HELEN ELLIS MEMORIAL HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS

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1. ADMISSION AND DISCHARGE OF PATIENTS:

A. The Hospital shall accept patients for care and treatment except for the following medical/disease categories: acute psychotic conditions or psychological aberrations requiring specialized psychiatric treatment or Hospital facilities, and/or when the patient would be harmful to himself/herself, Hospital staff or others; and, such procedures limited by the qualifications of the staff or Hospital services, such as open heart surgery. When the Hospital does not provide the services required by a patient or a person seeking necessary medical care, the Hospital or the attending practitioner, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient.

B. A patient may be admitted to the Hospital only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital.

C. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the prompt completeness and accuracy of the medical record, for necessary special instructions, including patient/family/significant other education regarding healthcare and maintenance, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. The practitioner who receives the referral shall acknowledge the transfer by initialing the chart and shall be responsible for the care of that patient until the patient has been discharges from the Hospital. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

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

E. In any emergency case in which it appears the patient will have to be admitted to a Hospital, the practitioner shall, when possible, first contact the admitting office to ascertain whether there is an available bed.

F. Practitioners admitting emergency cases shall be prepared to justify that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart within 24 hours of admission.

G. A patient to be admitted on an emergency basis who does not have a private practitioner, may select ant practitioner in the applicable service to attend him/her. Where no such selection is made, a member of the active staff on duty in the service will be assigned to the patient, on a rotation basis, whenever possible. The chief of each service shall provide a schedule for such assignment or designee.

H. Each member of the staff who does not reside in the immediate vicinity shall name a member of the Medical Staff who is a resident in the area who may be called to attend his patients in an emergency, or until he arrives. In case of failure to name such an associate, the Administrator, President of the Medical Staff, or Department Chief concerned, shall have authority to call any member of the active staff in such an event.

A practitioner who will be unavailable for over 24 hours will provide coverage and indicate, in writing, on the order sheet of the chart of each of hi/her patients the name of the practitioner who will be assuming responsibility for the care of the patient during his/her absence. The practitioner is also required to inform his/her answering service and the Medical Staff Office.

I. The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical service and approved by the Executive Committee.

J. The House Manager will admit patients on the basis of the following order of priorities:

1. Emergency Admissions:
   Within 48 hours following an emergency admission, the attending practitioner shall furnish to the Executive Committee, a signed, sufficiently complete documentation of need for this admission. Failure to furnish this documentation upon request, or evidence of willful or continued misuse of this category of admission, will be subject to appropriate action by the Executive Committee.
2. Urgent Admissions:
   This category includes those so designated by the attending practitioner and shall be reviewed as necessary by the Department Chief to determine priority when all such admissions for a specific day are not possible.
3. Pre-Operative Admissions:
   This includes all patients already scheduled for surgery. If it is not possible to admit all such patients, the President of the Medical Staff or Department Chief may decide the urgency of the specific admission.
4. Routine Admission:
   This will include all elective admissions involving all services.

K. Patient Transfers:
Transfer priorities shall be as follows:

1. Emergency Room to appropriate patient bed
2. Critical Care Unit to general care area
3. Cardiac Care Unit to general area
4. From temporary placement in an inappropriate geographic or a clinical service area to the appropriate area for that patient

No patient will be transferred without such transfer being approved by the responsible practitioner.

L. The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patient might be a source of danger from any cause whatsoever.

M. For the protection of patients, medical, nursing and other Hospital staffs, patients with acute psychiatric problems, or suicidal patients, should not be admitted to the Hospital. If such patient must be admitted to the Hospital on an emergency basis, arrangements must be made to transfer the patient to another institution where suitable facilities are available. Transfer arrangements must be made by the attending physician within a reasonable period of time.

Patients who have been certified for involuntary psychiatric examination under the Baker Act (F.S.394.463) and are admitted for medical stabilization prior to transfer to a receiving facility must be transferred to such facility upon discharge from the Hospital. Orders to rescind a certification, or to discharge a patient to any other location, including to his/her home, may only be written by a psychiatrist.

N. Admission to Critical Care Units:
New orders must be written when a patient is admitted to Critical Care Units. Standing orders for physicians will not be placed in effect until the physician writes an order on the record to implement his or her standing orders. Unit orders will not be automatically continued when the patient is transferred out unless the physician writes an order to do so.

O. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay per disease categories, as defined by the Utilization Review Committee of this Hospital.

Upon request of the Utilization Review Committee, the attending practitioner must provide written justification as to the necessity for continued hospitalization of any patient hospitalized longer than the estimated or assigned length of stay per DRG category, including an estimate of the number of additional days of stay and the reason therefore. This report must be submitted within 24 hours of receipt of such request. A simple confirmation of the patient's diagnosis is not sufficient. Failure to comply with this policy will be brought to the attention of the Executive Committee for action.

Physicians who receive correspondence from the Professional Foundation for Health Care (PRO) will be required to respond within the specified time period designated by the PRO. Copies of correspondences will be sent to the Medical Records Department.

P. Patients shall be discharged only on a written order of attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

Q. It shall be the duty of all staff members to secure autopsies whenever appropriate as possible. An autopsy may be performed only with a legal consent, obtained in accordance with state law. All autopsies shall be performed by a pathologist delegated this responsibility. Provisional anatomic diagnosis shall be recorded in the medical record within three (3) days and the complete autopsy protocol should be made a part of the medical record within sixty (60) days. The following criteria have been developed to identify deaths in which permission for an autopsy should be actively sought:

1. Unexpected deaths, including the following circumstances:
   a. admission for elective surgical procedure;
   b. admission for trauma or acute medical condition where prognosis was considered favorable, or initial course indicated favorable response to therapy;
   c. admission for therapy of chronic condition where discharge was expected;

d. death during diagnostic or therapeutic procedures (if case waived by medical examiner). This includes all on table, post-op and delayed complication deaths.
e. Apparently natural, but unexpected and not subject to forensic medical jurisdiction.

2. Deaths where significant diagnostic uncertainties exist or where the cause of death is not clinically certain.
3. Deaths where family and/or public health concerns exist.
4. Deaths resulting from high-risk infections and contagious diseases.
5. Deaths of patients on clinical study protocols approved by Institutional Review Board (IRB).
6. All obstetrical deaths (both incident to pregnancy, and within 7 days following delivery).
7. All perinatal, neonatal and pediatric deaths.
8. Deaths where the illness may have a bearing on surviving family members or a transplant recipient.
9. Deaths from known or suspected environmental or occupational hazards.
10. Deaths that are natural that are subject to but waived by a forensic medical jurisdiction, such as persons dead on arrival, deaths occurring within 24 hours of admission, deaths where the patient sustained or apparently sustained an injury while hospitalized.
11. All deaths of psychiatric patients.
12. Deaths when cause of death is sufficiently obscure to delay completion of death certificate.

