and/or surgical treatment is to be signed when the patient presents to the hospital for care.

B. The Minnesota Alliance for Patient Safety (MAPS) consent form shall be completed prior to surgical or other invasive procedures by the physician/surgeon. This includes procedures resulting in sterilization. Additional consent forms will also be utilized as required by law and/or regulation.

C.2.2 Informed Consent

A. The medical staff of CentraCare - Rice Memorial Hospital shall recognize and honor the Patients' Bill of Rights, including the informed consent component as set forth in Minnesota statutes.

B. It is the responsibility of the physician and/or surgeon to discuss with the patient the procedure and associated risks, benefits, available alternatives and the expected outcome. The physician/surgeon must document this discussion in the patient's record.

C. The physician/surgeon shall ensure that a consent form is signed by the patient, indicating understanding of the discussion.

Section D - Consultation

D.1 Request for Consultation

It is the responsibility of the attending practitioner and/or surgeon to obtain appropriate consultations. The attending practitioner or surgeon must document the consultation request and is responsible for supplying the consultant with all available and relevant information regarding the patient and the need for consultation.

D.2 Situations for Consultation

Appropriate situations for consultation may include when services needed by the patient are outside the scope of privilege of the attending; when the diagnosis remains unknown despite appropriate evaluations; when the stay is prolonged beyond usual length; or when there has been no response to treatment ordered.

D.3 Consultant Qualifications

Any qualified practitioner with clinical privileges can be called for consultation within his/her area of expertise and within the limits of clinical privileges that have been granted.

D.4 Documentation of Consultation

It is the responsibility of the consulting physician to complete a report of consultation in the patient's medical record. A satisfactory consultation includes examination of the patient and the medical record as requested by the attending practitioner. Proper documentation that such services were offered shall be noted in the patient's medical record. A documented opinion signed by the consultant must be included in the medical record. This documentation should include evidence of review of the patient's record, pertinent findings on examination of the patient, the consultant's opinion and recommendations. When operative procedures are involved, the consultation note, except in an emergency, shall be recorded prior to the operation (unless the surgeon is the one who performed the H&P).

D.5 Psychiatric Consultation

Psychiatric consultation and treatment should be requested for/offered to all patients admitted due to drug overdose or suicide attempt.

Section E – Medical Record Rules

E.1 Medical Record Requirements

These Rules and Regulations regarding Medical Records shall be interpreted to apply to all versions of the Medical Record, including but not limited to, electronic or paper forms of the record, and shall include the use of electronic signature.

E.1.1 All entries in the medical record must be dated, timed and authenticated.

E.1.2 The attending provider shall be responsible for the preparation of a complete and legible medical record for each patient to whom he/she provides care. Its contents shall be pertinent and accurate. This record shall be compiled by the hospital using interactive entry into CentraCare's Epic Health record and shall include, as appropriate to individual patient: identification data, complaint, personal history, family history, history of present illness, physical examination, provisional diagnosis or diagnostic impression, diagnostic and therapeutic orders, diagnostic and therapeutic procedures and test results, medical or surgical treatment, operative and invasive procedure reports, pathological findings, progress notes, consultation reports, discharge summary or discharge note (including final diagnosis, condition on discharge, discharge disposition and discharge instructions), code status and decisional capacity and autopsy report when applicable. All medical records must be complete and will not be filed until complete except at the direction of the Medical Record Committee.

E.1.3 All records are the property of CentraCare - Rice Memorial Hospital and shall not be removed from the premises except by a subpoena, court order, statute or order of the Governing Body. In case of patient readmission, all previous records shall be available for use by the attending physician. This shall apply whether the patient is attended by the same physician or another. Unauthorized removal of electronic or paper charts from the hospital is grounds for suspension of Medical Staff privileges and/or membership of the practitioner for a period to be determined by the Executive Committee of the Medical Staff.

E.2 History and Physical

E.2.1 A complete history and physical (H&P) examination shall be completed and documented for each patient no more than thirty (30) days before or 24 hours after admission, but prior to surgery or a procedure requiring anesthesia.

A. History and physicals must include:
1. patient identification;
2. chief complaint;
3. history of present illness;
4. review of systems;
5. personal medical history, including medications and allergies;
6. family medical history;
7. social history, including any abuse or neglect;

8. physical examination to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
9. data reviewed;
10. assessments, including problem list;
11. plan of treatment;
12. If applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion, which will be documented in the plan of treatment; and
13. in the case of a pediatric patient, the history and physical examination report must also include:
    a. Length or height; and
    b. Weight.

