

LEE MEMORIAL HEALTH SYSTEM

Cape Coral Hospital

Medical Staff

General Rules & Regulations

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Rule #1 – Introduction

1. Introduction

- a. In accordance with the Medical Staff Bylaws, the Medical Staff may adopt rules and regulations and policies as necessary to carry out its functions and meet its responsibilities under the Medical Staff Bylaws. Should a conflict exist between the provisions of the Medical Staff Bylaws and the rules and regulations, the Bylaws will prevail. The rules and regulations are binding on all Medical Staff members.
- b. Concerns about a failure to follow the rules and regulations may be referred to the Medical Executive Committee which may take any action available to it under the Medical Staff Bylaws to ensure compliance with the Medical Staff General Rules and Regulations.

Rule #2 – Admission

2. Admission

- a. No patient shall be admitted into the hospital until the admitting physician has stated a provisional diagnosis. Physicians admitting patients shall be responsible for issuing orders and information necessary to protect the patient, other patients and hospital staff when any danger exists.
- b. Except in an emergency, no patient shall be admitted to the hospital until provisional diagnosis or valid reason for admission has been documented. In the case of emergency, the diagnosis or reason for admission will be documented as soon as possible.
- c. A patient may be admitted to the hospital only by an appointee to the Medical Staff. All practitioners shall be governed by the official admitting policy of the hospital.
- d. All admitted patients shall be seen by the attending physician or his/her designee (i.e. Physician Assistant, covering physician or requested consulting physician) within a reasonable period of time after admission as clinically indicated. However, patients admitted or transferred to a critical care unit must be evaluated within two (2) hours by the attending physician or his designee.
- e. For admission of pregnant patients, refer to Emergency Care Section k.
- f. Consistent with health system policy, physicians with full training in Neurology and Physical Medicine and Rehabilitation may admit any patient to the Rehabilitation Hospital and assume full care of the patient. Physicians fully trained in Orthopedics and Rheumatology may admit to the unit and manage the rehabilitation of orthopedic and rheumatologic disorders respectively. Consults from other specialties should be obtained on a case-by-case basis. Physicians admitting to the Rehabilitation Hospital must follow all regulations and policies of the unit.

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- g. Each member of the Medical Staff who does not specifically request to opt out, will be part of the Organized Health Care Arrangement (“OHCA”) 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 one Notice of Privacy Practices at the time of admission/registration, which will include information about the OHCA with the Medical Staff. The OHCA covers activities only at the integrated delivery setting in the hospital. The physician’s private practice is not part of the OHCA. Therefore, in physician’s private practice, physicians must issue their own Notice of Privacy Practices and develop and comply with their own policies and procedures.
- h. According to facility policy, medical management of patients admitted to critical care units:
- i. The attending physician will retain authority and responsibility for the admission to and discharge from the critical care units and for the medical management of the patient except where special problems are designated to the care of the consultants.
 - ii. The decision to triage patients to the intensive care units, when a bed shortage directly affects patient care, will be given to the intensivists, if the facility has an intensivists program.
 - iii. Each attending physician will have an alternate to provide the patient with continuous medical care coverage.
 - iv. Surveillance responsibilities for the critical care area(s) will be under the direction of the Medical Staff Quality Committee. Problems arising in the care of patients are to be directed to the chairman of the appropriate committee.
 - v. In the event life support is terminated, documentation should be made of the circumstances and family/legal representative discussion. This documentation will be the responsibility of the physician and will be in the physician’s progress notes.
 - vi. Organ donation procurement agency will be contacted when appropriate.
- i. **Inpatient Transfer Priorities:**
- i. Transfer priorities shall be as follows:
 1. Emergency Room to appropriate patient bed.
 2. From Intensive Care Unit to General Care Unit.
 3. From Cardiac Care Unit to General Care Unit.
 4. From temporary placement in an appropriate geographic or clinical service area to the appropriate area for that patient.
 - ii. No patient will be transferred without such transfer being approved by the responsible practitioner.
- j. **Discharges**
- i. Patients shall be discharged on the written order of the attending physician. Patients or representatives of patients who leave the hospital against the orders or advice of the attending physician shall be presented with the prescribed hospital form releasing the hospital and physician from responsibility.
 - ii. **Death**
 1. In the event of a death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time.