These criteria are meant to provide guidance to the Medical Staff, rather than a mandate that a request for autopsy be made in each of these cases. Medical Staff are advised to document in the medical record when an autopsy is requested of family, but not approved.

R. Isolation procedures to be followed for any patient requiring isolation shall be in accordance with CDC guidelines as outlined in Isolation Techniques for Use in Hospitals. The current edition will be the adopted standard for Helen Ellis Memorial Hospital. A patient may be isolated according to guidelines in this booklet by the Infection Control Nurse, the House Manager, or appropriate Department Chief, only after the attending physician has been notified of the procedures.

S. Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When Hospital personnel determine that no discharge planning referrals are necessary in a particular case, this conclusion shall be noted on the medical record of the patient. Discharge planning should include the following:

1. referral and transfer plans;
2. methods of follow-up care;
3. pertinent information to the patient or patient's family regarding the health care needs of the patient, the permissible level of activity, drugs, diet, or other forms of therapy;
4. sources of additional help; and
5. procedures to follow in the event that complications ensue.

Any individual who cannot legally consent to his or her own care shall be discharged to the custody of a parent, legal guardian, person standing in loco parentis, or another responsible party.

If the patient is transferred to another health care facility, the responsible appointee shall enter all the 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 stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

2. MEDICAL RECORDS

2.1 General

It is the policy of the Hospital to assure a uniform medical record which contains sufficient information to identify the patient, support the diagnosis, justify the treatment, and document the course of treatment. Medical records shall be confidential, secure, authenticated, legible and complete.

2.2 Authorized Entries

Only individuals who have been approved by the Interdisciplinary Practice Council and Medical Executive Committee are authorized to make entries into the medical record. These individuals are Medical Staff members and licensed non-physician practitioners who contribute to the direct care of the patient. The attending physician shall be responsible for the preparation of a complete medical record. All medical record entries should include date and time.

2.3 Content Requirements – General Documentation

A. Patient Identification Data

B. History and Physical

1. Chief Complaint
2. History of Present Illness
3. Relevant past, social and family, psychosocial ,histories appropriate to the age of the patient (including current type and dosage of medication and allergies)
4. Inventory of body systems
5. Pediatric records should contain an evaluation of the child's developmental age; consideration of educational needs and daily activities as appropriate; immunization status; and the family's expectations for and involvement in the assessment, treatment and continuous care of the patient.
6. Physical Examination – A current physical examination shall include pertinent normal and abnormal findings covering each body system, with particular attention to the system or systems necessitating admission.
7. Impression
8. Treatment Plan

The H&P examination must be recorded in the record within 24 hours after admission unless surgery is to be performed in less than 24 hours, in which case the H&P must be recorded and included in the medical record prior to surgery, except in emergency situations.

If an H&P exam is performed thirty (30) days prior to admission and there is a change in patient condition during this interval, the changes must be recorded as the first Physician Progress Note. H & P can be provided by a non-staff physician as long as the H&P meets the time frame of not more than 30 days prior to the procedure, and a review and update has been provided. The Pre-Anesthesia evaluation performed by the Anesthesiologist may be used as an update to the attending physician's H & P examination.

1. If the H&P is not documented on the medical records of patients undergoing surgical procedures or potentially hazardous diagnostic procedures, the procedure will be cancelled.
2. Obstetrical records shall include a complete prenatal record provided by the attending physician. A durable, legible copy from the physician's office may be used provided any changes are recorded at the time of admission. In the event of surgery, an appropriate pre-operative note shall be recorded giving indications for surgery.

2.4 Operative Reports

Operative reports for inpatients and outpatients, including invasive procedures, must be hand written or dictated immediately after the procedure describing the findings, the technical procedures used, the specimen(s) removed, the pre- and post- operative diagnosis, type of anesthesia, estimated blood loss and the name of the primary physician and any assistants.

The completed operative report written or dictated is authenticated by the physician and filed in the medical record as soon as possible after the procedure. When the operative report is not in the medical record immediately after surgery, an operative progress note is entered in the medical record to provide pertinent information for any individual requiring to attend to the patient. All procedures requiring anesthesia will require a dictated operative report.

2.5 Progress Notes

Progress notes are required daily by the attending physician. These notes should reflect clinical observations, changes in condition, explanation for and results of tests, treatment, and family/patient wishes sufficient to permit continuity of care. Abnormal values and the rationale for the medical management should be fully explained.

2.6 Consultation Reports

The requesting physician will document/specify in the medical record for the consultation.

A written or dictated consultation report must be included in the medical record. The report must include the consultant's clinical impression, findings upon examination of the patient, and the consultant's recommendations. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

When operative or invasive diagnostic procedures are involved, the consultation note shall, except in emergency situations, be recorded prior to the procedure.

2.7 Discharge Summary

A discharge summary or clinical resume shall be placed on the chart within 30 days from discharge. The discharge summary must be authenticated by the attending

physician. The summary should concisely state the reason for hospitalization, the significant findings, procedures performed and treatment rendered, the patient's condition at discharge, and any specific instructions given to the patient and/or family, including the physical activity, diet, medications and dosage.

A discharge summary is required for all inpatients with a hospitalization greater than 48hours and all patients who have a Caesarean Section or who have expired. A final progress note may be substituted for only those inpatients with problems and interventions of a minor nature who require less than a 48 hour period of hospitalization.Such as, newborn infants, and normal, uncomplicated deliveries.

Final diagnoses shall be rendered in full as part of the discharge summary or final progress note signed and dated by the physician. It should also include the reason for admission, procedures, treatment, findings, conclusion and instructions.

2.8 Doctor's Orders/Verbal Orders

Diagnostic and therapeutic orders are written by members of the Medical Staff and non-physician practitioners who contribute to the direct care of patients at the direction of the physician. All orders for treatment shall be documented. All orders for treatment shall be written legibly. Orders which are not legible so as to be understood without reasonable question will not be carried out until the physician is contacted for clarification.

If the care is transferred from one physician to another, the transferring physician shall write an order to this effect. Copies of approved standing orders are acceptable if signed and dated by the attending physician.

Verbal orders from a physician may be taken by a registered nurse or authorized LPN. Authorized respiratory therapists, pharmacists, dieticians, physical therapist occupational therapies or case managers may receive verbal orders regarding treatment orders related to their area of expertise. Orders dictated shall be signed and dated by the person recording the order with the name of the physician.

For patient safety and to avoid miscommunication the use of verbal / telephone orders should be avoided except when medically necessary. When used, verbal/telephone orders should be signed as soon as possible but no later than 48 hours by the practitioner caring for the patient.

