RULES AND REGULATIONS

OF

THE MEDICAL STAFF

OF THE

ST. CLOUD HOSPITAL

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RULES AND REGULATIONS

A. ORIENTATION OF NEW ASSOCIATE MEDICAL STAFF MEMBERS

1. New Associate Medical Staff Members must make an appointment for orientation and complete this process prior to beginning practice in the hospital.

2. This orientation process will consist of the following:

   (a) Orientation to Medical Records Department, Nursing Staff in appropriate areas and other appropriate hospital staff.

   (b) Appropriate information will be provided or instructions on how to access the information will be made available, i.e. Medical Staff Bylaws; Medical Staff Credentials and Fair Hearing Manual; and Rules & Regulations, Disaster Plan, DRG Manual, other publications as appropriate.

   (c) A summary of pertinent Medical Staff meetings, meeting requirements and educational presentations, will be provided.

3. The orientation program will be under the supervision of the Vice President, Medical Affairs and the Medical Staff Office.

4. An opportunity will be provided for introduction to the Medical Staff Officers, the Vice President, Medical Affairs and Administrative personnel, as they are available, if so desired by the applicant.

B. PEER REVIEW POLICY

Whenever there are concerns or questions regarding the clinical competency or clinical practice or the care or treatment of a patient or patients or management of a case by any medical staff member; the information/chart shall be brought forward to the appropriate Department Chair or QI Committee to determine the need for a focused review.

At all stages of the focused review process the physician being reviewed is entitled to be informed of the concerns raised and respond to them.

If after review by a Physician Reviewer the care is found to be appropriate, no further action is taken.

If review by a Physician Reviewer finds that care did not meet the standard of care, the concerns are shared with the physician of record and brought forward for discussion at Department QI meeting, Department meeting or dealt with individually by the Department Chair.

If after review at the Department level care is found to be appropriate and concerns have been addressed, no further action is taken.

If review finds that the Standard of Care was not met, the case may be brought forward for discussion at Clinical Department Meeting

If concerns merit department discussion, discussion is documented in department meeting minutes and review outcomes are trended in the database and are noted as:

Appropriate Care

Documentation Concern
Care Management Recommendation
Some Aspects of Care Inappropriate
Referred for External Peer Review

At any time in the above process, the Department Chair may recommend actions be taken to the Vice President Medical Affairs and/or the Credentials Committee if corrective measures are warranted.

If External Peer Review is recommended, the request shall be submitted by the Department Chair, to the Vice President for Medical Affairs. The VPMA and the Department Chair will work together to identify and screen external reviewer candidates.

While members of the medical staff have the responsibility to participate in peer review, there are situations in which external review is desirable. The decision to seek external peer review is the responsibility of the department chair. Some situations in which peer review is desirable are:

- there is a conflict of interest among department members;
- the department members do not have the expertise to review the care in question;
- there is significant disagreement across department lines concerning the care in question;
- the department chair anticipates sufficient conflict, during the review process which could disrupt the harmonious functioning of the medical staff.

The external reviewer will be contacted by the VPMA, with the approval of the Department Chair and this person will be responsible for external peer review. External reviewer will meet with VPMA prior to review to be informed as to data being reviewed. The external peer reviewer will sign a Confidentiality Agreement.

External reviewer shall submit findings/recommendations to the VPMA who in turn shall forward the findings to the appropriate Department Chair for review and recommendation.

C. ADMISSION AND DISCHARGE OF PATIENTS

1. Patients may be admitted to Saint Cloud Hospital only by members of its Medical Staff. All practitioners shall be governed by the admitting policies of the hospital. The Medical Staff through the Executive Committee and departments will assist in the development and approval of these policies.

2. Each patient shall be the responsibility of a member of the Medical Staff. Such practitioner shall be responsible for the medical care and treatment, for the prompt completion and accuracy of the medical record, and for necessary special instructions. Whenever these responsibilities are transferred to another staff practitioner a note covering the referral and transfer of responsibility shall be entered into the Electronic Medical Record (EMR).

3. Except in emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

4. In the case of an admission through the Emergency Trauma Center, patients who do not have a private practitioner may have a choice of selecting any known practitioner on the Medical Staff, subject to the physician's acceptance of the patient, or being assigned in rotation to members of the active and associate staff.

5. Each member of the staff shall name a member of the Medical Staff who may be called to attend his/her patients in an emergency, or until he/she arrives. In case of failure to name such physician, the administrator of the hospital, Chief of the Medical Staff, or Chair of the department concerned, shall have authority to call any member of the active staff in such an event. Each member of the Medical Staff shall provide assurance of immediacy of adequate professional care as may be defined by his/her clinical department for his/her patients in the hospital by being available or having available through his/her office an eligible alternative practitioner with whom prior arrangements have been made. The alternate must be a member of the Medical Staff. Failure of the attending practitioner to meet the above requirements may result in loss of Medical Staff privileges and membership. Staff members who will be out of town for over 24 hours and do not have permanent arrangements for coverage should enter into the EMR, the name of the practitioner who will be assuming the responsibility for the care of those patients during his/her absence.

6. No patients will be transferred without such transfer being approved by the responsible practitioner.

7. The admitting practitioner shall be held 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 whenever his/her patient might be a source of danger from any cause whatever.

8. For the protection of patients, the Medical and Nursing staffs and the hospital, certain principles are to be met in the care of the potentially suicidal patient:
   (a) Any patient known to be suicidal in intent shall be admitted to the Mental Health Unit or in the event that facility is full, shall not be admitted to other floors in the hospital but shall be referred, if possible, to other institutions where suitable facilities are available. If no referral is possible, designated Behavioral Access Service Staff will assess patient in the Emergency Trauma Center

   If, in the judgment of the provider, serious medical problems exist of a higher priority than the underlying psychiatric problem, the patient should be admitted to the appropriate patient care unit under supervision per policy.

   (b) It is recommended that any patient known or suspected to be suicidal should have consultation by a member of the Department of Psychiatry.

   (c) In the event that a patient admitted to the general floors of the hospital is then found to be suicidal, he/she should be transferred when medically stable and a bed is available in the Mental Health Unit.

9. Admission to or discharge from Critical Care Units and Progressive Care Units.
   Admission to or discharge from Critical Care units and Progressive Care Units will be governed by their respective Admission and Discharge Criteria; contained in a separate policy.

10. The attending practitioner is required to document the need for continued hospitalization as specified in the utilization review plan and failure to do so shall be brought to the attention of the Executive Committee.

11. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner or without proper discharge, a notation of the incident shall be made in the patient's medical record.

12. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time and according to policies and procedures approved by the Executive Committee of the Medical Staff. Policies with respect to release of dead bodies shall conform to local law.

13. It shall be the duty of all staff members to secure meaningful autopsies whenever indicated. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the hospital pathologist, or by a practitioner delegated this responsibility. Provisional anatomic diagnoses shall be recorded on the medical record within 24 hours and the complete protocol should be made a part of the record within 30 days. Autopsy criteria are contained in the Rules and Regulations of the Medical Staff under the Department of Pathology.

14. Policy for Determining Which Patients Will Be Transferred to Another Hospital, In the Event of Unavailability of Service at St. Cloud Hospital

    Policy: In the event the St. Cloud Hospital is near its absolute capacity for patients and the requests for admission exceed that capacity, this policy and procedure will govern how the determination for patient admission or transfer will be made.

    Procedure: In the event that there is more than one patient competing for the last available functional bed at St. Cloud Hospital, the authority to determine who has access to that bed will be made by a consensus or majority vote of the nursing supervisor, the ETC physician present in the Hospital and the Chief of Staff or his/her designee.

    In the event that there is competition for the last functional bed, the nursing supervisor will notify the admitting physicians of those patients, of the unavailability of a bed for both patients. She (he) will confer (face to face, if possible) with the ETC physician and confer by phone, if necessary, with the Chief of Staff or his/her designee. It is the responsibility of these designated persons to understand the needs of the patient, the needs of the institution, and community, as well as the needs of the admitting physician. Assuming all avenues for patient accommodation have been explored, and no other option but patient transfer is available, the nursing supervisor will notify the physician of the patient needing transfer, that transfer is necessary. The transfer of the designated patient(s) will be made in accordance with federal COBRA-EMTALA guidelines.

D. MEDICAL RECORDS

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 an electronic signature.