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2. The attending physician shall be responsible for ensuring that all death certificates are completed and signed in a timely manner in accordance with all applicable laws.
3. Except in those situations specifically enumerated in section 406.11, F.S., examinations, investigations, and autopsies, the attending physician in charge of a person's care for the illness or condition which resulted in that person's

death is responsible for completing and signing a death certificate and furnishing the same to the funeral director who has assumed custody of the body.

iii. **Autopsy**

1. As stated in health system policy M03-01-109, Care of the Deceased, attempts may be made to secure autopsies in all cases of unusual deaths and those of medical-legal and educational interests. Members of the Medical Staff involved in the care of the patient may request an autopsy. While autopsies are encouraged for the following indications, it is recognized that autopsies cannot be performed without consent of the next of kin. Consent/permission to perform an autopsy will be documented in the medical record. At a minimum, the attending practitioner is to be notified. The following are appropriate indications for which requests for autopsies should be encouraged by the Medical Staff. In most cases relating to educational interests, the attending physician and pathologist must agree that the autopsy would be of educational value to the Medical Staff and health system.
2. Autopsies may be performed consistent with provisions of the consent for:
 - a. Any patient with sudden, unexpected death under the age of 40 years, declined by the medical examiner's office.
 - b. Obstetrical or neonatal deaths.
 - c. Patients whose condition may potentially reveal significant occult conditions.
 - d. Patients whose death is directly associated with a drug or transfusion reaction as a major contributory event, if declined by the medical examiner's office.
 - e. Patients that die in the hospital within 48 hours of a surgical or invasive procedure without underlying chronic disease or major traumatic injuries, if declined by the medical examiner's office.
3. Therefore, any death when next of kin and/or physician requests and consent is given; an autopsy will be performed in accordance with the provisions of the consent. To facilitate use of autopsy findings in performance improvement activities, the chairperson of the appropriate department receives a copy of each autopsy report for use in morbidity/mortality conferences and any other department-wide performance improvement activities.

Rule #3 – Consultations

3. Consultations

- a. The Medical Staff Bylaws, PART I, Section 2.7 – Basic Responsibilities of Applicants and Appointees, requires every applicant and appointee:

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2.7.8 to provide medical consultation in a timely fashion in accordance with all applicable Rules & Regulations and Medical Staff Policies.

- b. A physician should seek consultation if requested by or on behalf of the patient, or when, in the opinion of that physician, the advice of a specialist or another physician would enhance the quality of care provided the patient. Obtaining the consult is the responsibility of and must be either requested or approved by the attending physician.
- c. Consultations shall be defined as follows:

i. Routine Inpatient Consultations

1. Routine inpatient consultations are consultations requested for inpatients that do not require urgent intervention by the consulting physician. Inpatients with routine consultations shall be seen within 24 hours after the order for consultation is made. The official time of the consultation request will be the electronic record generated time for placement of the patient's name on specialist's EPIC consultation list. The physician requesting the consultation will make reasonable efforts to determine the existence of an established professional relationship with the patient and if such exists, the consult will be made to the physician with an established relationship. This type of consultation shall be made by the attending physician, after evaluating the patient, who will document an order with the following information: type of consult; consulted physician; and reason for the consult. Routine inpatient consultations are **mandatory** if the physician specialist is called by the attending physician because:
 - a. The specialist has an established professional relationship with the patient within the past six months; or
 - b. The consultant has performed a surgical, invasive, diagnostic or other procedure on the patient, and the professional judgment of the admitting or attending physician is that the patient requires the specialist to provide follow-up care and advice; or the patient's hospitalization is because of complications arising from the procedure performed by the specialist.
2. The attending physician who requests a consult may consult a specialist of their choice if a. and b. above do not apply. However, when the consult is **not** mandatory and to expedite patient care, if the consulted physician declines to accept the consult, then he/she must notify the requesting physician within sixty (60) minutes of the consult request being declined. If the consult is not accepted, then a mandatory consultation will be obtained from the physician on ED call for the specialty needed. A request for a consult, under this section, may not be declined by a physician on the Emergency Department call list at the time the initial consult is placed. If the physician on ED call for the specialty needed does not have privileges at the hospital at which the consult is needed, or if the physician is on regional call at an LMHS hospital different than the one at which the consult is needed, the attending physician in conjunction with the Acute Care Medical Officer for the hospital and/or the Chief Medical Officer or their designee, if necessary, will be responsible to find a consulting physician for the patient.

ii. STAT Inpatient Consultations

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1. STAT Inpatient Consultations are consultations that are requested for inpatients that, in the opinion of the attending physician, require urgent intervention by the consulting physician. This type of consultation shall be made by the attending physician who will document an order with the following information: type of consult; consulted physician; reason for consult; and phone number at which the attending physician may be reached directly (Example: STAT consult to Dr. John Doe for abdominal pain – please contact Dr. John Smith at 555-1212). **This type of consultation requires the attending physician to personally speak to the consulted physician.**
2. If the consulted physician hasn't responded within thirty (30) minutes, mandatory consultation will be obtained from the physician on ED call for the specialty needed. If the physician on ED call for the specialty needed does not have privileges at the hospital at which the consult is needed, or if the physician is on regional call at an LMHS hospital different than the one at which the consult is needed, the attending physician in conjunction with the Acute Care Medical Officer for the hospital and/or the Chief Medical Officer or their designee, if necessary, will be responsible to find a consulting physician for the patient. STAT inpatient consultations are mandatory if the physician specialist is called by the attending physician because:
 - a. The specialist has an established professional relationship with the patient within the last 6 months; or
 - b. The consultant has performed a surgical, invasive, diagnostic or other procedure on the patient, and the professional judgment of the admitting or attending physician is that the patient requires the specialist to provide follow-up care and advice; or the patient's hospitalization is because of complications arising from the procedure performed by the specialist.

