

RULES AND REGULATIONS
OF THE MEDICAL STAFF OF SKIFF MEDICAL CENTER

A. ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

1. Each patient's general medical condition shall be the responsibility of a physician member of the Medical Staff or an Advanced Practice Clinician ("APC") with appropriate clinical privileges.
2. Other direct medical care of patients shall be provided by a member of the Medical Staff or by other specified professional personnel under the appropriate degree of supervision by a licensed Practitioner (as defined and used in the Medical Staff Bylaws) with appropriate clinical privileges. If the Practitioner delegates these responsibilities to another staff member, he/she must write an order to that effect on the order sheet in the patient's record.
3. Obstetrical physicians or their on-call obstetrical physician designee, will be immediately available
4. Except in emergency, no patient shall be admitted without a provisional diagnosis.
5. Psychiatric consultation and treatment is available on an as needed basis through the Hospital's contracted telepsychiatry services.
6. Patients may be discharged on written order of a physician or an APC with appropriate clinical privileges.
7. Transfer of Patients:

7.1 Internal Transfer - Internal patient transfer priorities are as follows:

- (a) Emergency patient to an available and appropriate patient bed
- (b) From a special care unit to any general care room
- (c) From temporary placement in an inappropriate geographic or clinical service area to the appropriate area for that patient.

7.2 Transfer of Patients to the Hospital Emergency Room from Another Facility:

- (a) The ER physician on duty will have responsibility for accepting patients in transfer when contacted directly by telephone by the transferring physician, if the nature of the medical problem is emergent as defined by the Emergency Medical Treatment and Active Labor Act ("EMTALA") as amended and if it is within the capabilities of the Hospital. EMTALA currently defines an "emergency medical condition" as a condition so severe that lack of immediate medical attention will put the health of the patient, or the fetus of a woman in active labor, in serious jeopardy or will seriously impair bodily functions or organs. EMTALA states the hospital must provide an appropriate medical screening examination (MSE) within the capability of the hospital's

emergency department to determine whether or not an emergency medical condition exists. This MSE may be performed by a Qualified Medical Personnel ("QMP"). A QMP shall mean an Emergency Department physician, an attending physician, or an APC (specifically, a nurse practitioner or physician assistant). For obstetrical unit only, the QMP may also include an RN with specific competency completion regarding the Medical Screening Exam and the requirements within. Upon accepting a patient in transfer, the ER physician will promptly notify the on-call consulting physician. Consultant notification should include the referring physician's name and telephone number.

(b) Federal law requires the Hospital to accept appropriate transfers of patients with emergency medical conditions, if the Hospital has the specialized capabilities not available at the transferring hospital and has the capacity to treat those individuals. If the nature of the patient's problem suggests the need for care which may exceed the capabilities of Hospital, the ER physician on-call will discuss the case with the appropriate on-call consultant before accepting the patient in transfer.

If the ER physician determines, after consultation with the on-call consultant, that the patient's medical problems exceed the capabilities of the Hospital, he or she will suggest alternative referral sites to the transferring physician. It will be the responsibility of all physicians covering the ER to be aware of the scope of services within the Hospital's capabilities.

(c) If a patient is transferred to Skiff Medical Center from another hospital, and the receiving ER staff reasonably believes that the general transfer requirements of EMTALA (specified below under "General Requirements") were not met by the transferring hospital, the ER staff shall promptly report the alleged improper transfer to the Administrator on call for the Hospital. If the transfer is improper, Federal law requires that the improper transfer must be reported promptly to the Iowa Department of Inspections and Appeals, Health Facilities Division.

7.3 Transfers to Another Facility.

General Requirements. Federal law requires that a patient shall be transferred to another health care facility only upon the order of the Practitioner or his or her designee, only after the patient's informed written consent or the physician's certification has been obtained, only after arrangements have been made for admission with the other facility and its consent to receiving the patient has been documented, and only after the patient is considered sufficiently stabilized for transport. If applicable, the name and address of any physician who failed to appear within a reasonable time when called to provide necessary stabilizing treatment shall also be documented and accompany the transfer. All pertinent medical information necessary to ensure continuity of care must accompany the patient.