1. The attending provider shall be responsible for the preparation of a complete and legible medical record of each patient. Its contents shall be pertinent and current. This record shall be compiled by the hospital using interactive entry in to CentraCare's Epic Health record and shall include identification data; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services and others; provisional diagnosis, medical or surgical treatment; operative report; pathological

findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report when performed.

Inpatient Admissions:

2. A complete admission history and physical examination shall be recorded within 24 hours of admission.

   St. Cloud Hospital History and Physical exam timing for inpatient admissions will be in accordance with the regulatory requirements.

Ambulatory Surgery or Procedures:

3. All surgery or procedure patients need a full operative H&P, regardless of ASA class or planned level of sedation.

   An exception to the above requirement for a complete history and physical for patients is in the case of patients receiving electro-convulsive therapy (ECT) (see Medical Staff Bylaws of the St. Cloud Hospital).

   It is the physician's responsibility to ensure that the patient has been informed of the risks and benefits associated with any surgery or procedure and that an informed consent or eConsent has been signed, dated, and timed by the physician and patient.

4. Any procedures requiring sedation or anesthesia must have the seven elements in the immediate post op/procedure note and the full procedure/operative report.

5. Other procedures requiring sedation or anesthesia normally done in a designated procedural area but done somewhere else (e.g., endoscopy performed in ICU) require a procedure note with the seven elements.

6. The seven elements are:
   a. The name(s) of the licensed independent practitioner(s) who performed the procedure and their assistant(s).
   b. The name of the procedure performed.
   c. A description of the procedure.
   d. Findings of the procedure.
   e. Any estimated blood loss where appropriate.
   f. Any specimens removed.
   g. The postoperative diagnosis (or as applicable for bedside procedures).

7. An immediate post procedure note or full operative or procedure note must be completed, reviewed, and signed before the patient transfers to the next level of care.

8. 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 and results of tests and treatment. Documentation of patient evaluation shall be done every 24 hours by the attending physician or designated clinically privileged licensed health care provider, with the exception of Rehabilitation patients that need to be seen at least every 3 days.

9. Operative reports shall include a detailed account of the findings of surgery as well as the details of the surgical technique. Operative reports shall be entered immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record.

Communication of Courtesy Notification, Consult, Transfer of Total Care, Transfer of Partial Care:

1. **Consult** – **A service provided by a provider whose opinion or advice regarding evaluation and/or management of a specific problem is requested by another provider.**

    a. Urgent consults may be called to the responding provider by the requesting provider,
    b. Non-urgent consults will be entered and handled by the Contact Center.
    c. Call groups can exercise the right to have consultation requests more stringent than the above (e.g.: Hospitalists and CentraCare Surgeons want to be called for all consults regardless of time). All individuals within a call group will be subject to the call group directions.

2. **Transfer of total care** to another Medical Staff member shall indicate the complete transfer of all patient care responsibilities to that physician, who then becomes the attending of record.

    a. The order should be placed in the EHR, to reflect the transfer of care by the attending physician.

3. **Transfer of partial care** shall indicate the transfer of a portion of a patient's care to another credentialed provider who will become responsible for that portion of the patient's care. The remainder of the patient's care will remain the responsibility of the attending physician. A **Transfer of partial care** shall be ordered and must clearly state the specialty area of referral.

4. **Courtesy Notification** – Auto routing of provider documentation does exclude progress notes. If a progress should need to be forwarded the document shall be routed manually by the author. CentraCare does participate in Health Information Exchange and Care Everywhere practices of documentation for continuation of care. Provider documentation and patient results are released to patient’s MyChart immediately.

Other Requirements

1. The current obstetrical record shall include a complete prenatal record, which may be a legible copy of the attending practitioner's office record, transferred to the hospital before admission. In such instances an interval admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

2. Histories and Physicals, consultation reports, operative reports and discharge summaries in the patient's medical record shall be accurately dated and signed (authenticated) or initialed before the record is considered complete. All orders paper or electronic, protocols, and treatment plans, must be authenticated by the provider requesting them.

3. An official record of unapproved abbreviations will be maintained by Pharmacy and available on Policy Stat.

4. Final diagnosis shall be recorded in full and dated and signed by the responsible practitioner at the time of discharge of all patients. This will be of importance equal to the actual discharge order. The attending physician or dentist has the responsibility to establish the final diagnosis.

5. A discharge summary shall be entered within 24 hours on all medical records of patients hospitalized over 24 hours. The discharge summary should concisely state the reason for hospitalization, the significant findings, the procedures performed, and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent. Exceptions are:

    a. A discharge examination is not needed for normal newborns who stay less than 48 hours from their time of birth. If the newborn's stay in the hospital is greater than 48 hours a discharge exam needs to be documented on the medical record.
    b. A discharge summary for patients having minor operative or invasive procedures who are discharged within 48 hours will not be required unless a nursing home or other agency requires a discharge summary.
    c. Operative and invasive procedures routinely requiring hospitalization of 48 hours or less are considered minor procedures or interventions.
    d. A death summary is required for all patients who die during hospitalization. Completion of the Death Certification Notice shall be completed by the appropriate provider and filed electronically with the Minnesota Department of Health; Minnesota Registration and Certification System (MR&C).

6. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

7. Records may not be removed from the hospital's jurisdiction and safekeeping except in accordance with a court order, subpoena, or statute. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by 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.

8. Medical Staff members may have access to the medical records of patients for whom they are caregivers. All access to patient records will be regulated by Federal HIPPA regulations and applicable MN Statutes.

9. Access to all medical records of all patients shall be afforded to members of the Medical Staff for bonafide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee of the Medical Staff before records can be reviewed. Subject to the discretion of the Chief Medical Information Officer, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the hospital.

10. A paper order is to be date and signed by the referring provider before imported or scanned by Health Information Management. Verbal and Telephone Orders should be used infrequently and authenticated within 24 hours.

11. All of the patient's medical records shall be completed at the time of discharge, including progress notes, order authentication, final diagnosis, and discharge summary. When it is not possible,

because of awaiting final laboratory or other essential reports, the outstanding report should be referenced in the Discharge Summary and an addendum to the summary be completed when the result is available.

12. Medical Records Completion Policy Statement

Medical Staff participates to ensure timely completion of medical records in accordance with regulations and quality-of-care standards:

a. History and Physical exam of the patient is recorded for inpatient admissions in accordance with the regulatory requirements (due in 24 hours or immediately before surgery).
b. Operative notes are documented immediately after surgery (due before the patient moves to the next level of service, <24 hours).
c. It is recommended the Discharge Summary is completed within 24 hours of patient discharge. The Discharge Summary signature deficiency will be delinquent at 14 days (tasks in Epic must be green for the patient to be released).

Medical Record Completion Enforcement Procedure

1. Notifications of incomplete records greater than 30 days will be sent to providers and suspension will be activate by Medical Staff Office. A list will be distributed to Patient Access Department, ETC, Medical Information and Surgery Scheduling. Providers will not be able to schedule elective procedures within the hospital or be allowed to admit non-emergency patients to the hospital until medical records have been completed.

2. Medical staff with records not completed within 30 days of service shall be placed on non-admit status and corrective action may be taken. (Records are 30 days delinquent.)

3. Once a Medical Staff member has been placed on non-admit status* the Health Information Department shall provide the Medical Staff Office with weekly notices of records that remain incomplete. Each week the Medical Staff Office will notify the provider's clinic asking for an alternate coverage for on-call status.

4. Names of medical staff with non-admit status will be sent to ETC, Patient Access Department, Health Information Department and Surgery Scheduling.

5. 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 placed on non-admit status.

6. The Vice President of Medical Affairs shall notify providers when they have reached four non-admit statuses to review this policy.

7. Six non-admit statuses in the past 12 months may result in automatic voluntary resignation from the medical staff. The Credentials Committee will review for disciplinary action.

8. If a provider has notified the Health Information Department that they are on vacation, the provider will not be placed on non-admit status. The provider must complete their medical records within 72 hours of their return to work. It is the Medical Staff's responsibility to notify the Health Information Department of vacation plans.

9. Allied Health Professionals and/or Medical Associate members will be held to the same policy guidelines for completion of medical records if they are credentialed to dictate and/or update medical records. If records are 30 days delinquent, providers will be placed on "no access status*".

