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RICE MEMORIAL HOSPITAL

301 BECKER AVENUE SW
WILLMAR, MINNESOTA

MEDICAL STAFF RULES AND REGULATIONS

Adopted by Medical Staff: 03/03/2020

Approved by Board of Directors: 03/11/2020

Amended 10/6/2021

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Section A - General

A.1 Preamble

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

A.2 Definitions

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

A.3 Effect

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

Section B – Specific Requirements for Advanced Practice Provider Staff and Allied Health Professional Staff Members

B.1 Identification:

B.1.1 All written material by an APP/AHP Staff member made part of the medical record must be signed with the last name of the individual and the appropriate letters designating his/her position i.e., CNP, PA-C, etc.

B.1.2 The APP/AHP Staff member must always, wherever possible, wear a name badge specifying his/her name and position.

Section C – Reappointment Considerations

C.1 The Reappointment Procedure shall be done in such a manner that all members of the Medical Staff, APP or AHP Staff along with Telemedicine providers are reappointed every two years.

C.2 The application for reappointment shall address the items listed as a requirement for appointment in the Credentials Policy and in the medical staff bylaws and shall further require the member to submit any reasonable evidence of current ability to perform requested privileges, and currency of CME training. A physical or psychiatric examination can be mandated by the Executive Committee at the time of reappointment.

In addition to the application for reappointment, information regarding the following shall be submitted to the Department Chairman/Physician VP of Acute Care for consideration in the reappointment process:

C.2.1 Results of Ongoing Professional Practice Evaluation

C.2.2 Results of Focused Professional Practice Evaluation

C.2.3 Results of Risk Management Activities

A. Involvement in and results of Professional Liability Action – pending and past

C.3 The Department Chair/Physician VP of Acute Care shall review and approve, qualify or deny the request for specific privileges before sending the forms to the Privileging Committee/Medical Executive Committee (MEC) for final recommendations to the Board of Directors. Whenever the Privileging Committee's and MEC's recommendation to grant or deny privileges is in opposition to the Department Chairman's, the reasons must be clearly documented.

C.4 Whenever an appointment or specific privileges are not renewed or additional requested privileges are not allowed, the appeal mechanisms as outlined in the Fair Hearing Manual shall be utilized.

C.5 A statement shall be placed on the reappointment form affirming commitment to and participation in continuing medical education as required by the Minnesota State Medical Association and/or the Minnesota State Board of Medical Practice.

Section D – Protocols for Medical Staff Member Impairment

D.1 Impairment, Substance Abuse and Behavior Concerns

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

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

D.2 Prolonged Illness

Refer to Article 2.5 in the Medical Staff Bylaws.

Section E – Officer Compensation

E.1 Chief of Staff: The compensation for the Chief of Staff shall be:

An annual stipend in an amount mutually agreed to by the Medical Executive Committee and the Hospital. The stipend is to be paid twenty percent (20%) by the Medical Staff and eighty percent (80%) by the Hospital.

E.2 Vice Chief of Staff: The Compensation for the Vice Chief of Staff shall be:

An annual stipend in an amount mutually agreed to by the Medical Executive Committee and the Hospital. The stipend is to be paid twenty percent (20%) by the Medical Staff and eighty percent (80%) by the Hospital.

E.3 Secretary - Treasurer: The compensation for the Secretary - Treasurer shall be:

An annual stipend in an amount mutually agreed to by the Medical Executive Committee and the Hospital. The stipend is to be paid twenty percent (20%) by the Medical Staff and eighty percent (80%) by the Hospital.

Section F – Additional Medical Staff Committees

F.1 The Organization and Functions Manual describes all Medical Staff Committees.

Section G – Service Medical Advisors/Medical Directors

Medical advisors shall be appointed by the Chief Executive Officer, upon approval by the Medical Staff Executive Committee, and shall require confirmation by the Board of Directors. Service medical advisors/directors shall be members of the Active Medical Staff, who shall have prior training, experience, and/or interest in the particular area in which they shall be serving as medical advisor.