iii. ICU Patient Admission Consultations

1. An Intensivist shall be consulted for all patients admitted to the Intensive Care Units for longer than 24 hours. The intensivist shall determine whether the patient needs intensive care management.

iv. Pregnant Patient Consultations

1. Responsibilities regarding pregnant patients refer to Emergency Care Section k.

Rule #4 – Continuing Medical Education

4. Continuing Medical Education

- a. All staff physicians must meet Continuing Medical Education (CME) requirements as specified by their applicable licensing board (Florida Board of Medicine or Florida Board of Osteopathic Medicine).
- b. Physicians are required to obtain part of their CME credits in their respective specialty.

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Rule #5 –Disasters

5. Disasters

- a. See current Medical Staff and Hospital Disaster Plan.

Rule #6 - Emergency Care

6. Emergency Care

- a. As set forth in the Medical Staff Bylaws, members of the Medical Staff recognize the hospital's responsibilities under access to emergency care laws and recognize members of the Medical Staff share in the responsibility to provide physician services on an emergency basis in the Emergency Department in accordance with Medical Staff Rules & Regulations and Policies & Procedures. These Rules & Regulations, together with applicable health system policies and procedures, will govern the provision of emergency access to care in order to ensure appropriate access to patient care services and meet legal and regulatory obligations.
- b. Any patient applying for medical aid at the Emergency Department (ED) must first be given the opportunity to choose his personal physician. In the event that his/her physician does not have admitting privileges, the patient shall be referred to the physician on call. There will be a call roster, designating a physician to be available to the hospital within thirty-minute notice.
- c. When a patient is seen in the ED, has no personal physician, and requires follow-up he will be referred to the appropriate category back-up physician, without regard to the patient's ability to pay. It is the responsibility of that particular back-up physician to see the patient at least once for follow-up, in his/her private office, or in the ED at the time the patient presents to the ED. Any need for continued follow-up should be addressed at that time.
- d. Unassigned medical patients presenting to the Emergency Department within 30 days of discharge as a hospital inpatient (short-stay/observation and full admission patients) for the same condition shall be assigned to the discharging physician.
- e. Unassigned surgical patients presenting to the Emergency Department within ninety (90) days of discharge as a hospital inpatient (short-stay/observation and full admission patients) for a problem that is only related to the surgery or within thirty (30) days if no surgery is performed, and is only related to the initial complaint, shall be referred to the surgeon of record.
- f. Patients who sign-out "AMA" (against medical advice) from the hospital, then subsequently return, will be assigned to a new physician on call, if available.
- g. A determination as to whether the on-call physician must physically assess the patient in the Emergency Department is the decision of the Emergency Department physician. The consulting physician for Trauma, STEMI/Emergency Cardiology, and stroke emergencies must arrive within thirty (30) minutes. All other on-call physicians are expected to arrive at the hospital as soon as possible, but no later than 60 minutes after requested to come to the

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hospital to examine the patient, unless otherwise advised by the Emergency Department physician. When a regional call process is in place, and the physician on-call for that specialty is at a site other than the ED in question, and the patient is deemed to be unstable

for transfer, the on-call physician is expected to respond to the ED as soon as possible, but no later than 60 minutes after requested by the hospital, unless otherwise advised by the Emergency Department physician. Physicians on regional call will, if needed, be granted temporary and emergency privileges as per Part 3, Section 7.7 of the Medical Staff Bylaws.

- h. Although it is generally not acceptable to refer emergency cases to the on-call physician's office, if it is medically appropriate to do so, the Emergency Department physician may send an individual needing the services of an on-call physician to the physician's office. For example, a request by an Ophthalmologist with specialized equipment to see the patient in the office would result in the patient being evaluated and treated in a higher level of care.
- i. Although Departments of the Medical Staff will develop departmental rules to address situations in which the on-call physician cannot respond due to circumstances beyond the physician's control and situations involving simultaneous on-call duties, as appropriate, the physician on-call who is unable to meet his/her on-call responsibilities remains responsible for ensuring coverage.
- j. Assignment of patients with a local primary care physician (PCP):
 - I. This rule pertains to those patients requiring admission for general medical care and have a local Primary Care Physician (PCP).
 - II. ii. This rule only applies to PCPs, not the subspecialists who do not provide primary care services.
 - III. iii. PCPs with inpatient privileges can admit and provide general medical care to their own patients. PCPs can enter into a cross-coverage arrangement with another PCP or PCP group to admit and provide general medical care to their own patients.
 - IV. iv. A PCP who does not have admitting privileges may have an assignment agreement with a contracted Hospitalist or contracted Hospitalist group on the medical staff to provide inpatient care to the PCP's patients.
 - V. v. If a PCP enters into an assignment agreement, the PCP is required to notify the Medical Staff Service Office, in writing, who will provide inpatient services to patients requiring admission to Lee Health facilities. The PCP must notify both the campus and admitting physician.
 - VI. vi. The Hospitalist Services Line became a closed service on April 3, 2012. PCPs can retain assignment agreements that were in place at the time of closure. PCPs can also enter into a new assignment on a quarterly basis, in writing, but only with a Lee Health contracted Hospitalist group. If the assignment agreement is with a contracted Hospitalist group, then the PCP's patients will be managed consistent with the Hospitalist Service Line Model in which the Hospitalist groups cross cover each other.
 - VII. The Medical Staff Office is to maintain a list of all PCPs and who will provide inpatient care for their patients.
 - VIII. The Medical Staff Office is to provide a copy of this list to all Emergency Departments that are part of Lee Health.
 - IX. This list is to be updated quarterly and presented to the Emergency Departments, with any revisions, on a quarterly basis.

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- X. The Emergency Departments are to ask each patient, at each encounter, to identify their PCP.
 - XI. When a patient requires admission to the hospital for a general medical problem, the ED is to reference this list and contact the appropriate physician to arrange for inpatient admission.
 - XII. If a patient requests a different admitting physician than the one designated as above, the patient may be admitted to the physician requested if the physician agrees and has inpatient privileges.
 - XIII. Patients with PCP's who have not entered into an assignment agreement and do not practice in the hospital setting will be managed by the process for the admission of unassigned patients (see Department of Medicine R&R's Section VI. A.).
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- k. Pregnant patients whose fetus is of 20 weeks or greater gestational age, will be admitted by their primary obstetrician/gynecologist (or the Emergency Department on-call obstetrician if the patient is unassigned) regardless of their diagnosis. Pregnant patients presenting with non-obstetrical conditions whose fetus is of gestational age of less than 20 weeks, will be admitted to the appropriate medical or surgical physician according to the presenting diagnosis (i.e. acute appendicitis will be admitted to surgery and asthma exacerbation will be admitted by general medicine). If fetal age is unable to be determined by interviewing the patient or calculating estimated date of confinement based on the first day of last menstrual period, ultrasound may be ordered to determine fetal age. All consultations ordered for pregnant women are mandatory. The consulted physician is required to evaluate and treat the patient, and if requested by the attending physician, follow the patient until the time of her discharge from the hospital. This applies to ALL physicians actively practicing in LMHS hospitals.
 - l. Certified Nurse Midwives (CNM's) or Labor & Delivery Registered Nurses (LDRN's) may perform medical screening examinations consistent with health system policy and applicable screening protocols that outline the examination and/or diagnostic workup required to determine if an emergency medical condition exists for the laboring patient.
 - m. The hospital deems employed or contracted Emergency Physicians, Physician Assistants/ARNP's including, but not limited to Emergency Physicians the Physician Assistants/ARNP's contracted by the Emergency Physician Group to be qualified medical professionals for the purpose of providing appropriate medical screening examinations.
 - n. Failure or refusal of the on-call physician to meet Medical Staff responsibilities is a serious matter which may constitute a violation of state and/or federal law and may subject the physician to corrective action under the Medical Staff Bylaws as well as sanctions under federal and/or state law.

Rule #7 – General Conduct of Care

7. General Conduct of Care

- a. An appointee to the Medical Staff shall be responsible for the medical care and treatment of each patient in the Medical Center, for the promptness, completeness and accuracy of the medical record for necessary special instruction, and for transmitting reports of the condition of the patient to the referring practitioner, the patient, and to those persons authorized by the

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patient. Whenever these responsibilities are transferred to another Medical Staff appointee, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

- b. A patient who receives a code blue ER response will require the attending physician's, or covering physician's physical presence at the bedside as soon as possible but not greater than 90 minutes. If the patient is in the ICU, the Intensivist team or the attending physician's presence is required. If the admitting physician is a proceduralist and cannot respond because they are in a case, their covering physician or Intensivist team must present to the bedside within 90 minutes.
- c. All medications will have an appropriate stop date. The physician will be notified prior to the stop date and asked to verify the need for continuation of the medication(s). Certain classes of medications may be approved for dosing by Pharmacy. The Pharmacy and Therapeutics

Committee will approve medication-dosing protocols and/or guidelines with subsequent approval by the Medical Executive Committee.