   *Note: Non-admit status indicates that in addition to voluntary relinquishment of admitting privileges, the provider may not order any diagnostic or therapeutic interventions for patients; will not be allowed to cover call or to make rounds on hospitalized patients; and coverage for hospitalized patients will need to be arranged for by the staff member. The provider's clinic manager/president will be notified that the individual has been placed on non-admit status and that a replacement must be found to cover the provider's call and to round on any patients the provider may have in the hospital until non-admit status has been removed.

   *Note: No access status indicates the provider's functions at CentraCare have been inactivated and the provider may not order any diagnostic or therapeutic tests, round on hospitalized patients, or assist in surgery. The provider's clinic will be notified of placement on no access status.

Validation of (Family) Resident Medical Records

Purpose:

To assure that all legal, regulatory, and liability issues involving chart documentation are addressed when residents prepare reports.

To provide guidelines for institutional determination of the physician and/or advanced practice provider (APP) responsible for countersigning resident medical records.

Background:

As part of their education, residents are expected to prepare history and physicals, progress notes, discharge summaries, operative reports, and consultations. These various reports (and this list is not exhaustive) are prepared on patients who are admitted under the name of a member of the medical staff. This physician and/or the provider designated by the admitting physician, has the legal, regulatory (Joint Commission), and liability responsibility for the patient. Resident will document in each note/narrative, the name of the provider that is supervising the care of the patient.

Residents can hold one of two types of medical license in Minnesota. Until they have completed one year of postgraduate training, residents are issued a license that limits their medical practice to activities within the residency. After successful completion of the first year for US medical graduates and the second year for International medical graduates, they are encouraged to apply for a regular license. This allows them to carry on employment activities outside the residency if approved by the program director. However, their patient care activities when working as a resident are still required to be supervised. Supervising providers may differ in the degree of latitude granted residents to independently issue orders on patients. A frank discussion between the provider and the resident early in their interaction may reduce the possibility of misunderstandings.

Because they hold valid licenses, residents may enter orders or give verbal orders. Waiting for a supervising provider's co-signature before carrying out an order would delay care and be difficult to manage, and, thus, is unnecessary.

Medicare regulations stipulate what involvement of the supervising provider needs to have to properly bill for services to Medicare patients and avoid criminal fraud charges.

Policy Statement:

1. Every resident sees patients at St. Cloud Hospital under the supervision of a credentialed provider, except when working independently within an employment agreement outside of their residency contract.

2. Supervising providers, in their discretion, may delegate the responsibility of patient recordkeeping to a resident physician. Validation of a patient's record of care remains the responsibility of the supervising physician. Validation is required for H&P's, Progress Notes, ER Record or Note and Discharge Summaries. When an APP supervises a resident, the APP's documentation is the only information that can be utilized for billing purposes.

3. To help distinguish who the supervising provider is at any particular time, residents will include the provider's name as part of their narratives.

4. The supervising provider and the resident will discuss the resident's independent issuing of orders at the start of each rotation.

5. Orders, either written or verbal, initiated by a resident do not need to be co-signed.

6. The residency program will develop educational programs and written materials to help the attending staff comply with Medicare regulations regarding resident supervision.

7. Participation in the teaching program is voluntary for members of the Medical Staff. Non-participation with the program will not affect the provider's Medical Staff appointment or privileges.

Computerized Physician Order Entry (CPOE) Use and Enforcement

St. Cloud Hospital has established CPOE as the mechanism for placing orders. Providers, including physicians, and allied health providers are expected to use CPOE. To optimize patient care, it is recognized that cause may exist to not use CPOE. Specific cause shall include:

1. Order sets which by their unique nature are felt to require use of paper orders. The need for use of paper order sets is determined by the Medical Executive Committee with advice from the EPIC Inpatient Advisory Committee and the Chief Medical Information Officer.

2. Orders given for emergent care where the need for immediate care must supersede the mechanism of order entry.

3. Situations where extraordinary volume and urgency requires expediting the order process.

Consequences:

1. The CMIO will contact providers not using CPOE in an effort to optimize the system and to provide additional training as necessary.

2. The refusal to use CPOE without cause, as outlined above, or refusal to seriously engage the CPOE process will lead to suspension of privileges after 30 days. Therefore, this will result in the physician or Allied Health Provider being placed on Suspension Status as defined by the **Medical Record Completion Enforcement Procedure** under Medical Records in the Rules and Regulations of the Medical Staff. Elective cases or procedures may not be scheduled and only emergency situations may be amended.

3. Continued refusal to consistently use CPOE without cause will lead to placement on non-admit status, as defined by the **Medical Record Completion Enforcement Procedure** under Medical Records in the Rules and Regulations of the Medical Staff.

4. The CMIO will notify the Medical Staff Office when providers are felt to be non-compliant with use of CPOE as outlined above.

5. Providers will have the opportunity to present information demonstrating that they are adequately compliant through the VPMA and or the Chief of Staff. If agreement cannot be reached, the provider may appeal to the Credentials Committee. The Medical Executive Committee may hear appeals, if necessary subject to the procedure outlined in the **Corrective Action** provisions of the Medical Staff Credentials and Fair Hearing Manual.

E. ORDER SETS AND PROTOCOLS

Please see the Order Set/Protocol Development Process in the Appendix following the Rules and Regulations

F. GENERAL CONDUCT OF CARE

1. 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.

2. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital. In addition to obtaining the patient's general consent to treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure should be obtained. Appropriate forms for such consents should be adopted with the advice of legal counsel.

3. Diagnostic and therapeutic orders must be written by authorized practitioners. The order must be signed before the record is considered complete unless a shorter time limit is otherwise stated in policies governing specific activities (eg: Hospital Restraint Policy). Orders dictated over the telephone shall be signed by the appropriate qualified personnel to whom dictated with the name of the practitioner per his/her name. All telephone orders must be accompanied by a “readback”

of the order by the receiving qualified person and may be enacted only when verification is received from the physician dictating the order, that the order is correct as transcribed.

Only Registered Nurses or Pharmacists may transcribe medication orders.

4. The practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written out will not be carried out until rewritten or understood by the nurse. For oral and parenteral antibiotic orders, the physician must provide, on a form prescribed by the Infection Control Committee and acceptable to the Medical Staff, the indication for use, duration of use, and suspected/documented pathogen.

5. All previous orders are canceled when patients have surgical or invasive procedures that require general or regional anesthesia or deep sedation. Orders for patients having surgical or invasive procedures requiring local or mild and moderate IV sedation are not canceled.

6. All drugs and medications administered to patients shall be those approved for use in humans by the Department of Health and Human Services Food and Drug Administration. Drugs for clinical investigation shall be used in full accordance with rules and regulations as applied by the Food and Drug Administration and be approved for use within the institution by the St. Cloud Hospital Institutional Review Board.

7. (a) Psychiatric special treatment procedures which require documentation and justification in the medical record:

   (1) Restraints and Seclusion

   Medical Staff approved hospital policies/procedures will be followed in the use of restraints and seclusion.

   (b) There will be psychiatric multidisciplinary treatment plans with appropriate physician involvement and approval. Departmental policies/procedures will be followed.

8. The good conduct of medical practice includes the proper and timely use of consultation and referral. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized Medical Staff through Departmental Chairpersons and Executive Committee to see that those with clinical privileges do not fail in the matter of ordering consultations or referrals as needed.

9. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.

10. The attending practitioner is responsible for ordering consultation and referral when indicated. He/she will provide written authorization to request another attending practitioner to attend or examine his/her patient except in an emergency.

11. Chain of Command Patient Care
   (a) General Conduct of Care

   (1) If any caregiver has a question about the treatment of a patient by a physician, they are to report it to their immediate supervisor.

(2) If the matter is not taken care of to the satisfaction of the immediate supervisor, then the appropriate administrative nursing supervisor, Director or Coordinator shall be contacted and the physician/dentist shall be informed that the Chain of Command Policy is being followed.

If the caregiver is not satisfied with the resolution reached at any level, they may request the review be taken to the next step.

(3) The nursing supervisor, Director or Coordinator shall contact the involved physician/dentist and seek resolution.

(4) If direct contact could not be made or if resolution was not successful, the Chair of the Clinical Department of the type of patient being treated will be called. If, for whatever reason, the Chair of the Clinical Department feels that their objectivity in reviewing the issue may be compromised (partners with the physician of concern), he/she may defer the issue to the Chief of Staff.

Notification of the event to the Vice President of Medical Affairs is also accomplished as soon as possible (by next business day) to assist in the process as necessary or as information only if the question is resolved at this step.