Services/Programs Requiring Medical Advisors/Directors

G.1 Anesthesia Service Director

G.2 Cancer Program Medical Advisor

G.3 Dialysis Service Director

G.4 Hospice Program Medical Advisor

G.5 Respiratory Care Service Director

G.6 Cardiac Rehabilitation

G.7 Pulmonary Rehabilitation

Section H – Administrative Details

H.1 Dues and Assessments

H.1.1 Annual dues of members of the Active Medical Staff of Carris Health - Rice Memorial Hospital shall be determined by the MEC on an annual basis in May of each year and shall be payable before September 1st. Individuals becoming members of the staff after December 31st, shall pay one-half the established dues.

H.1.2 Special assessments for any cause may be voted by a majority of the Active Staff present at any regular staff meeting.

H.1.3 Special assessments shall apply only for the year in which the assessment is levied.

H.1.4 Original or re-application for any category of Medical Staff membership may have a nonrefundable fee, paid to the Hospital as an offset against the cost of the Credentialing process, which is billed semi-annually. The categories of Medical Staff membership to which a fee applies, and amount of the fee for the various categories, may be suggested by the Chief Executive Officer, but shall only take effect upon approval by the Medical Executive Committee.

Section I – Medical Record Rules

I.1 Medical Record Requirements

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

I.1.2 The attending provider shall be responsible for the preparation of a complete and legible medical record for each patient to whom he/she provides care. Its contents shall be pertinent and accurate. This record shall include, as appropriate to individual patient: identification data, personal, family and history, history of present illness, physical examination, provisional diagnosis, diagnosis or diagnostic impression, reason for admission/treatment, diagnostic and therapeutic orders, diagnostic and therapeutic procedures and test results, medical or surgical treatment, operative and invasive procedure reports, pathological findings, progress notes (including revisions of treatment plan), consultation reports, discharge summary (including final diagnosis, condition on discharge and discharge instructions) and autopsy report when applicable. All medical records must be complete and will not be filed until complete except at the direction of the Medical Record/Utilization Review Committee.

I.1.3 All records are the property of Carris Health - Rice Memorial Hospital and shall not be removed from the premises except by a subpoena, court order, statute or order of the Governing Body. In case of patient readmission, all previous records shall be available for use by the attending physician. This shall apply whether the patient is attended by the same physician or another.

I.2 History and Physical

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

A. History and physicals must include:
1. patient identification;
2. chief complaint;
3. history of present illness;
4. review of systems;
5. personal medical history, including medications and allergies;
6 family medical history;
7. social history, including any abuse or neglect;
8. physical examination to include pertinent findings in those organ systems relevant to the presenting illness and to co-existing diagnoses;
9. data reviewed;
10. assessments, including problem list;
11. plan of treatment; and
12. If applicable, signs of abuse, neglect, addiction, or emotional/behavioral disorder, which will be specifically documented in the physical examination, and any need for restraint or seclusion, which will be documented in the plan of treatment.

13. in the case of a pediatric patient, the history and physical examination report must also include: 1. Length or height; and 2. Weight.

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

I.2.2 When an H&P has been completed within thirty (30) days before admission, an updated medical record entry must be completed and documented in the patient's record within twenty-four (24) hours after admission. In all cases, the update must be documented prior to surgery or a procedure requiring anesthesia. The update note must document any changes in the patient's condition since the H&P was performed that may be significant for the planned course of treatment. If no changes in condition have occurred, since the H&P was performed, the licensed practitioner may indicate, "Upon examination, no change has occurred in the patient's condition since the H&P was completed."

I.2.3 A complete H&P is required on all obstetrical cases delivered via scheduled cesarean section. For those obstetrical cases that result in vaginal delivery, the prenatal record may be substituted for the H&P if the last prenatal visit occurred within two weeks of admission.

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

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

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

I.2.7 **Cancellations, Delays, and Emergency Situations**

A. When the history and physical examination is not recorded in the medical record before an elective, non-emergent surgical case or other invasive procedure (including, but not limited to, endoscopy, colonoscopy, bronchoscopy, cardiac catheterizations, radiological procedures with sedation, and procedures performed in the Emergency Room), the operation or procedure will be canceled or delayed until a complete history and physical examination is recorded in the medical record.

B. When there is not time to document a consult or history and physical prior to an emergency operation this documentation needs to be done within 6 hours of the finish of the operation.

I.3 Informed Consent

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

I.4 Operative/Delivery Reports

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

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

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

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

I.5 Progress Notes

I.5.1 Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Documentation of patient evaluation shall be done every 24 hours by the physician(s) or designated clinically privileged licensed health care provider actively involved in the patient's care.