Verbal and telephone orders related to restraints are considered high risk, therefore, will be authenticated (date/signature) within 24 hours.

The physician shall immediately countersign or authenticate any orders or progress notes written by a medical assistant in the physician's employ, who has been properly credentialed and approved for privileges. Nursing personnel will not carry out such orders unless they have been authenticated in writing by the attending physician, or confirmed verbally by the attending physician if authentication is found to be missing.

DNR Orders shall be written and signed by the responsible attending physician before they can be implemented by Hospital personnel. Verbal DNR Orders will not be accepted unless witnessed by two registered nurses.

2.9 Release of Medical Information

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

2.10 Other Documentation

A. Organ Donors

Documentation in medical records involving organ or tissue donation shall be in accordance with the Hospital's policy and procedure.

B. Rubber-Stamp Signatures and Authentication

Rubber stamp signatures and auto-authentication, are permitted within the Health Information Management guidelines. Policy HIM 2.12.

2.11 Attending Physician Responsibility

A. All patients shall be admitted to an attending physician who is ultimately responsible for the medical care.

B. The H&P and Discharge Summary should be reviewed by the attending physician and signed by the dictating physician or if appropriate, their representative.

C. An attending physician should make daily rounds on each patient or by individually rounding and recording a signed note in the chart.

2.12 Confidentiality and Removal of Records

Medical records are the property of the Hospital. All medical records shall remain confidential as outlined in the Hospital's policy and procedure. Original medical records shall leave the Hospital campus only pursuant to a court order, subpoena, or as authorized by the Federal or State statute. Unauthorized removal of patient records is grounds for corrective action.

Inpatient medical records will be maintained on the corresponding nursing unit while the patient is hospitalized. The medical record will accompany the patient to all clinical sites. The record may temporarily be removed for photocopying purposes to facilitate continuity of patient care.

Physicians will be provided a copy of their dictation according to Hospital's distribution practice.

2.13 Timely Completion of Medical Records

1. Medical records must be completed within 30 days of the patient's discharge.

2. A single signature on the face of the record shall not suffice to authenticate the entire record.

3. No practitioner, for the sake of completing a record, shall complete a medical record on a patient in whose case he/she has not participated.

4. Delinquent Records and Suspension

   a. The Medical Records Department will notify the Medical Staff on a bi-weekly basis of incomplete / delinquent components of the record.

b. Physicians will have seven (7) days from written suspension notification to complete the records. Failure to complete records at the end of seven (7) days will result in automatic suspension of privileges.
c. Suspension of privileges includes loss of admitting privileges, ability to schedule surgery and/or render consultations. Copies of suspension list/letters will be sent to Administration, Admitting, Central Scheduling, Emergency Services, Nursing and Surgery. Three consecutive weeks on suspension will result in an appearance before the MedicalExecutive Committee for an explanation of record completion practices.
d. A suspended physician may continue to treat patients currently in-house and perform surgery on in-house patients.
e. An admitting physician or service may not assign or transfer care to a suspended physician until such physician is removed from suspension.
f. The Medical Records Department will notify all appropriate departments after chart completion that the physician has been removed from suspension and privileges reinstated.
g. If a physician is placed on suspension four (4) times in a calendar year, he/she will appear before the Medical Executive Committee as disciplinary actions including termination may be implemented. Reports of delinquent record practices are included in the physician's credentialing and reappointment process.
h. Physicians anticipating extended time away (vacation, CME, sabbatical, illness, disability, etc.) will not be placed on suspension, provided the Medical Records Department has been notified of the anticipated duration of the leave. Upon return, incomplete or delinquent records will be completed within seven (7) days.

2.14 The incomplete medical record(s) of physicians who have left the Medical Staff and cannot be accessed by mail or phone, and those of deceased physicians, may be declared closed with approval of the Interdisciplinary Practice Council.

3. GENERAL CONDUCT OF CARE

3.1 General Consent Form

A General Consent for Treatment signed by or on behalf of every patient admitted to the Hospital, must be obtained at the time of admission, except in emergency situations. It is the practitioner's responsibility to obtain informed consent before the patient is treated. Refer to Section on Informed Consent.

3.2 Medical Treatment of Minors

Medical treatment of minors without parental consent should be accomplished according to current Florida Statutes.

A. Obtaining Consent
Reasonable effort to identify the minor and obtain consent must be made.
B. Documentation – Rendering Care Without Consent
The record must reflect the reason for rendering care without consent.

3.3 Treatment of Minors – Special Medical Conditions

Treatment of minors for medical conditions professed to be infectious, contagious, communicable, or for the purposes of obtaining rehabilitative or medical treatment for drug abuse or dependency may be provided on the minor's consent and shall not be

subject to later disaffirmation by reason of minority (Ref. Florida Statues 384.061 and 397.099)

3.4 Orders For Treatment

All orders for treatment shall be in writing, dated and authenticated by the physician. A verbal order shall be considered to be in writing if dictated to a duly authorized or privileged person (i.e., RN, pharmacist, respiratory therapist) functioning within that person's sphere of competence and authenticated by the responsible practitioner.

The physician's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "Renew", "Repeat", or "Continue" Orders is not acceptable.

3.5 Cancellation of Previous Orders For Patients Going to Surgery

All previous orders, including standing drug orders, are canceled when patients go to surgery with the exception of local anesthetic given for an Endoscopy. In these cases, it is permissible for the physician to write an order to resume pre-op orders.

3.6 Medication Administration

All drugs and medications administered to patients shall be those listed in the latest edition of United States Pharmacopeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluations.

3.7 Investigational Drugs

Drugs for bonia fide clinical investigations may be exempt. Following approval by the Hospital Institutional Review Board, these medications shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

3.8 Application of Automatic Stop Orders If Not Reordered By Physician

Automatic stop orders shall apply unless reordered by a staff member:

A. Narcotics, Hypnotics, Sedatives and Anticoagulants
   After five (5) days on all standing orders for narcotics, hypnotics, sedatives, and anticoagulants.

B. Antibiotics
   After seven (7) days on all standing orders for antibiotics.

C. Medication Orders
   After thirty (30) days on all medication orders.

3.9 Patient's Own Medications

A patient's own medications that are brought to the Hospital cannot be administered unless the drugs have been identified by a pharmacist in accordance with hospital policy, and the attending physician has written an order allowing the patient to use his/her own medications. Self administration of medication is prohibited.

3.10 Standing Orders for Medications

All medication orders shall clearly state the administration times of the time interval between doses. Physician's Standing Orders may not include pre-printed dosages for narcotics, sedatives, tranquilizers or hypnotics. Specific dosages for these items must be handwritten by the physician.

