SARASOTA MEMORIAL HOSPITAL

MEDICAL STAFF

RULES & REGULATIONS

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MEDICAL STAFF OF SARASOTA MEMORIAL HOSPITAL

RULES AND REGULATIONS

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ARTICLE I
ADMISSION

Section 1. Who May Admit Patients:

(a) A patient may be admitted to the Hospital only by physicians, dentists and podiatrists who have been appointed to the Medical Staff and who have been granted privileges to admit patients.

(b) Except in an emergency, no patient shall be admitted to the Hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

Section 2. Admitting Member's Responsibilities:

(a) Each patient shall be the responsibility of a designated member of the Medical Staff. In the case of a group practice, the member who admits the patient shall be considered the responsible, designated Medical Staff member. Such member shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to any referring member.

(b) The following precautions shall be taken in the care of potentially suicidal or dangerous patients:

(1) Psychiatric consultation shall be obtained when there is reasonable suspicion that a patient may be suicidal or dangerous.

(2) A patient known or suspected to be suicidal or dangerous shall be constantly attended by an adult family member or qualified attendant.

(3) A patient known or suspected to be suicidal or dangerous shall be admitted to a psychiatric facility following medical stabilization.

Section 3. Care of Unassigned Patients:

The care of any patient who presents to the Emergency Care Center, who has no personal practitioner, and who does not request assignment to a specific member of the Medical Staff, and who requires any consultation and/or Hospital admission, shall be assigned to the appropriate practitioner[1] on the Emergency Care Center back-up roster.

Section 4. Dental Patients:

A patient admitted by a dentist shall receive the same basic medical appraisal as patients admitted for other services, and shall be the combined responsibility of the attending dentist and a physician member of the Medical Staff.

(a) The dentist's responsibilities shall include:

(1) a dental history;

(2) a record of dental examination;

(3) a pre-operative diagnosis;

(4) an operative report, describing the findings and technique used. Any tissue removed shall be submitted for pathologic examination.

(5) progress notes related to dental care;

(6) summary of hospital course; and

(7) discharge order.

(b) The consulting physician's responsibilities shall include:

(1) general medical history;

(2) a physical examination, with emphasis on the condition of the patient and suitability for anesthesia and operation;

(3) general medical care during hospitalization;

Section 5. Podiatric Patients:

A patient admitted by a podiatrist shall receive the same basic medical appraisal as patients admitted for other services, and shall be the combined responsibility of the attending podiatrist and a physician member of the Medical Staff.

(a) The podiatrist's responsibilities shall include:

(1) a podiatric history;

(2) a record of podiatric examination;

(3) a pre-operative diagnosis;

(4) an operative report, describing the findings and technique used. Any tissue removed shall be submitted for pathologic examination.

(5) progress notes related to podiatric care;

(6) summary of hospital course; and

(7) discharge order.

(b) The consulting physician's responsibilities shall include:

(1) general medical history;

(2) a physical examination, with emphasis on the condition of the patient and suitability for anesthesia and operation;

(3) general medical care during hospitalization;

Section 6. Clinical Psychology Patients

Responsibilities and specific privileges of clinical psychologists will be as defined by the rules and regulations of the Department of Psychiatry.

Section 7. Alternate Coverage:

(a) Members of the Medical Staff are responsible for the continuous care of their hospitalized patients by being available or by arranging for alternate coverage by another qualified member of the Medical Staff with appropriate clinical privileges.

(b) The appropriate department chairperson or section chief is authorized to arrange for alternate coverage whenever indicated.

Section 8. Transfer of Patients:

(a) When the Hospital does not provide the services, personnel, technology, or equipment necessary for proper care of a particular patient, the Hospital and the attending physician shall, as a combined responsibility, assist the patient in making arrangements for care in an alternate facility. Transfer of such patient shall be arranged so as to minimize jeopardy to the patient's health and safety.

(b) All transfers from the Hospital shall comply with COBRA legislation. If the patient is to be transferred to another health care facility, the responsible member shall enter all appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to provide for continuity of care shall accompany the patient.

Section 9. Priorities for Admission:

(a) The Admitting Office shall admit patients on the basis of the following order of priorities:

(1) **Emergency Admissions** - includes those patients whose life is in immediate danger or whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger.

(2) **Urgent Admissions** - includes non emergency patients whose admission is considered imperative by the attending physician. Urgent admissions shall be given priority when beds become available over all other categories except emergency.

(3) **Pre-Operative Admissions** - includes patients already scheduled for operation. If it is not possible to accommodate such admissions, the Chairperson of the Utilization Review Committee may decide the priority of any specific admission.

(4) **Routine Admissions** - includes elective admissions involving all clinical services. These patients shall be given an appropriately scheduled reservation in accordance with the Hospital's utilization review plan.

(b) Before admitting a patient, the attending physician or a designee shall contact the admitting office to ascertain whether there is an available bed. If there is any question or conflict concerning the admission of a patient, the Chairperson of the Utilization Review Committee shall determine the necessity and or appropriateness of the admission.

Section 10. Transfer Priorities:

Transfer priorities shall be as follows:

(a) from Emergency Care Center to an appropriate patient care area;

(b) From obstetric patient unit to a general patient unit;

(c) From an intensive care unit to a general patient unit;

(d) From a cardiac care unit to a general patient unit; and

(e) From temporary placement in a nonclinical area to an appropriate clinical service area.

Section 11. Emergency Admissions:

(a) The history and physical examination must clearly justify an emergency admission and must be recorded on the patient's chart within twenty four (24) hours of admission.

