

INFORMATIONAL AMENDMENTS TO THE BYLAWS, RULES AND REGULATIONS OF THE UNIVERSITY OF IOWA HOSPITALS AND CLINICS AND ITS CLINICAL STAFF

RE: BYLAWS AMENDMENT CHANGING PATIENT CARE RULES AND REGULATIONS WITH RESPECT TO VERBAL ORDERS

Article VIII, Section 4 is amended to read as follows:

Section 4:

Orders for medication or treatment shall be in writing, shall be timed and dated, and shall be signed by the member or practitioner giving the order with the following exceptions:

- A. In cases of emergency, ~~oral~~ verbal orders may be accepted from members or practitioners
- B. In cases when the member or practitioner is unable to be present to write the necessary order and delaying administering the medication or performing the treatment would be adverse to the patient's welfare.
 - 1. ~~An order may be dictated over the telephone to a registered nurse after the registered nurse has described the patient's condition to the member or practitioner; or~~
 - 2. ~~An order may be dictated over the telephone to a pharmacist when the member or practitioner concurs with a medical order change as recommended by a pharmacist; or~~
 - 3. ~~An order pertaining to respiratory care may be dictated over the telephone to a respiratory therapist after the respiratory therapist has described the patient's condition to the member or practitioner.~~
- C. All verbal orders will be accepted and documented per hospital policy.

~~All orders must be written in the patient's medical record by the registered nurse, pharmacist or respiratory therapist who receives the order and must be personally signed within three (3) days by the member or practitioner who delivers the order.~~

D. Verbal orders regarding bed occupancy will be accepted and documented per hospital policy.

~~Orders specifying the bed occupancy category to which a patient is to be admitted or transferred shall be in writing, shall be dated and shall be signed by the physician or dentist giving the order. Oral orders specifying bed occupancy category assignment may be accepted from physicians or dentists by a registered nurse, including a registered nurse assigned to utilization management responsibilities. An oral order specifying bed occupancy category assignment which is accepted by a utilization management registered nurse may be communicated by that registered nurse directly to a registered nurse on the nursing unit for transcription into the Patient's medical record. In all other cases, the order must be written in the patient's medical record by the registered nurse who receives the order. All oral orders specifying the bed occupancy category to which a patient is to be admitted or transferred must be personally signed within 48 hours by the physician or dentist who delivers the order.~~

Medical students who have completed two years of medical school may write orders. Written orders by medical students shall be co-signed by the patient's attending physician or house staff member under his/her supervision before they will be carried out by the nursing staff or any other professional staff. It is the responsibility of the medical student to obtain the co-signature.

For the purpose of these Patient Care Rules and Regulations, the words "sign" and "signature" include an electronic signature pursuant to a verification protocol approved by the Hospital Information Systems Advisory Subcommittee.

EXPLANATION

This amendment removes detailed time frames, references to staff who may accept verbal orders, process for accepting and documenting verbal orders. The intent is to reference hospital policy for these issues. This revision will reduce the need to revise the bylaws as verbal order policy evolves and changes. This amendment now also meets regulatory standards imposed on the institution and brings this component of health care into compliance.

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RE: BYLAWS AMENDMENT CHANGING PATIENT CARE RULES AND REGULATIONS WITH RESPECT TO POST-ANESTHETIC PROGRESS NOTES

Article VIII, Section 8 is amended as follows:

Section 8:

A surgical procedure shall be performed only upon the informed consent of the patient or the patient’s legal representative, except in emergencies or pursuant to a court order. Operative reports dictated or written immediately after surgery record the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered immediately. The medical record should reflect a post-anesthetic ~~visit made after the patient left the post anesthesia care unit or other recovery area~~ evaluation made by an individual qualified to administer anesthesia within 48 hours after surgery. This report should document the cardiopulmonary status, level of consciousness, observations and/or patient instructions given, and any complications occurring during post-anesthetic recovery. All tissues removed will be sent to the Pathology Laboratory, where such examinations will be made as may be considered necessary to arrive at a diagnosis. Reports of such examinations shall be signed by the responsible physician and filed in the medical record and in the pathology files.

In addition, when tissues that have been removed at other institutions are to be used as a basis for developing, recommending or continuing a treatment plan by an Attending Physician or Dentist, the tissues shall be sent to the Pathology Laboratory for a formal examination prior to implementing the treatment plan, unless, in the best medical judgment of the attending physician/dentist, a delay in starting treatment would constitute a significant hazard for the patient. Specific exceptions to this policy may be granted by the Diagnostic Services Subcommittee following a written petition from a clinical division or department.

EXPLANATION

This amendment is recommended to comply with Medicare Conditions of Participation Interpretive Guidelines for post-anesthesia evaluations.

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RE: BYLAWS AMENDMENT RELATING TO DISCHARGE SUMMARY CRITERIA

Article VIII, Section 9 is amended to read as follows:

Section 9:

Patients shall be discharged only upon written order of a member or practitioner. Patients who sign out against medical advice shall be requested to sign a suitable release form. Records of discharged patients shall be completed within fourteen days following discharge. The clinical resume should be concise, include information relative to the reason for hospitalization, pertinent findings; procedures performed and care, treatment and services provided, ~~what action has been taken relative to the findings~~; the condition of the patient on discharge; and instructions given to the patient and/or the family as appropriate. ~~particularly in regard to physical activity limitations, medications, and diet~~. All final diagnoses shall be recorded in full. ~~without abbreviations or symbols~~.

EXPLANATION

This amendment is recommended to comply with Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards.