

# MEDICAL STAFF



# RULES AND REGULATIONS

**2008**

**NORTHSIDE HOSPITAL & TAMPA BAY HEART INSTITUTE**  
**RULES AND REGULATIONS – INDEX**

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RULES & REGULATIONS  
NORTHSIDE HOSPITAL & TAMPA BAY HEART INSTITUTE**

**I. PATIENT’S RIGHTS, ETHICS, & RESPONSIBILITIES**

1. Advance Directives, Withdrawal of Life Support, and Do Not Resuscitate Order

The Medical Staff shall comply with Florida Statute 765.102 as follows:

The artificial prolongation of life for a person with a terminal or end-stage condition or in a persistent vegetative state may secure for him/her only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the patient. In order that the rights and intentions of a person with such a condition may be respected even after they are no longer able to participate actively in decisions concerning themselves, and to encourage communication among such patient, family members, or Health Care Surrogate, and the physician, the Legislature declares that the laws of this State recognize the right of a competent adult to make an advance directive instructing their physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make the treatment decision for them in the event that such person should be found to be incompetent and suffering from a terminal condition, an end-stage condition, or a persistent vegetative state. Life support may not be withheld or withdrawn unless the patient or patient’s representative makes a request to withhold or withdraw life support. Physicians may not make this decision independently.

NOTE: A Do Not Resuscitate order shall be considered to be in writing if written directly by a physician or if issued as stated above and issued verbally to two licensed Registered Nurses and witnessed by both Registered Nurses (See “Continuum of Care” – “Verbal or Telephone Orders” and “Hazardous Verbal Orders”).

When a patient presents with a “Florida Do Not Resuscitate Order” on Florida Department of Health, Bureau of EMS yellow DH Form 1896, the Florida DNRO is to be honored by all hospital services and units upon confirmation by patient/family/surrogate that the DNRO is to remain in effect.

The patient/family/surrogate may revoke a hospital DNR or Florida DNRO at any time.

When a patient with a previously authorized Do Not Resuscitate (DNR or No Code) order or Florida DNRO is scheduled for surgery, an informed consent discussion regarding the management of the DNR status during the perioperative and postoperative periods must be conducted and documented by the attending physician or surgeon and/or anesthesiologist prior to surgery.

The Medical Staff shall comply with the “Life Prolonging Procedures Act,” Florida Statute 765.301 and with 765.401 F.S. “Absence of Advance Directive. Refer to Functional Policies # 2.9 “Advance Directives – Patient Self Determination Act and #2.10 “Withholding or Withdrawing of Life Prolonging Procedures.”

2. Determination of Patient Condition Prior to Withholding or Withdrawal of Life Prolonging Procedures

In determining whether the patient has a terminal condition, has an end-stage condition, or is in a persistent vegetative state or may recover capacity, or whether a medical condition or limitation referred to in an advance directive exists, the patient's attending or treating physician and at least one other consulting physician must separately examine the patient. The findings of each examination must be documented in the patient's medical record and signed by each examining physician before life-prolonging procedures may be withheld or withdrawn.

3. Determination of Capacity

The Medical Staff shall comply with Florida Statute 765.20 (2). If a patient's capacity to make health care decisions for herself or himself or provide informed consent is in question, the attending physician shall evaluate the patient's capacity and, if the physician concludes that the patient lacks capacity, enter that evaluation into the patient's medical record.

If the attending physician has a question as to whether the patient lacks capacity, another physician shall also evaluate the patient's capacity and enter that evaluation into the patient's medical record.

4. Transfer of Patient Care Responsibility - Refusal to Comply with a Patient's Treatment Decision

A physician who refuses to comply with the advance directives of a patient, or the treatment decision of his/her surrogate, shall make reasonable efforts to transfer the patient to another health care provider who will comply with the declaration or treatment decision. This rule does not require a physician to commit any act which is contrary to his/her moral or ethical beliefs concerning life-prolonging procedures, if the patient:

- a. Is not in an emergency condition; and
- b. Has received written information upon admission informing the patient of the policies of the hospital regarding such moral or ethical beliefs.

A physician who is unwilling to carry out the wishes of the patient because of moral or ethical beliefs must within 2 days either:

- a. Transfer the patient to another physician; or
- b. If the patient has not been transferred, carry out the wishes of the patient or his surrogate.

5. Request for Change of Physician

When a hospitalized patient or his/her family or health care surrogate requests to change physicians, Administration will provide the patient and/or family/surrogate with a list of members of the Medical Staff. It is the responsibility of the patient or his/her family/surrogate to notify the attending physician that he/she is off the case and that another physician on the staff has agreed to take the case.

The patient and/or family will contact the physician of their choice to take care of the case, if the physician decides to accept the patient; he/she will notify the nurses' station. The attending physician will document a verbal or written order for the transfer and will notify the nurses' station that they have signed off the case.

6. Patients Leaving Against Medical Advice

A patient who proposes to leave the hospital against the advice of any Medical Staff member should, if at all possible, be required to sign a statement to this effect, (doctor should explain risks of signing out against medical advice), and to release the attending staff member or staff members and hospital from all responsibility in the matter.

**II. ADMISSION AND DISCHARGE OF PATIENTS**

1. Types of Patients

The Hospital may accept patients for care and treatment except for the following disease categories:

- a. Psychiatric patients and patients with acute alcoholism who are difficult to control.
- b. Any patient known or suspected to be suicidal in intent.
- c. Pregnant patients will be treated only in the Emergency Room. If a pregnant patient requires admission, they will be transferred to an appropriate facility for inpatient care following stabilization in the ER.

2. Age of Patients

Patients accepted for admission to Northside Hospital shall be no younger than eighteen (18) years old. Patients younger than eighteen (18) will be transferred to an appropriate hospital for inpatient care.

3. Admission of Patients by Staff Members Only

Only a Member of the Medical Staff may admit a patient to the Hospital. The official admitting policy of the Hospital shall govern all practitioners.

A Member of the Medical Staff shall be responsible for the medical care and treatment of each patient (inpatient or outpatient) and for prompt, complete and accurate medical records. Whenever these responsibilities are transferred to another Staff Member a note covering the transfer of the responsibility shall be entered on the order sheet of the medical record.

4. Provisional Diagnosis Necessary for Admission

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

5. Declaration of Emergency Admission

Staff Members admitting emergency cases shall be able to explain to the Executive Committee why the emergency admission was an emergency. The history and physical examination must clearly justify the patient being admitting on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.

6. Required Admission Tests

Required admission tests are those required by State or Federal laws, Rules and Regulations, and may change from time to time. An active surveillance screening culture for MRSA will be completed on all high risk patients upon admission and when a patient is transferred into the critical care units.

7. Required Admission Vaccines.

Required admission vaccines are those mandated by Florida Statute and include Influenza and Pneumococcal vaccine screening and administration to eligible patients. Vaccine requirements and criteria may change from time to time.

8. Admission During Acute Care Bed Shortage

a. Emergency admissions according to grade will be given first priority:

GRADE I CRITICAL (cases which must be hospitalized at once)

GRADE II IMMEDIATE (cases which must be hospitalized within twenty-four (24) hours)

GRADE III URGENT (the problem is not critical or immediate but approaching that stage and requiring hospitalization at earliest admission possible)

b. Cancellation of elective bookings will be made on a priority basis that will include: type of case, length of time patient has been booked, and distance patient must travel, and the ease with which such cancellation can be communicated to the patient.

9. Transfer of Patients

Except in cases of emergency, no patient shall be transferred from any room or Special Care Unit without such transfer being approved by the responsible Staff Member.

10. Admissions To or Discharge From Special Care Units

If any questions as to the validity of admission to or discharge from the Special Care Units should arise, that decision is to be made through consultation with the Chair of the Special Care Unit Committee, or in their absence, the Chair of the Department of Medicine or Surgery, or the Chief of the Medical Staff.