(b) A patient admitted as an emergency admission who has no personal physician, who does not request assignment to a specific member of the Medical Staff, and who requires any consultation and/or Hospital admission, shall be assigned to the appropriate physician on the Emergency Care Center back-up roster. The emergency physician on duty in the Emergency Care Center requesting the consultation shall determine the appropriate specialist for consultation and/or admission from the Emergency Care Center back-up roster. A department chairperson or the Chief of Staff shall mediate if controversy arises concerning the determination of the responsible physician.

(c) The chairperson of each department shall provide a monthly assignment schedule to the Emergency Care Center listing the physician with privileges in that department responsible for emergency consultations and/or admissions during any 24-hour period. Unless otherwise arranged with the Emergency Care Center, call responsibility changes at 7:00 AM each morning. The physician responsible for the patient is the physician on call for the respective department at the time consultation is requested by the emergency physician, notwithstanding the time the consultant actually returns the call.

(c) If a physician assigned to the Emergency Care Center back-up roster is unable to take assignment when scheduled, it shall be that physician's responsibility to arrange for a qualified substitute and to notify the Emergency Care Center.

(d) Failure of the assigned member to respond to an emergency call may result in a professional review action pursuant to the provisions of the *Credentialing Procedures Manual*, unless that member presents, in writing, an acceptable reason for not attending the patient to the Chief of Staff. An unexcused failure to respond to an emergency call shall be reported immediately to the Medical Executive Committee for appropriate review and action.

ARTICLE II
MEDICAL ORDERS

Section 1. General Requirements:

(a) All orders must be dated, timed, and authenticated promptly by the ordering practitioner, except as noted in Article II, Section 3(b) regarding authentication of verbal orders.

(b) Orders must be entered in the electronic medical record utilized by the hospital. By policy, the hospital may establish exceptions to this rule which permit orders to be entered by hand if written clearly, legibly, and completely. Orders which are illegible or improperly written shall not be carried out until they are clarified by the ordering member and are understood by the care provider.

(c) The use of the terms "renew," "repeat," and "continue" standing alone on orders is not acceptable.

(d) All previous orders shall be cancelled when patients go to procedure. Post-operative orders must be reviewed and re-entered in the electronic medical record. Orders such as “resume all pre-operative orders” are not to be used.

(e) Orders for "daily" tests or procedures shall state the number of days and shall be reviewed by the attending physician at the end of the expiration of said days unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued must be rewritten in the same format that it was originally recorded if it is to be continued.

(f) Orders for all medications and treatments for all patients shall be under the supervision of the attending physician and shall be reviewed by the attending physician in a timely manner to assure discontinuance when no longer needed.

(g) Standing orders must be approved by the Medical Executive Committee. These orders shall be signed by the attending staff member. Specific orders written for patients take precedence over standing orders, which shall constitute orders for treatment only in the event the attending staff member has not written specific orders.

(h) All orders must be completely reviewed and re-entered in the electronic medical record when a patient is transferred from one service to another.

(i) When medication or treatment is to be resumed after an automatic stop order has beeemployed, the orders that were stopped must be rewritten.

(j) No order shall be discontinued without the knowledge of the attending physician, unless the circumstances causing the discontinuation constitute an emergency.

(k) The use of abbreviations, signs, and symbols in the medical record is strongly discouraged. No abbreviations, signs, or symbols shall be used in recording the patient's admitting or discharge diagnosis, in recording the name of a medication, in the contents of a patient consent form, or for documentation of unusual complications. Hospital policies governing "Do Not Use" abbreviation lists or approved abbreviation lists shall be followed in all cases.

Section 2. Who May Write Orders:

(a) Medical Staff members and Allied Health Professionals shall have the authority to write orders only as permitted by their licenses and by the clinical privileges and or scope of practice in the Hospital.

(b) All orders must be entered in the patient's record, dated, and signed, as appropriate, by the responsible member.

(c) Registered, unlicensed resident physicians are permitted to write orders for treatment at the sole discretion and responsibility of the Medical Staff member responsible for the patient's care.

(d) Persons authorized to write orders for recovery of organs and tissue in accordance with hospital policy and within the scope of their licensure by the State of Florida.

Section 3. Verbal Orders:

(a) The preferred method of documenting orders is for the clinician/physician to enter orders into Sunrise Clinical Manager (SCM). Verbal orders are to be used infrequently. A verbal order (either in person or via telephone) for medication or treatment shall be accepted only under circumstances when it is impractical for such order to be given in writing by the responsible member. The verbal/phone order recipient will document the order in SCM, including the name of the physician who gave the order, the name of the recipient, and the date and time of receipt of the order. **The recipient will read back the order to the clinician including the physician's first and last name to verify the order and to verify attribution of the ordering clinician.** Clinicians will immediately have the opportunity to review and co-sign orders. SCM creates an electronic flag to alert the clinician that an order needs to be signed. If the order is handwritten on the paper physician order form, the order recipient will flag the order to be signed.

(b) All verbal orders must be signed within 48 hours by the ordering practitioner or another practitioner who is responsible for the care of the patient and authorized to write orders.

(c) A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order in the proper place in the medical record of the patient.

(d) A verbal order shall include the date, time and signature of the person to whom the verbal order has been given.. Any verbal order may be signed by any physician involved in the case.

Acceptance of a verbal order is limited to the following, with noted restrictions:

(1) a physician, dentist or podiatrist with clinical privileges at the Hospital;

(2) a professional nurse;

(3) a licensed practical nurse;

(4) a pharmacist who may transcribe a verbal order pertaining to drugs;

(5) a respiratory therapist who may transcribe a verbal order pertaining to respiratory therapy treatments;

(6) a physical therapist who may transcribe a verbal order pertaining to physical therapy treatments; and

(7) a radiology technician who may transcribe a verbal order pertaining to radiological tests and or therapy treatments.