7.4 Transfers Demanded by Patients. A transfer demanded by an emergency or

critically ill patient or the patient's family is not permitted until a Practitioner has explained to the patient or his or her family the seriousness of the condition and generally not until a Practitioner has determined that the condition is sufficiently stabilized for safe transport, and so documented. In each such case, the appropriate release form is to be executed. If the patient or the patient's authorized representative refuses to sign the release, a completed form without the patient's signature and a note indicating refusal must be included in the patient's medical record.

The unstable patient to be transferred from Skiff Medical Center to another facility will be examined shortly before transfer by a Practitioner. The patient should be rendered reasonably stable for transfer. Orders should be given by the transferring Practitioner for treatment of any anticipated medical problems that may occur during the transfer.

B. MEDICAL RECORDS

1. A complete, legible medical record on every patient admitted to the hospital is the sole responsibility of the Practitioner in accordance with the Medical Staff Bylaws (hereinafter "Bylaws").
2. When the history and physical examination are recorded by a medical student or resident the attending physician shall review such history and physical, make changes as indicated, and shall countersign to indicate his approval of the contents. Note: an APC may not countersign documentation from a medical student or resident.
3. Progress notes shall be recorded with sufficient frequency to cover all events, complications and treatments, and to ensure comprehensiveness of the record.
4. Operative reports shall be written or dictated immediately after surgery, and shall include all of the findings made at surgery, as well as the details of the procedure per the Center for Medicare and Medicaid Services ("CMS") guidelines and Hospital policies.
5. Signature Requirements
 - 5.1. The methods for authentication of patient record entries shall be hand written or electronic signature (stamp signatures are not acceptable).
 - 5.2. Facsimile of original hand written or electronic signatures are acceptable.
6. Symbols and abbreviations may be used in the medical record only when they have been approved by the Medical Staff. Each abbreviation shall have only one meaning. The list of approved symbols and abbreviations shall be updated periodically, and shall be appropriately distributed throughout the Hospital.
7. Medical records shall be removed from the Hospital's jurisdiction and safekeeping only in accordance with Hospital policy. Unauthorized removal of records from the

Hospital shall constitute valid grounds for suspension of privileges and termination of membership, on the recommendation of the Medical Staff Executive Committee.

8. Members of the Medical Staff seeking access to medical records for purposes of research shall make written request for such information to the hospital President or his/her designee. The written request shall include a detailed description of the information sought and the purpose for which the information is sought. The hospital President, or his/her designee shall then consult with the Mercy's Privacy Officer.
9. Medical records should be kept complete and current. Provision for enforcement of rules, as set up by the Quality and Performance Improvement Committee will be the responsibility of the Executive Committee (in accordance with Hospital Policy).

If records remain incomplete beyond the above time frame, the Medical Records manager shall notify the responsible Practitioner when the Practitioner is on-site at the facility of the delinquency. Failure to complete all identified delinquent records within seventy-two (72) hours of notice will result in automatic suspension of admitting, clinical and consulting privileges as provided in the Bylaws. The Medical Records Director will notify the admitting office, OR Supervisor and Quality Management of the suspension.

10. Diagnoses and procedures shall be classified and carefully indexed according to the Standard Nomenclature of Disease.

C. CONDUCT OF CARE

1. A consent form, signed by the patient or on his/her behalf by someone authorized to do so, shall be executed for every patient at the time of admission. Under circumstances when this cannot be done, as in the case of an unaccompanied minor, an unconscious patient, or when treatment is felt to be imperative, there should be evidence in the record of each such situation.
2. A special consent form should be completed for patients undergoing surgery or any other medical procedure or course of treatment. The Practitioner performing the procedure(s) must obtain and document informed consent from the patient prior to the performance of the procedure(s). The informed consent shall include a discussion of the patient's diagnosis, the general nature and purpose of the procedure(s) together with the known risks, if any, of death, brain damage, quadriplegia, paraplegia, the loss or loss of function of any organ or limb, or disfiguring scars associated with such procedure(s), with the probability of each if determinable, reasonably feasible alternatives and prognosis, if no treatment is provided. The consent form shall also include an acknowledgment that the disclosures of the above information has been made and that all of the patient's questions have been answered in a satisfactory manner. Only then will the Practitioner performing the procedure will sign, date and time the consent form. Nurses will assist in this process by witnessing the patient's signature on the consent forms. Consents shall be valid for thirty (30) days after signature. Consents shall also include permission, to dispose of tissues, and the identity of the surgeon. The consent must be signed by the Practitioner performing the

procedure prior to the start of the procedure.