3.11 Disaster Plan – Physician Function

In the event of disaster situation, members of the Medical Staff shall function as prescribed by the Disaster Plan of the Hospital.

3.12 Physician Employees – Allied Health Personnel

Personnel who are the employees of individual physicians (or groups) shall be subject to the standards of conduct and policies established by the Hospital.

3.13 Hospital Patient restraint Policy

Organizational restraint policy defines the mechanism for ensuring patient safety by defining interdisciplinary responsibilities in the restraint of patients.

3.14 Moderate Sedation

Moderate sedation privileges will be credentialed at the time of appointment and competency will be reviewed at the time of reappointment. Criteria developed by the Medical Staff must be met to obtain and maintain these privileges.

3.15 Consultations

A. Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise. Consultation by 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, the Chief Executive Officer, the President of the Medical Staff or the appropriate department chairperson shall at all times have the right to call in a consultant or consultants.

B. Except in an emergency, consultation is required in the following situation: (local option)
   a. When the patient is not a good risk for operation or treatment;
   b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed;
   c. Where there is doubt as to the choice of therapeutic measures to be utilized;
   d. In unusually complicated situations where specific skills of other practitioners may be needed;
   e. In instances in which the patient exhibits severe psychiatric symptoms;
   f. When requested by the patient of his/her family.

C. The attending practitioner is primarily responsible for requesting consultations when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending practitioner to attend or examine his/her patient in an emergency.

D. For routine consults, the consulting physician must see the patient within 24 hours. The attending physician should call the consultant if he/she wants the consult to occur sooner.

   For "stat" consults, the consulting physician must see the patient within 6 hours. The attending physician is encouraged to contact the consultant directly.

E. If a nurse has any reason to doubt or question the care provided to any patient, or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of his/her superior who, in turn, may refer the matter to the Administrative Director of Nursing Services. If warranted, this

Administrative Director may bring the matter to the attention of the Department Chief in which the practitioner has clinical privileges. When circumstances are such as to justify such action, the Chief may request a consultation.

F. Psychiatric or psychological consultation and treatment shall be offered to all patients who have attempted suicide or who have taken a chemical overdose.

3.17 Miscellaneous

A. Each patient must be visited at least once daily by the attending physician or by a physician designated by the attending physician.

B. Rebuking or censoring a nurse or other employee in the presence of a patient or a visitor is prohibited.

C. Any complaints against the management or conduct of the Hospital, including complaints against the Chief Executive Officer, the nurses, the Board and other employees of the Hospital and Medical Staff shall be filed with the Medical Executive Committee and shall not be discussed elsewhere.

D. It shall be the responsibility of each practitioner on the Medical Staff to report, in writing, to the President of the Medical Staff or the Chief Executive Officer any conduct, act or omission by Medical Staff members, in good conscience, which is believed to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violates professional ethics.

4. GENERAL RULES REGARDING SURGICAL CARE

A. Recommendations for specific privileges within general surgery, or the surgical subspecialties, is the responsibility of the Credentials Committee and the Executive Committee, and shall be based, in part, on demonstrated experience and specific types of procedures performed. All final decisions regarding the granting or denying of clinical privileges shall be made by the Governing Board of the Hospital.

~~B.~~ Privileges in general surgery and/or all surgical subspecialties, shall be limited to board qualified and/or board certified specialists. The restriction shall apply to all procedures performed in surgical suites, and to all procedures performed anywhere in the Hospital. If a practitioner attempts to schedule an operative procedure for which he/she has not been granted privileges, the surgery supervisor shall inform the practitioner of this fact and immediately notify the Chief of Department of Surgery and Chief Executive Officer.

C. The history and physical examination must be recorded in the patient's medical record prior to the performance of a surgical procedure. (Except in severe emergencies, the pre-operative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure.) If not recorded, the operation shall be canceled. In any emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to the induction of anesthesia and start of surgery. H & P can be provided by a non-staff physician as long as the H&P meets the time frame of not more than 30 days prior to the procedure, and a review and update has been provided. The Pre-Anesthesia evaluation performed by the Anesthesiologist may be used as an update to the attending physician's H & P examination.

D. A patient admitted for dental care is a dual responsibility involving the dentist and a physician member of the Medical Staff.

1. Dentist's Responsibilities

a. A detailed dental history justifying the Hospital admission;

b. A detailed description of the examination of the oral cavity and a pre-operative diagnosis;

c. A complete operative report, describing the finding and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the Hospital pathologist for examination;
d. Progress notes as are pertinent to the oral condition;
e. Clinical resume (or oral summary statement).

2. Physician's Responsibilities
   a. Medical history pertinent to the patient's general health;
   b. A physical examination to determine the patient's condition prior to anesthesia and surgery;
   c. Supervision of the patient's general health status while hospitalized.

3. The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

E. A patient admitted for podiatry care is a dual responsibility involving the podiatrist and a physician member of the Medical Staff. The attending physician must be notified prior to the admission and must concur with the admission. The patient is admitted by the attending physician and discharged when both the podiatrist and physician concur. The practice of podiatry shall be limited to podiatry, which is limited to examination, diagnosis, treatment and care of conditions and functions of the human foot, within the confines noted below and privileges approved by the Medical Staff and Board.

1. Podiatrist's Responsibilities
   a. A detailed podiatric history justifying Hospital admission;
   b. A detailed podiatric physical examination and a pre-operative diagnosis;
   c. A complete operative report describing the finding and technique. All tissue and fragments shall be sent to the Hospital pathologist for examination;
   d. Progress notes as are pertinent to the condition;
   e. Clinical resume or summary statement.
2. Physician's Responsibilities
   a. Medical history pertinent to the patient's general health;
   b. A physical examination to determine the patient's condition prior to anesthesia and surgery;
   c. Supervision of the patient's health status while hospitalized.
3. The discharge of the patient shall be on written order when both the podiatrist and physician member of the Medical Staff concur.
4. Podiatric outpatients also shall have a documented adequate medical history and physical examination before outpatient procedures are to be done.
5. Podiatric medical or surgical procedures are to be limited to those privileges delineated by the applicant, and approved by the Surgery Department, Medical Staff and Board.

F. Written, signed, informed surgical consent shall be obtained and made a part of the patient's medical record prior to any operative or medical diagnostic procedure, including, but not limited to:

1. Major or minor surgery which involves the entry into a body, either through an incision or through one of the natural body openings;
2. Any procedures in which anesthesia is used, whether an entry into the body is involved or not;
3. All non-operative procedures which involves more than a slight risk of harm to the patient, or which involves the risk of a change in the patient's body structure or permanent scars. It includes, but is not limited to:

Bronchoscopy	Spinal Tap	Intravenous Urogram
Colonscopy	CAT Scan	Proctoscopy with Biopsy
Gastroscopy	Bone Marrow Biopsy	Esophagoscopy
Stress Test	Subclavian Catheter	

4. All other diagnostic procedures which the Medical Staff determines require a specific explanation to the patient. Any doubt as to the necessity of obtaining a special consent of the patient for a procedure should be resolved in favor of procuring the consent.