I.6 Discharge Summaries (aka: Clinical Resumes)

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

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

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

C. A final progress note may be substituted for a discharge summary in cases with hospitalization of less than 48 hours and for normal newborn infants. The final progress note should include any instructions given to the patient and/or family. A final progress note may not be substituted in cases described in I.6.1(B).

I.7 Autopsy Reports

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

I.8 Completion Requirements

I.8.1 Inpatient

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

B. Reports of operation or delivery shall be documented by the physician performing the procedure immediately following the operation/procedure/delivery. If the report is dictated, a brief descriptive note which summarizes the procedure must be documented in the record immediately following the procedure to provide information prior to the final report being available. Dictated operative reports must be completed within 24 hours of the operation. Physicians who electronically document their operative/procedure/delivery reports at the conclusion of the event need not complete this interim note.

C. Discharge summaries shall be documented immediately upon patient discharge, but not later than 15 days after discharge.

D. Verbal orders shall be signed within 14 days.

E. Cancer Center documentation shall be completed within 3 working days of the visit.

F. The total record, including signatures, shall be completed within 30 days of discharge. Days absent for illness, vacation, continuing education, etc are not counted when calculating delinquency.

I.8.2 Outpatient

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

B. Operative/procedure reports shall be documented immediately following the event as noted in I.8.1(B)

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

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

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

F. Physicians**,** Podiatrists, or Advanced Practice Registered Nurses (APRNs) that are not members of the Medical Staff/Advanced Practice Practitioner/Allied Health Provider Staff may order outpatient diagnostic, therapeutic (excluding Observation and Outpatient Surgical), rehabilitative or Hospice services via authenticated order; providing they are:

1. Responsible for the care of the patient
2. Licensed to practice in the state where he or she provides care to the patient
3. Acting within his/her scope of practice under state law

Licensure will be verified by Medical Staff Services. Orders require detail as noted in I.8.2(C).

G. Physician Assistants that are licensed to practice in Minnesota may order outpatient diagnostic and rehabilitative services within their scope of practice. Orders require detail as noted in I.8.2(C).

Amended section G on 08/04/2020: Delegation Agreements are no longer required for Physician Assistants in Minnesota.

H. Chiropractors that are licensed to practice in Minnesota may order outpatient diagnostic services as permitted by policy Use of Diagnostic Imaging Services by Chiropractors. Orders must meet the specifications noted in I.8.2(C).

I.8.3 Emergency Records

A. The emergency record shall be documented within 24 hours following discharge/transfer of the patient from the Emergency Department. The emergency record shall include:

1. adequate patient identification;
2. information concerning the time of the patient's arrival, means of arrival and by whom transported;
3. pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to his/her arrival at the hospital;
4. description of significant clinical, laboratory and imaging findings;
5. diagnosis and treatment given;
6. condition of the patient on discharge or transfer, and
7. final disposition, including instructions given to the patient and/or his/her family, relative to necessary follow up care

I.9 Incomplete Records

I.9.1 Procedure to be followed when patient records are not completed within the specified time period:

A. Physicians with incomplete records in the time periods outlined above shall be notified in writing that they have one week to complete their records. Failure to complete the records within that time period shall result in automatic suspension of privileges pursuant to the Carris Health - Rice Memorial Hospital Medical Staff Bylaws.

B. The manager of Health Information Services or designee shall notify the Chair of the Privileging Committee, Chief of Staff and the Chief Executive Officer or designee which physician(s) or other licensed independent practitioner is not in compliance with the record completion requirements.

C. The Chairman of the Privileging Committee shall notify the individual physician(s) or other licensed independent practitioner affected when privileges are suspended via certified letter (with returned signed receipt).

D. The Chief Executive Officer or designee shall notify Patient Access, Emergency Department, Surgery, Chief Nursing Officer and Hospital

Administration of the name(s) of the physician(s) or other licensed independent practitioner whose privileges are suspended.

E. Procedure for reinstatement of privileges is outlined in the Medical Staff Bylaws.

I.10 Admissions and Discharges

I.10.1 An admission diagnosis, even if tentative, must be stated as part of the admitting orders of all patients. This applies whether the order is provided via telephone or direct documentation. In the case of an emergency, such statement shall be recorded as soon as possible.