B. Exception: H&Ps for fistulograms and other Interventional Radiology procedures, and bone marrow biopsies are considered complete without a chief complaint, family history or social history.

C. Exception for ECT Procedures:
Concerning patients receiving electro-convulsive therapy (ECT), a medical history and physical examination must be completed as follows:

1. A full operative history and physical must be completed and documented within 30 days prior to initiation of ECT as per the Medical Staff Bylaws, Policies, and Rules and Regulations of Rice Memorial Hospital for a medical history and physical examination.

2. On-going full operative history and physical examinations are required at 6- month intervals unless otherwise indicated during pre-ECT treatment assessment, or the patient condition changes as identified by the psychiatrist or anesthesiologist.

3. An interval history and physical examination for ECT must be completed and documented prior to the start of each treatment. The minimum elements of the interval history and physical are:
    - Chief Complaint/HPI
    - Procedure planned
    - Past Medical and Surgical history
    - Current medication review
    - Allergies
    - Physical examination to include heart and lung assessment & mental status
    - Overall assessment
    - Plan for this ECT treatment

E.2.2 When an H&P has been completed within thirty (30) days before admission, an updated medical record entry must be completed and documented in the patient's record within twenty-four (24) hours after admission. In all cases, the update must be documented prior to surgery or a procedure requiring anesthesia. The update of the history and physical examination must

A. Reflect any changes in the patient's condition since the date of the original H&P was that might be significant for the planned course of treatment; or
B. State that there have been no changes in the patient's condition.

E.2.3 Obstetrical records shall include a complete prenatal record, which may be legible copies of the attending physician's office records transferred to the Hospital prior to admission.

A. Prenatal records must be signed and dated
B. A complete H&P is required on all obstetrical cases delivered via scheduled cesarean section.
C. For those obstetrical cases that result in vaginal delivery, the prenatal record may be substituted for the H&P if the last prenatal visit occurred within two weeks of admission.
    1. An interval admission progress note must be written that includes pertinent additions to the history and subsequent changes in the physical findings.
D. If no prenatal record is present, a complete history and physical is required except in emergency cases.

E.2.4 In cases for which moderate sedation, deep sedation or anesthesia will be utilized, a current history and physical must be available for review prior to the procedure.

E.2.5 Those patients that are found to require emergency surgery/invasive procedures will not require an H&P prior to the procedure. The licensed practitioner will be required to document a brief note regarding the patient's condition and planned procedure prior to the induction of anesthesia. The complete H&P must be documented post-procedure. The Emergency Record may be used in lieu of an H&P in this situation provided all required components of the H&P are included.

E.2.6 A transfer summary may be used in lieu of an H&P provided all required H&P components are included for those patients admitted and promptly transferred to another hospital.

E.2.7 Cancellations, Delays, and Emergency Situations

A. When the history and physical examination is not recorded in the medical record before an elective, non-emergent surgical case or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, radiological procedures with sedation, and procedures performed in the Emergency Department), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record, ***unless*** the attending physician states in writing that an emergency situation exists.

B. In an emergency situation, when there is no time to record a complete history and physical, the attending physician may utilize the Emergency Department note, which shall meet the documentation requirements in Section E.9.1 by recording an admission or progress note immediately prior to the procedure. The admission or progress note will document, at a minimum, an assessment of the patient's condition, heart rate, respiratory rate, blood pressure and diagnosis. Immediately following the emergency procedure, the attending physician is then required to complete and document a full history and physical examination.

E.3 Informed Consent

Informed consent is required for all cases of invasive/surgical procedures requiring anesthesia. CentraCare - Rice Memorial uses the Minnesota Alliance for Patient Safety (MAPS) Informed Consent. Physicians shall discuss the risks and benefits of the procedure, including any risks associated with not performing the procedure, and shall sign the consent form as documentation of the consent. The patient's signature on the consent form indicates understanding of the discussion.

E.4 Operative/Delivery Reports

E.4.1 Any procedures requiring sedation/anesthesia must have the following seven elements in the immediate post-op/procedure note and the full procedure/operative report:

A. The name(s) of the licensed independent practitioner(s) who performed the procedure and his/her assistants;
B. The name of the procedure performed;
C. A description of the procedure;
D. Findings of the procedure (including complications);
E. Any estimated blood loss;
F. Any specimens removed; and
G. The postoperative diagnosis.

E.4.2 Operative and Delivery reports shall be completed immediately after the procedure. In cases where these reports are dictated, a brief operative or delivery note must be documented in the record to provide information until the transcribed report is available in the record.