11. Review of Patient's Length of Stay

The attending Staff Member is required to document the need for continued hospitalization after specific periods of stay as identified by the Quality Committee of the Hospital, and approved by the Executive Committee. This documentation must contain:

- a. Adequate written record of the reasons for continued hospitalization. (A simple reconfirmation of the patient's diagnosis is not sufficient.)
- b. The estimated period the patient will need to remain in the hospital.
- c. The plans for post-hospital/discharge care.

Upon request of the Information and Resource Management Committee, the attending Staff Member shall provide written justification of the necessity for continued hospitalization of any patient hospitalized thirty (30) days or longer, including an estimate of the number of additional days of stay and the reason therefore. This report shall be submitted within seventy-two (72) hours of receipt of such request. This process may be repeated at thirty- (30) day intervals. Failure to comply with this policy will be brought to the attention of the Executive Committee for action.

#### 12. Discharge Procedure

Patients shall be discharged only on the written signed order of a Staff Member. The medical record front sheet shall be completed and signed as a condition of the patient's discharge. A discharge summary shall be dictated on each patient no later than thirty (30) days following discharge of the patient except for short stay admissions (forty-eight (48) hours or less), where a written discharge note sufficient to justify the diagnosis and warrant the treatment and end result is required. A dictated summary is required on all deaths regardless of length of stay. All discharge summaries shall be signed or countersigned by the responsible Staff Member. Should a patient leave the Hospital against the advice of the responsible physician, or without proper discharge, the procedures for patients discharged against medical advice should be followed.

#### 13. Patient's Leaving Against Medical Advice

Patients who propose to leave the Hospital against the advice of any Staff Member should, if possible, be required to sign a statement to this effect and to release the attending Staff Member or Staff Members and the Hospital from all responsibility in the matter.

#### 14. Death Procedure

In the event of a Hospital death, the deceased shall be pronounced dead by the attending Staff Member or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a Member of the Medical Staff. Exceptions shall be made to the medical record entry in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to law.

#### 15. Autopsy Procedure

The Medical Staff recognizes the importance of the autopsy as a source of clinical information in quality improvement activities. Each member is expected to attempt to secure an autopsy in any case which meets Medical Staff criteria for the consideration of an autopsy. The physician is expected to document the consideration of autopsy, discussion with family/significant other, and consent or refusal in the medical record. With the exception of Medical Examiner cases, the hospital pathologist shall perform autopsies. The physician requesting the autopsy will be notified of the date and time the autopsy will be performed. The Pathologist is expected to communicate the performance of the autopsy and the results and pathological diagnosis to the attending physician and provide a written report for inclusion in the medical record. Data collected on performance of autopsies and results of autopsies is communicated to the Medical Staff Departments.

When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within 48 hours and the complete protocol is included in the record within sixty - (60) days, except in unusual or difficult cases.

#### Criteria for consideration of an Autopsy

- a. Unanticipated death.
- b. Intraoperative or procedural death.
- c. Death occurring within 48 hours after surgery or an invasive diagnostic procedure, with the exception of endoscopic procedures or Swan Ganz insertion.
- d. Death where the cause is sufficiently obscure to delay completion of the death certificate.

An attempt will be made to contact the attending physician when an autopsy is to be performed to allow him/her the opportunity to participate.

#### 16. Life Threatening Emergencies

An emergency is defined as a condition in which the life of the patients is in immediate danger and any delay in administering treatment will increase the danger.

In an emergency, any Staff Member, regardless of departmental or staff status, shall be expected to do all in his power to save the life of a patient, including the calling of such consultations as may be available.

Physicians associated with the Medical Education Program who respond to a Code Blue, BRAT, or Rapid Response shall follow appropriate protocols and procedures. Communication with the appropriate attending or consulting physician must be established immediately.

#### 17. Observation Status to Full Admit

Between the twenty-fourth (24<sup>th</sup>) and forty-seventh (47<sup>th</sup>) hour of a patient's designation as Outpatient Observation Status, the Case Manager/Nurse will contact the attending physician to request an order to discharge the patient or make the patient a "Full Admit". Lack of a direct physician response will constitute an order for "Full Admit". The Case

Manager/Nurse will write the order to change the patient admission status to “Full Admit” as a verbal order to be signed by the physician on his/her next visit.

### **III. MANAGEMENT OF INFORMATION**

#### **1. Medical Record Preparation**

The attending physician shall be responsible for the preparation of a complete medical record for each inpatient and outpatient visit. The record shall include patient identification data, chief complaint, personal history, family history, history of present illness, physical examination, and other special reports such as consultations, clinical laboratory and radiology services and other, provisional diagnosis, medical or surgical treatments, operative reports, pathological findings, progress notes, final diagnosis, condition on discharge, discharge summary or note and autopsy report when performed. In all instances, the content of the medical record shall be sufficient to identify the patient, support the diagnosis, justify the treatment, document the course and results, and promote continuity of care among health care providers.

#### **2. History and Physical Examination**

A complete medical history and physical examination will be completed and documented for each patient no more than 30 days before or 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia service.

A dictated history and physical Examination is preferred; however, a handwritten history and physical may be used if it meets all of the components required, is legible, and is placed on the medical record within 24 hours of admission or registration, or prior to surgery or a procedure requiring anesthesia, whichever comes first. The medical history and physical examination must be completed and documented by a physician who is credentialed and privileged by the hospital’s medical staff to perform an H&P. (as defined in the Conditions of Participation, section 1861 (r) of the Act).

Section 1861 © defines a physician as the following:

- Doctor of medicine or osteopathy;
- Doctor of Dental surgery or of Dental medicine;
- Doctor of Podiatric Medicine;
- Doctor of Optometry.

When the H&P is conducted within 30 days before admission or registration, an update must be completed and documented by a licensed practitioner who is credentialed and privileged by the hospital’s medical staff to perform an H&P. An updated examination of the patient, including any changes in the patient’s condition, must be completed and documented within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia services, before admission or registration. The updated examination of the patient, including any changes in the patient’s condition, must be completed and documented by a physician in accordance with State law and hospital policy. If upon examination, the licensed practitioner finds no change in the patient’s condition since the H&P was completed, he/she may indicate in the patient’s medical record that the H&P was reviewed, the patient was examined, and that “no change” has occurred in the patient’s condition since the H&P was completed. Any changes in the patient’s condition must be documented by the practitioner in the update note and placed in the patient’s medical record within 24 hours of admission or registration, but

prior to surgery or a procedure requiring anesthesia services. Additionally, if the practitioner finds that the H&P done before admission is incomplete, inaccurate, or otherwise unacceptable, the practitioner reviewing the H&P, examining the patient, and completing the update may disregard the existing H&P and conduct and document in the medical record a new H&P within 24 hours after admission or registration, but prior to surgery or a procedure requiring anesthesia.

In the instance where a history and physical has not been placed on the record within 24 hours or prior to surgery or a procedure requiring anesthesia services, it is acceptable for either the emergency room note or a consultation to suffice as the history and physical providing it contains all the elements of an H & P as noted below.\*

When a physician assistant, advanced registered nurse practitioner, resident, or intern, performs the history and physical examination, the supervising physician is responsible for validating and countersigning the H&P.

\*An admission history and physical shall include the following:

- Chief Complaint
- Details of present illness
- Relevant past medical/surgical history to include current medications and drug allergies.
- Relevant past, social, and family histories as appropriate to the age of the patient
- Review of body systems
- Relevant physical examination
- Statement on the conclusions or impressions drawn
- Statement on the course of action planned for the patient.

An Osteopathic musculoskeletal examination is required as an integral part of the history and physical performed by osteopathic physicians on their admitted patients, unless contraindicated. The reason for omitting the musculoskeletal examination is documented in those cases where this examination is contraindicated.