   The only exception to the written consent requirement of this section will be those situations where the patient's life or health is in immediate jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery or medical procedure cannot be immediately obtained from patients, guardians, or next of kin, these circumstances should be fully explained in the patient's medical record. A consultation in such instances is desirable before the emergency operative or medical procedure is undertaken, if time permits. In the case of an emergency, the consent of a patient is implied.

   A member of the Anesthesia Department will perform a pre-anesthesia evaluation. The pre-anesthesia evaluation must include appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated. This evaluation must include the patient's previous drug history, other anesthetic experience and any potential anesthetic problem. During the pre-operative assessment the anesthesiologist shall obtain informed consent for the administration of anesthesia as noted on the written surgical consent.

   The anesthesia provider shall review the patient's condition immediately prior to induction of anesthesia and shall check equipment, drugs and gas supply.

5. Safety management and identification procedures are followed to enhance patient safety. Comprehensive interdisciplinary surgical and invasive procedure identification and safety management guidelines, as outlined in Universal Protocol – Surgical Site Identification Surgical Services MOR Policy # 2021, are followed. Specifically, before a procedure begins, the patient's identification, operative site and surgical procedure are re-verified.

G. Anesthesia provider(s) shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The anesthesia record should also include a description of events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or body products, the technique(s) used, unusual events during the anesthesia period, and the status of the patient at the conclusion of anesthesia.

H. All tissues and other objects removed during a surgical procedure, as identified for examination in the Gross Only Specimens Medical Staff policy, shall be properly labeled, packaged in preservative as designated, and identified as to whom is authorized to carry out all orders which will ensure optimum technical procedures. This specimen must be accompanied by pertinent clinical information, including its source and the pre-operative and post-operative surgical diagnosis. The pathologist's authenticated report shall be made a part of the patient's medical record.

I. No observer may be present in the operating room unless written permission is obtained from the patient. Verbal permission also is required from the operating room supervisor and attending physician or surgeon.

~~J.~~ An electrocardiogram shall be required pre-operatively for any patient receiving a an anesthetic, where there is a high risk involved. This applies to any patient over age 50. The electrocardiogram shall have been performed within of one year the date of admission.

~~K.~~ For any outpatient surgical procedure requiring the services of an anesthesiologist, the surgeon shall follow established Hospital policy and procedures.

L. All laparoscopic procedures will be performed in the surgery department.

M. All surgery patients, including locals, must receive instructions to take their cardiac medication pre-operatively, in the usual dosage and fashion. Failure to do so could result in the cancellation of the surgery for the day.

~~N.~~ Instruments should be counted on all procedures in which the likelihood exists that an instrument could be retained.

O. A surgical assistant or scrub nurse employed by a surgeon will be permitted to assist in the surgical suite, provided that prior approval has been received from the Credentials Committee, subject to approval of the Medical Executive Committee and Board. Such approval must follow the procedures established in the Medical Staff Bylaws. The surgeon assumes liability for all actions of this person and must provide assurance that the surgical assistant has received training and can demonstrate a knowledge of the sterile scrub procedure and sterile technique. The surgical assistant or scrub nurse will not be permitted to perform any duties that are considered within the realm of the surgeon or registered nurse.

P. Anesthesiology will be considered as having primary responsibility for patient care in the Recovery Rooms.

Q. General rules regarding surgical care will apply to all surgical areas.

5. SCHEDULING OF SURGICAL CASES

~~A.~~ Elective Surgery: Elective cases are scheduled through Central Scheduling. Surgeons will coordinate add-on elective cases with the OR Control Desk during regular hours (before 3:00p.m.). After 3:00 p.m., cases to be done in the next 24-48 hours may be added by calling the House Manager.

B. Urgent Cases: Cases which need to be done within the next 24 hours will be scheduled by the attending surgeon, who will notify the anesthesiologist of the planned surgery and the time of day that he/she and the patient would be ready for surgery. The surgery will be performed at this designated time unless medical evaluation by the anesthesiologist dictates otherwise.

C. Emergency Cases: These will be done as soon as possible when deemed necessary by attending surgeon.

D. All elective surgery on in-house patients will be scheduled for surgery by the attending physician so that elective cases will try to end by 5:00 p.m.

E. All conflicts and abuses of surgical scheduling should be brought to the attention of the Chief of Surgery.

F. The presence of all members of the operating team in scrub suits and the patient in the operating room is required at the scheduled time for surgery. The operating surgeon must be named when the case is scheduled and is responsible for the surgical care of the patient before, during, and after the operation. All members of the surgical team shall make every effort to start the case on time. The first case start time will be monitored regularly. All unexplained delays for the day will be reviewed by the OR

Director. Chronic offenders shall be subject to appropriate disciplinary action as determined by the Chief of Surgery. In no case, shall general anesthesia be started until the surgeon is present in the Hospital. Operating time will be released promptly when a case is canceled or the patient and surgical team are not available on schedule.

G. Planned procedures must be identified on the schedule with the patient's name, age, diagnosis and procedure to be performed. Unrelated elective procedures may not be added to a case after it is posted if other cases are already posted to follow. The case will be done as originally posted, or rescheduled. Cases requiring frozen sections should be posted as such at the time the case is scheduled. Infectious cases must be posted at the end of the operating room schedule or as otherwise authorized by the Operating Room Director or the Director's designee.

6. EMERGENCY SERVICES

6.1 Qualifications for Emergency Care Physicians

Emergency medical services shall be provided by qualified physicians who are licensed to practice in the State of Florida and who are members of the Medical Staff.

6.2 Requirements for Registering Emergency Department Patients

All patients presenting themselves to the Emergency Department for treatment shall be registered.

6.3 Requirements for Emergency Department Patients to Provide Private Physician's Name

All patients presenting themselves to the Emergency Department for treatment shall be requested to furnish the name of their private physician who can be contacted by the Emergency Department or attending physician.

6.4 Requirements for Emergency Department Medical Record

A medical record shall be kept for every patient receiving emergency services. The record shall include:

1. Adequate patient identification (name, age, sex are minimum requirements);
2. Patient's arrival including date, time, means of arrival, and by whom transported;
3. Pertinent history of the injury/illness including details relative to first aid or emergency care given to the patient prior to arrival at the Emergency Department;
4. Description of significant clinical, laboratory and radiology findings;
   a. Diagnosis;
   b. Treatment provided;
   c. Condition of patient at time of discharge or transfer; and
   d. Final disposition including time of discharge/transfer; instructions to patient and/or family necessary for continuing or follow-up care.