Section 4. Orders for Specific Procedures:

(a) Orders for procedures such as physical therapy, therapeutic diets, and respiratory therapy shall be entered in the patient's record, dated and timed, and signed or countersigned by the ordering practitioner.

(b) All "NO CODE" orders shall be written physician orders pursuant to Hospital Policy on Do Not Resuscitate (DNR) orders.

(c) Restraint or seclusion is a special procedure that must be justified in the medical record by the following:

(1) A verbal or written time-limited order must be obtained for each use of restraint or seclusion;

(2) An order for each use of restraint or seclusion must be obtained within two (2) hours of the initiation of either intervention. Once an order is obtained for either intervention, it must be renewed or cancelled after twenty-four (24) hours. A face-to-face patient assessment by the physician is necessary to reorder restraint or seclusion after the initial twenty-four (24) hours.

For a patient with primary behavioral health needs, an order for restraint or seclusion must be obtained within one (1) hour of initiation of either intervention. The order must be time-limited using age specific time frames, i.e. Adult: 4 hours, Age 9 to 17: 2 hours, and Under age 9: 1 hour. The order may specify that an RN may reassess need to continue restraint or seclusion at age specific intervals up to a maximum of twenty-four (24) hours, i.e. Adult: 4 hours, Age 9 to 17: 2 hours, or Under age 9: 1 hour. 3

(3) The needs of the patient, including but not limited to, determination of vital signs, reassessment of nutritional status, reassessment of the neurovascular status of extremities restrained, and reassessment of mental status must be attended to while a patient is restrained or secluded pursuant to Hospital policy.

Section 5. General Requirements

(a) All medications shall be administered by, or under the supervision of, appropriately licensed personnel in accordance with laws and governmental rules and regulations governing such acts and in accordance with these rules and regulations.

(b) Medications to be administered shall be verified with the prescribing practitioner's orders and properly prepared for administration.

(c) The patient shall be identified prior to medication administration and each dose of the medication administered shall be recorded properly in the patient's medical record.

(d) Medication errors and adverse drug reactions shall be reported immediately in accordance with established procedures.

(e) Medications to be administered must be supplied by the hospital pharmacy. Exceptions are permitted in the event a patient is admitted on a medication which the pharmacy cannot supply, the drug is identified, and the patient's physician writes an order for the patient to receive his/her own medication and for sample drugs approved by the Medical Directors of the ECC and the Community Medical Clinic.

Section 6. Who May Administer Medications

(a) Physicians who are members of the Medical Staff.

(b) Other individuals who have been granted clinical privileges to write medication orders by the Credentials Committee of the Medical Staff.

(c) Registered Nurses as approved by Nursing policies and procedures.

(d) Licensed Practical Nurses as approved by Nursing policies and procedures.

(e) Florida Licensed Respiratory Care personnel may administer medications germane to the pratice of Respiratory Care. Also, included in this category are:

(1) Certified Pulmonary Function Technologists
(2) Registered Pulmonary Function Technologists
(3) Certified Cardiopulmonary Technologists
(4) Registered Cardiopulmonary Technologists

(f) Registered Radiologic Technologists (contrast media only) under the direction of the Chief of Radiology and as certified by the Director of Imaging Services.

(g) Registered Nuclear Medicine Technologists (Radiopharmaceuticals) under the direction of the Chief of Radiology and as certified by the Director of Imaging Services.

(h) Students undergoing clinical rotations provided their programs have a formal affiliation with Sarasota Memorial Hospital and they are under the direct supervision of the program clinical faculty member or an employee of Sarasota Memorial Hospital approved to administer medications.

(i) Patients may self-administer medications prescribed to them provided the prescribing physician assesses that the patient has the capability to do so and the physician writes an order allowing this action.

ARTICLE III
MEDICAL RECORDS

Section 1. General Rules:

(a) A medical record shall be maintained for each patient who is evaluated or treated as an inpatient, ambulatory care patient, or emergency patient.

(b) The contents of the record shall be pertinent and current, accurately written, and promptly completed. A single attending physician shall be identified in the medical record as being responsible for the patient at any given time.

(c) The Health Information Management Department shall publish a list of abbreviations, acronyms, and symbols that are not to be used in the medical record. No person making an entry in the medical record shall use an abbreviation, acronym, or symbol on that list, in any form.

(d) The following requirements shall be enforced by all clinical department chairpersons:

(1) Histories and physicals must be documented on the chart within twenty-four (24) hours following admission of the patient. Histories and physicals may be performed by residents or by Allied Health Professionals who have been granted privileges or given permission by the Hospital to perform histories or physicals. Histories and physicals performed by residents or Allied Health Professionals must be countersigned by the admitting physician.

(2) All consultations shall contain the date of the consultation and shall be documented on the patient's chart.

(3) Progress notes shall be written at least daily on all critically ill patients

(4) All operations performed shall be fully described by the operating surgeon in the Operative Report, and the surgeon or his/her Allied Health Professional shall record information immediately after the procedure consistent with that required in Sections 6 and 7 of this Article.

(5) A clinical Discharge Summary shall be dictated within thirty (30) days of the patient’s discharge. The elements of this dictation shall be consistent with that required in section 11 of this Article.

Section 2. Authentication:

Except as otherwise specified by the Bylaws or Bylaws Related Documents:

1) Authentication shows authorship and assigns responsibility for an act, event, condition, opinion, or diagnosis and demonstrates a status in which a document or entry has been signed manually or electronically by the individual who is legally responsible for that document or entry. The author responsible for ordering, providing, or evaluating the health care service should promptly authenticate every entry in the health record.