(5) If the Chair of the Clinical Department or Vice Chair of the Clinical Department is not available, the Chief of Staff, the Chief of Staff-Elect, or the Secretary of Staff are to be called, in that order.

(6) If the Chair of the Clinical Department is not able to resolve the problem, it may be turned over to the Chief of Staff.

(7) The Chair of the Clinical Department and/or Chief of Staff may refer the matter to Article II of the Medical Staff Credentials and Fair Hearing Manual.

12. Medication orders must be renewed as follows:

(a) Doctor's order for Schedule 2 Controlled Substance must be renewed every three (3) days, unless ordered for a specific length of time.

(b) Doctor's order for oral and injectable antibiotics must be renewed every five (5) days, unless ordered for a specific length of time.

(c) Doctor's order for oral and injectable anticoagulants must be renewed daily, unless ordered for a specific length of time.

13. Code Blue Policy

Purpose:

The intent of this policy is three-fold:

First, to facilitate physician to physician communication regarding the status of the patient who is in the process of a Code Blue event;

Secondly, to facilitate communication with family and loved ones in a situation which is filled with fear and uncertainty;

Third, to vest authority in the first-responder physician to direct the care of the patient by recruiting whatever resources he/she thinks is appropriate.

Background:

The period of management during and following a Code Blue emergency is critical. For many patients, the post code management period is merely a continuation of the medical management process they have been receiving. For other patients, such as those receiving elective surgical procedures or those hospitalized for mental health concerns, the focus of care may assume an intensely medical focus; a focus which may not be in the expertise of the managing physician.

In the past, under these circumstances, it has not been uncommon for the managing physician to request, over the phone, that the patient receives a "stat" internal medicine consult for diagnosis and ongoing management. This directive may be given to the nurse at the scene or to a "good Samaritan" responder such as an emergency medicine physician. The Medical Staff acknowledges that adequate management of a Code Blue event requires a physician manager who is on site and able to render care to the patient and provide council to a family and loved ones who are in a state of fear and uncertainty.

In the past, managing physicians have attempted to manage the post code situation from home, leaving the nurse to call other physicians to assume management of a patient; a patient with whom they are unfamiliar leaving them to discuss prognosis with family members who have had no prior experience with them or their specialty. The Medical Staff views this practice as being inherently unfair to physicians who may respond and may represent an abdication of physician responsibility to patients and the patients' families. It is with this in mind that the following policy is created.

Policy:

The first-responder physician to a Code Blue situation (generally a family practice resident or emergency medicine physician) will render assistance to the Code Blue Team and assume responsibility for assessment and creating a transition of management for the patient. This first-responder physician is vested with the authority to direct the presence of any on-call physician resources, which he/she deems desirable for the management of the patient and/or the patient's family. He/she may direct the presence of on-call physician resources directly by phone or by directing a nurse to request a physician's presence at the bedside.

The authority of the first-responder is absolute, in this situation. His/her judgment will be based on the needs of the patient, the patient's family and the capability of the first-responder physician and his/her continued availability.

The Medical Staff intends this policy to provide optimal support to the first-responder physician's judgment at the scene of an, often, chaotic situation in which medical care needs to be rendered with technical expertise and sensitivity to human dignity. The Medical Staff will hold physicians accountable for their behavior if the spirit of this policy is violated.

This procedure is not meant to preclude constructive dialogue between the first-responder physician and any on-call Medical Staff physician regarding directives. The intent of this policy is, however, to provide optimal support for a first-responder physician in a difficult situation. The intent of this policy and procedure is for the first-responder physician to have clear authority to do what he/she considers is in the best interest of the patient and his/her family.

The Medical Staff further recognizes that there will be situations in which a physician who is requested to respond may be unable to do so because of extenuating circumstances (eg: a surgeon who is in the operating room). This policy is not meant to hold on-call Medical Staff physicians accountable for events, which are beyond their control.

Procedure:

1. The first-responder physician may direct the bedside presence of the on-call managing physician for the benefit of the patient and family and/or to manage the orderly transition of care to new physicians.

2. The first-responder physician may direct the bedside presence of other on-call physicians who he/she deems necessary for the diagnosis and/or ongoing management of the patient's care.

3. If faced with the refusal of an on-call Medical Staff physician to comply with the directives of the first-responder physician, he/she may activate the Chain of Command Policy and contact the Chair of the physicians Department to attain compliance. In this situation, a report of this non-compliance will be lodged with the Medical Staff Office and may be considered as grounds for corrective action under Article II of the Medical Staff Credentials and Fair Hearing Manual.

Policy on Code Blue Orders and Follow-up

In a situation requiring a Code Blue response, such a response will take place unless there is a specific physician order that there be No Code Blue response. A verbal order requesting that there be No Code Blue response will be required to be counter signed (authenticated) within twenty-four (24) hours of the time the order was issued by a responsible physician.

Procedure:

1. Weekly reminders will be placed in the physician's progress note area of the patient's chart requesting review of the patients No Code Blue status.

2. NCB (No Code Blue) and DNR (Do Not Resuscitate) are not approved abbreviations.

14. Criteria for Consideration as Organ Donor
    (a) Brain Death
    (b) Age less than 65
    (c) No systemic sepsis
    (d) No primary cancer
    (e) No premortem disease
    (f) Consent

15. Brain Death Criteria - see the St. Cloud Hospital *Brain Death, Guidelines for the Determination of Policy* found on the CentraNet under Policies and Procedures, Patient Care.

G. Policy on the Use of Latex Gloves by Physicians

Purpose:

To minimize the use of latex containing gloves by detailing who may use these gloves and under what conditions they may be used.

To allow St. Cloud Hospital personnel, patients and visitors to avoid contact with natural rubber latex allergen, whether it be by touching or breathing. To protect those who work at St. Cloud Hospital from evolving sensitization to natural rubber latex allergen.

Scope of the Policy:

All those who work at St. Cloud Hospital.

Introduction:

Natural rubber latex products are used extensively at St. Cloud Hospital. Allergy to latex is increasing in health care workers nationwide and is becoming a cause of morbidity among those who work at the Hospital. Those who work at the Hospital may contact latex directly by touching latex containing products such as gloves or catheters or contacting clothing such as scrub suits or lab coats that have been the repository for airborne latex allergen. In addition, airborne latex allergen can be distributed through the Hospital's ventilation system, for inhalation by personnel at sites far distant from the source of the allergen.

There is evidence that those who work at hospitals are at risk for the development of latex allergy by virtue of high levels of exposure over long periods of time. Recently employees at St. Cloud Hospital and members of its Medical Staff have developed skin and pulmonary symptoms from latex at an accelerating rate.

Those who have developed pulmonary symptoms (bronchospasm) are at a particular disadvantage since it is hard to avoid the latex aeroallergen, which is distributed widely by ventilation systems. These individuals exist in a virtual sea of aeroallergen. Their disability may be subject to Hospital liability under the Americans with Disabilities Act (ADA), given recent and evolving case law.

St. Cloud Hospital has used over 120,000 pair of high allergen powdered latex gloves per year (> 400 pair/day). Some of the allergen from these gloves entered into the ventilation system, was inhaled and deposited on clothing. Latex antigen from gloves may be impossible to totally contain. Efforts to contain this antigen should be aimed at elimination of known and controllable sources of this antigen. Studies at the Mayo Clinic indicate "that rubber glove allergen content is the most important determinant of latex aeroallergen levels in the surgical setting". Powder acts as a vehicle for latex distribution.

The Hospital has an obligation to those who work here to minimize contact with latex allergen as a way of minimizing their evolving development of latex allergy. Some of those who work here have developed latex allergy. For all, avoidance of latex allergen is critical.

The Hospital has an obligation to its patients and those who visit here. These persons may have latex sensitization. Patients are screened for symptoms suggestive of latex allergy and are placed in latex precaution. It is difficult, however, to totally protect them from aeroallergen and clothing deposited allergen. The Hospital may be liable for adverse outcomes to patients and visitors from latex exposure unless reasonable efforts are made to contain the problem. This possible liability may be shared with members of our Medical Staff who knowingly *chooses* to continue using products, which place coworkers, patients and visitors at risk.

Policy:

1. Natural rubber latex gloves may only be used at St. Cloud Hospital in the operating rooms (includes the operating area of the Family Birthing Center). Latex containing gloves shall not be used in any other areas of the Hospital.

2. Natural rubber latex gloves may only be used by physicians in the operating rooms. All other operating suite personnel, including surgical assistants, surgical techs., nurses and perfusionists must use non-latex (synthetic) gloves.