E.4.3 An operative report is required for all cesarean section deliveries.

E.4.4 Before moderate or deep sedation or anesthesia, a pre-sedation or pre-anesthesia evaluation shall be completed and recorded in the patient's record.

Immediately before administering moderate or deep sedation or anesthesia, the patient is re-evaluated with conclusions recorded. A post anesthesia evaluation is completed and recorded after any procedure requiring anesthesia.

E.4.5 Obstetrical epidurals only require a procedure note that includes the reason for procedure and procedure findings.

E.5 Progress Notes

E.5.1 Progress notes shall be recorded at the time of interaction. Progress notes should give a pertinent, chronological report of the patient's course in the Hospital and should reflect any change in condition and the results of treatment. Documentation of patient evaluation shall be done at least every 24 hours by the physician(s) or designated clinically privileged licensed health care provider actively involved in the patient's care.

E.5.2 The attending practitioner is required to document the need for continued hospitalizations; failure to do so shall be brought to the attention of the department chair.

E.6 Discharge Summaries (aka: Clinical Resumes)

E.6.1 Discharge summaries will be completed by the medical physician discharging the patient and will briefly recapitulate the significant physical and laboratory findings, procedures performed and treatment rendered, final diagnoses (reason for hospitalization), patient condition on discharge and the specific instructions and arrangements for future care, including physical activity, limitations, medications, diet and follow-up care.

A. Discharge summaries are required on all medical and surgical cases with length of stay more than 48 hours.

B. Discharge summaries are required on the following cases regardless of length of stay: Cesarean Sections, Deaths (excluding Hospice patients who are on Respite status and patients in an Alternative Care Bed [ACB]), and Transfers to other Acute Care Facilities. A transfer summary may be used in lieu of a discharge summary provided all required components of the discharge summary are included.

C. A final progress note may be substituted for a discharge summary in cases with hospitalization of less than 48 hours and for normal newborn infants. The final progress note must include the following:
   a. Final diagnosis
   b. Outcome of hospitalization
   c. Disposition of case
   d. Provision for follow-up care including any instructions given to the patient and/or family.

   A final progress note may not be substituted in cases described in E.6.1(B).

E.7 Autopsy Reports

E.7.1 When an autopsy is performed, provisional anatomic diagnosis should be documented in the medical record within 3 days and the complete report should be made part of the medical records within 30 business days unless additional time is required for results of special testing, etc.

E.8 Outpatient

E.8.1 Surgery and/or invasive procedures requiring anesthesia require a history and physical as described in Section E.2 of this document.

E.8.2 Operative/procedure reports shall be documented immediately following the event as noted in E.4.

E.8.3 Outpatient therapeutic and diagnostic services may be ordered as noted in C.1.4 and completion (signature, etc.) will be the responsibility of the ordering provider. All orders for outpatient services must include adequate clinical information to verify the purpose and appropriateness of the requested service.

E.8.4 Records of outpatient services are integrated into the patient's medical record with results communicated to the ordering provider. The ordering provider retains responsibility for communicating the results and any recommendations for follow-up examination or further treatment to the patient.

E.9 Emergency Records

E.9.1 The emergency record shall be documented within 48 hours following discharge/transfer of the patient from the Emergency Department. The emergency record shall include:
   A. adequate patient identification;
   B. information concerning the time of the patient's arrival, means of arrival and by whom transported;
   C. pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his/her arrival at the hospital;
   D. description of significant clinical, laboratory and imaging findings;
   E. diagnosis and treatment given;
   F. condition of the patient on discharge or transfer, and
   G. final disposition, including instructions given to the patient and/or his/her family, relative to necessary follow up care

E.10 Documentation Requirements for Other Patient Classifications:

E.10.1 Alternative Care Bed (ACB):

A pre-arranged hospital stay that does not qualify for hospice and does not meet the medical necessity requirements for hospitalization.

A. Documentation: An H&P is not required. Nursing progress notes shall be documented but no rounding from a provider will occur during an ACB stay.

E.10.2 Respite Hospice:

Short-term temporary respite care to those needing intermediate to skilled nursing service.

A. Documentation: An H&P or an update to an H&P done within the last 30 days must be completed within 24 hours of admission for respite care.

E.10.3 Outpatient Observation:

Services furnished to evaluate an outpatient's condition to determine the need for possible admission as an inpatient.