2) For paper-based records, acceptable methods to identify the author include written signature or initials combined with a signature legend on the same document. Acceptable methods of identifying the author in electronic health record include auto-authentication, electronic signatures or computer key. Acceptable methods for authenticating a scanned document may follow paper or electronic guidelines.

   a) All entries must be legible and complete and must be authenticated, dated and timed promptly by the person (identified by name and discipline) who is responsible for ordering, providing, or evaluating the service furnished.

   b) Initials can be used to authenticate entries such as flow sheets, medication records, or treatment records. They should not be used for such entries as narrative notes or assessments. Initials should never be used for entries where a signature is required by law. Authentication of entries by only initials should be avoided because of the difficulty in positively identifying the author of an entry based on initials alone and distinguishing that individual from others having the same initials.

      When the healthcare provider chooses to use initials in any part of the record for authentication of an entry, there should be corresponding full identification of the initials on the same form or on a signature legend. A signature legend may be used to identify the author and full signature when initials are used to authenticate entries. Each author who initials an entry must have a corresponding full signature on record.

   c) Auto-authentication is used when the author directly keys in his or her entry into the electronic health record. The author of each entry should take specific action to verify that the entry is his or her entry or that he or she is responsible for the entry and that the entry is accurate.

   d) Electronic Signature (also known as computer key or other code) is the authentication method to sign electronic documents or orders that were transcribed or ordered on behalf of the provider. When electronic signature is used, the provider is responsible for reviewing/editing the entry for accuracy and completing within a timely fashion. Authorized users are required to sign a statement ensuring that they alone will use the computer key.

3) A countersignature requires a professional to review and, if appropriate, approve action taken by another practitioner. Countersignatures should be used as required by state licensing or certification statutes related to professional scope of practice. The entries of individuals who

are required to practice under the direct supervision of another professional should be countersigned by the individual who has authority to evaluate the entry. Once countersigned, the entry is legally adopted by the supervising professional as his or her own entry.

4) All other health record entries including transcribed reports shall be authenticated as soon as possible not exceeding 30 days from visit or discharge.

Section 3. Contents:

(a) A complete medical record shall include:

(1) identification data;

(2) date of admission and discharge;

(3) an adequate medical history;

(4) an adequate physical examination;

(5) a provisional admitting diagnosis;

(6) a statement of the conclusions or impressions drawn from the admission history and physical examination;

(7) A plan of care, including diagnostic and therapeutic orders, including those for:

(i) Medications;

(ii) Treatments;

(iii) Restorative and rehabilitative services;

(iv) Activities;

(v) Social Services;

(vi) Diet

(8) appropriate informed consent to include risks, benefits, and alternatives to treatment. This may be documented in multiple locations to include but not limited to history and physical report, pre-procedure progress notes, consultations, orders or the surgical consent form;

(9) clinical observations, progress notes, nursing notes, consultation reports;

(10) reports of procedures, tests, and the results, including operative reports;

(11) reports of pathology and clinical laboratory examinations, radiology and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures; and

(12) conclusions at termination of hospitalization, including the provisional diagnosis or reason(s) for admission, the principal and additional or associated diagnoses, the clinical resume or final progress note, and, when appropriate, the autopsy report.

(b) All medical record forms shall be standardized. All new forms proposed for use in the medical record shall be submitted to appropriate clinical departments, and the Clinical Forms Committee for review, comment, and approval. The Medical Records Committee shall approve (or reject) all forms specifically requiring physician documentation recommended for inclusion in the medical record.

(c) Unauthorized deletions, additions, or substitutions of written material in the medical record are prohibited.

Section 4. History and Physical (H&P):

(a) A complete history and physical examination shall be recorded on the patient's chart within twenty-four (24) hours following admission. This report shall reflect a comprehensive current physical assessment by a Medical Staff member or Allied Health Professional who has been granted privileges or given permission by the Hospital to perform histories or physicals. Each such report shall be signed by a physician. If a complete physical examination has been performed within 30 days prior to admission, a durable, legible copy of this report may be used in the patient's Hospital medical record, provided this report was recorded by a Medical Staff member, or Allied Health Professional, and there has been no change subsequent to the original examination. In this case an update note identifying changes or no changes must be completed within 24 hours of admission. In the situation where the inpatient is going to surgery or having a procedure within the first 24 hours of admission, the current H&P, including update note if H & P completed prior to admission and less than 30 days, must be on the medical record prior to having the surgery or procedure. After the initial H & P progress notes may serve as updates.

If the patient is having surgery or other procedure that places the patient at risk and/or involves the use of anesthesia or moderate sedation there must be a current H&P on the patient record. If the H & P was performed prior to the day of the surgery or procedure and is less than 30 days old, the Medical Staff Member, or Allied Health professional, must document the change (s) or indicate that there is no

change in the patient's status in the medical record prior to having the surgery or procedure.

An abbreviated history and physical pertinent to the specific procedure being performed may be used for patients that are receiving outpatient surgical and or other procedures. This means, at a minimum, any procedure utilizing anesthesia or moderate sedation .

(b) When a patient is readmitted within thirty-(30) days for the same or a related problem, an interval history and physical examination, or admission note reflecting any subsequent changes may be used in the medical record, provided the original information is readily available.

(c) The medical record shall document a current, thorough physical examination prior to the performance of an operation. When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled unless the attending physician states in writing that an emergency situation exists, or that any such delay would be detrimental to the patient.