A short history and physical is acceptable for outpatient surgery. The short history and physical should contain the following elements: Indications/reasons for procedure/admission to the hospital; procedure/plan; short history relevant to the surgery, medications and allergies; physical examination to include HEENT; cardiovascular, respiratory, abdomen and neurology/extremities.

#### Outpatient Services Requiring a History and Physical (Short Form H&P)

Bone Marrow Biopsy

Lumbar Puncture

Liver Biopsy

Thoracentesis

Paracentesis

Chemotherapy

Intraocular Lens Injection

All Special Procedures, I.E., Arteriograph, Neph Tube

Placement, Drainage, Angioplasty, Stent Placement, Tip, etc.

Myelogram  
Arthogram  
Breast Biopsy  
Biopsy Done in CT Scanning  
Diskogram  
TEE

### Outpatient Services Not Requiring a History and Physical

Central Line Placement  
Port Flush  
Blood Transfusion  
IV Antibiotic Administration  
IV Fluid Replacement  
PIC Line Placement  
IV Medication Infusion  
Therapeutic Phlebotomy

A history and physical report from a physician who is not currently on staff can be used as long as it meets the Medical Staff requirements for a current and complete H&P and that a physician on Staff with **privileges to perform history and physical examinations** reviews, confirms the findings and authenticates the document.

In the event a patient signs out against medical advice (AMA) prior to being examined by the attending physician/designee, the emergency room history and physical examination will be deemed the H&P for the medical record.

Prior to any operation or any potentially hazardous invasive procedure, the history and physical shall be recorded. In the event of an **emergency** surgery, the history and physical may be handwritten, if not possibly before surgery, then immediately after.

## 2. Operative Reports

Operative reports shall include the name of the surgeon and assistants, a detailed account of findings at surgery, the technical procedures used, the specimens removed, estimated blood loss, any complications, and the postoperative diagnosis. An operative report or other high-risk procedure progress note is entered into the medical record immediately after the procedure when the full operative or other high-risk procedure report cannot be entered into the record immediately after the operation or procedure.

## 3. Report of Consultation

Consultation reports must include a dictated or handwritten opinion of the consultant, pertinent findings upon examination of the patient, the consultant's opinion and recommendations. A limited statement such as "I concur" does not constitute an acceptable report of consultation. It should be made clear in the record if the consultant is merely rendering an opinion and suggestions on therapy and/or procedures and/or if assuming the responsibility for the care of the patient.

## 4. Discharge Summary

A discharge summary shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours. It should concisely summarize the reason for hospitalization, the significant findings, the procedures performed and treatment rendered the patient's condition on discharge, and any specific instructions given to the patient and/or family including the physical activity, diet, medications, and dosage. In the event of the patient's death, a summary statement should be added to the record, which indicates the events leading up to the patient's demise, irrespective of the duration of hospitalization. If the attending physician had not seen the patient prior to the patient's death, although admitted to his/her service, a note stating such should be documented.

For those patients hospitalized for an illness of a minor nature, which requires a stay of less than forty-eight (48) hours, a final progress note, which includes condition of patient at discharge, instructions given to the patient/family to include, diet, activity, medications, and follow-up instructions as applicable may be substituted.

The use of a discharge summary dictation service for summarizing a hospital visit is permitted upon proper written notification provided to the Director of Health Information Management. The physician is responsible for signing each individual report after dictation acknowledging full legal responsibility for the accuracy and content of such dictation. The physician is also responsible for ensuring the individual/company is notified of any incomplete records needing dictation of summaries.

5. Progress Notes

Progress notes shall be accurately dated, timed and signed by the responsible staff member.

Pertinent progress notes shall be recorded at the time of observation of the patient, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients. On all other patients, progress notes shall be written at least every two (2) days.

6. Dating and Signing of Clinical Entries

All Clinical entries in the patient's medical record shall be accurately dated and signed by the responsible staff member upon his/her next visit to the hospital.

For those entries requiring counter-signatures, to include those made by physician assistants, residents, interns, and students, the responsible medical staff member shall sign such entries upon his/her next visit to the hospital.

Authentication may be handwritten or by electronic signature provided the staff member signs the appropriate hospital forms stating that he/she is the author of the entries and is the only one who has possession of the security code for authenticating such entries. The use of rubber stamps is permitted on prescriptions with a printed valid name, address and telephone number for outpatient ancillary testing only.

7. Final Diagnosis

Final diagnosis/procedures shall be recorded using acceptable disease and operative terminology at the time of discharge. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, then the final diagnosis shall be recorded as soon as possible after all essential reports have been received by the responsible staff member.

8. Correction of Errors

When errors are made, the person making the correction should draw a single line through the error, correct if needed and initial/date.

a. Procedure for Making Changes or Amendments to Record Entries Prior to Patient Discharge:

Any individual who discovers an error or omission on his/her own entry shall immediately upon discovery correct it and do so in accordance with the procedures in this section.

Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated) and initialed.

Typographical errors noted in dictated reports may also be corrected any time prior to completion of the record. The error shall be lined through (not obliterated) and initialed.

Errors or omissions discovered later shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined through (not obliterated). The person making the change shall sign and note the time and date of the change and the reason for the change. The new entry shall also state who was notified of the change and time and date of such notification.

Any individual who discovers an error or omission of his/her own, or a possible error made by another individual, shall immediately upon discovery notify the person who made the initial entry, and the patient's attending physician, if he/she is not the person who made or discovered the entry, and any other physicians, nurses or other individuals who may have seen and relied upon the original entry.

b. Changes or Amendments to Record Entries After Patient Discharge

Changes or amendments to record entries after patient discharge but before completion of the record shall be made in accordance with the procedures set forth

9. Unavailability of Physician for Completion of Records

When it has been determined that a physician is unavailable permanently or protractedly, or in the event of a death, the Information/Resource Management Committee has the authority to grant permission to retire the medical record(s).

10. Availability of Record for Readmitted Patient

When a patient is readmitted to the hospital, previous health information is readily available to the treating medical staff, both on the computer system and/or in paper form. When records are located off-site in secured storage, if needed urgently, the medical reports can either be faxed or delivered based on the physician's need. If not deemed an emergent situation, the record will be delivered with the next scheduled delivery.

11. Release of Medical Record Information

Written consent of the patient is required for release of medical information to persons not otherwise authorized by law or regulations to receive this information.

12. Staff Member Access to Medical Records

Access to medical records of all patients shall be afforded to Members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of information concerning the individual patients. The appropriate Medical Staff Committee shall approve all such projects before records may be studied. Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the Hospital.

13. Custody of Medical Records

Records may be removed from the Hospital's control and safekeeping only in accordance with a lawful subpoena, court order, or as otherwise provided by Federal or State Law.

14. Use of Symbols and Abbreviations

Abbreviations, acronyms, and symbols are acceptable for entry in the medical records as published in the approved abbreviations list. Included in the approved abbreviation list is a "DO NOT USE" abbreviation list that must be followed also.

15. Incomplete Medical Records

Within thirty- (30) days of the patient's discharge the medical record should be completed. The medical record will be considered delinquent if the History & Physical and Discharge Summary, and when applicable, the Operative Report and Consultation, are absent from the medical record or are unsigned.

**Suspension Procedure:**

- a. A medical record is deemed incomplete if not fully authenticated within thirty (30) days of discharge.
- b. Offenders of the Medical Record Policy will be contacted by letter informing them that they have seven (7) days from receipt of the letter to arrange and appointment to complete their records.
- c. Once the charts are pulled, there will be a seventy-two (72) hour window for completion of all records that have been pulled.
- d. If a physician will be unavailable for a period of seven (7) days or more, such as vacation, and prior notice is given to the Health Information Services Department, a fourteen (14) day grace period will be given for completion of records upon return.