I.10.2 Patients presenting for care who have no identified primary provider shall be assigned to the appropriate Medical Staff member on call.

I.10.3 All patients admitted to the hospital shall have adequate diagnostic studies to support the admitting diagnosis and establish safety of any planned procedures.

I.10.4 Patients requiring admission to ICU must be seen by a physician immediately prior to or within 30 minutes of admission (see M.3). Admitting diagnosis and orders are required as noted in I.10.1.

I.10.5 Patients shall be discharged only by written order. The attending provider is encouraged to examine the record to ensure it is as complete as possible including the documentation of appropriate reports, final diagnosis and appropriate signature(s). Patients who do not meet discharge criteria must be examined by an attending provider and discharged or admitted by that provider's order.

I.10.6 Patients desiring to leave the hospital against the advice of their attending provider shall have this status (AMA) documented in their medical record. These patients shall be requested to sign the "Waiver of Responsibility for Discharge" form. If the patient refused to sign this form, refusal shall be documented on the form and signed by two witnesses. Details shall also be documented in the Nurse's Notes.

I.11 Orders and Consents

I.11.1 Orders

All orders for treatment shall be documented by the ordering provider. Under certain circumstances, an order may be given to an authorized person who will record it as a verbal or telephone order. Verbal orders or Telephone orders may be given when a provider does not have immediate access to a computer for order entry or in emergent situations. Verbal or telephone orders may be signed by any physician participating in the care of the patient. Regardless of order type, the order must be signed, dated and timed.

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

B. Physician co-signatures are not required on orders given by Nurse Practitioners, Physician Assistants and Certified Nurse Midwives ~~with the exception of admission and discharge orders.~~

Amendment approved 10/6/2021

I.11.2 General Consent

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

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

I.11.3 Informed Consent

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

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

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

I.12 Consultation

I.12.1 It is the responsibility of the attending physician and/or surgeon to obtain appropriate consultations. Appropriate situations for consultation may include when services needed by the patient are outside the scope of privilege of the attending; when the diagnosis remains unknown despite appropriate evaluations; when the stay is prolonged beyond usual length; or when there has been no response to treatment ordered.

I.12.2 It is the responsibility of the consulting physician to complete a report of consultation in the patient's medical record.

I.12.3 Psychiatric consultation and treatment should be requested for/offered to all patients admitted due to drug overdose or suicide attempt. Proper documentation that such services were offered shall be noted in the patient's medical record.

I.13 Medical Staff Compliance

I.13.1 To assure compliance with these medical record rules, the Medical Executive Committee shall, in concert with Health Information Services personnel, develop a systematic plan to evaluate individual compliance.

I.13.2 Failure to comply with the medical record requirements shall result in notification in writing to the staff member or privilege holder, followed by automatic suspension of hospital privileges as provided in the RMH Medical Staff Bylaws.

Section J – Drug Formulary

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

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

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

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

Section K – Policies and Plans

K.1 Service and Department Policies

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

K.2 Staff Plans

K.2.1 Disaster Plan

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

K.3 Multi-Departmental Policies and Protocols

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

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

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

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

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

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

Section L – Surgery Rules

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

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

L.3 A preoperative admission note with date and time shall be documented by the surgeon on the Progress Record of all outpatient and inpatients scheduled for surgery.

L.4 A consent form shall be signed by the patient prior to surgery (see I.11.3). This form becomes part of the patient's record.

L.5 A physician's pre-anesthesia note with date and time shall be documented in the medical record of all outpatients and inpatients scheduled for surgery that specifically includes information relative to the choice of anesthesia for the anticipated procedure. Whenever a Certified Registered Nurse Anesthetist (CRNA) generates the pre-anesthesia note, it must be countersigned by an anesthesiologist.

L.6 When indicated, the surgeon is responsible to obtain a consultation by another physician prior to surgery and postoperatively.

L.7 The medical record shall include a daily progress note by the physician actively involved in the patient's care.

L.8 All operations performed shall be fully described by the operating surgeon immediately after surgery. Discharge from the recovery room shall be ordered by the anesthesiologist or other responsible physician.

L.9 The medical record shall include a dated, timed, and signed post-anesthetic visit made after the patient has left the recovery area, describing the presence or absence of anesthesia related complications.

L.10 All vital tissues removed at operation shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a pathological diagnosis.