3. The use of natural rubber latex containing gloves by physicians:
   A. Physicians are strongly encouraged to use non-latex gloves;
   B. Physicians may use low allergen latex non-powdered gloves if they feel that the tactile and barrier qualities of non-latex gloves are unacceptable;
   C. High allergen latex powdered gloves are not encouraged for use by any physicians. These gloves may only be used by physicians upon written petition to the Medical Executive Committee, detailing a compelling reason to use such gloves based on tactile and barrier qualities. Written petition will only be allowed after the physician has attended or viewed the video of the mandatory educational program given by Dr. M. Yassin on September 22, 1999 and has tried-on recommended alternatives to high allergen powdered latex gloves.
   D. Physicians may not use high allergen latex gloves in the operating rooms after December 31, 1999 unless a written petition exemption is granted by the Medical Executive Committee.
   E. Any physician who is granted an exemption to use high allergen latex gloves, will have that use monitored as to location and number of gloves used. Any exempted physician must reapply, yearly, for continued exemption. All attempts will be made to confine the use of high latex allergen powdered gloves to a minimum number of surgical rooms.

H. GENERAL RULES REGARDING SURGICAL CARE

1. Except in severe emergencies, the preoperative diagnosis/proposed surgical procedure must be recorded on the patient's medical record by the attending surgeon prior to any surgical procedure. If not recorded the operation shall be canceled. The attending surgeon must assure required laboratory tests are recorded on the patient's medical record prior to any surgical procedure. If not recorded the operation shall be canceled. In any emergency the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.

2. A patient admitted for dental care is a dual responsibility involving the dentist and physician member of the Medical Staff.

   (a) Dentist's Responsibilities:

      (1) A detailed dental history justifying hospital admission;

      (2) A detailed description of the examination of the oral cavity and a pre-operative diagnosis;

      (3) A complete operative report, describing the findings and technique. In cases of extraction of teeth the dentist shall clearly state the number of teeth and fragments removed. All tissue shall be sent to the hospital pathologist for examination.

(4) Progress notes as are pertinent to the oral condition;

(5) Clinical resume (or summary statement).

(b) Physician's Responsibilities:

(1) Medical history pertinent to the patient's general health;

(2) A physical examination to determine the patient's condition prior to anesthesia and surgery;

(3) Supervision of the patient's general health status while hospitalized.

(c) The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

3. Written, signed, informed, surgical consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully documented on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

4. The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow up of the patient's condition.

5. In all surgery, the staff member with surgical privileges will be responsible for the number and qualifications of his/her assistants. In any surgical procedure with unusual hazard to life the assistant must be a physician who is present and scrubbed.

6. All 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 tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

I. EMERGENCY CALL POLICY

Statement of Policy:

The Medical Staff of the St. Cloud Hospital will provide physician coverage 24 hours a day, seven days a week to patients presenting to the Emergency Department. In addition to the Emergency Department physicians, there will be a physician call schedule, which will be prospective, list all specialties and subspecialties, and list individual physician names.

1. It is expected that a physician, after being called will respond to provide patient assessment. Any needed procedure and/or treatment which falls into the realm of the physician's usual scope of patient care will be used as a guideline when providing care for patients during on call hours in the emergency room. If, after assessing the patient, the physician concludes a treatment or procedure is needed which is not best provided personally, the physician will assist the Emergency Department physician in appropriate disposition of the patient or will facilitate referral to another physician on

the medical staff. When appropriate the ETC physician will call the primary care physician or the on-call physician for the patient's group prior to calling the specialist on call.

2. All individuals with clinical privileges will be subject to call at the discretion of the Department Chair.

3. No one will be expected to provide call more often than every 3rd day without his or her permission. Thus, for services with only one or two physicians with clinical privileges, there may be days with no one assigned to call.

4. Members of the medical staff and individual practitioners with clinical privileges who are unable to be on call on an assigned day are responsible to arrange coverage and notify the hospital Communication Center of the change.

5. It is understood that call physicians must prioritize their time based upon the urgency of the situation. A physician is not expected to leave a patient in the Operating Room or a procedure room. There may be instances when the physician is unable to leave a patient's bedside. In this situation, the call physician will discuss the situation with the ER and come to a mutually agreed upon plan. The on-call physician will keep the ER informed of situations where resources at our institution, such as surgery, are at capacity. This may require strong consideration that these cases bypass our hospital.

6. A physician/dentist must respond promptly by telephone and if requested, must be able to attend to a patient within 30 minutes response time unless a greater or lesser time is otherwise specified of notification by the Emergency Department. The physician will assess the patient and assist the Emergency Department in appropriate disposition of the patient after evaluation if the individual cannot be cared for at SCH.

7. The actual name of the physician must be on the call roster. Listing the name of a group rather than an individual is not acceptable.

8. Department Chairs are responsible for the call roster planning and development for their specialty.

9. Suspected violations of this policy must be reported to the respective Hospital Department Chair and should include the date, the practitioner's name and the suspected violation.

    a. This information must also be forwarded to the VPMA, and the physician's group representative.

    b. The Department Chair with the assistance of Risk Management is responsible for reviewing the available information and talking to the involved practitioner. If there are no issues identified in this review the case will be closed, with a letter stating that a review was conducted with no findings identified going into the medical practitioner's file and forwarded to the VPMA and president of the medical staff.

    c. If the Department Chair, in review discovers issues of concern with the practitioner, they will meet with the involved practitioner, to review the EMTALA/ On Call Policy and discuss expectations. The Department Chair may request the assistance of the VPMA and /or the president of the medical staff for this meeting. A letter to this effect will be placed in the practitioner's credentials file. Repeat occurrences may lead to a review of those violations by the full Medical Executive Committee.

    d. If the practitioner who initially brought the matter to the attention of the Department Chair

is not satisfied with the outcome of the Department Chair review, they can contact the Chief of Staff in writing asking that a second review of the incident be initiated.

e. The Chief of Staff or the VPMA will conduct a review of to be completed within two weeks of being contacted. This will consist of a review of the previously accumulated information, discussions with the involved practitioner and the person bringing forth the complaint, Risk Management, and others who may be able to provide helpful information.

f. If there are no issues identified, the case will be closed. A letter stating that a review was conducted with no findings identified will be placed into the medical practitioner's file.

g. If the Chief of Staff and/or the VPMA in their review discover issues of concern, these will be addressed. There may be system issues with communications, etc., which do not directly involve a practitioner, which need to be addressed. If there are issues with an individual practitioner, they will meet with the involved practitioner, to review the EMTALA/ Emergency Call Policy and discuss expectations. A letter to this effect will be placed in the practitioner's credentials file. Repeat occurrences may lead to a review of those violations by the full Medical Executive Committee.

J. EMERGENCY SERVICES

1. The Medical Staff shall adopt a method 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.

2. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The 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 the patient prior to his/her arrival at the hospital;
   (d) description of significant clinical, laboratory and roentgenologic 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.

3. There shall be a periodic review of emergency room medical records by the department of emergency medicine to evaluate quality of emergency medical care.

4. St. Cloud Hospital does not always have the appropriate personnel and resources for acute surgical treatment of thoracic aortic emergencies. St. Cloud Hospital, therefore, may not accept such patients except as circumstances dictate for diagnosis, initial stabilization and transfer.

To expedite appropriate transfer, St. Cloud Hospital, will maintain transfer agreements with one or more regional referral hospitals for these conditions.

St. Cloud Hospital cares for all patients regardless of race, creed, gender, age or payment source in compliance with Federal COBRA/EMTALA laws.

5. There shall be a plan for the care of mass casualties at the time of any major disaster, based upon the hospital's capabilities in conjunction with other emergency facilities in the community. The disaster plan shall be rehearsed twice a year.

6. Trauma Director

   (a) The Trauma Medical Director oversees and is responsible for the medical direction of the Trauma Service. Responsibilities include oversight of all trauma related Standards of Care for the trauma patient and address issues related to these standards as needed.
   (b) Members of the Trauma Service have a direct reporting relationship to the Trauma Medical Director. The Trauma Medical Director has full management authority over participating Trauma Surgeons and monitors compliance/non-compliance with Trauma Standards of Care and with contractual obligations and intervenes as necessary.
   (c) The Trauma Medical Director has administrative authority, accountability and responsibility for the development and evaluation of a Trauma System that ensures that patients receive quality trauma care.