*If the physician is on suspension prior to taking time off, there will be no grace period.*

If the physician is on suspension and attempts to schedule a procedure or admit a patient all calls will be forwarded to Administration for approval. **Suspension includes rounding, progress note entry, orders and any other aspect of patient care until the suspension is lifted. Physicians on suspension will be allowed to attend to their inpatients. Surgeons will be allowed to operate on inpatients scheduled for surgery prior to the time of suspension until the suspension is lifted. An associate may not transfer care back to the suspended physician during the suspension.**

- e. If a physician remains on the suspension list for 30 days, a certified letter will be sent from the Chief of Staff to the physician on suspension and to the Section Chief of that specialty that they have another 30 days (a total of 60 days) to complete their medical records or they will have to attend the Medical Executive Committee to explain why they cannot complete their medical records. The letter will advise the physician “failure to appear before the Executive Committee will mean automatic suspension of all privileges, including admissions through the emergency department”. The letter will also inform the physician if he/she is suspended it is reportable by law to the State. If records are completed, all reports dictated and signed, prior to the meeting date, attendance will not be required. As a courtesy, the Medical Staff Office will additionally call these physicians and remind them to complete their medical records.
- f. If the medical records are not completed the physician must report to the next Medical Executive Committee meeting. At that meeting, the Committee will talk to the physician and determine how to proceed to get the medical records completed.
- g. If the physician does not attend the Medical Executive Committee, a letter will be sent certified mail to the physician informing him that he has voluntarily resigned. The Chief of Staff signs this letter.
- h. To be reinstated, the physician must apply for appointment to the medical staff, as outlined in Article IV of the Medical Staff Bylaws. The affected physician shall be notified by the Chief of the Medical Staff prior to the effective date of termination and shall be entitled to due process as outlined in Article X of the Medical Staff Bylaws.

17. HIPAA/Organized Health Care Arrangement

Each member of the Medical Staff will be part of the Organized Health Care Arrangement with the Hospital, which is defined in USC 164.520(d)(1)(HIPAA Privacy Regulations) as a clinically integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. This arrangement allows the Hospital to share information with the provider and the provider’s practice for purposes of the provider’s payment and practice operations. The patient will receive a Notice of Privacy Practices in Admissions, which will include information about the Organized Health Care Arrangement with the Medical Staff.

**III. GENERAL CONDUCT OF CARE**

1. Consent for Treatment

A general consent for treatment form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting office should notify the attending staff member whenever such consent has not been obtained. When so notified, it shall, except in emergencies, be the attending staff member's obligation to obtain proper consent before the patient is treated at the hospital.

2. Directions for Treatment

Staff member's directions for treatment shall be entered upon the prescribed hospital form. Such directions may be written, typewritten or printed.

3. Administration of Drugs and Medications

All drugs and medications administered to patients shall be those listed in the latest edition of: United States Pharmacopoeia, National Formulary, American Hospital Formulary Service or A.M.A. Drug Evaluations. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

4. Cancellation of Directions for Treatment at Time of Surgery

All previous directions for treatment are canceled when patients go to surgery.

5. Regular Attendance by Attending Physician

The attending physician or appropriate consultant should attend his/her patient at the bedside on not less than a daily basis. The attending is responsible for seeing that such coverage is provided.

6. Consultations

Except in an emergency, consultation is deemed advisable in the following situations:

- a. When the patient is not a good risk for operation or treatment.
- b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.
- c. Where there is doubt as to the choice of therapeutic measures to be utilized.
- d. In unusually complicated situations where specific skills of other Staff Members may be needed.
- e. In instances in which the patient exhibits severe psychiatric symptoms or suicidal tendencies.
- f. When requested by the patient or his family.
- g. Where individual departmental requirements, credentialing decisions, or other Bylaws, Rules and Regulations provisions specify.

7. Mandatory Consultations

In cases where a consultation cannot be obtained based on the consultant agreeing to see a requested consult on a voluntary basis the following procedure will be activated:

1. The case will be reviewed by a member of the consultation review board for the following:

- a. Clear documentation that the attending physician has spoken to or made very possible attempt to directly communicate with all staff members able to provide appropriate consultation on the Medical Staff.
  - b. the attending physician must document in the medical record that the consultation is medically necessary while the patient is an in-patient at NSH
  - c. The medical condition, factors and circumstances warranting consultation while an in-patient at NSH
2. Once all of the conditions listed above are reviewed and if the review board member agrees consultation is required, the consultation board member will then select and contact an appropriately credentialed and available member of the Medical Staff to provide consultation and care as needed.
3. Failure to provide consultation and care as stated in #2 above, will result in referral to the Medical Executive Committee and the penalty will be:
- 1<sup>st</sup> violation- 3 day suspension
  - 2<sup>nd</sup> violation-7 day suspension
  - 3<sup>rd</sup> violation-14 day suspension
  - 4<sup>th</sup> violation-21 day suspension
  - 5<sup>th</sup> violation-Adverse Action
4. The members of the Consultation Review Board will be:
- a. Each Department Chair
  - b. Chief of Staff
  - c. Chief of Staff Elect
  - d. Secretary/Treasurer
5. The following hierarchy for contacting and requesting review will be as follows:
- Department Chair
    - a. Chief of Staff
    - b. Chief of Staff Elect
    - c. Secretary/Treasurer

8. Record of Consultation

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient and the consultant's opinion and recommendations. When operative procedures are involved, the consultation note shall, except in emergencies so verified on the record, be recorded or dictated prior to the operation.

9. Responsibility for Requesting Consultation

The attending Staff Member is primarily responsible for requesting consultation when indicated. It is the duty of the Department/Section Chair and the Executive Committee to see that Staff Members do not fail in the matter of calling consultants when needed. Stat/Urgent Consults must be Physician to Physician.

10. Review of Need for Consultation

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, she shall call this to the attention of her superior, who in turn may refer the matter to the Director of Nursing Service. If warranted, the Director of Nursing Service may bring the matter to the attention of the Chair of the Department/Section wherein the attending Staff Member has clinical privileges. Where circumstances are such as to justify such action, the Chair of the Department/Section may himself request a consultation.

11. Availability of Consultation Services

Qualified Staff Members in the Hospital can be called upon for consultation within their area of expertise and, if they accept the patient, are expected to respond within twenty-four (24) hours or sooner if clinically indicated.

12. Written Orders for Treatment Required

All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to qualified personnel. In addition to RN's and LPN's, the following persons are authorized to accept verbal orders in the field of their expertise: Respiratory Therapists, X-ray Technologists, Nuclear Medicine Technologists, Dietitians, Occupational Therapists, Physical Therapists, Speech Therapists, Pharmacists, and Case Managers/Social Workers. All verbal orders shall be signed by the qualified person to whom they are dictated with the name of the physician per his/her own name. Specifications of personnel who are determined to be qualified shall be included in Hospital policy and approved by the Executive Committee of the Medical Staff.

Verbal orders must be authenticated by the physician as soon as possible with the exception of the initial non-behavioral restraint order. That order must be authenticated within 48 hours. A covering physicians may sign on verbal/telephone orders. Admitting Registrars and Health Information Coders may document clarification of the sign/symptom/diagnosis on an outpatient order/script if needed for accurate coding.

13. Legibility of Orders

Orders must be written legibly and completely. Illegible or improperly written orders will not be carried out until they are clarified and can be understood by the nurses. The terms "renew", "repeat" and "continue orders" are not acceptable. All previous orders are canceled when a patient goes to surgery.

14. Take-Home Drugs

A prescription must be written for any prescription legend drug that is to be sent home with a patient.

15. Designation of Alternate Staff Member

Every Staff Member shall be responsible for naming another Staff Member to care for his patients when he/she is not available. In case of failure to do this, the Chief of Staff, Department Chair, or their designee, shall have the authority to call an appropriate Staff Member, if necessary.

16. Electrodiagnostic Interpretations

- a. Qualifications for interpreting electrodiagnostic examinations shall be established by the Department of Medicine and through the appropriate mechanism are incorporated in the Rules and Regulations of the Hospital. Those qualifications shall be utilized in determining the delineation of privileges and the credentialing process.
- b. Electrodiagnostic examinations shall be interpreted within forty-eight (48) hours.