- d. Medications, treatments or corrective procedures shall be administered or carried out only upon the order of an appointee to the Medical Staff.
- e. Medications will not be left in a patient's room unless secure or to be self-administered upon physician's order. In keeping with the commitment to patient safety, medication reconciliation is to be performed by the Medical Staff per health system policy M03-03-563. This is especially important at admission and discharge and upon change in level of care.
- f. Patient Restraints: orders for the use of restraints shall be issued in accordance with hospital policy.

Rule #8 – Laboratory Service and Orders

8. Laboratory Service and Orders

- a. Laboratory services shall be provided by the hospital to insure as complete service as possible. Examinations which cannot be made in the laboratory shall be referred to an outside laboratory which is under the direction of a physician, preferably a Pathologist. It will be charged to the patient. Each physician is required to order or have proof of a hemoglobin/hematocrit and urinalysis within 72 hours of the time of admission and all pre-operative lab work (CBC, urine) should be done within seven (7) days prior to surgery.

Rule #9 – Medical Records & Physician Orders

9. Medical Records

- a. **General**

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- i. The medical record must contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient's progress and response to medications and services. All patient medical record entries must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with hospital policies and procedures. All records must document the following as appropriate:
 1. A medical history and physical examination as explained in more detail below.
 2. Admitting diagnosis
 3. Results from all consultative evaluations of the patient and appropriate findings by clinical and other staff involved in the care of the patient
 4. Documentation of complications, hospital acquired infections, and unfavorable reactions to drugs and anesthesia.
 5. Properly executed informed consent forms for procedures and treatments specified by the Medical Staff, or by Federal or State law if applicable, to require written patient consent.
 6. All practitioners' orders, nursing notes, reports of treatment, medication records, radiology, and laboratory reports, and vital signs and other information necessary to monitor the patient's condition.
 7. Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care.
 8. Final diagnosis with completion of medical records within 15 days following discharge.
- ii. A medical record must be maintained for every inpatient and outpatient.
- iii. The attending physician is responsible for the preparation and maintenance of a complete medical record for each patient who receives services. All records will be maintained under a medical record number, which forms the basis for the unit record incorporating inpatient, outpatient and emergency medical records.
- iv. The patient's medical record shall be completed within fifteen (15) days of discharge. If the medical record remains incomplete on the fifteenth (15th) day after discharge, it will be considered delinquent and Health Information Management (HIM) will notify the practitioner.
 1. If the practitioner's medical records remain delinquent at thirty (30) days from discharge, the practitioner will be contacted (telephone call, and/or, e-mail notice) by the VP of Operations in collaboration with the Chairman of the Department or Section Chief, and may be given three (3) days to complete them. If the medical records remain delinquent at the end of the three (3) days, the practitioner will have the right of hospital admitting, consulting, and surgical privileges suspended until all records are completed. The affected practitioners may not admit, consult or do procedures under the name of another practitioner in his group practice. The practitioner may continue care of present patients, but care of new patients is not permitted. On completion of records, the practitioner will be reinstated.
 2. Each health system facility is considered a separate entity for purposes of record completion. Privileges will only be suspended at the facility(ies) at which there are delinquent records.
 3. The "Administrator on Call" is responsible for supporting the loss of privileges and may grant limited exceptions when appropriate.
 4. All incomplete charts must be completed before being granted an application for reinstatement.

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5. To avoid suspension, practitioners are responsible for notifying Health Information Management prior to vacations or other absences. Practitioners should complete records prior to absences. Practitioners will not be granted additional time for record completion if an absence occurs after the practitioner has been placed on suspension.
6. No medical record will be filed if incomplete unless the VP of Operations, under the authority of the Executive Committee, directs filing of an incomplete record because there is no reasonable method available for its completion.
- v. No physician shall inspect the record of a patient not his/her own unless the he/she is acting as a consultant, as chairman of a clinical department or Section Chief, or as a representative of any committee of the Medical Staff which is charged with the duty of reviewing the quality of care rendered in the hospital.
- vi. All records are the property of the hospital, and shall be removed from the hospital's jurisdiction and safekeeping only in accordance with the court order, subpoena or statute. All x-ray films shall remain the property of the hospital and shall be kept on the file as part of the record, and may be disposed of in accordance with the law. The release or disclosure of health information will be in accordance with applicable laws and health system policy.
- vii. The attending physician shall assist the Medical Record Administrator in coding charts in accordance with the International Classification of Diseases and Current Procedural Terminology.
- viii. All writing on the medical record shall be in black or blue ink.
- ix. No blocking out or erasure should be made on the existing record. The physician may date and sign a correction, giving the reasons for the change and signing the note. If a written error is made, it should be crossed through with a single line, the correction written above, and the correction initialed and dated. Incorrect report forms (lab, x-ray, etc.) shall not be removed from the record. Corrections shall be made by writing "corrected, see supplemental report." Such supplemental reports shall bear the date of submittal, not of the original report.
- x. Medical records must be retained in their original or legally reproduced form in accordance with health system policy and procedure which shall not be less than 5 years.
- xi. Reference to writing and charting include documentation by electronic means.