A. Documentation Requirements:
   1. Provider order for Observation Services
   2. Admission documentation of the medical necessity for observation services including the monitoring and treatment to be administered during the outpatient observation period
   3. Progress notes documented at least daily along with a final progress note including the final diagnosis, summary of the patient's condition and care received once the patient is stable for discharge or requires admission as an inpatient.

E.11 Completion Requirements

All medical record documentation for inpatient and outpatient visits will be completed no later than 48 hours after patient contact. Documentation not completed within 48 hours will become delinquent in accordance with the Delinquent Documentation Policy.

Federal Regulations dictate that these types of documentation must be completed within 24 hours, they will be considered deficient if incomplete at 24 hours and delinquent if not completed within 48 hours:

E.11.1 Histories and Physicals not present on admission must be completed within 24 hours of patient admission by the admitting/attending provider.

E.11.2 Consultations

E.11.3 Operative or Procedure Reports (including Delivery Reports)

Reports of operation or delivery shall be documented by the physician performing the procedure immediately following the operation/procedure/delivery. If the report is dictated, a brief descriptive note which summarizes the procedure must be documented in the record immediately following the procedure to provide

information prior to the final report being available. Dictated operative reports must be completed within 24 hours of the operation. Physicians who electronically document their operative/procedure/delivery reports at the conclusion of the event need not complete this interim note.

E.11.4 The total record, including signatures, shall be completed within 30 days of discharge. Days absent for illness, vacation, etc are not counted when calculating delinquency. It is the responsibility of the provider to notify Health Information Management of vacation plans or other absences. The provider must complete their medical records within 72 hours of their return to work.

E.12 Medical Record Completion Enforcement Procedure

E.12.1 Procedure to be followed when patient records are not completed within the specified time period:

A. Physicians or other licensed independent practitioners with incomplete records in the time periods outlined above shall be notified in accordance with the Delinquent Documentation Policy. Failure to complete the records within the required timeframe (30 days) shall result in action up to, and including, automatic suspension of privileges pursuant to the CentraCare – Rice Memorial Hospital Medical Staff Bylaws. Suspension will be activated by the Medical Staff Office.

B. The Chair of the Privileging Committee (or designee) shall notify the individual physician(s) or other licensed independent practitioner affected when privileges are suspended.

C. The Manager of Credentialing and Privileging or designee shall notify the following persons and departments of the physicians or other licensed independent practitioners whose privileges have been suspended:
1. Chief of Staff
2. Physician Director of Acute Care
3. Senior Director of Acute Care
4. Patient Access, Emergency Department, Surgery Department
5. Clinic of the suspended Provider if they cover call

D. Health Information Management Department shall communicate the status of the incomplete records with the Medical Staff Credentialing and Privileging office.

E. If dictation has been completed on an incomplete record but the record has not been available for signature, the provider will be allowed one week grace period before being suspended.

F. Reinstatement of privileges is automatic upon completion of delinquent records. Failure to complete the medical records within 30 days following notice of suspension will result in automatic resignation from the Medical Staff or APP/AHP Staff.

G. Six suspensions in the past 12 months may result in automatic resignation from the Medical Staff or APP/AHP Staff. The Privileging Committee will review for disciplinary action.

Section F – Surgery Rules

F.1 Patients admitted for elective surgery shall be directed by the attending physician to present themselves for admission in time to have necessary diagnostic examinations, consultations, evaluations, and preparation prior to surgery.

F.2 A patient admitted for oral surgery or podiatric care is a dual responsibility involving the oral surgeon or podiatrist and a physician member of the Medical Staff.

F.2.1 Oral Surgeon responsibility: The oral surgeon shall prepare a detailed dental history justifying the Hospital admission; a detailed description of the oral cavity and preoperative diagnosis; a complete operative report and progress notes as are pertinent to the oral condition; and a discharge summary or final progress note as required. Tissue including teeth and fragments shall be sent to the Hospital pathologist for examination when appropriate per Hospital policy.

F.2.2 Podiatrist responsibility: The podiatrist shall prepare a detailed podiatric examination of the feet and preoperative diagnosis; complete operative report; progress notes as are pertinent to the podiatric condition; and discharge summary or final progress note as required. Tissue removed shall be sent to the pathologist for examination when appropriate per Hospital policy.

F.2.3 Physician responsibilities: The Physician shall provide a medical history pertinent to the patient's general health; a physical examination to determine the patient's condition prior to induction of anesthesia and the procedure; and supervision of the patient's general health status while hospitalized.

F.3 In surgical cases undergoing general anesthesia or monitored anesthesia care, a current history and physical meeting the requirements noted in E.2 must be on the chart prior to elective surgery. The nursing unit is to notify surgery by telephone when a history and physical is not present prior to patient transfer to surgery.