3. Anesthesia services require a separate consent. Once the informed consent discussion is completed and full informed consent is obtained by the anesthesia practitioner from the patient, the anesthesia practitioner will sign, date and time the consent. This must be completed prior to the start of the procedure.
4. All orders for treatment shall be in writing. A verbal order shall be acceptable if dictated to licensed nurses (may take all orders), pharmacists (may take medication orders only), and registered or certified therapists (may take only orders pertaining to the therapy they are providing) by the responsible member of the Medical Staff. Such orders shall be entered on the electronic health record, authenticated by the person to whom dictated, and shall include the name of the Medical Staff member giving the order. All orders, including verbal orders, must be dated, authenticated and timed by the prescribing Practitioner or another Practitioner responsible for the care of the patient (even if the order did not originate with him or her) within 48 hours. Orders for outpatient diagnostic tests, consultations, and therapies may be taken by respective departmental staff.
5. Orders shall be written completely and legibly and shall be understandable. No order will be carried out until they are fully clarified.
6. Medications listed below shall be automatically discontinued after a specified time unless the order indicates an exact period of time, the order indicates an exact number of doses to be administrated, or the Practitioner reorders the medication. The medications and their stop-order times are:
 - 6.1. Narcotics - fourteen (14) days
 - 6.2. Antibiotics - fourteen (14) days

The pharmacy shall notify the prescribing Practitioner within twelve (12) to twenty-four (24) hours before a medication order has reached its maximum duration. The prescribing Practitioner must acknowledge the notification by providing an order to renew, change or discontinue the medication as appropriate. If the notification has not been acknowledged, Hospital Staff will continue giving the medication or treatment until the Practitioner can be contacted for further orders.

7. **HOSPITAL DEATHS AND AUTOPSIES** - In accordance with written Hospital protocols, the Iowa State Organ Procurement Organization (ISOPO) shall be notified in a timely manner of individuals whose death is imminent or who have died in the Hospital, and the Hospital shall collaborate with the ISOPO in informing the family of each potential donor of their options to donate organs, tissues or eyes or to decline to donate.
 - 7.1 Hospital Deaths - In the event of a Hospital death, the deceased shall be pronounced dead by the attending physician or the physician's designee (including an RN) within a reasonable period of time.

7.2 (a) Reportable Deaths to the County Medical Examiner - Reporting of deaths affecting the public interest to the County Medical Examiner's Office shall be carried out when required by and in conformance with State law. Deaths affecting the public interest include, but are not limited to, any of the following:

1. Violent death, including homicidal, suicidal, or accidental death.
2. Death caused by thermal, chemical, electrical or radiation injury.
3. Death caused by criminal abortion including self-induced, or by sexual abuse.
4. Death related to disease thought to be virulent or contagious which may constitute a public hazard.
5. Death that has occurred unexpectedly or from an unexplained cause.
6. Death of a person confined in a prison, jail or correctional institution.
7. Death of a person if a physician was not in attendance within thirty- six (36) hours preceding death, excluding pre-diagnosed terminal or bedfast cases for which the time period is extended to thirty (30) days, and excluding terminally ill patients who were admitted to and had received services from a hospice program, if a physician or a registered nurse employed by the program was in attendance within thirty (30) days preceding death.
8. Death of a person if the body is not claimed by a relative or a friend.
9. Death of a person if the identity of the deceased is unknown.
10. Death of a child under the age of two years if death results from an unknown cause or if the circumstances surrounding the death indicate that sudden infant death syndrome may be the cause of death.