b. History and Physical Examination

- i. A physical examination and medical history shall be completed no more than 30 days before or 24 hours after an admission or registration, but prior to surgery, procedures requiring anesthesia services, any high risk procedures, and other procedures requiring an H&P. This examination must be placed within the patient's medical record within 24 hours of admission or registration, or prior to surgery, procedures requiring anesthesia services, any high risk procedures, and other procedures requiring an H&P, whichever comes first. In addition, an updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission is required. This updated examination must be completed and documented in the patient's medical record within 24 hours after admission, but prior to surgery, procedures requiring anesthesia services, any high risk procedures, and other procedures requiring an H&P.

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- ii. For surgical patients, the anesthesiologist's review of the patient's history to identify any current updates and the physical exam which content is determined by an assessment of the patient's condition and any co-morbidities in relation to the surgery may serve as the updated examination.
- iii. The H&P update must document that the patient has been examined, the H&P reviewed, and any changes or "no change" has occurred in the patient's condition since the H&P was completed.
- iv. The H&P content must adhere to regulatory requirements of DNV, Florida Statutes and Center for Medicare and Medicaid (CMS) Conditions of Participation. An admitting diagnosis and proposed treatment plan shall be documented. The medical evaluation and risk assessment of patients are the responsibilities of a physician, oromaxillofacial surgeon, or other practitioner qualified to perform such evaluations and assessments.
- v. When medical histories and physicals are performed by non-physicians, by the responsible physician shall be in accordance with applicable law.

c. Progress Notes

- i. A progress note shall be written within twenty-four (24) hours of admission and immediately after surgery. Progress notes shall be recorded routinely as indicated by the condition of the patient. The final progress note should include the condition of the patient and any instructions given to the patient and/or family; unless documented elsewhere in the record.

d. Informed Consent

- i. In accordance with Florida law, it is the physician's responsibility to obtain the expressed, informed consent of patients or their representatives when the procedure to be performed is surgical, or is invasive and involves a significant risk of adverse or injurious outcome to the patient, or when required by the prevailing professional standard of care. Informed consents must be obtained and documented in the medical record. Hospital staff or persons designated by the physician may assist with obtaining consent forms or other documentation relating to informed consent consistent with hospital policy.

e. Operative Report

- i. An operative report describing techniques, findings, and tissues removed or altered shall be dictated and signed by the surgeon immediately following surgery. The operative report will contain at least the following:
 - 1. SR.1a Name and hospital identification number of the patient;
 - 2. SR.1b Date and times of the surgery;
 - 3. SR.1c Name(s) of the surgeon(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);
 - 4. SR.1d Pre-operative and post-operative diagnosis;
 - 5. SR.1e Name of the specific surgical procedure(s) performed;
 - 6. SR.1f Type of anesthesia administered;
 - 7. SR.1g Complications;
 - 8. SR.1h A description of techniques, findings, and tissues removed or altered;
 - 9. SR.1i Estimated blood loss (specify N/A if no blood loss);
 - 10. SR.1j Surgeons or practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and

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closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and,

11. SR.1k Prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).
- ii. The operative report shall be dictated in its entirety before the patient is transferred to the next level of care (e.g. before the patient leaves the post anesthesia care area).

f. Immediate Post-Operative or Post-Procedure Note

- i. An immediate post-operative or post-procedure note is required to be entered into the medical record (as per P&P: Post-Surgical/Procedure Notes) if there is a dictation turn around delay. This shall include, as applicable, identification or description of:
 1. the surgeon and assistants;
 2. pre-op procedure and post-op procedure diagnosis;
 3. procedures performed;
 4. specimens removed and disposition;
 5. estimated blood loss (EBL) and blood administered;
 6. any complications.
 7. type of anesthesia administered
 8. grafts, implants, or drains
- ii. If information identified in the post-operative note is available in nursing documentation; it is acceptable if authenticated as accurate by the attending surgeon.
- iii. If any area is not applicable (N/A), it must be designated as such and not just left blank.