K. Guidelines for Acceptance of Transfers

It is the policy of this hospital to accept patients for inter-hospital emergency transfers from within the boundaries of the United States who are suffering from emergency medical conditions that are in need of stabilizing treatment within the capabilities and capacity of this facility but not available at the original facility treating the patient. Such acceptance will be without regard to the financial ability or method of payment of the patient, or the race, creed, color, national origin, sex, sexual preference, or condition of disability of the patient to the extent that such disability is not a decisive medical factor in the ability of this hospital to care for the patient. The guidelines set forth in these guidelines shall apply to all departments of the hospital.

1. EMTALA requires that if you are contacted and the hospital has the capability and capacity to care for the patient which cannot be cared for appropriately at the sending hospital, you are required to accept the patient.

2. The Emergency Trauma Center will continue to accept appropriate patients in transfers with one call to the Emergency Department.

3. The Emergency Physicians will decide if the patient requires further emergency room evaluation or if the patient can be referred directly to an admitting physician.

4. The admitting physician will be called and given the transfer information including the name of the patient, the name of the physician, and the name and phone number of the sending facility.

5. The attending physician can then decide to see the patient in the Emergency Room upon arrival, or make the patient a direct admission after consultation with an appropriate accepting physician.
6. Transfers may be refused but only under particular circumstances and with precise

documentation.

a) Major burns should not be accepted.
b) Any potential or diagnosed thoracic aortic injury or dissection should be deferred.
c) Replants of digits should be discussed with the on call specialist before acceptance.
d) Pediatric trauma can be accepted with the understanding that prolonged multi-system involvement may require a transfer after initial stabilization.

7. If the physician calling is requesting advice on treatment, and the consensus is that the patient can be served equally well at he sending hospital, transfer may be deferred.

8. Any transfer not accepted will be referred to QI by dictating on line 11, (Patient number 222222) name of patient, birth date, name of calling physician, and facility. This dictation should include the just of the conversation and resolution.

L. CREDENTIALING PRACTITIONERS IN THE EVENT OF A DECLARED DISASTER

PURPOSE: To outline the procedure for practitioners who do not possess medical staff or allied health staff membership and delineated privileges/functions at St. Cloud Hospital to practice at St. Cloud Hospital during a declared disaster/emergency (defined as an officially declared emergency, whether it is local, state or national).

POLICY: Practitioners who do not possess medical staff privileges at St. Cloud Hospital may practice at this hospital during an "emergency." Emergency privileges may be granted when the Hospital Incident Command System (HICS) (i.e.: activation of the Hospital's emergency operation plan) has been activated and the organization is unable to handle the immediate patient care needs as determined by the Incident Commander. Emergency privileges may be granted by the President or Vice President of Medical Affairs of the Hospital or their designee(s). The responsible individual is not required to grant privileges to any individual and is expected to make decisions on a case-by-case basis.

Procedure:

Practitioner

1. Complete a temporary emergency privilege/function form found in the Emergency Operation Plan located on the CentraNet.
2. Sign a statement attesting that the information given to the hospital is accurate.
3. Agrees to be bound by all hospital policies and rules, as well as Medical Staff Bylaws and Rules and Regulations, as well as any directives from the Department Chairperson, supervising physician, or any other hospital or medical staff leader.
4. The following information **must** be available in order to grant temporary emergency privileges:
    a. Valid professional license to practice in the State of Minnesota., with a valid photo ID issued by a state, federal or regulatory agency.
        Note: depending upon the extremity of the disaster, out of state medical licensure may be accepted if so declared by the State of Minnesota
    b. A current hospital photo ID card.
    c. Name of hospital where the practitioner has active membership
    d. Malpractice insurance coverage.

Photocopies of the above listed documents must be made and retained. Verification of the above information should be done as soon as the immediate situation is under control and is completed within 72 hours from the time the volunteer practitioner presents to the organization by the Medical Staff Office.

In addition to the above, verification shall include querying of the National Practitioners Data Bank and the OIG. Hospital affiliation will be verified by telephone, a copy of the practitioner's license will be maintained in the Medical Staff Office. Verification of malpractice insurance will be obtained from the most current hospital affiliation and must be in accordance with coverage requirements required of all medical staff applicants. In the event these verifications cannot be completed immediately, emergency privileges may still be issued.

Emergency temporary privileges are recommended by and require signature from the VPMA or President of the Hospital or their designee. Medical Staff coordination is accomplished by the Chief of Staff/designee who will assign practitioners as appropriate.

Emergency Privileges will:

- Reflect the practitioner's training and specialty
- Be granted for the duration of the disaster only
- Automatically terminate at the end of the needed services
- May be immediately terminated by the Chief of Staff or his designee in the event any information is received that suggests that the person is not capable of rendering services
- Termination of these emergency privileges, regardless of cause does not entitle the practitioner to request a hearing or other due process.

Emergency Disaster privileges shall be granted to an appropriately qualified practitioner based upon the needs of St. Cloud Hospital to augment staffing due to the disaster situation. Federally deployed practitioners shall be limited in their privileges to the scope of their Federal employment. To the extent feasible, the practitioner will be assigned to a Medical Staff or Allied Health Professional member, in the same specialty, with whom to collaborate in the care of disaster victims.

Emergency Disaster privileges terminate when patients are out of imminent danger of death or serious deterioration of condition, the service is no longer needed or at the discretion of the President/VPMA or their designated representatives.

The credentials files are considered peer review and will be maintained as confidential to the full extent authorized by law.

M. MEDICAL ASSOCIATES AND ALLIED HEALTH PROFESSIONALS

Medical associates and Allied Health Professionals shall be assigned to an applicable clinical department(s) by the Credentials Committee considering their clinical activities.

(a) Medical Associates

(1) Qualifications and conditions of practice for medical associates are delineated under Article X, Section I-a of the Bylaws.

(2) Medical associates shall not be appointed for more than two (2) years and shall be reviewed every two (2) years by the applicable clinical department, the Credentials Committee**,** Executive Committee of the Medical Staff and approved by the Quality/Safety and Professional Affairs Committee of the Board of Directors (name change 9/25/07).

(3) Specific categories of medical associates are listed below with particular qualifications, functions and responsibilities delineated as appropriate.

(1) Clinical Psychologists

(a) Qualifications and duties of all clinical psychologists are as provided in the job description titled "Staff Psychologist" as defined by their function list.

(b) Clinical psychologists employed by the hospital who are medical associates are also governed by the Personnel Policies of the Saint Cloud Hospital, in consultation with the Department of Psychiatry.

(c) Functions for Clinical Psychologists are defined by the Department of Psychiatry and outlined on the current function list recommended by the Credentials and Medical Executive Committees and approved by the Quality/Safety and Professional Affairs Committee of the Board of Directors (name change 9/25/07).

(b) Allied Health Professionals

(a) Qualifications, selection, and conditions of practice allied health professionals are delineated under Article X, section 2 of these Bylaws.

(b) Allied health professional appointments shall not be for more than two (2) years duration. Allied health professionals shall be reviewed every two (2) years by the applicable clinical department(s), the Credentials Committee, Executive Committee, and Performance Improvement Committee of the Board of Directors.

Allied Health Professionals shall have their scope of practice defined on the currently approved and delineated Clinical functions form.

Individuals normally credentialed as Allied Health Professionals may alternatively, be credentialed using the Human Resources standards of the Joint Commission. Such individuals would function under a specific job description, which would delineate their clinical functions.

(c) It shall be the responsibility of the employer to see that the allied health professional operates within the confines of his/her approved functions and with the degree of supervision previously designated. Failure to do so on the part of the employer will bring automatic suspension of the allied health professional, according to Article X, Section 2. A physician employer would be subject to corrective action under Article II of the Medical Staff Credentials and Fair Hearing Manual.

(d) It shall be the duty of the Chair of his/her Clinical Department, upon learning of any breach of conduct or performance beyond the functions so outlined, to make a simultaneous report of the complaint to the physician/hospital employer, the Chairman of the Credentials Committee, the Vice President of the Medical Staff**,** the Chief of the Medical Staff, and the Chief Executive Officer of the hospital.

(e) Some specific categories of medical assistants are listed below. In all cases, persons requesting allied health professional functions shall provide evidence of current

registration or licensure by the appropriate governing bodies, evidence of malpractice insurance, evidence of good health from a medical professional, a minimum of one peer reference, and a chronological summary of employment including dates and reasons for termination.