(d) History and Physical Report contents should include but need not be limited to the following:

a. Chief Complaint
b. History of Present Illness
c. Allergies and Medications
d. Past Medical, Social and Family Histories
e. Physical Examination
f. Review of Systems
g. Impression
h. Plan for Care
i. Informed Consent/Risks, benefits, and alternatives to treatment (when applicable)

Section 5. Progress Notes:

(a) Progress notes shall provide a pertinent chronological report of the patient's course of care in the Hospital. Progress notes can be written by Medical Staff members and Allied Health Professionals as permitted by their delineated clinical privileges and or scope of practice. All such progress notes shall be legible, shall document the date and time of observation, and shall contain sufficient information to insure continuity of care at the Hospital or other health care facility to which the patient might later be transferred. Where 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 treatments. Pertinent progress notes may also be made by residents.

(b) Progress notes shall be written at least daily on critically ill patients, and on those where there is difficulty in diagnosis or management of the clinical problem. The frequency of recording progress notes shall be contingent on and consistent with the condition of the patient and the severity of the patient's illness.

(c) Progress note documentation shall include, but need not be limited to the following:

(1) comments that describe the current status of the patient, including the patient's response to the treatment regimen;

(3) any complications, new symptoms, or additional diagnoses for which the patient is to be evaluated or treated;

(4) plans for additional workups, consultations, or definitive treatment(s); and

(5) discharge planning.

(d) If the patient's condition is stable and unchanged, a statement documenting such shall be adequate.

Section 6. Documents required prior to an operation:

(a) Except in emergencies, the following data shall be recorded in the patient's medical record prior to operation or the operation shall be automatically canceled:

(1) verification of patient identity;

(2) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(3) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and operation;

(4) provisional diagnosis;

(5) laboratory test results;

(6) consultation reports;

(7) patient consent to include: physician documentation of consent (risks, benefits, and alternative to care) and a form signed by the patient or the patient's legal representative and witnessed by a qualified nurse;

(8) x ray reports, if applicable; and

(9) other ancillary reports, if applicable.

(b) Except in the case of an emergency, the patient should not be transported to the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report has been received.

(c) In an emergency, when there is no time to record the complete history and physical examination a progress or admission note describing a brief history and appropriate physical findings and the preoperative diagnosis is recorded in the medical record prior to surgery.

Section 7. Operative Records:

(a) An Immediate Post-Operative Note shall be completed in the medical record immediately after operation and shall contain:

(1) Name of primary surgeon and assistants
(2) Procedures performed
(3) Description of each procedure
(4) Findings
(5) Estimated blood loss
(6) Specimens removed
(7) Post operative diagnosis

(b) The Immediate Post-Operative Note may be completed by the surgeon's Allied Health Professional, as permitted by his/her delineated clinical privileges and scope of practice, at the direction of the surgeon and authenticated by the surgeon within 24 hours.

(c) An Operative Report shall be completed within 48 hours of the operation, and the completed operative report shall be signed by the surgeon and filed in the patient's medical record as soon as possible thereafter.

Section 8. Anesthesia Note:

Separate pre- and post- anesthesia evaluations shall be documented in the medical record of all patients undergoing an operation and shall specifically include, but not be limited to, information relative to the choice of anesthesia for the procedure anticipated, any unusual risk possibilities related thereto, and where relevant, previous drug history, and other anesthetic experiences. At least one post anesthesia note shall describe the presence or absence of anesthesia related complications.

Section 9. Pathology Report and Disposition of Surgical Specimens:

(a) All specimens removed during a surgical procedure shall be documented on the operative record, properly labeled, packaged appropriately, identified in the operating room or operating suite as to patient and source, and sent to the laboratory for examination by or under the supervision of a pathologist. The specimen shall be accompanied by pertinent clinical information, including the pre operative and post operative surgical diagnosis.

(b) The following specimens are not required to be sent to the laboratory for examination:

(1) specimens that by nature or condition do not permit fruitful examination, such as cataract, orthopedic appliance, calculi, foreign body, or a portion of bone removed only to enhance the operative procedure;

(2) therapeutic radioactive sources, the removal of which shall be guided by radiation safety requirements;

(3) traumatically injured parts that have been amputated and for which examination for either medical or legal reasons is not deemed necessary;

(4) specimens known to rarely, if ever, show pathological change, and removal of which is highly visible post-operatively, such as the foreskin from the circumcision of a newborn infant;

(5) placentas that are grossly normal and have been removed in the course of operative and nonoperative obstetrics; and

(6) teeth, if the number, including fragments, is recorded in the medical record.

(c) The pathologist shall document the receipt of all surgically removed specimens and shall sign the pathology report which shall become part of the patient's medical record. Results of any intra operative consultation by a pathologist, including frozen section interpretations, shall be documented in the medical record by the pathologist. The pathology report shall be filed in the medical record within twenty four (24) hours of completion, if possible.

(d) Foreign bodies and objects may be referred to the Hospital pathologist at the option of the attending surgeon.

(e) The disposition of surgical specimens, whether discarded or submitted to pathology, shall be recorded in the operative record.

Section 10. Exchange of Medical Information

Upon written authorization of the patient, the Health Information Management Department shall transmit information to other hospitals or healthcare facilities requesting data concerning the patient's previous admissions, record name, birthdate, and dates of previous hospitalization. Similarly, the Health Information Management Department, upon written authorization of the patient, may request information from other hospitals or health care facilities concerning the patient. Information received in response to said request shall not become part of the patient's medical record at the Hospital unless authenticated by the attending physician as part of the current medical record.