F.4 A preoperative admission note with date and time shall be documented by the surgeon on the Progress Record of all outpatient and inpatients scheduled for surgery.

F.5 A consent form shall be signed by the patient prior to surgery (see E.3). This form becomes part of the patient's record.

F.6 A physician's pre-anesthesia note with date and time shall be documented in the medical record of all outpatients and inpatients scheduled for surgery that specifically includes information relative to the choice of anesthesia for the anticipated procedure. Whenever a Certified Registered Nurse Anesthetist (CRNA) generates the pre-anesthesia note, it must be countersigned by an anesthesiologist.

F.7 When indicated, the surgeon is responsible to obtain a consultation by another physician prior to surgery and postoperatively.

F.8 The medical record shall include a daily progress note by the physician actively involved in the patient's care.

F.9 All operations performed shall be fully described by the operating surgeon immediately after surgery. Discharge from the recovery room shall be ordered by the anesthesiologist or other responsible physician.

F.10 The medical record shall include a dated, timed, and signed post-anesthetic visit made after the patient has left the recovery area, describing the presence or absence of anesthesia related complications.

F.11 All vital tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis.

F.11.1 Specimens removed during surgical procedures are ordinarily sent to the pathologist for evaluation.

F.11.2 The Medical Staff, in consultation with the pathologist, decides the exceptions to sending specimens removed during a surgical procedure to the laboratory.

A. Exceptions are made only when the quality of care has not been compromised by the exception, when another suitable means of verification of the removal has been routinely used, and when there is an authenticated operative or other official report that documents the removal.

B. The limited categories of specimens that may be exempted from the requirement to be examined by a pathologist include, but need not be limited to, the following:

1. Specimens that by their nature or condition do not permit productive examination, such as a cataract, orthopedic appliance, foreign body, or portion of rib removed only to enhance operative exposure;

2. Therapeutic radioactive sources, the removal of which is guided by radiation safety monitoring requirements;

3. Traumatically injured members that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

4. Foreign bodies (e.g., bullets) that, for legal reasons, are given directly in the chain of custody to law enforcement representatives;

5. Specimens known to rarely, if ever, show pathologic change, and removal of which is highly visible postoperatively, such as the foreskin from the circumcision of a newborn infant;

6. Placentas that are grossly normal and have been removed in the course of operative and non-operative obstetrics;

7. Teeth, provided the anatomic name or anatomic number of each tooth, or fragment of each tooth, is recorded in the medical record; and;

8. Bone, cartilage, and soft tissue removed for total or partial replacement of a hip or knee osteoarthritis. Fractured hips should still be submitted, and consideration should be given to submitting tissue showing chalky deposits for microscopic evaluation of crystal induced arthropathy.

F.12 Ambulatory Care Services

F.12.1 Ambulatory care services shall be defined as non-emergency health care services provided to patients who do not remain in the hospital more than 24 hours, for example, ambulatory surgery with or without general anesthesia, blood transfusions, I.V. therapy, etc. The 24-hour time period starts at the time the patient arrives in designated room following surgery and post-anesthetic recovery.

F.12.2 Ambulatory care services shall meet the same standards of quality that apply to inpatient care provided by the hospital and chart completion requirements shall be the same as for other medical records.

F.12.3 Ambulatory care service provided on an outpatient basis shall be consistent with departments applicable to inpatient services, anesthesia, and postoperative recovery. Any patient who has received anesthesia other than a local shall meet discharge criteria and be accompanied home by a designated person. Patients who do not meet discharge criteria must be examined by a physician and discharged or admitted by that doctor's order. If admitted, this examination shall meet the requirements as noted in E.2. If discharged the note shall include items as noted in E.6.1(C).

F.12.4 Any instructions for follow-up care shall be given to the patient and/or responsible family member and documentation thereof place in the hospital record.

Section G – Emergency Services Coverage

1. G.1 The medical staff shall adopt a system of providing medical coverage in the emergency services area, consistent with the hospital's basic plan for delivery of such services. Patients who present with a potential emergency medical condition will have a medical screening exam (MSE) performed by an Emergency Medicine physician, or any other privileged physician acting within the scope of his/her privileges; or any Physician Assistant (PA), Nurse Practitioner (NP), Registered Nurse (RN), Certified Nurse Midwife (CNM), or Licensed Psychologist (LP) practicing within the scope of his/her functions and who has been approved by the Medical Staff and Board of Directors.