17. Physician On-Call Arrangements

Physicians who have signed off call are to arrange coverage by a Member of the Medical Staff of the appropriate specialty.

Physicians who have served on the active staff for 20 years or longer may be granted an exemption from further Emergency Room call responsibilities.

Medicine – On-Call

1. All General Medicine call is voluntary
2. Sub-specialists who have their own call will not be on the Primary call schedule
3. Physicians who give away their General Medical call two (2) or more times, without taking call, will be removed from the medicine E.R. call list. After a one year suspension the physician may submit a written request to be included on the General Medical call list only if they are taking the call themselves.
4. When a physician gives up call, his call will be replaced from a pool of those who want more call. The Medical Staff office will assign the call from the pool in a rotating fashion.

**PATIENTS READMITTED WITH IN 30 DAYS OF DISCHARGE**

Discussion ensued regarding a policy on patients being readmitted within 30 days of discharge. Currently there is no policy that states an unattached patient must be readmitted to the same physician within 30 days of readmission. In order to ensure continuity of care, the MEC recommended that a language addition be made to the Rules and Regulations, #VIII, Emergency Services to be titled Readmission within 30 days of discharge.

**RECOMMENDATION:** If a patient returns to the ED within 30 days of discharge, they will be readmitted to the physician that original assumed care. If readmitted 30 days following prior discharge, the patient may be admitted to the on call physician. The exemption to this rule will be for one or both of the following two reasons:

1. Patient signs out AMA; or
2. Patient receives a termination letter from the attending physician; or
3. Patient refuses initial physician

If the patient meets the exception than the patient is to be admitted to the “On-Call” physician

18. Chain of Command

Medical Staff and hospital staff have the responsibility to cooperate in their mutual efforts to assure delivery of patient care of the highest quality in accordance with the

established policies, procedures, and standards of the hospital. Utilization of the Chain of Command facilitates problem resolution related to patient care concerns and problems.

When hospital staff encounters issues, which cannot be resolved at the hospital level, the Department Director/designee will contact the Chief of Service. If the issue remains unresolved, the Chief of Staff will be notified.

When a physician encounters an issue requiring resolution, he/she will contact the Charge Nurse of the patient care unit (or Department Director for ancillary services). If the issue is not resolved, the physician will notify the clinical manager of the unit. If the issue remains unresolved, the physician will notify the Department Director, the Chief Nursing Officer, the Hospital Administrator on call, and the Chief of Service.

#### IV. MEDICATION MANAGEMENT

##### 1. Medication Orders

All medication orders shall contain the following information:

- |                                      |   |
|--------------------------------------|---|
| i. Patient's Name                    | v. Route of Administration                |
| ii. Date/Time                        | vi. Frequency of Administration           |
| iii. Name of Drug (Brand or Generic) | vii. Duration of Therapy (if appropriate) |
| iv. Strength                         |   |

Medication orders shall be written in a clear metric notation only and shall *avoid* the use of a leading decimal and the use of zeroes after a decimal (e.g. 1.0).

Orders for "as needed" or "PRN" medications shall specify the indication(s) for use and be specific for dose and dosage frequency.

When an order is written to hold a medication, this will take effect immediately unless the prescriber specifies a time to implement. Medications will be resumed upon the prescriber order.

Orders for blanket resumption of medication orders are not accepted.

Medication orders shall contain only standard abbreviations.

Northside Hospital will maintain an unapproved abbreviations list. Abbreviations in the "DO NOT USE" list include: Q.D., q.i.d., QD, q.d., qd; Q.O.D., QOD, q.o.d., qod, U (for unit), IU; MS; MSO4 or MgSO4; use of a Trailing Zero (X.O mg); and Lack of Leading Zero (.Xmg).

Do Not Use abbreviations are spelled out using daily, every other day, unit, international unit, morphine sulfate and magnesium sulfate. Use a leading zero – (write 0.X mg) but do not use a trailing zero, (write Xmg).

##### 2. Medications supplied by the Patient (Home Medications)

The physician must write an order to allow the use of patient supplied medications.

The order must include the drug to be administered, dose, frequency permitted, and any other cautions the physician wishes to extend to the order.

**PROCEDURE:**

1. Pharmacy and therapeutics committee will maintain a list of medications that are considered high-risk. The list will be reviewed periodically.
2. A list of look-alike sound like drug names will be published and circulated to bring awareness.
3. Places where high risk medications are stored will be labeled to alert pharmacy and nursing to use precaution.
4. Clinical data fields in eMAR will be utilized to alert nursing to high-risk medications.

**HIGH RISK MEDICATIONS - RISK REDUCTION STRATEGIES 2007**

<b>Risk Reduction Strategy</b>	<b>Amiodarone infusions</b>	<b>Cardioplegics</b>	<b>Chemotherapy/ Antineoplastics</b>	<b>Concentrated opioids for oral administration</b>	<b>Electrolyte Infusions (potassium/phosphate/TPN)</b>
Reduce options; available in only limited/standardized concentrations	X	X		X	X
Commercially available premixed IV solutions used		X			X
Medication barcode must be scanned prior to nurse administration in areas using eMAR	X		X	X	X
Requires co-signatures in eMAR before administration in areas using eMAR			X	X	
Limited access/segregation of high risk medications		X	X		X
Preprinted order forms or protocols available/in use	X				X
Mixed by a pharmacist only (not a technician)			X		
<b>Additional safety precautions</b>	Screened for interactions with other medications that prolong Q-T interval Label comment to filter		A second pharmacist must check dose and labeling. Must be administered by chemotherapy qualified nurse.		A second pharmacist checks the TPN orders. TPN is re-ordered daily. Label comments on TPN to use filter.

## HIGH RISK MEDICATIONS - RISK REDUCTION STRATEGIES 2007

Risk Reduction Strategy	Epidural and PCA Infusions	Heparin and LMWH	Hypertonic/ Hypotonic solutions (3% Saline, Sterile Water)	Insulin	Propofol and Neuromuscular Blocking Agents	Warfarin
Reduce options; available in only limited/standardized concentrations	X	X	X	X	X	
Commercially available premixed IV solutions used	X	X	X			
Medication barcode must be scanned prior to nurse administration in areas using eMAR	X	X	X	X	X	X
Requires co-signatures in eMAR before administration in areas using eMAR	X	X	X	X	X	
Limited access			X			
Preprinted order forms or protocols available/in use	X	X		X		X
Mixed by a pharmacist only (not a technician)						
Additional safety precautions	Nursing will label epidural tubing to distinguish it from IV tubing.	Automatic renal dosing adjustments made for Lovenox based on patients CrCl				Screened for drug interactions. Standard dosing time.

### V. OPERATIVE, INVASIVE, AND PROCEDURE SETTINGS

#### 1. Emergency Care and the Operating Room

In any emergency, the attending physician shall make at least a comprehensive note in the medical record regarding the patient's condition prior to induction of anesthesia and the start of surgery.

## 2. Podiatric Surgical Patients

A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a physician of the Medical Staff.

### a. Delineation of Privileges

Podiatric privileges shall be granted on the basis of education, training, experience and demonstrated ability. Criteria for the delineation of such privileges shall be established by a committee consisting of:

1. The Chief of the Section of Orthopedics, Neurosurgery and Podiatry.
2. The Chief of the Section of General Surgery.
3. Two members of the Department of Medicine or Family Practice appointed by the Chief of Staff.
4. One Podiatrist appointed by the Chief of Staff.

### b. Podiatrist's Responsibilities

1. A detailed podiatric history justifying hospital admission.
2. A detailed description of the examination of the area(s) to be treated and preoperative diagnosis.
3. A complete operative report.
4. Progress notes as are pertinent to the podiatric area condition.
5. Discharge Summary.