Section 11. Discharge Summaries:

(a) All relevant diagnoses established by the time of discharge, as well as all operative procedures performed and complications experienced, shall be recorded on the face sheet, using acceptable disease and operative terminology that includes topography and etiology as appropriate ("Standard Nomenclature of Diseases and Operations").

(b) A clinical discharge summary shall be included in the medical records of all patients except (1) those with minor problems who require less than a forty-eight (48) hour period of hospitalization, (2) normal newborn infants, and (3) uncomplicated obstetrical deliveries. A final progress note may be substituted for a discharge summary for the above identified patients. The final progress note should which should include the outcome of hospitalization, disposition of the case, final diagnoses, and provisions for follow-up care including any instructions given to the patient or the patient's representative.

(c) The discharge summary shall include~~:~~

(1) the reason for hospitalization;

(2) the significant findings;

(3) including any complications;

(4) the procedures performed and treatment rendered;

(5) the condition of the patient on discharge; and

(6) any specific, pertinent instructions given to the patient or the patient's representative.

(d) When pre printed instructions are given to the patient or the patient's representative, the record shall so indicate. A copy of the pre printed instruction sheet used shall be on file in the Health Information Management Department.

(e) Discharge summaries shall be dictated by the attending physician or designee and signed by the attending physician.

Section 12. Failure to Complete Medical Records:

It is the responsibility of each practitioner to prepare and complete medical records within thirty (30) days following discharge of the patient from the Hospital, except as follows: (1) histories and physicals must be completed (dictated or handwritten) within 24 hours post admission, and (2) post-operative note must be completed immediately post-operatively and operative report must be dictated within 48 hours. The failure to appropriately complete medical records shall result in temporary relinquishment of clinical privileges and may result in the complete relinquishment of clinical privileges as set forth in the Hospital's policy regarding the appropriate completion of medical records.

Section 13. Possession, Access, and Release:

(a) Regardless of the media on which it is stored, all medical records are the physical property of the Hospital and shall not be taken from the confines of the Hospital. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the attending physician.

(b) Access to the medical records of all patients shall be afforded to Medical Staff members in good standing for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Publication of compiled data requires written Hospital approval.

(c) Subject to the discretion of the President, former Medical Staff members shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

(d) Written consent of the patient or the patient's legal representative is required for release of medical information to those not otherwise authorized to receive information.

Section 14. Filing of Medical Record:

No medical record shall be permanently closed until the attending physician completes it, except on order of the Medical Records Committee.

ARTICLE IV
CONSULTATIONS

Section 1. General:

(a) The attending physician shall be responsible for requesting consultation when indicated and for calling in a qualified consultant.

(b) Requests for a consultation shall be entered on the order sheet in the patient's medical record.

(c) It is the combined duty of department chairpersons and the Medical Executive Committee to make certain that Medical Staff members request consultations when so required.

Section 2. Who May Give Consultations:

Any Medical Staff member with clinical privileges at the Hospital can be asked for consultation within his area of expertise. Consultation by members or other practitioners associated in the same office should be avoided insofar as possible. In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the Medical Executive Committee, the Chief of Staff has the right to order consultation.

Section 3. Required Consultations:

(a) In the ordinary course of events, the attending physician shall decide when consultation is required for a given clinical situation.

(b) Consultation(s), either in an individual case, a certain type of case, or for all patients, may be mandated during the delineation of clinical privileges of a Medical Staff member.

Section 4. Psychiatric Consultations:

(a) Psychiatric consultation shall be obtained when there is reasonable suspicion that a patient may be suicidal or dangerous.

Section 5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to operation, the consultant's report shall be documented on the medical record prior to operation, except as provided in Article III, Section 6.

Section 6. Mandatory Consultations:

(a) When a consultation requirement is imposed by the Medical Executive Committee during the delineation of clinical privileges, the required consultation shall not be rendered by an associate or partner of the affected member.

(b) Failure to obtain required consultations shall constitute grounds for precautionary suspension pursuant to the *Credentialing Procedures Manual*.

Section 7. Contents of Consultation Report:

(a) Each consultation shall be documented by a written report which shall be made part of the patient's medical record.

ARTICLE V
INFORMED CONSENT

Section 1. Responsibility for Obtaining Informed Consent:

(a) The Hospital's general consent form must be signed by the patient or the patient's representative at the time of admission.

(b) It shall be the responsibility of the appropriate performing practitioner or like credentialed practitioner to obtain informed consent for all patients undergoing surgery, special procedures, receiving blood or blood products and/or any other treatment which has potential serious risks to the patient.

(1) the attending surgeon or like credentialed practitioner shall obtain the patient's consent to any operative procedure to be undertaken;

(2) the performing practitioner or like credentialed practitioner performing a non-routine or high-risk medical procedure shall obtain informed consent for any such procedure.

(3) the performing practitioner or like credentialed practitioner ordering blood or blood components shall obtain informed consent prior to its administration.

(4) the anesthesiologist or anesthetist shall obtain informed consent prior to the administration of general or conductive anesthesia.

(c) Except in emergencies, the procedure, operation, or the administration of blood or blood products shall be automatically canceled and/or rescheduled if a completed consent form is not included in the medical record.

(d) Whenever the patient's condition prevents the obtaining of an informed consent, every effort shall be made and documented to obtain the consent from the patient's legally authorized representative prior to the procedure, operation, or administration of blood or blood products and such effort shall be documented in the patient's medical record. Any emergencies involving a minor or otherwise incompetent patient in which consent cannot be immediately obtained from parents, legal guardian or legally authorized representative should be fully explained on the patient's medical record. If possible, a consultation regarding the nature of the emergency and the patient's incapacity to consent_shall be obtained before any operative procedure is undertaken.

(e) Should additional operations or procedures be required during the patient's stay at the Hospital, a separate consent form shall be completed.

(f) If two (2) or more specific procedures are to be done at the same time and such information is known in advance, a single consent form may be utilized

(g) A single informed consent for blood or blood products is sufficient for any course of therapy which may include more than one transfusion.

Section 2. Definitions:

The following definitions shall be applied when obtaining consent to treatment:

(a) **Informed Consent**: The consent obtained from a patient or the patient's legally authorized representative after that individual has been informed by the appropriate performing practitioner or like credentialed practitioner of the nature of the proposed treatment or procedure, the substantial risks and hazards inherent in the proposed treatment or procedure, and the medically acceptable alternative treatments or procedures available to the patient.

(b) **Emergency**: A situation when, in competent medical judgment, the proposed surgical or medical treatment or procedure is immediately necessary and any delay caused by an attempt to obtain a consent would further jeopardize the life, health, or safety of the patient.

(c) **Emancipated Minor**: An individual under the age of eighteen (18) years who (1) has been adjudicated an adult, or (2) is or has been married.

Section 3. Who May Consent:

(a) A competent adult or emancipated minor may authorize medical treatment or surgical procedure to be performed upon his/her body, and the consent of no other person shall be required or shall be valid.

(b) Written consent shall be obtained from the legally appointed guardian of a non-emancipated minor, or if there is none, from the parents of a non-emancipated minor, before any surgical or medical procedure is performed, or blood or blood products are administered except in the following cases:

(1) where emergency medical care or treatment is to be rendered to a minor who has been injured in an accident or who is suffering from an acute illness, disease, or condition such that, within a reasonable degree of medical certainty, delay in initiation or provision of emergency medical care or treatment would endanger the health or physical well being of the minor. In such cases, if the consent cannot be immediately obtained because the identity of such parent or guardian cannot be identified, or if such parent or guardian cannot be immediately located by telephone, emergency medical care or treatment may be administered without such consent. Notification to the

parents or guardian shall be accomplished as soon as possible after the emergency medical care or treatment is administered. The Hospital records shall then reflect the reason why such consent was not initially obtained and shall contain a statement by the attending physician that immediate emergency medical care or treatment was necessary for the patient's health or physical well being.

(2) Medical and health services to determine the presence of or to treat pregnancy.

(3) Treatment for or advice about alcoholism or drug abuse.

(4) Treatment for sexually transmissible diseases.

(c) Written consent shall also be obtained in all non emergent situations from the legally authorized representative of any incompetent adult before any surgical or medical procedure is performed, or blood or blood products are administered.

Section 4. Incompetent Patients:

Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as to treatment. When a patient has been declared incompetent by a court, a consent form signed by the court appointed legal guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the particular patient involved, the consent of the patient's legally authorized representative shall be obtained. Certain circumstances may warrant a second medical or psychiatric opinion regarding the patient's lack of capacity to participate in health care decision-making.

Section 5. Unusual Cases:

(a) When questions arise regarding patient consent or when unusual circumstances occur not clearly covered by these rules and regulations, the physician shall promptly confer with Hospital Administration concerning such matters. The Hospital will assist the physician relative to such matters. However, it is the ultimate responsibility of the physician to comply with the requirements contained in these rules and regulations.

(b) Telephone consent shall be permissible when a delay in obtaining consent on behalf of an incompetent individual or a minor would result in harm to the individual.

(1) In such a case, the physician who will perform the procedure or provide the treatment may, in the presence of at least one (1) witness who is on the line with the physician, convey the information via telephone. If telephone

consent is given, the physician giving the information must document in the medical record exactly what was told to the patient's representative and must date time and sign such notation. The witness shall sign the note as well, certifying that he or she heard the information being transmitted by the physician and also heard the patient's representative give consent.

(2) If telephone consent is provided, confirmation of the consent by telegram, facsimile, or written letter shall be promptly requested.

(c) Clinical departments may propose specialized consent forms for specific procedures when deemed desirable or when legally required. Such forms shall become effective when approved by the appropriate clinical department, the Medical Records Committee and the Medical Executive Committee.

Section 6. Surgical Procedures Resulting in Sterilization:

No request and or consent other than from the patient will be accepted for an operative procedure resulting in sterilization. Before consenting to a sterilization procedure, the patient must be informed and understand that the restoration of fertility is unlikely. In the case of an incompetent patient, all requests for a sterilization procedure must be submitted to both the attending physician and the President, who shall then determine the appropriate actions to be taken.

Section 7. Termination of Pregnancy:

(a) In all cases, termination of pregnancy shall be performed consistent with and as authorized by law and Hospital policy.

Section 8. Refusal to Consent:

A patient or, if incompetent, the patient's legal representative, retains the right to refuse medical treatment, even in an emergency situation. If a patient continues to refuse such treatment after an explanation of the potential risks that could result from lack of treatment, a refusal of care and appropriate release of responsibility form should be executed, and, if possible, signed by the patient. Such form(s) shall be kept in the patient's medical record.

ARTICLE VI
DISCHARGE

Section 1. Who May Discharge:

Patients shall be discharged only on a written order of the attending physician. Should a patient leave the Hospital against the advice of the attending physician, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Hospital's release form.

Section 2. Discharge Planning:

(a) Discharge planning shall be offered to all patients pursuant to Hospital policy.

Section 3. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing, and the statement shall become a part of the permanent medical record of the patient.

ARTICLE VII
AUTOPSIES

Section 1. Autopsies and Disposition of Bodies:

(a) The remains of any deceased patient, including a fetal or neonatal death, shall not be subjected to disposition until death has been officially pronounced by a physician, and the event adequately documented in the patient's medical record within a reasonable period of time by the attending physician or another designated Medical Staff member or resident.

(b) The body of a deceased patient can be disposed of only with the consent of the patient's legal representative, and only after an entry has been made and signed in the deceased patient's medical record by the attending physician or his designee. Death certificates are the responsibility of the attending physician and must be completed within twenty-four (24) hours of death, if possible.

(c) It shall be the duty of all Medical Staff members to request consent for autopsies according to the criteria set forth in Hospital policies. An autopsy may be performed only with proper consent in accordance with state law and pertinent Hospital policies. A copy of the autopsy report shall be forwarded to the patient's attending physician and included in the patient's medical record.

(d) The autopsy report shall be completed within sixty (60) days from death unless special studies or outside consultations remain pending.

Section 2. Medical Examiner's Cases:

It is the responsibility of the attending physician or an alternate to notify the Medical Examiner of any cases meeting the criteria in Chapter 406.11, Florida Statutes, which define Medical Examiner's cases.

ARTICLE VIII
MISCELLANEOUS

Section 1. Disaster Plan:

(a) The Hospital plan for the care of mass casualties shall be rehearsed twice a year by key Hospital personnel, including Medical Staff members. Each member of the staff shall become familiar with the plan and shall be assigned and shall report to posts, either in the Hospital or elsewhere.

(b) The Chief of Staff and the President shall work as a team to coordinate activities and shall give directions. In cases of evacuation of patients from one section of the Hospital to another, or evacuation from the Hospital premises, the Chief of Staff or the President, or their respective designees, shall authorize the movement of patients.

Section 2. General Rules Regarding Medical Staff Affairs:

(a) Medical Staff members shall not discuss with any other individuals the transacted business or discussions that occur within the confines of any official Medical Staff meetings or meetings of its committees or departments.

(b) Medical Staff members shall not record or otherwise transcribe the proceedings of such meetings without the unanimous consent of all those in attendance.

(c) Written attendance records shall be maintained for all meetings of the Medical Staff, departments, and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee. Minutes of meetings shall reflect the educational programs and clinical reviews conducted at each meeting.

Section 3. Research Activities:

(a) Participation in research projects by Medical Staff members is encouraged. To ensure adequate compliance with any applicable laws, regulations or guidelines, Medical Staff members shall consult with and obtain the approval of the Institutional Review Board regarding any research projects in which they propose to participate.

(b) Policy considerations pertaining to medical and or scientific research projects of the Medical Staff shall be reviewed by the Institutional Review Board and by the President.

(c) The results of all research projects, clinical, statistical, or otherwise, and all publications written or provided by Medical Staff members using the name of the Hospital, must be submitted to the President for approval prior to any publication.

(d) Specific protocols shall be followed in the case of any pharmaceuticals to be used. Such protocols shall be submitted to the Pharmacy and Therapeutics Committee, and, when appropriate, to the Hospital's Institutional Review Board, for review and approval.

Section 4. Reporting Change of Address Phone Number:

The home address and phone number, office address and phone numbers, and on call residence and phone numbers of every member of the Medical Staff are to be on record in the Medical Staff Office of the Hospital. Changes to the above data are to be reported within fifteen (15) days.

Section 5. Definitions:

The definitions contained in the *Medical Staff Bylaws* and the Bylaws-Related Documents are hereby incorporated by reference and shall apply to these rules and regulations as well.

Section 6. Reporting Temporary Cessation of the Exercise of all Clinical Privileges

If a Medical Staff member wishes to temporarily cease the exercise of all of their clinical privileges, responsibilities, and prerogatives for more than 60 days, he/she must report this to the Medical Staff Office and request a leave of absence according to Section 3.F: PROCEDURE FOR LEAVE OF ABSENCE in the *Credentialing Procedures Manual*. Failure to do so will be considered a voluntary relinquishment of clinical privileges and medical staff membership.

ARTICLE IX
ADOPTION AND AMENDMENT

Section 1. Adoption:

Adoption of the *Rules and Regulations* shall require the identical procedure as that described for adoption of the *Bylaws* in Section 10.2-1 of the *Bylaws*. The *Rules and Regulations* shall become effective immediately upon approval of the Board.

Section 2. Amendment:

The *Rules and Regulations* shall be amended by a two-thirds majority vote of a quorum of the Medical Executive Committee present and eligible to vote at any regular or special meeting of the Medical Executive Committee. Amendments shall become effective immediately upon approval of the Board. The Medical Executive Committee shall be responsible for informing the Medical Staff of amendments to the *Rules and Regulations*

Section 3. Standards of Practice:

The *Rules and Regulations* shall set standards of practice that are to be required of each individual exercising clinical privileges in the Hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. The *Rules and Regulations* shall have the same force and effect as the *Medical Staff Bylaws* and the *Credentialing Procedures Manual*.

Section 4. Compliance with Health Care Quality Improvement Act:

It is the intent of the Medical Staff of Sarasota Memorial Hospital that these *Rules and Regulations* be in compliance with the provisions of the *Health Care Quality Improvement Act of 1986*, as amended (the "Act"). In the performance of peer review activities conducted on behalf of the Board, the Medical Staff and its committees shall be deemed to be conducting professional review activities, as defined in the Act, on behalf of the Board as a professional review body. Reporting of professional review actions shall be conducted in accordance with the Act and applicable state and federal law.

Amendment Process

- Vote by MEC
- Approved by Board
- Notify the Medical Staff