G.2 To meet the needs of our patients, members of the medical staff shall rotate call within their clinical department or specialty.

G.2.1 In any department or specialty with four (4) or more full-time active staff members, the active staff members shall provide call coverage in a continuous and uninterrupted manner. Frequency of call for these physicians can be determined by the specific department or specialty.

G.2.2 In any department or specialty with less than four (4) full-time active staff members, call will be 1 in 4 (24-hour periods) for each member of that department; this includes holidays and weekends. This plan shall be reviewed annually or with any change in department member status. If a department/specialty wishes to defer from the established 1 in 4 requirement, a proposal can be submitted to the MEC for review/approval.

G.2.3 Physicians who are unavailable to attend patients for greater than 30 consecutive days should notify the Department Chair and are not obligated to take call during this time. Physicians who expect to be unavailable for greater than 90 consecutive days should request a leave of absence as outlined in Bylaws Article 2.5.

G.2.4 Members of the courtesy medical staff are encouraged to provide call coverage within their specialty.

G.3 Members of the Medical Staff who are called to provide care for a patient shall present to the Emergency Services area within thirty (30) minutes for an emergency call and within (60) minutes for a routine call.

Section H - Pediatric Sedation for Diagnostic Tests

H.1 All patients <11 years of age having diagnostic procedures requiring parenteral sedation shall be evaluated prior to the procedure by a provider credentialed and privileged to do so.

H.1.1 Patients who shall undergo scheduled procedures [e.g. MRI] which necessitate parenteral sedation and/or analgesia shall have:

A. A history and physical performed.

B. Pre-procedural orders written by privileged provider.

C. A pre-procedural evaluation by privileged provider.

D. Sedation/anesthesia performed in accordance with usual procedures and protocols.

E. Be discharged by order of privileged provider.

H.1.2 Patients who shall undergo procedures [e.g. MRI] which necessitate parenteral sedation and/or analgesia while being evaluated in the Emergency Department shall be managed by the Emergency Department physician.

Section I – Screening of Pregnant Patient in Possible Labor

I.1 All pregnant patients who present to CentraCare - Rice Memorial Hospital shall undergo an appropriate medical screening examination.

I.1.1 Patients who are less than 20 weeks gestation shall be screened by the Emergency Services provider on duty at the time of presentation.

I.1.2 Patients who are 20 weeks or greater gestation shall be screened in the obstetrics area of the hospital by a nurse trained in labor and delivery. The results of this screening shall be reviewed with a medical staff physician with privileges in labor and delivery prior to the discharge of any patient.

Section J - Guidelines on Requesting an Autopsy

J.1 Autopsies can be important teaching and quality assessment tools in any hospital, and autopsy examination of deceased patients is actively encouraged at Rice Memorial Hospital. If the family does not wish a complete autopsy, a limited autopsy directed to the specific areas of most interest can be done. The following are criteria designed to aid in selecting the most appropriate instances in which to request an autopsy.

J.2 Coroner notification is required in some deaths occurring in hospitals.

J.2.1 Minnesota Statute 390.11 requires Coroner investigation of certain deaths (investigation may or may not include an autopsy). All sudden or unexpected deaths and all deaths that may be due entirely or in part to any factor other than natural disease processes must be promptly reported to the coroner or medical examiner for evaluation. Sufficient information must be provided to the coroner or medical examiner. Reportable deaths include but are not limited to:

A. Unnatural deaths, including violent deaths arising from homicide, suicide, or accident;

B. Deaths due to a fire or associated with burns or chemical, electrical, or radiation injury;

C. Unexplained or unexpected perinatal and postpartum maternal deaths;

D. Deaths under suspicious, unusual, or unexpected circumstances;

E. Deaths of persons whose bodies are to be cremated or otherwise disposed of so that the bodies will later be unavailable for examination;

F. Deaths of inmates of public institutions and persons in custody of law enforcement officers who have not been hospitalized primarily for organic disease;

G. Deaths that occur during, in association with, or as the result of diagnostic, therapeutic, or anesthetic procedures;

H. Deaths due to culpable neglect;

I. Stillbirths of 20 weeks or longer gestation unattended by a physician;

J. Sudden deaths of persons not affected by recognizable disease;

K. Unexpected deaths of persons notwithstanding a history of underlying disease;

L. Deaths in which a fracture of a major bone such as a femur, humerus, or tibia has occurred within the past six months;

M. Deaths unattended by a physician occurring outside of a licensed health care facility or licensed residential hospice program;