### c. Physician's Responsibilities

1. Medical history pertinent to the patient's general health.
2. A physical examination to determine the patient's condition prior to anesthesia and surgery.
3. Supervision of the patient's general health status while hospitalized.

## 3. Written, Informed Surgical Consent

Written, signed, informed (i.e., risks, benefits and alternatives as explained by the physician) surgical consent shall be obtained prior to the operative procedure except in emergencies. In emergencies involving a minor or unconscious or otherwise incompetent patient in whom consent for surgery cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken, if time permits.

4. Informed Consent for Additional Surgery

Should a second or any additional operation be required during the patient's stay in the hospital, a new consent specifically worded should be obtained for the additional surgery. If two (2) or more specific procedures are to be carried out at the same time, and this is known in advance, they may all be described and consented to on the same form.

5. Anesthesia Record

The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic and post-anesthetic follow-up of the patient's condition. The anesthesia record shall be maintained as a permanent part of the patient's record.

6. Qualified Surgical Assistant

The decision to use a physician first assistant will be determined by and at the sole discretion of the attending surgeon. Prior to the beginning of a case and the complexity of the case a determination will be made if a first physician assistant is needed in-order to proceed or if a non-physician first assistant will be requested.

7. Report of Operation

All operations performed shall be fully described in a dictated operative report, to include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports are to be dictated or written immediately following all operative and invasive procedures. The operative report shall be promptly signed by the chief operating surgeon and placed in the medical record as soon as practical after the operation.

8. Specimen Examination

All specimens removed during the operation requiring microscopic examination shall be promptly sent to the hospital pathologist who shall appropriately examine the specimen to arrive at a pathological diagnosis and report same in writing properly signed. Properly executed request slips shall accompany all specimens. Other specimens, including hardware, implants and stones, will be sent as needed, at the discretion of the surgeon. All instances of specimens not sent will be documented on the medical record. Removed hardware, other than permanently implantable devices that are required to be tracked, may be released to a patient, provided a release form signed by the patient and including information regarding risks related to biomedical material is obtained.

9. Operating Room Policies

Policies from the Operating and Recovery Rooms will be posted in Surgery and the Recovery Room and distributed to each member of the Surgical Department/Sections. The member of these Departments/Sections shall acquaint themselves with the contents of this written plan and shall abide by the various policies, rules and regulations mentioned therein.

10. Documentation Before Surgery

The guidelines as established from time to time by the Department of Surgery and Anesthesiology as to pre-operative documentation and testing, will be adhered to.

11. Donated Anatomical Parts

Any physician performing a procedure involving removal of anatomical parts from a donor pursuant to donating of such anatomical parts as provided in Florida law, shall record on the progress notes of donor's record a statement describing the procedure of removal and the destination, or immediate disposition, of such anatomical part or parts.

**VI. OUTPATIENT SURGICAL AND MEDICAL PROCEDURES**

1. Patient Selection

A. Surgical

- a. The American Society of Anesthesiologists (ASA) Physical Status Classification is used in the selection of patients.

Acceptability of patients is as follows:

- i. ASA Class I patients acceptable.
- ii. ASA Class II patients may be acceptable following consultation with and approval of the Anesthesiologist.
- iii. ASA Class III patients rarely will be acceptable and must be approved by the Department Chair.

B. General

- a. Healthy patients for elective procedures.
- b. No blood transfusion anticipated except when the primary purpose of the out-patient admission is transfusion.
- c. Patient not expected to be admitted.
- d. No known infectious cases, abscesses, or otherwise "dirty cases."

2. History and Physical Examination

Every outpatient's clinical record must contain documentation of a medical history and physical examination including at least:

- a. Recitation of the chief complaint, significant past illnesses, concurrent illnesses, including allergies, and medications.
- b. Description of the physical findings at the contemplated operative site, plus a statement relative to the examination of the cardiovascular and respiratory system.
- c. A provisional diagnosis will be recorded prior to the procedure.

3. Documentation and Testing Before Out-Patient Surgery

The guidelines as established from time to time by the Departments of Surgery and Anesthesiology as to pre-operative documentation and testing will be adhered to.

4. Pre-Operative Evaluation

An abbreviated pre-operative evaluation will be required on all patients undergoing general or regional anesthesia and may be completed by the Anesthesiologist.

5. Signing of Consent for Treatment Form

All consent for treatment forms must be signed before pre-op medication is given.

6. Pre-Medication

Pre-medication is determined by the surgeon and/or anesthesiologist and may be administered by licensed personnel.

7. Anesthesia Record

The Anesthesiologist will keep a complete anesthesia record on all patients.

8. Recording of Vital Signs and Relevant Information

Vital signs and relevant information will be forwarded and reported to the Anesthesiologist and/or Surgeon.

9. Emergency Care

If the attending Surgeon, and/or Anesthesiologist is not present during an emergency, the nurse in charge may call another available physician until the attending doctor can be reached.

10. Post-Operative Care

Post-operatively, general anesthetized patients will remain in the hospital recovery room and post-recovery lounge for two (2) hours or more. If local anesthesia, the patient shall remain the hospital at least thirty-(30) minutes after which the patient may be discharged at the discretion of the Surgeon. Deviations will be at the discretion of the Anesthesiologist and/or Surgeon and so documented on the patient's record.

11. Post-Anesthesia Evaluation

The Aldretti System will be used as a guideline for the evaluation of the post-anesthetic patient.

12. Surgeon's Notes

Upon entry to the recovery room suite, the Surgeon shall, in addition to any post-operative orders, add to the out-patient record a descriptive statement of pathological state encountered and the procedures performed.

13. Discharges

There will be a written order for discharge by a physician.

Post-medicated patients are not to be discharged for thirty-(30)minutes unless specifically ordered to do so by a physician.

All post-operative general anesthetized patients must be discharged in the custody of a responsible party who is able to drive the patient home.

14. Medical Record

The medical record shall be completed and filed in accordance with the provisions of the Medical Staff Bylaws, Rules and Regulations pertaining to inpatients.

**VII. ANESTHESIA SERVICES**

1. Pre-Anesthetic Care and Post-Anesthetic Follow-Up

The medical records of patients administered anesthesia shall contain a physician pre-anesthesia assessment indicating choice of anesthesia for the contemplated procedure and a post-anesthesia note entered after the patient has left the post-anesthesia unit or other recovery area.

2. The Section Chief of Anesthesia Services Responsibility for Monitoring the Quality of Anesthesia Care Rendered in the Hospital

The Section Chief of Anesthesia shall be responsible for the following:

- a. Monitoring the quality of anesthesia care rendered by anesthesiologists anywhere in the hospital.
- b. Developing regulations for anesthetic safety.
- c. Assuring evaluation of the quality and appropriateness of anesthesia care throughout the hospital.

3. Medical Staff Approval of Anesthesia Safety Regulations

Anesthesia safety regulations developed by the Section Chair of Anesthesia and shall be approved by the Medical Staff.

4. Anesthesia personnel are not permitted to dispense controlled substances to other anesthesia personnel from their kit except in a bona fide emergency as defined by Medical Staff Rules and Regulations. Any additional controlled substances needed must be checked out from the pharmacy, ADC, or controlled medication storage area. When ADC is not used, the controlled substance removed is documented on the Controlled Substance Record.

## **VIII. EMERGENCY SERVICES**

### **1. Emergency Patient Care shall be Guided by Written Policies and Procedures**

There shall be written policies and procedures specifying the scope and conduct of patient care to be rendered in the Emergency Department/Service. Such policies and procedures shall be enforced, must be approved by the Chief of the Emergency Department and Hospital administration, and shall be reviewed at least annually, revised as necessary, and dated to indicate the time of the last review.