(b) To the Iowa Department of Inspections and Appeals. The Hospital must report to DIA any deaths that occur while a patient is restrained or in seclusion, or where it is reasonable to assume that a patient's death is a result of restraint or seclusion.

7.3 Death Certificates --Unless there is a non-natural cause of death, the medical certification of death shall be completed and signed by the physician, physician's assistant or advanced registered nurse practitioner in charge of the patient's care for the illness or condition which resulted in death. This certificate should be completed within seventy-two (72) hours after receipt from the funeral director or individual who initially assumes custody of the body (Per Iowa Code 144.28).

7.4 The Medical examiner will be responsible for completion of the Death Certificate for all deaths that meet Medical Examiner criteria (listed above).

7.5 Autopsies –For deaths that meet the Medical Examiner criteria (listed above) the Medical Examiner is responsible for the autopsy arrangements and cost. If the family requests an autopsy and the initial cause of death is NOT listed as Medical Examiner criteria, the family is responsible for the costs. The facility maintains a contract for autopsy services for such instances.

8. All health care providers, including physicians appointed to the Medical Center's medical staff and APCs, have the legal and ethical responsibility to prevent disclosure of confidential or privileged patient information, except as allowed or required by law or the patient has executed an authorization permitting disclosure. Questions concerning the circumstances pursuant to which such information may be disclosed shall be directed to the Hospital Privacy Officer.

9. **PHYSICAL AND PHARMACOLOGICAL RESTRAINTS AND SECLUSION.**
A Practitioner order is necessary for the use of a physical or pharmacological restraint device or seclusion. The order must specify the type, clinical justification and time limit, which shall not exceed the limits set forth in approved Hospital policies.
When the Practitioner responsible for a patient's care is not immediately available to assess the patient and determine the need for restraint or seclusion for behavior management purposes, specifically trained staff (RN, NP or PA) may initiate the intervention pursuant to an adopted protocol, authorized by the Practitioner, but a Practitioner must see and evaluate the need for restraint and seclusion within one (1) hour after the initiation of the intervention. Although the Hospital does not provide behavioral management services, patients may present to the facility with psychiatric conditions. Treatment in those cases shall be limited to management of the patient's medical needs. If the patient requires ongoing behavioral management, the patient shall be transferred to an appropriate psychiatric facility. In the event the patient cannot be transferred to an appropriate psychiatric facility, Hospital policies for the use of restraints or seclusion for behavioral management shall be followed.

10. **SPECIAL ORDERS.**

10.1 Patient's Own Drugs and Patient Self-Administration. Drugs brought into the Hospital by a patient may not be administered unless the drugs have been identified and there is a written order from the Practitioner to administer the drugs. In order to ensure product integrity, proper dose and frequency, and within date usage, home medications need to be in the prescription bottle, blister pack, or other such original container as dispensed by a pharmacy. Pill planners or other containers not originally dispensed will not be identified for hospital use. Self-administration of medications by a patient is permitted on a specific written order by the authorized prescribing Practitioner and in accordance with established Hospital policy.

10.2 Do Not Resuscitate (DNR) Orders.

(a) After the DNR decision has been made, this directive must be written as an

order by the Practitioner on the electronic health record.

(b) All facts, considerations and consents pertinent to this decision should be documented by the Practitioner in the progress notes.

(c) Verbal orders for DNR status generally are not appropriate or acceptable. However, verbal DNR orders may be used under circumstances where the patient is currently under the care of the Practitioner from whom the order is sought and the Practitioner has personal knowledge of the patient's terminal condition and the wishes of the patient and/or family. Under these circumstances, a verbal telephone order personally given by the Practitioner may be received by a registered nurse and witnessed by one other registered nurse, who must also hear the order and co-sign the order written on the chart. Telephone orders must be countersigned by the ordering Practitioner and appropriate documentation made in the progress notes within 24 hours of issuance.

(d) DNR orders should be reviewed on a regular basis and may be rescinded at any time.

(e) In addition to DNR orders, patients may utilize other advance care planning orders including those provided by the Iowa Department of Public Health such as the Iowa Physician Orders for Scope of Treatment.