Each patient's emergency record shall be signed by the Emergency Department physician in attendance, who is responsible for its clinical accuracy, and incorporated into the patient's Hospital medical record.

6.5 Requirements for Emergency Department Control Register

A control register identifying all persons seeking emergency services must be established. The control register must be continuously maintained and shall include at least the following:

1. Identification to include patient name, age and sex;
2. Date, time and means of arrival;
3. Nature of complaint;
4. Disposition; and
5. Time of departure.

6.6 Emergency Department Criteria for Seeing Private Patients

Physicians may see private cases in the Emergency Department insofar as they do not interfere with the routine of the Emergency Department. These patients will be registered and charged in accordance with current Hospital policy.

6.7 Emergency Department Criteria for Evaluation and Treatment of Private Patients

Physicians referring private cases to the Emergency Department for evaluation and treatment should notify the Emergency Department physician prior to the arrival of the patient. The Emergency Department is not to be used as a holding unit for private patients requiring direct admission or routine care and treatment.

6.8 Criteria for Referral of Patients for Follow-up Care

All patients treated in the Emergency Department should be referred to their private physician for follow-up care or to the appropriate specialist. If a private physician is unavailable, referral to the appropriate specialist on-call be initiated, unless the patient is treated definitively by the Emergency Department physician.

6.9 Assignment of On-Call Coverage

Physicians appointed to the active staff shall be assigned on call responsibility in their specialty/subspecialty based on the organization's need for on-call coverage.

6.10 Exemption from On-Call Coverage

Physicians with more than 10 consecutive years of Emergency Department coverage at Helen Ellis Memorial Hospital may be considered for exemption from Emergency Department call. Requests for exemption must be in writing to the appropriate Department Chief and the Chief Executive Officer. Requests will be considered so long as adequate coverage by the appropriate specialty/subspecialty will still be provided to the Emergency Department.

6.11 Responsibility for On-Call Physician to Provide Replacement Coverage

It shall be the responsibility of the physician on-call to provide replacement coverage in the event he/she is unavailable on the scheduled call date. The physician shall notify the Medical Staff Office in a timely manner of the change in on-call coverage to assure this change is distributed to all affected departments.

6.12 On-Call Physician Responsibility for Providing Emergent/Urgent Care

It shall be the responsibility of the on-call physician, if contacted by the Emergency Department physician during the on-call period, or if requested by the patient, to provide follow-up care for the patient's emergency problem in the specialty for which he/she is covering.

6.13 On-Call Physician Responsibility for Providing Follow-up Care Following Release From the Emergency Department

Follow-up care for patients who have been treated and released from the Emergency Department will be rendered at the on-call specialist's office. The optimal time frame in which this follow-up visit occurs is to be determined by the treating physician and documented in the medical record. The treating physician will inform the on-call specialist of the referral. The on-call specialist is obligated to see the patient, without consideration of pay or status, for at least one follow-up visit.

6.14 On-Call Physician Responsibility for Answering Calls Promptly

It shall be the responsibility of the on-call physician to respond by telephone promptly. An emergency call should be answered within 15 minutes; a routine call within one (1) hour. If a call is not answered promptly, the concern will be referred to the appropriate Department Chief for review and, if necessary, the chain of command, as outlined in the Medical Staff Rules and Regulations, will be followed. A physician to physician contact will determine if immediate treatment/visit is required, or if the patient is to be scheduled following discharge from the Emergency Department for one follow-up visit. On call physicians are required to come to the Emergency Department when immediate examination or care is needed as determined by the ED physician.

6.15 Procedures Not to be Performed in the Emergency Department

Except under extenuating circumstances, the following procedures shall not be performed in the Emergency Department:

1. Suction abortion;
2. Elective cardioversion;
3. Elective minor surgical procedures at the discretion of the Emergency Department physician;
4. General anesthesia, major regional block;
5. Endoscopic procedures;
6. Repair of major wounds, tendon and ligament injuries
7. Orthopaedic: open reductions requiring general anesthesia.

6.16 Emergency Department Role/Responsibility in Disaster Preparedness

There shall be a plan for the care of mass casualties at the time of any major disaster, based on the Hospital's capabilities in conjunction with other emergency facilities in the community. The Emergency Department Medical Director, President of the Medical Staff and Chief Executive Officer will work as a team to coordinate activities and directions. The disaster plan is rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. Refer to Helen Ellis Memorial Hospital Bylaws – Disaster Plan.

7. CRITICAL CARE UNITS

A. The critical care units have been designed to provide highly specialized medical/nursing care to critically ill or potentially ill patients. Appropriate policies and procedures for admission, treatment and discharge of patients shall be developed by the Medical Staff and nursing staff.

B. A Medical Director of the critical care units will be appointed bi-annually by the Medical Executive Committee. The appointment of the Medical Director for critical care units shall be approved by the Board.

C. The Medical Director is delegated the authority to make final decisions based on patient assessment regarding the admission or discharge of a patient from the unit in accordance with established policies, and InterQual guidelines, and will be subject to later review by the Critical Care Committee. The attending physician will always be notified of any transfer prior to it being implemented.

D. The Critical Care Committee is delegated the responsibility of reviewing operation of the units and forwarding of recommendations for improvements to both the medical and nursing staffs and Administration. The Committee is scheduled to meet twelve (12) times each year and will consist of physicians, nursing and administration.

E. The attending physician is responsible for his/her patient. It is expected that the attending physician will request consultation with a specialist in the following circumstances:

1. Cardiology Consult
   a. For any patient with confirmed or suspected AMI
   b. For any patient requiring cardiac cath and/or angioplasty
2. Pulmonary Consult
   a. For any patient requiring ventilator support for one (1) day or more
3. Neurology or Neurosurgeon Consult
   a. For any patient with unexplained coma lasting more than 24 hours
   b. For any patient with an intra-cerebral bleed, progressive neurological decline or intractible seizures
4. Surgery/Cardiology Consult
   a. For any patient requiring a permanent pacemaker
   b. For any patient who is a candidate for a surgical procedure
5. Nephrology Consult
   a. For any patient requiring dialysis
6. Gastroenterology Consult
   a. For any patient with GI bleed requiring transfusion
7. Other Critical Care Consult
   a. For any patient with central line monitoring (e.g., Swan-Ganz, CVP, arterial lines)

F. The consulting physician, upon notification, must see the patient within six (6) hours for an emergent consult and within twenty-four (24) hours for a non-emergent consult. Such a request, however, does not alleviate the attending physician of his/her responsibility for care of the patient.