Physician Assistants and Advance Practice Nurses shall ensure that a current practice agreement and/or delegated prescribing agreement outlining his/her scope of practice with a sponsoring physician is provided to the Medical Staff Office with each appointment or reappointment or when revised.

Physician Assistants and Advanced Practice Nurses wishing to order radiographic examinations may be able to demonstrate eligibility in his/her practice agreements as outlined in the application criteria.

(1) Advanced Practice Nurse
(2) Audiologist
(3) Cardiovascular Perfusionist
(4) Certified Nurse Midwife
(5) Certified Registered Nurse Anesthetist (CRNA)
(6) Dental/Oral Dental Assistant
(7) Orthopedic Assistant
(8) Physician Assistant
(9) Surgical Tech, Surgical Assistant, RN First Assistant

N. MEDICAL STAFF APPLICATION/REAPPLICATION AND CLINICAL PRIVILEGES FORMS

1. The application and reapplication for Medical Staff membership, including the forms requesting clinical privileges, may be revised from time to time as necessary, by the Credentials Committee. These revisions will become effective when approved by the Board of Directors, after consulting with and receiving recommendations from the Credentials Committee and the Medical Executive Committee of the Medical Staff.

2. When a revision of previously accepted forms for any Department's privileges is recommended, it shall be discussed by the Credentials Committee who will forward the proposed revisions to the relevant clinical department(s) where it will be added to the agenda for the next clinical department meeting. The final revisions will be approved by the Credentials Committee and the Medical Executive Committee of the Medical Staff. The final revisions will be approved by the governing body after consulting with and receiving written recommendations from the Credentials Committee and the Medical Executive Committee of the Medical Staff.

O. Consulting Category of the Medical Staff Guidelines for Medical Staff Recommendation to the Board of Directors

A. Bylaws Criteria

A. Must be a service not represented currently on the Medical Staff
B. The service must be requested by a Department of the Medical Staff

II. Guidelines for the Medical Staff's Recommendation to the Board of Directors:
The Medical Staff's recommendation will be on a case-by-case basis, based on its

judgement as to the need for the requested service in the Community and the risk to patients of exempting the practitioner from the 30 minute response time. There also may be situations, which would require evidence that some intermediate degree of coverage is needed.

A. Request for cognitive privileges
   1. The requesting practitioner or his/her peer group should be available for phone consultation 24 hours per day.

B. Request for procedural privileges
   1. The requesting practitioner or his/her peer group should be available for phone consultation 24 hours per day.
   2. Because Consulting Category involves an exemption to the 30 minute response time, it is important to determine whether the risk of life threatening acute complications inherent in the privilege(s) requested warrants assurance that patients will be attended to in a timely manner by physicians capable of dealing with those complications.

      a. The judgment to be made by Credentials and Executive Committees of the Medical Staff would be:
         - Acceptable risk relative to absence of 30 minute response time**,** or**;**
         - Unacceptable risk relative to absence of 30 minute response time**,** or**;**
         - Acceptable risk relative to absence of 30 minute response time with some arrangement for local coverage.

      b. If "acceptable risk" then practitioner may be recommended for privileges without regard to the 30 minute response time.

      c. If "unacceptable risk" then Consulting Category status should not be recommended

      d. If "acceptable with some arrangement for local coverage" the Medical Staff may recommend granting of Consulting Status with sufficient evidence that the recommended Degree of local coverage is agreed to and arranged for prior to the granting of the requested privileges.

P. Medical Staff Impaired Physician Policy

Purpose

- To ensure optimal quality of care for all patients
- To maintain a safe environment for patients, employees and other Medical Staff members
- To provide a positive medical assistance program to the impaired physician

Definition of term:

Impaired Physician: One who is unable to practice medicine with reasonable skill and safety to patients because of a physical or mental illness, including deterioration through the aging process, or loss of motor skill, or excessive use of abuse of drugs or chemicals, including alcohol.

Responsibility: It is the duty of the members of the Medical Staff to share their concerns regarding potential impairment of themselves or other members of the Medical Staff with the designated Hospital and Medical Staff personnel. When serious concerns are raised they should be reported to the Department Chair of the possible impaired physician or to the Vice President of Medical Affairs

Hospital Policy Regarding Impaired Physicians

Physician members of the medical staff are required to self-report if they use any illegal drugs or any drugs illegally. The use of physician prescribed medications which may have the effect of impairing judgment or performance or DWI/DUI or other criminal legal process must be self-reported to the Department Chair or Vice President of Medical Affairs.

If any individual working in the hospital has a reasonable suspicion that a physician appointed to the medical staff is impaired, the following steps should be taken:

1. The individual who suspects the physician of being impaired must give an oral or, preferably, written report to the Department Chair, Vice President of Medical Affairs or the Chief of Staff. The report must be factual and shall include a description of the incident(s) that led to the belief that the physician might be impaired. The individual making the report does not need to have proof of the impairment but must state the facts that led to the suspicions.

2. If, after discussing the incident(s) with the individual who filed the report, the Department Chair, VPMA or Chief of Staff believes there is enough information to warrant an investigation, the VPMA shall request that the VPMA, COS/COS Elect, department leadership and other appropriate individuals meet.

3. If agreed, an intervention should be arranged with appropriate parties. The physician shall be told that he/she may suffer from an impairment that affects his or her practice. The physician should not be told who filed the report, and does not need to be, but may be, told the specific incidents contained in the report.

4. To determine the severity of the problem and its genesis, the physician may be required to undergo physical and/or psychological examinations to determine the physician's chance of rehabilitation and whatever modalities should be employed.

5. Depending upon the severity of the problem and the nature of the impairment, the hospital shall, as an alternative to Corrective Action under the Medical Staff Credentials and Fair Hearing Manual:
   a) Require the physician to participate in the rehabilitation program, such as the Minnesota Health Professional Services Program,
   b) impose appropriate restrictions on the physician's practice
   c) immediately suspend the physician's privileges until rehabilitation has been accomplished if the physician does not agree to discontinue his/her practice voluntarily.
   d) Report to the Minnesota Licensing Board or other agencies, as required by Minnesota law, in the event of non-compliance with the recommendations made by the hospital.

6. The original report and a description of the actions taken by the VPMA or Chief of Staff should be included in the physician's confidential credentials file. If the investigation reveals that there is no merit to the report, the report shall be shall be destroyed. If the investigation reveals that there may be some merit to the report, but not enough to warrant immediate action, the report shall be included

in the confidential portion of the physician's credentials file. Also, the physician's activities and practice may be monitored until it can be established whether there is an impairment problem.

7. The Vice President of Medical Affairs or the Chief of Staff shall inform the individual who filed the report that follow-up action was taken.

8. This process is confidential under the peer review statute.

9. The Hospital shall determine whether any conduct must be reported to any government agencies such as the Department of Health, Office of Professional Medical Conduct, and what further steps must be taken.

Rehabilitation

Hospital and medical staff leadership shall assist the physician in locating a suitable rehabilitation program. The physician shall not return to hospital practice until it is established, to the hospital's satisfaction, that the physician has successfully completed a rehabilitation program in which the hospital has confidence. Depending upon the severity of the impairment, follow-up/monitoring may be required after the physician returns to work.

Reinstatement

1. Upon sufficient proof that a practitioner who has been found to be suffering an impairment has successfully completed a rehabilitation program, the Vice President of Medical Affairs, Chief of Staff or Department Chair may recommend that practitioner for reinstatement to the medical staff.

2. In considering an impaired practitioner for reinstatement, the hospital and its medical staff leadership must consider patient care interests paramount.

3. The hospital must first obtain a letter from the physician director of the rehabilitation program where the practitioner was treated. The practitioner must authorize the release of this information. The letter shall state:
   a) whether the practitioner is participating in the program
   b) whether the practitioner is in compliance with all the terms of the program
   c) whether the practitioner attends meetings (as appropriate)
   d) to what extent the practitioner's behavior and conduct are monitored
   e) whether, in the opinion of those doctors, the practitioner is rehabilitated
   f) whether an aftercare program has been recommended to the practitioner and, if so, a description of the aftercare program
   g) whether, in his/her opinion, the practitioner is capable of resuming medical practice, and providing continuous, competent care to patients

4. The practitioner may be required to inform the hospital of the name and address of his/her primary physician, and must authorize that physician to provide the hospital with information regarding his/her condition and treatment. The hospital may require an opinion from other physician consultants of its choice.