10.3 Practitioner Prescribing and Dispensing. Practitioners shall follow the Iowa Board of Medical Examiners' rules regarding practitioner self-prescribing and self-dispensing.

Prescribing or dispensing controlled substances to members of the Practitioner's immediate family is allowable only in accordance with Iowa Board of Medical Examiners rules.

D. SURGERY

1. The Surgical Services Department shall be responsible for the scheduling operations of upcoming surgical and endoscopic procedures.

1.1. Priority. Except in emergency, operations will be scheduled within approved surgical block time or on a first-come, first-serve basis. True emergencies will have priority over elective procedures. As soon as the emergency situation is addressed, the schedule will resume at the point of interruption.

1.2. Medical Records.

Prior to surgery or any procedure requiring anesthesia services and except in the cases of emergencies: 1) a history and physical ("H&P") must be completed no more than thirty (30) days prior to surgical procedure. If the H&P was completed within thirty (30) days before the patient's registration or admission, an updated H&P will be completed within twenty-four (24) hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services. 2) a medical record entry indicating that the H&P was

reviewed, the patient examined, and that the physician concurs with the finding of the H&P. If patient changes are identified during the updated evaluation, the Practitioner documents the changes in the updated note. 3) An H&P must be updated on the day of and prior to surgery or any procedure requiring anesthesia services regardless of whether one was completed in the previous thirty (30) days.

An Operating Room Registered Nurse shall be responsible for checking the medical record for completion of history and physical examination and any preoperative testing prior to surgery. With the exception of true emergencies, if history and physical is not able to be completed and cannot be obtained prior to surgery, the Surgical Services Manager or designee may cancel the procedure.

2. All specimens removed during a surgical procedure in the operating rooms, delivery rooms, emergency rooms, or anywhere in the hospital shall be sent to the pathologist for evaluation in accordance with Hospital policy.
3. Consulting physicians performing outpatient surgical procedures must remain in Newton until patient is discharged or he/she must arrange for acceptable local Practitioner coverage.
4. The surgeon is responsible for the postoperative care of the patient. This responsibility includes personal participation in and direction of postoperative care, including the management of postoperative complications. This responsibility extends through the period of convalescence until the residual effects of the surgical procedure are minimal. The surgeon is responsible for determining when the patient should be discharged from the Hospital. The surgeon may transfer care of the postoperative patient by asking for an official consultation or making prior arrangement and agreement with a local Practitioner.

E. TRAUMA SERVICE

1. The Hospital Trauma Director shall manage trauma-specific credentialing requirements and apply such credentialing requirements in accordance with American College of Surgeons standards and Iowa Department of Public Health rules.

F. ADVANCED PRACTICE CLINICIAN

APCs (as defined in the Bylaws) shall not have admitting privileges at the Hospital unless they have entered into an exclusive agreement with the Hospital. An APC who has an exclusive agreement with the Hospital may be granted admitting privileges at the Hospital. An APC who has an exclusive agreement with the Hospital may practice at the Hospital as an independent advanced practice clinician to the extent permitted under Iowa law. APC qualifications and the procedure for granting APCs practice privileges are stated under Section 7 of the Bylaws.

1. MEDICAL AND SURGICAL ASSISTANTS.

Medical and Surgical Assistants are persons who are not employees of the Hospital, and who are not members of the Medical Staff or of the regular Advanced Practice Clinician Staff, but who work from time to time in the hospital and are employed by and responsible to members of the Medical Staff and who work under the Medical Staff member's direction and supervision. Supervising Medical Staff members shall show proof of liability insurance covering the medical or surgical assistant involved. All Medical and Surgical Assistants must request privileges to provide services in the Hospital under the direction and supervision of a Medical Staff member and shall do so on an appropriate form approved by the Board of Trustees. Applicants shall submit information pertaining to their educational background and their experience in the specialty in which the privileges are requested, providing dates, places and descriptions of duties performed and by whom supervised. Medical and Surgical Assistants shall be governed by the sections on Termination of Privileges and Review Procedure as set forth in this Article.