G. Transfer of care and responsibility must be arranged by the primary physician and is accomplished only after the consultant agrees to assume care. Details of the transfer, with time and date, must appear on the order sheet and progress notes and appropriate transfer forms.

H. Patients who require admission to special care units must be seen by the attending physician within six (6) hours of notification.

I. The attending physician is expected to evaluate his/her patient daily and to order transfer from the unit as soon as it is warranted. Upon transfer, a new set of orders must be written by the attending physician or an order must be written to continue the existing orders. Progress notes should be written, dated and signed each day.

8. CLINICAL SERVICES

Each service is expected, within its collegial framework, to adopt various procedural rules that fits its local needs. Essential organizational commitments dictate that these must include rules to implement the credentials function and the ongoing medical care evaluation activities of the Medical Staff.

9. INFORMED CONSENT

A. Responsibility for Obtaining Informed Consent

1. After admission, it shall be the responsibility of the attending appointees to obtain consents from patients in the following circumstances:
   - 1.1 the surgeon shall obtain the patient's consent to any surgical procedure to be undertaken, including ambulatory surgery;
   - 1.2 the appointee performing a non-routine or high risk medical procedure shall obtain the patient's consent;
   - 1.3 the anesthesiologist or anesthetist shall obtain the patient's informed consent prior to the administration of anesthesia.
2. Except in emergencies, a failure to include a completed consent form in the patient's medical record prior to the performance of the procedure shall automatically cancel the procedure.
3. Whenever the patient's condition prevents the obtaining of a consent, every effort shall be made, and documented, to obtain the consent of the patient's representative prior to the procedure. Any emergencies involving a minor or otherwise incompetent patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin should be fully explained on the patient's medical record. If possible, a consultation shall be obtained before any operative procedures is undertaken.
4. Should a second operation be required during the patient's stay in the Hospital, a second consent shall be obtained. If two or more specific procedures are to be done at the same time and this is known in advance, they may all be described and consented to on the same form.
5. The responsible physician or his or her designee must discuss and document the outcome of any treatments or procedures to the patient or, when appropriate, the guardian or surrogate, and family, whenever those outcomes differ significantly from the anticipated outcome(s).

B. Definitions

The following definitions shall be applied when obtaining consent to treatment in the Hospital.

1. Informed Consent – Consent obtained from the patient or the patient's representative after being informed by the attending appointee of the general nature of the procedure, the alternatives to it, and the substantial risks and hazards associated with the procedure.
2. Emergency – A situation, when, in competent medical judgement, 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.
3. Emancipated Minor – An individual under the age of 18 who professes to have been infected with, or exposed, or contagious with a communicable disease, or who seeks care relating to pregnancy.

C. Who May Consent

1. A competent adult or emancipated minor may authorize any medical or surgical procedure to be performed upon his or her body, and the consent of no other person will be required or will be valid. Emancipated minors can consent to procedures on themselves and on their children.
2. Written consent shall be obtained from the parents or legal guardian of a minor before any surgical or medical procedure is performed on the minor, except in the following cases in which minors may consent for their own care:

a. emergencies;
b. minors seeking treatment for infectious, contagious or communicable diseases;
c. minors seeking treatment for drug abuse or dependency; or
d. pregnant minors seeking care related to their pregnancy.

3. An unwed minor mother may consent to medical or surgical services for her child.
4. Written consent shall also be obtained in all non-emergency situations from the legal representative of any incompetent adult before any surgical or medical procedure is performed.

D. 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 guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the particular patient involved, the consent of the person's next of kin shall be obtained.

E. Unusual Cases

Where questions arise regarding patient consent or unusual circumstances occur not clearly covered by these rules and regulations, the attending appointee shall promptly confer with Hospital management concerning such matters. The Hospital will make every effort to assist the attending appointee in obtaining the required consent and providing information relative to such matters. However, it is the ultimate responsibility of the attending appointee to comply with the requirements contained in these rules and regulations.

F. Sterilization and Abortion

1. Sterilization – No consent other than from the patient will be accepted for a surgical procedure resulting in sterilization. Before consenting to a sterilization procedure, the patient must be informed and understand that the restoration of fertility is unlikely.
2. Abortion – Any competent pregnant woman may authorize an abortion to be performed and the consent of no other person is required. A written consent must be obtained and placed in the medical record before an abortion can be performed. If the pregnant woman is mentally incompetent, the informed consent of a legal guardian shall be obtained.

10. M.D. AND D.O. SURGICAL ASSISTANTS CRITERIA

Physician privileges to assist in surgery at Helen Ellis Memorial Hospital are limited to those physicians or conditions herein:

A. Any qualified surgeon, from any surgical specialty, may assist another surgeon in the operating room.
B. Physicians having subspecialties, other than surgery, may assist where such subspecialty expertise is required (i.e., gastroenterology, pulmonary medicine, etc.).
C. Any physician with a minimum of six (6) months training in surgery obtained as a part of a qualified residency. Operating room experience during residency training is required.
D. Any physician with five (5) years experience assisting in surgery at Helen Ellis Memorial Hospital or any other Hospital found acceptable by the Medical Executive Committee.

E. In emergency cases where the customary surgical assistants are not available or cannot be provided, any M.D. or D.O. may assist.

F. It shall always be the right and decision of the patient's surgeon to select, approve or disapprove of the surgical assistant based upon his knowledge of the assistant's skill and ability so long as the physician surgical assistant meets the criteria herein.

G. Physicians with five (5) years or more experience in surgical assisting at Helen Ellis Memorial hospital, who do not meet the above criteria will be placed on probationary period for six (6) months during which time all assists at surgery will be critiqued and reviewed by the attending surgeon. Review forms will be completed by the attending surgeon in critique of the physician surgical assistant's ability during surgery.

11. OBSTETRICAL AND NEWBORN NURSERY RULES AND REGULATIONS

A. Recommendations for specific privileges within obstetrics, and the newborn nursery, are the responsibility of the Credentials Committee with input from the Medical Executive Committee, and shall be based, in part, on demonstrated experience and specific types of procedures performed. All final decisions regarding the granting or denying of clinical privileges shall be made by the Governing Board of the Hospital.

B. Privileges in obstetrics and gynecology shall be limited to physicians who have completed a residency program in obstetrics and gynecology and only these physicians, shall be permitted to attend deliveries and cesarean sections as primary attending to the mother.

C. Certified nurse midwives, through their training and under the supervision of an obstetrician having staff privileges, shall be permitted to attend normal deliveries in accordance with privileges recommended by the Credentials Committee.

D. Obstetrical patients shall be admitted in accordance with policies and procedures established jointly by the Hospital and the Department of Obstetrics and Gynecology. Such procedures are to specify the laboratory tests, examinations and other special monitoring which is to be performed under certain specified conditions. The attending physician, as well as the individuals responsible for the care of the patient and the baby before, during and after the delivery are to be named when delivery is scheduled.