g. Physician Orders

- i. Medicine, treatments, or corrective procedures shall be administered or carried out only upon the order of a staff physician, dentist or podiatrist; or allied health practitioner as permitted by law. The administration of ordered medications to patients shall be carried out only by a registered nurse (R.N.), licensed practical nurse (L.P.N.), respiratory therapist (R.T.), radiological technician (C.R.T.), or Cardiovascular Technologist, acting within the scope of their assigned duties or as permitted by law.
- ii. Orders for treatment shall be written on the doctor's order form and signed by the attending practitioner. An order that is dictated to licensed nurses, either in person or by telephone, shall be considered in writing, or shall be signed by the person taking the order, with the notation of the name of the ordering (responsible) practitioner. Similarly, licensed Respiratory Therapists, Speech Therapists, Occupational Therapists, Physical Therapists, Pharmacists and Registered Dietitians, Radiology Technologists, Ultrasound Technologists, Nuclear Medicine Technologists, Cat Scan Technologists and Magnetic Resonance Imaging Technologists employed by the health system or contracted with the health system may accept verbal orders (either in person or by telephone) from practitioners for procedures or treatments within their respective service; such orders shall be signed by the person receiving them, with a notation of the name of the responsible practitioner.
 1. Any verbal order shall be considered to be in writing if dictated to and authenticated by a duly authorized professional. All verbal orders shall be signed by the appropriately authorized person to whom dictated with the name of the ordering practitioner. Only currently licensed RN's, LPN's, Pharmacists, Respiratory and Physical Therapists and other personnel indicated in the Patient Care Policies and procedures M03-03-922, Verbal Orders, approved

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by the Executive Committee may accept verbal orders. All other verbal orders shall be countersigned by a practitioner responsible for the care of the patient within thirty (30) days of discharge. Failure to do so shall be brought to the attention of the Executive Committee of the Medical Staff for appropriate action. When more than one practitioner shares the responsibility of patient care, one may sign for another.

- iii. Pre-printed orders shall be formulated by conference between individual physicians and appropriate hospital representatives. Once agreed upon, they may not be changed by either party without the consent of the other. These orders are to be reviewed every two years by physicians and nursing personnel.
- iv. All medications will have an appropriate stop date. The physician will be notified prior to the stop date and asked to verify the need for continuation of the medication(s).
- v. Certain classes of medications may be approved for dosing by Pharmacy. The Pharmacy and Therapeutics Committee will approve medication-dosing protocols and/or guidelines with subsequent approval by the Medical Staff Executive Committee.
- vi. The practitioner's orders (verbal or written) must be written clearly, legibly and completely, dated, timed and include practitioner's printed name beneath the signature and/or four-digit identification number. In addition, the practitioner's identification number will be recorded under the ordering practitioner's name for verbal orders. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.
- vii. All elements of a complete medication order need to be present prior to medication order entry, dispensing, and administration. The elements of a complete medication order are: name (generic or brand), exact dosage strength (unless the medication is available in only one form and there can be no ambiguity about the strength ordered (Example: Lomotil 1 tablet), route, dose interval, and reason for administration of PRN medications (i.e. constipation, cough, diarrhea).
- viii. All orders for medication, whether written or verbal, shall be expressed by strength of drug per volume or dose (e.g. "25 mg per cc, 20 mg per cc, or 50 mg capsules"); unless the medication is available in only one form and there can be no ambiguity about the strength ordered. Nursing staff shall clarify any verbal medication order expressed by volume only with the prescribing practitioner before administration of medication. Practitioners who are administering the medication shall verify medication and dosage when someone else has drawn up the medication.
- ix. All existing medication orders shall automatically expire when the patient undergoes an operative or invasive procedure. Following the procedure, the surgeon or attending physician must write a new order for medications to be administered post-operatively.
- x. The professional who carries out the practitioner's order shall document the same pursuant to health system policy and procedure. The discharge order should be written "DISCHARGE PATIENT," dated and timed. Written orders sent in with the patient should become part of the medical record for physician signatures and the loose slip destroyed after the physician signs the order on the chart.
- xi. Reference to writing and charting include documentation by electronic means.

h. Discharge Summary or Death Summary

- i. Upon discharge, a discharge summary shall be completed and signed by the attending physician for all patients hospitalized over 48 hours except normal newborns and uncomplicated obstetric deliveries. In these cases, a final progress

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note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the summary. The summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to the patient and/or family, i.e., instructions relating to physical activity, medication, diet, and follow-up care. When designated by the pathologist, tumor staging (T-N-M) shall be included as part of the discharge summary. A discharge summary is to be completed for all inpatients who expire, even if the length of stay is less than 48 hours. The attending physician of record shall be responsible for ensuring that all death certificates are completed and signed in a timely manner in accordance with all applicable laws.

i. Tumor Registry

- i. Completed in accordance with state law. Cancer cases are to receive TNM staging at the time of diagnosis. The pathologist identifies cases needing T-N-M staging. The physician responsible for recording the TNM stage is in order of default: Surgeon, Oncologist, Radiation Therapist, Attending Physician. The basis for staging must precede the TNM stage. For inpatients and outpatients, the TNM stage must be written in the medical record.