N. Deaths of persons not seen by their physician within 120 days of demise;

O. Deaths of persons occurring in an emergency department;

P. Stillbirths or deaths of newborn infants in which there has been maternal use of or exposure to un-prescribed controlled substances including street drugs or in which there is history or evidence of maternal trauma;

Q. Unexpected deaths of children;

R. Solid organ donors;

S. Unidentified bodies;

T. Skeletonized remains;

U. Deaths occurring within 24 hours of arrival at a health care facility if death is unexpected;

V. Deaths associated with the decedent's employment;

W. Deaths of nonregistered hospice patients or patients in non-licensed hospice programs; and

X. Deaths attributable to acts of terrorism.

The coroner or medical examiner shall determine the extent of the coroner's or medical examiner's investigation, including whether additional investigation is needed by the coroner or medical examiner, jurisdiction is assumed, or an autopsy will be performed, notwithstanding any other statute.

J.2.2 If an autopsy is ordered by the Coroner, a signed Authorization for Autopsy is not required but is appreciated since it facilitates the investigation.

J.3 It is suggested that an autopsy be requested for deaths with:

J.3.1 Uncertain cause of death on clinical grounds

J.3.2 Unanticipated medical complications, including obstetric deaths

J.3.3 Family concerns which may be allayed by autopsy findings

J.3.4 Temporal association with invasive diagnostic or therapeutic procedures

J.3.5 Participation in clinical trials (protocols) approved by the Institutional Review Board

J.3.6 Neonatal and pediatric age

J.3.7 Known or suspected environmental, infectious, or occupational hazard

J.3.8 Transplant donors, where findings could impact transplant recipients

In these cases, a signed Authorization for Autopsy is required.

J.4 Consent shall be obtained by the attending physician or designee. An "Authorization for Autopsy" form must be completed in full (including any limitations) and signed by the next of kin or Agent for Health Care if the patient has a Health Care Directive. Telephone permission is acceptable, but two witnesses must sign the authorization. The determination of next of kin status according to the State of Minnesota has been made legally in rank order as:

J.4.1 Healthcare Agent

J.4.2 Spouse

J.4.3 Adult Child

J.4.4 Parent

J.4.5 Adult Sibling

J.4.6 Adult Grandchildren

J.4.7 Grandparent

J.4.8 Legal Guardian

J.4.9 Adult exhibiting special care/concern

Note: If husband and wife are legally separated, the right of either spouse descends to the next of kin. Divorce terminates legal relationship.

J.5 In all cases, the attending or admitting physician is encouraged to call the pathologist directly to discuss the case. This allows discussion of any specific questions that should be investigated, any family requests, or any special procedures that should be followed (including appropriate handling of infectious risks). Should the attending not contact the pathologist, the pathologist shall attempt to contact the attending physician to discuss the case and ensure that he is aware that an autopsy is being performed.

J.6 In cases of inpatient deaths, there shall be no charge to the patient's estate or family. In emergency room deaths not ordered by the coroner, the patient's estate or family shall be billed for the procedure and use of the Rice Memorial Hospital facilities, unless otherwise arranged with the pathology department. All autopsies ordered by the coroner shall be billed to the Kandiyohi County Coroner's Office.

Section K – Drug Formulary

K.1 Drugs used in the treatment of patients shall be only those recognized and approved by the FDA or listed in Micromedex for clinical and/or investigational use.

K.2 All new drugs to be used in CentraCare - Rice Memorial Hospital must be evaluated and recommended by the Medication Use Committee and Patient Care Committee before they are added to the hospital formulary.

K.3 The Patient Care Committee may limit the duration of administration of drugs that are felt to be dangerous if used over a prolonged time and a list of such drugs and their duration of recommended use shall be forwarded through the Executive Committee to the staff.

K.4 Orders for medication are governed by policies and procedures which have been approved by the Medical Staff.

Section L - Locum Tenens and Temporary Privileges Considerations

L.1 Request

Request for a practitioner to either serve in a locum tenens capacity or be granted temporary privileges must be initiated by a request from within the department in which the practitioner shall be practicing.

L.2 Time Period

A. Temporary clinical privileges may be granted for a time period not to exceed 120 days.

B. Locum Tenens privileges may be granted for a time period not to exceed twelve (12) months, unless the Department Chair or Medical Executive Committee recommends a longer period for good cause.