5. The hospital needs to know from the primary care physician the precise nature of the practitioner's condition, and the course of treatment as well as the answers to the questions posed in (3 e-g).

6. Assuming all of the information received indicates that the practitioner is rehabilitated and capable

of resuming care of patients, the hospital must take the following additional precautions when restoring clinical privileges:

a.) The practitioner may be required to identify physicians who are willing to assume responsibility for the care of his/her patients in the event of his/her inability or unavailability.

b.) The practitioner shall be required to obtain periodic reports for the hospital from his/her primary care physician for a period of time specified by the Credentials Committee stating that the practitioner is continuing treatment or therapy, as appropriate, and that his/her ability to treat and care for patients in the hospital is not impaired.

7. The practitioner's exercise of clinical privileges/functions in the hospital may be monitored by a physician appointed by the VPMA or Credentials Committee. The nature and duration of that monitoring shall be determined by the Credentials Committee after its review of the circumstances.

8. This policy and procedure does not alter the Medical Executive Committee's authority under the provisions of the Medical Staff Bylaws to investigate and take action as it deems appropriate in any case coming to its attention, but the Medical Executive Committee shall whenever reasonably possible deter to the Credentials Committee to initially address any matter involving practitioner impairment.

Q. Proctoring Policy for St. Cloud Hospital Medical Staff

Purpose: To ensure patient safety while providing educational value to Enhance the scope of practice for physicians.

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 proctorship. The Department Chairperson or Credentials Committee may recommend to the Executive Committee additional proctoring requirements.

The Department Chairperson may recommend to the Credentials Committee the waiving of any predetermined proctoring requirements. The Credentials 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 Credentials 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 Credentials 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.

R. Video Swallow Evaluation Orders by Speech Therapists Protocol

I. PURPOSE:

A. To identify specific circumstances in which a speech therapist may order a video swallow evaluation.

B. To decrease waiting time when video swallow evaluations, also known as (dynamic radiological assessment of the oral, pharyngeal, and cervical esophageal physiology during swallowing; performed in collaboration with a radiologist) are used as a diagnostic tool

II. PROTOCOL

A. Physician will order a speech therapy evaluation/consultation. Speech therapist will determine need for and may order a video swallow evaluation.

B. A video swallow evaluation will be completed (if indicated) for the purpose of making a diagnosis and establishing an appropriate management and treatment plan in patients with suspected, or who are at high risk for, oropharyngeal dysphagia.

C. Standard of care and standards of practice are per the Video Swallow Evaluation Orders by Speech Therapists Policy, available on the CentraNet.

S. Dietitian Orders

I. PURPOSE:

A. To identify specific circumstances in which a Registered Clinical Dietitian may place orders.

B. To meet the needs of patients most efficiently and effectively.

II. GUIDELINE:

A. Registered Clinical Dietitian will review diet orders on assigned patient care unit(s).

B. After nutritional assessment, Registered Clinical Dietitian may:

   a. Initiate and modify diet order
   b. Modify diet texture
   c. Initiate or change a calorie level
   d. Initiate or change enteral feeding after a provider referral for tube feeding
   e. Initiate or modify therapeutic diet order
      i. Registered Clinical Dietitian may not order or discontinue or change a fluid restriction
   f. Initiate or change oral nutritional supplements (see Nutrition Services: Nourishments for Patients policy)
   g. Conduct nutrition education/counseling
   h. Initiate referrals to outpatient nutritional services

T. Physical Therapy Orders

I. PURPOSE:

A. To identify specific circumstances in which a Physical Therapist may treat patients without a physician or advanced practice provider order.

B. To meet the needs of patients most efficiently and effectively and reduce administrative burden for physicians and advanced practice providers.

II. GUIDELINE:

A. A physical therapist, who has been licensed for greater than one year, may treat patients for up to an initial 90-day period without the order of a physician, physician assistant, advanced practice registered nurse, chiropractor, podiatrist or dentist.

U. Ethical and Religious Directives

I. PURPOSE:

All members will abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the United States Conference of Catholic Bishops (USCCB), as interpreted by the local Bishop (or, local Ordinary) with respect to their practice at the Hospital. No member will engage in activity at the Hospital that is prohibited by the Directives at the Hospital.

GLOSSARY

The definitions that apply to terms used in these Medical Staff Rules & Regulations are set forth in this Glossary as well as in the Credentials Policy. In the event of a discrepancy, the definitions in this Glossary shall override.

1. "ADVANCED PRACTICE PROVIDER" means a type of provider who provides a medical level of care or performs surgical tasks consistent with granted clinical privileges, training, and scope of practice and must be consistent with all statutory and regulatory requirements This category includes advanced practice registered nurses and physician assistants.
2. "PHYSICIAN ASSISTANT" means an individual who is a graduate of a physician assistant program approved by the Accreditation Review Commission on Education for Physician Assistants or one of its predecessor agencies, and/or has been certified by the National Commission on Certification of Physician Assistants and who is licensed to practice medicine as per MN State Statute
3. COLLABORATING PHYSICIAN" means a member of the Medical Staff with clinical privileges, who has agreed to collaborate with advanced practice providers as required by state law and/or the Hospital's Medical Staff.
4. COLLABORATION/COLLABORATE" means to work in partnership with advanced practice providers.

ATTACHMENT A - CONDITIONS OF PRACTICE APPLICABLE TO ADVANCED PRACTICE PROVIDERS

1. Standards of Practice for Advanced Practice Providers:

(a) Advanced practice providers must exercise only those specific clinical privileges granted to them by the organizations Governing Body and must be within the scope of the license or other legal credential authorizing them to practice in this state, with any restrictions thereon, and must be consistent with all statutory and regulatory requirements. As a condition of being granted privileges, advanced practice providers specifically agree to abide by the standards of practice set forth in this Section. The standards of practice set forth in this section do not apply to hospital outpatient departments. In addition, as a condition of being permitted to utilize the services of advanced practice providers in the Hospital, Medical Staff members who serve as Collaborating Physicians also specifically agree to abide by the standards set forth in this Section and must have privileges to see and care for inpatients.

(b) The following standards of practice are applicable to advanced practice providers in the Hospital:

(1) Admitting Privileges. Advanced practice providers may be granted admitting/privileges and therefore may admit patients on behalf of their Attending Physician. Attending Physicians must maintain privileges to see and care for inpatients. It will then be documented in the medical record that review has taken place with an attending physician within the same service/department An attending physician will be available to the advanced practice provider for patient consultations, education, and patient referrals.

(2) Consultations. Advanced practice providers may provide consultations, gather data and order tests. Advanced practice providers will review consultations as needed with an attending from the same specialty service. Physicians and advanced practice providers may specifically request in the consultation order that the consultation be reviewed with or performed by a physician. If the order specifies consultation must be reviewed by a physician, the physician must document in the medical record that this review has taken place.

(3) Emergency On-Call Coverage. Advanced practice providers may not independently participate in the emergency on-call roster in lieu of their Collaborating/Attending Physicians.

(4) Daily Inpatient Rounds. Advanced practice providers may perform daily inpatient rounds in collaboration with the rounding Physician.

2. Oversight by Collaborating Physician:

(a) Any activities permitted to be performed at the Hospital by an advanced practice provider may be required to be performed only under the oversight of the Collaborating Physician.

(b) If the Medical Staff appointment or clinical privileges of the Collaborating Physician are resigned, revoked or terminated, or the advanced practice provider fails, for any reason, to maintain an appropriate collaboration relationship as required, the advanced practice provider's clinical privileges will be automatically relinquished, unless another Collaborating Physician is approved as part of the credentialing process.

3. Responsibilities of Collaborating Physicians:

(a) Physicians who wish to utilize the services of an advanced practice provider in their clinical practice at the Hospital must notify the Credentialing Verification Office of this fact in advance and must ensure that the individual has been appropriately credentialed and privileged in accordance with this Policy.

(b) The number of advanced practice providers acting in collaboration with a Medical Staff member, as well as the care they may provide, will be consistent with applicable state statutes and regulations and any other policies adopted by the Hospital. The Collaborating Physician will make all appropriate filings with the state regarding the collaboration and responsibilities of the advanced practice provider, to the extent that such filings are required.

APPENDIX

I. SCH Order Set/Protocol Development Workflow Process
II. SCH Therapy Plan Development Workflow Process
SCH Smart Set Development Workflow Process

Revised: 12/13/2023