L. 10.1 Specimens removed during surgical procedures are ordinarily sent to the pathologist for evaluation.

L.10.2 The Medical Staff, in consultation with the pathologist, decides the exceptions to sending specimens removed during a surgical procedure to the laboratory.

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

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

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

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

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

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

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

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

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

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

L.11 Ambulatory Care Services

L.11.1 Ambulatory care services shall be defined as non-emergency health care services provided to patients who do not remain in the hospital more than 24 hours, for example, ambulatory surgery with or without general anesthesia, blood transfusions, I.V. therapy, etc. The 24 hour time period starts at the time the patient arrives in designated room following surgery and post-anesthetic

recovery.

L.11.2 Ambulatory care services shall meet the same standards of quality that apply to inpatient care provided by the hospital and chart completion requirements shall be the same as for other medical records.

L.11.3 Ambulatory care service provided on an outpatient basis shall be consistent with departments applicable to inpatient services, anesthesia, and postoperative recovery. Any patient who has received anesthesia other than a local shall meet discharge criteria and be accompanied home by a designated person. Patients who do not meet discharge criteria must be examined by a physician and discharged or admitted by that doctor's order. If admitted, this examination shall meet the requirements as noted in I.2. If discharged the note shall include items as noted in I.6.1(C).

L.11.4 Any instructions for follow-up care shall be given to the patient and/or responsible family member and documentation thereof place in the hospital record.

Section M – Emergency Services Coverage

M.1 The medical staff shall adopt a system of providing medical coverage in the emergency services area.

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

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

M.2.2 In any department or specialty with less than four (4) full-time active staff members, call will be 1 in 4 for each member of that department; this includes holidays and weekends. This plan shall be reviewed annually or with any change in department member status.

M.2.3 Physicians who are unavailable to attend patients for greater than 30 consecutive days should notify the Department Chair and are not obligated to take call during this time. Physicians who expect to be unavailable for greater than 45 consecutive days should request a leave of absence as outlined in Bylaws Article 2.5.

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

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

Section N - Pediatric Sedation for Diagnostic Tests

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

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

A. A history and physical performed.

B. Pre-procedural orders written by an anesthesiologist.

C. A pre-procedural evaluation by an anesthesiologist.

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

E. Be discharged by order of an anesthesiologist.

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

Section O - Locum Tenens and Temporary Privileges Considerations

O.1 Request

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

O.2 Time Period

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

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

O.3 Responsibilities and Privileges

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

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

O.3.3 Medical Staff dues shall be waived

O.3.4 Are not eligible to vote or hold office

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

O.3.6 A yearly maximum of 180 working days

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

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

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

Section Q – Screening of Pregnant Patient in Possible Labor

Q.1 All pregnant patients who present to Carris Health - Rice Memorial Hospital shall undergo an appropriate medical screening examination.

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

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

Section R - Guidelines on Requesting an Autopsy

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

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

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

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

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

C. Unexplained or unexpected perinatal and postpartum maternal deaths;

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

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

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

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

H. Deaths due to culpable neglect;

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

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

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

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

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

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

O. Deaths of persons occurring in an emergency department;

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

Q. Unexpected deaths of children;

R. Solid organ donors;

S. Unidentified bodies;

T. Skeletonized remains;

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

V. Deaths associated with the decedent's employment;

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

X. Deaths attributable to acts of terrorism.

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

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

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

R.3.1 Uncertain cause of death on clinical grounds

R.3.2 Unanticipated medical complications, including obstetric deaths

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

R.3.4 Temporal association with invasive diagnostic or therapeutic procedures

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

R.3.6 Neonatal and pediatric age

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

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

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

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

R.4.1 Healthcare Agent

R.4.2 Spouse

R.4.3 Adult Child

R.4.4 Parent

R.4.5 Adult Sibling

R.4.6 Adult Grandchildren

R.4.7 Grandparent

R.4.8 Legal Guardian

R.4.9 Adult exhibiting special care/concern

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

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

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

Adopted by the Active Medical Staff of Carris Health - Rice Memorial Hospital, Willmar, Minnesota.
Date: 03/03/2020

Approved by the Carris Health Board of Directors, Willmar, Minnesota.
Date: 03/11/2020

Amended Section I.8.2 (G): 08/04/2020 approved by MEC.