Categories of APCs eligible to provide services as determined by the Board of Trustees are as follows:

<u>Profession</u>	<u>Independent or Dependent on Supervision</u>
Certified Registered Nurse Anesthetist	Independent
Certified Nurse Midwife	Independent
Dentist	Independent
Optometrist	Independent
Podiatrist	Independent
Advanced Registered Nurse Practitioners	Dependent (except as provided in Section F, above)
CADC	Dependent
Mental Health Counselor	Dependent
Physician Assistant	Dependent
Psychologist	Dependent
Social Worker	Dependent

PODIATRIST

INDEPENDENT ADVANCED PRACTICE CLINICIAN

1. The applicant for clinical privileges in podiatry shall be a graduate of an approved school of podiatry, licensed in the State of Iowa, according to Chapter 149 of the Code of Iowa. The applicant shall possess a good moral character and shall have demonstrated knowledge and skill in that particular branch of podiatry in which he/she has been granted privileges.
2. Every patient scheduled for podiatric surgery shall have a recorded history and physical examination provided by an approved Practitioner with H & P privileges. The podiatrist will perform an update to the existing history and physical examination and assess the medical risks of the procedure on the patient. They must have an agreement with a Practitioner on the Medical Staff – established and declared- who is available to respond should any medical issue arise with the patient.
3. The scope and extent of surgical procedures shall be specifically delineated and granted in the same manner as all other surgical privileges. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of Surgery.
4. Podiatrists having clinical privileges in the hospital shall be subject to the same Rules and Regulations of the Medical Staff to the extent that these are applicable to podiatry.

OPTOMETRIC STAFF
INDEPENDENT ADVANCED PRACTICE CLINICIAN

1. An optometrist shall be eligible for appointment to the Advanced Practice Clinician Staff for optometric clinical privileges.
 - 1.1 Who have graduated from a school or college of optometry accredited by the Council on Optometric Education of the American Optometric Association; and
 - 1.2 Who are licensed by the State of Iowa; and
 - 1.3 Who possess background, experience and training which assures, in the judgment of the Board of Trustees, that any patient treated by them in the Hospital will be given a high quality of optometric care.
2. Privileges granted to optometrists shall be limited to the examination, diagnosis and treatment of the eye. Privileges in optometry shall be granted to optometrists having training, experience, and demonstrated competency on a level commensurate with that provided by training as required by the National Board of Examiners in Optometry and the Iowa Board of Optometry. The scope and extent of privileges shall be presented as a list, which shall be reviewed by the Credentials Committee and shall be granted by the Board of Trustees in the same manner as for all other privileges.
3. Optometrists shall comply with the applicable Bylaws, Rules and Regulations of Skiff Medical Center, and such policies and procedures approved by the Executive Committee as may apply.
4. If an optometrist judges that a patient may need to be admitted, the optometrist will arrange for a Practitioner with admitting privileges to perform the history and physical and admit the patient. The Practitioner will be responsible for the care of any medical problem that may be present or that may arise during hospitalization. The optometrist shall be responsible for the optometric history and physical examination and all appropriate elements of the patient's record.

DENTIST

INDEPENDENT ADVANCED PRACTICE CLINICIAN

1. The applicant for clinical privileges in dentistry shall be limited to graduates of an approved dental school, and hold a current license to practice in the State of Iowa. The applicant shall possess a good moral character and shall be professionally competent in privileges requested.
2. Each dental patient admitted to the hospital or scheduled for a surgical procedure must have a recorded history and physical examination by a Practitioner with H & P privileges. The dentist will perform an update to the existing history and physical examination and assess the medical risks of the procedure on the patient. They must have an agreement with a Practitioner on the Medical Staff – established and declared- who is available to respond should any medical issue arise with the patient. This Practitioner will be responsible for the medical treatment and medical record of that patient. The dentist performing the procedure will be responsible for the operative report and other appropriate dental records.
3. Dentists having clinical privileges shall be subject to the same Rules and Regulations of the Medical Staff to the extent that these are applicable to dentistry.