### **2. Treatment in the Emergency Department**

Patients applying for admission or treatment in the Emergency Department who have or allege having no attending physician shall first be seen by the Emergency Department physician or other qualified medical personnel, and shall then be assigned to Members of the Medical Staff, based on the call roster established by the Department Chair. All patients who present to the Emergency Department shall have a medical screening examination that will be performed by an Emergency Medicine physician or the Nurse Practitioner/PA prior to the disposition.

### **3. Assurance of Physician Coverage**

A viable system that will ensure regular and total “on-call” physician coverage of the Emergency Department shall be in effect within the capacity of hospital services currently available, as indicated in the Medical Staff Bylaws.

### **4. Physician Director**

A physician member of the medical staff shall direct the Professional Activities of the Emergency Department.

### **5. Review and Evaluation of Care**

A review and evaluation of the quality and appropriateness of emergency patient care shall be performed by the medical staff and documented. Such review and evaluation shall involve the use of the emergency medical record and pre-established criteria.

### **6. Procedures Not To Be Performed**

Written policies and procedures for emergency patient care shall include specifications of the Medical Staff procedures that may not be performed in the Emergency Department/Service.

### **7. Instructions to Emergency Medicine Service Patients**

Instructions to the Emergency Medicine Service patient and/or family must be documented in the medical record.

### **8. Emergency Medical Record Content**

An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient’s hospital record, if such exists. The record shall include:

- a. Adequate patient identification.

- b. Information concerning the time of the patient's arrival includes the means of arrival and by whom transported.
  - c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital.
  - d. Description of significant clinical, laboratory and roentgenologic findings.
  - e. Diagnosis.
  - f. Treatment given.
  - g. Condition of the patient on discharge or transfer.
  - h. Final disposition, including instructions given to patient and/or his family, relative to necessary follow-up care.
9. Responsibilities of ER Call Physician

When on ER call to the Emergency Department for a given specialty, it shall be the duty and the responsibility of that physician to assure the following:

- a. Immediate availability, at least by telephone, to the Emergency Department Physician for his or her scheduled ER call period, or to secure a qualified alternate in the event he/she is temporarily unavailable.
- b. Arrival or response to the Emergency Department shall be within a reasonable timeframe. Generally, response is expected within 30 minutes. If no response within the allotted time, a call will be placed to the physician's cell phone and have an additional 15 minutes to respond. If no response, the ER physician will go to the backup call list. The Emergency Department Physician, in consultation with the ER physician, shall determine whether the patient's condition requires the ER call physician to see the patient immediately. The determination of the Emergency Department physician shall be controlling in this regard.
- c. A refusal or failure to timely respond shall be reported immediately to the Chief of the appropriate Department and the Hospital Chief Executive Officer or designee, who shall review the matter and determine how to address the situation. If the refusals or failure to respond is found to be deliberate, or if it is a repeated occurrence, the matter shall be referred to the Medical Executive Committee for further investigation and appropriate disciplinary action.
- d. With the exception of Neurology, if a physician treats a patient in response to an emergency call, care must be continued through the episode that created the emergency medical condition. The physician who was on ER call the day the individual presented with the emergency medical condition or by the patient's primary care physician or other physician of the patient's choice may provide this care.
- e. In the case of Neurology, when a Stroke alert is called, the Neurologist on the ER call schedule will be called for both the immediate and emergent care of the patient. If the patient is already assigned a neurologist, the on ER call neurologist will discuss the case with the patient's current or former neurologist when the patient is out of the "Stroke" emergent phase and **by noon** on the following day. Together the physicians will then determine who will continue care. If the two physicians are unable to confer or cannot come to a mutually agreed upon conclusion as

to who will continue care, the final decision will be that of the neurologist who responded to the Stroke and he/she is responsible for communicating that decision to the other neurologist.

f. Arrival and response time to the Emergency Department for STEMI call will be 15 minutes. If response is not received within 15 minutes, the Emergency Physician will then contact the next Cardiologist on call.

g. Neurology on-call response time to Emergency Department for Stroke. Acceptable responses:

- Phone response-15 minutes
- In-person response-30 minutes

## **X. PATHOLOGY SERVICES**

### **1. Pathology Specimens**

All tissues and specimens removed at the time of a procedure, except for those exempted by the Medical Staff shall be sent to the Pathology Department.

The following surgical specimens need **not be submitted** to the Pathology Department:

- a. Bone removed as part of corrective or reconstruction orthopedic procedures.
- b. Cataracts removed by phacoemulsification
- c. Dental appliances
- d. Fat removed by liposuction
- e. Foreign bodies such as bullets, etc. that consist of medicolegal evidence.
- f. IUDs without attached soft tissue
- g. Medical devices such as catheters, gastrostomy tubes, myringotomy tubes, stents, and sutures that have not contributed to the patient's illness, injury or death.
- h. Middle ear ossicles.
- i. Orthopedic hardware and other hardware including radiopaque mechanical devices without tissue attached.
- j. Skin or normal tissue removed during cosmetic or reconstructive surgery
- k. Teeth without attached soft tissue
- l. Therapeutic radioactive sources (seed implants etc.)
- m. Toenails and fingernails that are grossly unremarkable.

The following specimens may be given a gross diagnosis only unless, at the discretion of the pathologist, depending on clinical circumstances it is determined that a microscopic is necessary or unless the referring clinician requests a microscopic examination.

- a. Nasal bone and cartilage from rhinoplasty and septoplasty.
- b. Hernia sacs.
- c. Accessory digits.
- d. Bunions and hammertoes
- e. Prosthetic breast implants without attached tissue.

## **XI. RADIOLOGY SERVICES**

### **1. Completeness of Request for Service**

Any request for radiologic services and/or examinations shall contain a concise statement of the reason for the examination. The attending staff member or consultant shall be responsible for providing this information.

2. Tele-Radiology

Tele-Radiology will be allowed in the Department of Radiology by qualified Radiologists who meet the standards of the Medical Staff Bylaws, are contracted with the Radiology Group at Northside Hospital and Heart Institute and are credentialed through the medical staff process. Tele-Radiology may be used for the interpretation of diagnostic x-ray procedures.

**XII. SPECIAL CARE UNITS (ICU, CCU, NICU, CVICU, CSU, ETC)**

1. Attendance to Patients

When a patient is admitted to the Special Care Unit, the attending physician or consultant must see the patient within **eight (8) hours**. Thereafter, the attending physician or consultant must perform a daily visit to his/her patient in these units.

**XIII. ALLIED HEALTH PROFESSIONAL AFFILIATE STAFF**

1. Special Considerations - Physicians' Assistants

Physicians' Assistants may be members of the Allied Health Professional Affiliate Staff. The Physician Assistant (PA) is a person qualified by academic and clinical training to provide patient services under the supervision and responsibility of a doctor of medicine or osteopathy who is, in turn, responsible for the performance of the PA. The requirements that they must meet in order to participate in this hospital are:

- a. They must be certified by the State of Florida.
- b. They must be approved by the credentialing process established by the Medical Staff Bylaws.
- c. Their duties must be clearly defined in writing by the physician under whom they work, who is responsible for their actions, and approved by the Chair of the Department/Section in which that physician works. Their supervising physician must be an active or courtesy staff member in good standing on the medical staff.
- d. All orders and progress notes written by a Physician's Assistant must be co-signed by the supervising physician.

2. Liability and Indemnification

All members of the Allied Health Professional Affiliate Staff shall be required to sign a statement indicating:

- a. That they are independent contractors, and not agents, servants, joint ventures, or employees of the hospital.

- b. That they will indemnify the hospital from any act of negligence on their part.
- c. That appropriate malpractice insurance, in the minimum amounts as prescribed by the Board of Trustees has been obtained (up-to-date certificates of insurance must be in the Allied Health Professional Affiliate's file in the Medical Staff Office at all times).

#### **XIV. MEDICAL EDUCATION**

##### **1. Interns and Residents (House Physicians)**

Interns and Residents may be employed as demands may warrant, and in accordance with the Medical staff bylaws.