Rule #10 –Performance Review Program for New Medical Staff Members

10. Performance Review Program for New Medical Staff Members

- a. New members of the Medical Staff shall be evaluated pursuant to the Medical Staff Bylaws (Part III, Sections 5 and 6) and Medical staff policies and Procedures (Focused Professional Practice Evaluation, Medical Staff Peer Review Policy, Medical Staff Case Review Process and Timelines, Medical Staff Expectations of Physicians Granted Privileges, and Medical Staff Physician Performance Feedback Report). Technical Quality, Patient Safety, Citizenship, Service Relationships, and Resource Utilization shall be evaluated to permit a determination by the Medical Staff that the new Medical Staff member is meeting performance expectations.
- b. Each Department Chairman shall be responsible for overseeing the performance review program for new Medical Staff members assigned to the chairman's department, and for making recommendations to the Facility Medical Executive Committee regarding whether or not the new member is meeting performance expectations.
- c. As applicable, the Department Chair, or as designated by the Department Chair the relevant Section Chief, shall be responsible to do the following regarding all new Medical-Staff members assigned to a given section:
 - i. Review all available information regarding professional performance not less than every six (6) months for the first year of membership, to include, but not limited to:
 1. OPPE data
 2. Personal Interactions with the practitioner, as indicated
 3. Detailed medical record review, as indicated
 4. Interviews of hospital staff interacting with practitioner, as indicated
 5. Surveys of hospital staff interacting with practitioners, as indicated
 6. Chart audits based on medical staff defined criteria, as indicated

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- ii. Receive, review and evaluate complaints of any nature or any reports of substandard professional performance, and determine an appropriate action, including but not limited to:
 - 1. appointing a preceptor/proctor to scrub with or be present during procedures or treatment performed by the new Medical Staff member;
 - 2. personally observing the new Medical Staff member's performance during surgery or other procedures or treatments;
 - 3. reviewing or requesting others to review medical records of the new Medical Staff member's patients; and
 - 4. recommending a summary suspension of the new Medical Staff member's privileges in whole or in part.
 - iii. Confer, as deemed necessary, with other members of the Section regarding the performance of any new Medical Staff member.
- d. The Facility Medical Executive Committee may determine and direct, on an individual basis, the use or implementation of additional or special methods of review of a particular new Medical Staff member's performance or activities. The same, however, shall in no case be less stringent than the performance review program described in this rule.

Rule # 11 – Surgery Services

11. Surgery Services

- a. Anesthesia
 - i. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation (within 48 hours prior to surgery/procedure and as per FM#2442 Pre-anesthesia evaluation) and post-anesthetic follow-up (within 48 hours after surgery/procedure and as per FM #0493 Post-Anesthesia evaluation) of the patient's condition. Anesthesiologists will be available in time to evaluate their patients adequately before surgery and will be immediately available until the last patient under their supervision is discharged from the Recovery Room.
- b. Surgeons
 - i. Surgeons should be in the operating room and ready to commence the operative procedure at time of induction of anesthesia except in case of emergency.
- c. Assisting surgeons
 - i. The use of an assistant surgeon in the operative room is at the discretion and direction of the attending surgeon. The assistant must be a member of the Medical Staff.
- d. Pathology Services/Tissue specimens
 - i. Tissues removed at operation shall be sent immediately to the pathology laboratory, if clinically indicated and diagnostic, by the physician in charge to be examined and reported upon by the pathologist, either microscopically or macroscopically, according

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to the policies established between the Hospital and the pathologist. Any exception to this rule must be cleared through the Chief of Surgery or the Facility Medical Executive Committee. Iatrogenic objects or materials are required to be sent to the pathology laboratory.

- e. Criteria relating to Surgery Scheduling
 - i. The administrative Department of Surgical Services at each LMHS facility will create policies to allow for the efficient scheduling of surgical cases. Such policies shall allow for timely intervention in urgent surgical cases and should set guidelines to assist physicians in determining if a case is “urgent” such that the case should receive priority treatment in the scheduling process.

- f. Universal Protocol
 - i. The administrative Department of Surgical Services at each Hospital will create policies to establish universal protocols that must be utilized by all surgeons in every OR at the facility at which the policies apply. Such policies shall address at the very least issues such as timeouts and surgical site marking as well as patient identification.

- g. Enforcement
 - i. The Chairman of the Department of Surgery, the President of the Medical Staff, the Acute Care Medical Officer of the Hospital and/or the Chief Medical Officer or his/her designee shall have authority to enforce all surgical rules and regulations and may cancel a surgical procedure if the rules have been violated.