L.3 Responsibilities and Privileges

L.3.1 Status shall be temporary or locum tenens with rights of Active Staff, APP or AHP Staff as applicable

L.3.2 May admit patients either as their primary responsibility or in conjunction with another Active Staff member if admitting privileges are granted

L.3.3 Medical Staff dues shall be waived

L.3.4 Are not eligible to vote or hold office

L.3.5 May participate in transactions of department and/or medical staff if it involves a subject or patient in which he/she is involved

L.3.6 A yearly maximum of 180 working days

L.3.7 If it appears that the practitioner is expected to be here for an extended period of time, he/she may be requested by the Department Chair to apply for full Active Staff, APP Staff or Allied Health Staff privileges with full responsibilities.

Section M - Medical Students, Advanced Practice Provider and Allied Health Students

M.1 Medical Students, Advanced Practice Provider and Allied Health Students must be currently enrolled in an officially sponsored program of an approved medical school, advanced practice provider or allied health school. Services rendered and areas of practice must be within the privilege areas granted to the assigned preceptor with all documentation produced by the student countersigned by the responsible preceptor.

Section N – Protocols for Medical Staff Member Impairment

N.1 Impairment, Substance Abuse and Behavior Concerns

N.1.1 The process for evaluation and management of concerns regarding potential physician impairment are outlined in the Practitioner Health Policy.

N.1.2 Licensed independent practitioners and other professional staff will be educated about recognizing impairment and disruptive behavior patterns, and when and how to report concerning incidents or behaviors.

N.2 Prolonged Illness

Refer to Article 2.5 in the Medical Staff Bylaws.

Section O – Policies and Plans

O.1 Service and Department Policies

O.1.1 The policies developed by designated departments and services of the Medical Staff shall be adopted by majority vote of the members voting at a meeting at which a quorum is present, providing they do not conflict with staff policy or Medical Staff Bylaws, or these Rules and Regulations.

O.2 Staff Plans

O.2.1 Disaster Plan

In the event of a disaster, CentraCare – Rice Memorial Hospital's Incident Command System shall be used to organize the hospital and medical staff response. This system coordinates with other community agencies involved in the response to the disaster.

O.3 Multi-Departmental Policies and Protocols

O.3.1 Recognizing the desirability of having defined policies and protocols to assist with the standardization and continuity of care patterns across departments, the following course is strongly encouraged.

A. Formulation of policies and/or protocols which impact medical staff members of multiple departments should, except in extenuating circumstances, be developed by a means which involves at least one member of each department which could foreseeably be affected by the policy or protocol.

B. After a draft copy of a proposed multi-departmental policy and/or protocol has been composed; it shall be distributed to each department in which members are likely to be impacted, with a specified time given for comment to be returned to the composing body.

1. If a policy and/or protocol enjoin specific duties to a group of members, a draft copy shall be distributed to each individual member of that group, with a specified time given for comments to be returned to the composing body.

C. The final version of the policy and/or protocol shall be forwarded to the Executive Committee, which shall accept the policy/protocol as written, accept an amended version of the policy/protocol, reject the proposal, or return the policy/protocol to the composing body with instructions for further consideration and/or modification.

D. A multi-departmental policy/protocol shall not go into effect until it has been approved by the Executive Committee.

Section P – Proctoring Policy for Rice Memorial Hospital Medical Staff

P.1 Purpose:

To ensure patient safety while providing educational value to enhance the scope of practice for physicians and APPs.

P.2 Policy:

The general requirements discussed in this policy, as well as those required for specific privileges as defined on the application criteria forms, represent the minimum required for successful completion of a proctorship. The Department Chairperson or Privileging Committee may recommend to the Executive Committee additional proctoring requirements.

The Department Chairperson may recommend to the Privileging Committee the waiving of any predetermined proctoring requirements. The Privileging Committee shall determine on a practitioner-specific basis whether or not a specific proctoring requirement shall be waived.

Proctoring may involve both direct observation and concurrent review, as appropriate to the privileges being proctored; and retrospective review which occurs after the medical record has been completed.

Proctoring is required for:

1. Requests for new privileges with identified proctoring requirements.

Proctoring may be required at the discretion of the Privileging and/or Executive Committee:

1. As a condition of privilege renewal for privileges performed so infrequently that assessment of current competence is not feasible.

2. Whenever the Privileging and/or Executive Committee determines that additional information is needed to assess a practitioner's current competence.

3. Whenever recommended by the Chief of Staff, Department Chairperson or designee who has authorized the granting of conditional/provisional or temporary privileges.

Adopted by the Active Medical Staff of CentraCare - Rice Memorial Hospital, Willmar, Minnesota.

Date: 12/5/23

Approved by the CentraCare – Willmar Area Advisory Board, Willmar, Minnesota.

Date: 12/6/23