Interns and Residents may make appropriate medical record entries. All orders, history and physicals, and discharge summaries written by Interns and Residents must be counter-signed by the attending physician.

The performance of Interns and Residents shall be monitored and documented by their individual preceptors.

#### **XV. TEMPORARY PRIVILEGES**

##### **1. CIRCUMSTANCES FOR TEMPORARY PRIVILEGES**

There are only two circumstances under which temporary clinical privileges may be granted. The circumstances for which the granting of temporary privileges is acceptable include the following:

- To fulfill an important patient care, treatment, and service need.
- When an applicant with a complete application that raises no concerns is awaiting review and approval of the Medical Executive Committee and the Board of Trustees.

Temporary privileges for the fulfillment of an important patient care, treatment, and service need shall not exceed one hundred and twenty (120) days and shall automatically terminate at the end of the specific period for which they were granted.

Temporary privileges granted to an applicant with a complete application who is awaiting final approval shall not exceed one hundred and twenty (120) days and shall convert to medical staff appointment when approved by the Board of Trustees.

A Practitioner shall not be entitled to the procedural rights afforded by these Bylaws because of his/her inability to obtain temporary privileges or because of any termination of temporary privileges.

##### **2. QUALIFICATIONS**

Prior to temporary privileges being granted, an applicant for such privileges must demonstrate that he/she possesses the following:

- a. A current license within this state.
- b. Current and unrestricted DEA registration.
- c. Relevant training and experience.
- d. Evidence of current competence related to the temporary privileges requested
- e. Ability to perform the privileges requested.
- f. Query and evaluation of the National Practitioner Data Bank
- g. A complete application.
- h. No current or previously successful challenge to licensure or registration.
- i. No subjection to involuntary termination of medical staff membership at another organization.
- j. No subjection to involuntary limitation, reduction, denial, or loss of clinical privileges.

Additionally, as soon as possible, the Hospital shall verify the applicant's status as an Ineligible Person. For this purpose, the applicant shall provide his/her Medicare UPIN, and the Hospital shall check the OIG Sanction Report and the GSA List. If the applicant is excluded from such participation, temporary privileges shall not be granted; any exclusion subsequent to having been granted temporary privileges shall result in immediate termination of such privileges. When applying for temporary privileges, each applicant shall agree to be bound by the Medical Staff Bylaws, Rules and Regulations, departmental rules and regulations, and applicable Hospital policies.

### **3. CONDITIONS AND AUTHORITY FOR GRANTING TEMPORARY PRIVILEGES**

Temporary privileges may be granted by the Chief Executive Officer upon receiving a recommendation from the appropriate department Chair or Chief of Staff under the conditions noted below. Individuals practicing based on temporary privileges shall be acting under the supervision of the Chair of the department to which he/she is assigned. All temporary privileges shall be time-limited, as specified for the type of temporary privileges and temporary privileges granted for a specific patient care need shall not exceed the length of stay of the specific patient. A practitioner may be granted temporary privileges under this condition for no more than two patients in a twelve (12) month period. After the practitioner has been granted temporary privileges under this condition for the care of a second patient within twelve months he/she will be invited to apply for Medical Staff membership.

Temporary privileges shall be specifically delineated, and may include the privilege to admit patients. A request for temporary privileges shall be made in writing.

### **4. LOCUM TENENS**

After receipt of a written request for temporary privileges, a Practitioner qualified as described in Section 2, who has been hired to substitute for a member of the Medical Staff who is temporarily unable to provide services, may be granted temporary privileges as a Locum Tenens in order to fulfill an important patient care need that would be created by the Medical Staff member's absence and could not otherwise be met by the existing members of the Medical Staff. The locum tenens Practitioner shall not be granted temporary privileges that are in excess of those granted to the Medical Staff member being temporarily replaced. Temporary privileges granted under this condition shall not exceed ninety (90) days or the term of absence of the Medical Staff member, whichever is less. Up to another successive ninety (90) day term of temporary privileges may be granted if the Staff member's absence exceeds the first ninety (90) day period.

### 3. **DISASTER PRIVILEGES**

#### Disaster Response and Recovery:

Potential disaster situations shall be described in the Hospital Emergency Preparedness Plan<sup>1</sup> and is defined as any occurrence that inflicts Destruction or distress and that creates demands exceeding the capabilities of the Hospital to handle in a normal or routine way. Such occurrence may be due to a natural disaster or a man-made disaster.

**Disaster privileges are not to be confused with Emergency Privileges** and may be granted when the Emergency Management Plan has been activated and the hospital is unable to handle the immediate patient needs. During disaster(s) in which the Emergency Management Plan has been activated, the CEO or Chief of the Medical Staff or their designees(s) have the option to grant disaster privileges.

The CEO or Chief of Staff of their designee(s) may grant disaster privileges upon presentation of any of the following:

- A current picture hospital ID card
- A current license to practice medicine and a valid picture ID issued by a state, federal, or regulatory agency,
- Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).
- Identification indicating the individual has been granted authority to render patient care, treatment and services in disaster circumstances.
- Current personal knowledge by a hospital or medical staff member regarding the practitioners' identity.

Temporary privileges granted under this condition shall not exceed the disaster response and recovery period or ninety (90) days, whichever is less. In the event that the disaster creates extreme urgencies a Practitioner would be permitted to provide patient care using emergency privileges.

### 5. **EMERGENCY PRIVILEGES**

In an emergency, any Practitioner, to the extent permitted by his/her license, and regardless of Medical Staff membership status, staff category or clinical privileges, shall be permitted to do everything possible to save the life of a patient or to save the patient from serious injury, including the loss of limb or function. When the emergency no longer exists, care of the patient shall be assigned to a Medical Staff member with the appropriate clinical privileges to provide the care needed by the patient. If the Practitioner who provided emergency care wishes to continue to care for the patient, but does not possess the appropriate clinical privileges, the Practitioner may request such privileges if properly qualified. An emergency is a condition in which serious or permanent harm would result to a patient or in which the life of a patient is in immediate danger and any delay in administering treatment would add to that danger.

## TEMPORARY DISASTER PRIVILEGES APPLICATION AND APPROVAL FORM

A. Identifying Data

Name of Practitioner: \_\_\_\_\_ Specialty: \_\_\_\_\_  
 Name of Agency Represented (if applicable): \_\_\_\_\_  
 Signature of Applicant: \_\_\_\_\_ Date: \_\_\_\_\_

B. Core Information for Temporary Disaster Privileges – Temporary disaster privileges may be granted upon presentation of any of the following. Photocopies should be obtained if possible.

Core Element	Yes/No	Photocopy?	Verification Date
Current picture hospital ID card			
A current license to practice and a valid picture ID issued by a state, federal, or regulatory agency.			
Identification indicating that the individual is a member of a Disaster Medical Assistance Team (DMAT).			
Identification indicating that the individual has been granted authority to render patient care in emergency circumstances, such authority having been granted by a federal, state, or municipal entity.			
Presentation by current Hospital or Medical Staff member(s) with personal knowledge regarding the practitioner's identity.			

Temporary disaster privileges granted by:

Name: \_\_\_\_\_ Signature: \_\_\_\_\_ Date: \_\_\_\_\_

C. Additional information

1. Practitioner issued appropriate Hospital security identification? Yes  No
2. Practitioner assigned to medical staff member to collaborate in care of disaster victims?  
 Yes  No  Name of Medical Staff member: \_\_\_\_\_
3. Department assignment/Chair: \_\_\_\_\_ Triage assignment: \_\_\_\_\_

D. Additional information verified by Medical Staff Office

Information Verified	Verification Method	Verification Date
Drug Enforcement Agency registration		
Certificate of malpractice insurance, except for practitioners deployed by the Federal government who are covered by the Federal Tort Claims Act		
List of hospital affiliations where the practitioner holds active staff privileges, or evidence of government agency employment		
National Practitioner Data Bank		
OIG List		
GSA List of Excluded Providers		