**CERTIFIED REGISTERED NURSE ANESTHETIST (CRNA)
INDEPENDENT ADVANCED PRACTICE CLINICIAN**

1. A CRNA shall be eligible for appointment to the Advanced Practice Clinician affiliate staff as an independent Practitioner for certified registered nurse anesthetist privileges if the CRNA:
 - 1.1 has successfully completed an approved nurse anesthesia training program;
 - 1.2 is licensed by the Iowa State Board of Nursing;
 - 1.3 is an advanced registered nurse Practitioner; and
 - 1.4 is certified by the National Board of Certification and Recertification for Nurse Anesthetists (NBCRNA).
2. Each patient admitted to the hospital or scheduled for a surgical procedure must have a recorded history and physical examination by a member of the active medical staff. The CRNA will be responsible for performing and documenting a pre-anesthetic assessment and evaluation of the patient, including requesting consultations and diagnostic studies; selecting, obtaining, ordering or administering pre-anesthetic medications and fluids; and obtaining informed consent for anesthesia.
3. CRNAs shall comply with applicable rules and regulations and policies and procedures of the Hospital.
4. The CRNA's scope of practice includes but is not limited to the following:
 - 4.1 assessing the surgical patient including preoperative pre-anesthesia assessment and verification that the patient is an appropriate candidate to undergo the planned anesthesia
 - 4.2 assessing the patient intraoperatively and postoperatively
 - 4.3 developing and implementing an anesthetic plan
 - 4.4 selecting and initiating the planned anesthetic techniques which may include general, regional, epidural, spinal, bier blocks, local anesthesia, intravenous sedation and monitored anesthesia care.
 - 4.5 selecting, obtaining or administering the anesthetics, drugs, and fluids necessary to manage the anesthetic, to maintain the patient's physiologic homeostasis and to correct abnormal responses to anesthesia or surgery
 - 4.6 selecting, applying or inserting appropriate non-invasive and invasive monitoring modalities for collecting and interpreting patient physiological data

- 4.7 managing a patient's airway and pulmonary status using endotracheal intubation, mechanical ventilating, pharmacological support, respiratory therapy or extubation
- 4.8 managing emergence and recovery from anesthesia by selecting, obtaining, ordering or administering medications, fluids or ventilatory support in order to maintain homeostasis, to provide relief from pain and anesthesia side effects or to prevent or manage complications
- 4.9 performing and documenting a post-anesthesia assessment once the patient is sufficiently recovered from the acute administration of the anesthesia so as to participate in the evaluation, e.g., answer questions appropriately, perform simple tasks. For those patients who are unable to participate in the post-anesthesia evaluation (non-communicative at baseline or mechanical ventilator etc), the anesthesia provider should document the reason for the patient's inability to participate
- 4.10 releasing or discharging patients from the post-anesthesia care area and provide post-anesthesia follow-up evaluation and care related to anesthesia side effects or complications
- 4.11 ordering, initiating, or modifying pain relief therapy through the utilization of drugs, regional anesthetic techniques or other accepted pain relief modalities including epidural or intrathecal analgesia during labor
- 4.12 responding to emergency situations by providing airway management, administration or emergency fluids or drugs and using basic or advanced cardiac life support techniques

**CERTIFIED NURSE MIDWIFE (CNM)
INDEPENDENT ADVANCED PRACTICE CLINICIAN**

1. A CNM shall be eligible for appointment to the Advanced Practice Clinician affiliate staff as an independent practitioner for certified nurse midwife privileges if the CNM:
 - 1.1 has successfully completed the Accreditation Commission for Midwifery Education (ACME) (formerly the American College of Nurse Midwives - ACNM) accredited nurse midwifery program; and
 - 1.2 has an unrestricted license by the Iowa State Board of Nursing to practice as an advanced practice nurse in the nurse midwifery category; and
 - 1.3 is certified by the American Midwifery Certification Board (AMCB), or be actively seeking initial certification and obtain the same on the first examination for which eligible; and
 - 1.4 is currently certified in ACLS and NRP; and
 - 1.5 carries current professional liability insurance coverage issued by a recognized company and of a type and in an amount equal to or greater than the limits established by the Board of Trustees.
2. The CNM shall be permitted to admit his or her patients to the Hospital after notification of the CNM's collaborating physician. Each patient admitted to the hospital or scheduled for a surgical procedure must have a recorded history and physical examination no more than 30 days prior to admission and no longer than 24 hour after admission and before any surgery or procedure requiring anesthesia. The history and physical may be performed by the CNM as long as the history and physical is countersigned by a physician member of the active medical staff.
3. CNMs shall comply with applicable rules and regulations and policies and procedures of the Hospital.
4. The CNM's scope of practice includes but is not limited to the following:
 - 4.1 Assess, diagnose, monitor, promote health and protection from disease and manage care to adolescent and adult females focusing on pregnancy, childbirth, the postpartum period, gynecological needs and the care of the well newborn during the first 28 days of life.
 - 4.2 Manage and deliver an obstetrical patient, who has had no major complications during her pregnancy, and who is expected to have an essentially uncomplicated labor and delivery. In accordance with hospital policy, the CNM should seek consultation with a collaborating physician in accordance with physician privileges for women who present with the pre-existing medical conditions and obstetrical complications. After consultation with the collaborating physician, the patient may

1) remain under CNM management, 2) be collaboratively managed for the remainder of the intrapartum period, or 3) become medically managed by the physician.

4.3 Intrapartum management including:

- Confirmation and assessment of labor and its progress
- Assessment of maternal and fetal status during labor including conducting fetal surveillance and interpretation of fetal monitor tracing
- Order routine laboratory, radiological, sonographical, and other diagnostic examinations
- Collect specimens for pathological examination
- Administer local or pudendal anesthesia and ordering epidural anesthesia when indicated
- Perform amniotomy
Co-manage with consulting physician moderate-and high-risk conditions including but not limited to: Pre-eclampsia, gestational diabetes, preterm labor, chorioamnionitis
- Perform induction of labor
- Apply management strategies and therapeutics to facilitate physiologic labor progress (no less than 36 weeks gestational age and not more than 42 weeks completed gestation)
- Manage spontaneous vaginal delivery
- Perform cord blood sampling
- Explore the uterus and manually remove placenta fragments
- Perform and repair midline/mediolateral episiotomies
- Repair first and second-degree perineal lacerations and other associated lacerations
Apply techniques for management of emergency complications and abnormal intrapartum events
- Assist the consulting physician in surgery and other medical procedures.

4.4 Postpartum management including:

- Provide care to mothers and infants in the postpartum period
- Perform hemorrhage stabilization with physician consultation if needed
- Manage midwifery elements of selected high-risk conditions after consultation with physician
- Monitor vital signs, lochia, fundus, and bladder functions in the immediate postpartum period
- Conduct postpartum rounds and examination
- Facilitation of the initiation, establishment, and continuation of lactation

4.5 Manage the care of the well newborn:

- Evaluate the newborn including initial gestational age assessment and initial and ongoing physical and behavioral assessment
- Apply methods to facilitate adaptation to extrauterine life: Stabilization at birth, resuscitation, and emergency management
- Refer newborn to pediatrician for further evaluation and care as indicated

CODE OF CONDUCT

Practitioners who provide patient care services at Skiff Medical Center shall comply with the Hospital's Medical Staff Code of Conduct Policy. The Skiff Medical Center Chief Medical Officer and Medical Executive Committee shall investigate matters and take enforcement actions in accordance with the aforementioned Code of Conduct Policy.

PRACTITIONER HEALTH

Practitioners who provide patient care services at Skiff Medical Center shall comply with the Hospital's Medical Staff Practitioner Health Policy. The Skiff Medical Center Chief Medical Officer and Medical Executive Committee shall investigate matters and take enforcement actions in accordance with the aforementioned Practitioner Health Policy.

REVIEWED, REVISED AND APPROVED by the Medical Staff on November 12, 2018.



Medical Staff President

REVIEWED AND APPROVED by the Board of Directors on December 5, 2018.



Chairman of the Board