E. Complete medical records shall be available at the LDRP room and shall accompany the patient to the delivery room when it is utilized. These records are to contain pertinent prenatal information. Rules and procedures shall be developed governing the identification of the patient, recovery room procedures, and attire for the LDRP and delivery room.

F. A roster shall be maintained on the patient unit which identifies those physicians who have been granted obstetrical/gynecological and newborn nursery privileges, including a delineation of those privileges granted. This roster shall be available at all times to appropriate nursing personnel.

G. A consent form shall be completed, and executed by the patient at the time of admission, in accordance with established Hospital protocol. The form may be submitted earlier at such times as the prenatal records are transmitted to the unit.

H. Written, signed, informed surgical consent shall be obtained and made part of the patient's medical record prior to any cesarean or invasive medical diagnostic procedure in accordance with Hospital protocol.

The only exception to the written consent requirement of this section will be those situations where the patient's life or health is in immediate jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor in which consent for surgery or medical procedure cannot be immediately obtained from patients, guardians, or next of kin, these circumstances

should be fully explained in the patient's medical record. In case of an emergency, the Consent of a patient is implied.

I. The anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. The anesthesia record also should include a description of events taking place during the induction of, maintenance of, and emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood products, the techniques used, unusual events during the anesthesia period, and the status of the patient at the conclusion of anesthesia. A separate record shall be utilized when an epidural is administered. The anesthesiologist is responsible only to the mother and is not responsible for neonatal resuscitation.

J. Sponges should be counted on all procedures in which the possibly exists that a sponge could be retained. Sharps and related miscellaneous items should be counted on all procedures.

K. Infants admitted to the newborn nursery shall be examined by a physician upon admission to the nursery and within 24 hours prior to discharge. The findings of such examination shall be recorded in the newborn's medical record.

L. Consultation shall be required for newborn infants who are delivered with specific medical elements or deficiencies as defined by the pediatric service.

M. Specific criteria shall be developed to define a "high-risk infant" and those conditions under which transfer of the neonate to a Level II or Level III facility shall be required. Transfer agreements with at least two institutions shall be in place.

N. The physician or other authorized Hospital personnel shall complete the birth certificate in a reasonable time period as prescribed by Florida Statute. Nurses in the nursery shall initiate and maintain appropriate medical records for each infant. The newborn's record must adequately document significant observations, procedures and care rendered to the newborn.

O. Criteria shall be developed which defines those conditions under which transfer of the mother to a Level II or Level III facility shall be required.

P. Only a pediatrician or a neonatal nurse practitioner under contract, each having appropriate certification as reviewed by the Credentials Committee and approved by the Board, shall attend cesarean sections and other deliveries when requested by the obstetrician, as primary attending to the infant.

Q. Family practitioners shall be granted nursery privileges, including circumcisions, in accordance with criteria established by the Credentials Committee. In the instance of a complicated delivery or cesarean section, a pediatrician or neonatal nurse practitioner under contract shall be responsible for the care of the newborn for the first 24 hours after delivery, or when circumstances dictate.

R. Separate call schedules shall be maintained for coverage of the Emergency Department and the Newborn Nursery Department.

S. Emergency Department call shall be the responsibility of all pediatricians on the Active Staff. Other qualified practitioners may request this category of ER call privileges and may be assigned to the schedule, subject to a recommendation from the Credentials Committee and approval by the Board.

Neonatal-related service coverage for the cesarean sections or complicated deliveries shall be provided under contract by pediatricians or neonatal nurse practitioners qualified by training and experience, subject to a recommendation from the Credentials Committee and approval by the Board.

Newborn Nursery call for uncomplicated deliveries of mothers not having previously selected a physician for the newborn, shall consist of those qualified physicians as recommended by the Credentials Committee and approved by the Board.

T. A gross examination of every placenta is to be performed at the time of delivery by the obstetrician or certified nurse midwife performing the delivery. Findings are to be recorded in the Labor & Delivery Record. If clinical indicators or placenta appearance warrant further investigation, the placenta shall be sent to Pathology for consultation.

U. A sample of cord blood is obtained by the obstetrician or certified nurse midwife from all deliveries and sent to the Laboratory where it is retained.

V. If circumcision of a newborn male is desired, the mother, in consultation with the appropriate attending physician, is to decide which physician shall perform the circumcision.

12. CHAIN OF COMMAND IN THE EVENT OF UNAVAILABILITY:

If, at any time, the President and Vice-President are, both, unavailable or unable to fulfill the obligations of the President, the duties of such office shall be temporarily assumed by the following persons in the order in which they are listed:

a. Secretary-Treasurer of the Medical Staff;
b. Chief of the Department of Medicine;
c. Chief of the Department of Surgery;
d. Chief of the Department of Obstetrics/Gynecology;
e. Assistant Chief of the Department of Medicine;
f. Assistant Chief of Department of Surgery;
g. Assistant Chief of Department of Obstetrics/Gynecology

Chain of Command for Patient Management Questions:

The Medical Staff recognizes that all health care providers have the right and responsibility to question and/or clarify a patient" prescribed therapy. Patient management questions should be referred via the Medical Staff chain of command as defined below:

a. Attending/Prescribing Physician
   All questions regarding patient care should be referred initially to the attending and/or prescribing physician.
b. Department Chief
   1. If a question cannot be resolved by communication between the hospital staff and the attending/prescribing physician, the concern should be reviewed with the Department Chief/Vice-Chief of the appropriate clinical specialty.
   2. Medical Staff departments include the following: Surgery; Medicine; and Obstetrics/Gynecology. Subspecialities within these departments with a Medical Director include: Anesthesia; Emergency Medicine; Diagnostic imaging; and Pathology
   3. The Department Chief/Vice-Chief may direct the question to an appropriate Medical Director of one of these subspecialities.
c. President of the Medical Staff
   1. If a question cannot be resolved through discussion and communication at the Department level, the issue should be referred to the President of the Medical Staff for final disposition.
   2. In the absence of the President of the Medical Staff, the Vice-President of the Medical Staff shall assume the responsibility.
   3. If the President and Vice-President of the Medical Staff are not available, the responsibility for rendering a decision shall be with the Department Chief, with collaboration from Hospital Administration as necessary.

13. MEDICAL SCREENING EXAMINATION (Qualified Medical Professional)

For purposes of the Emergency Medical Treatment and Active Labor Act (EMTALA), the following individuals are authorized as Qualified Medical Professionals to perform Medical Screening Examinations upon individuals who present in the Emergency Department or 8th floor O.B. Unit triage:

1. Physician Assistant or Advanced Registered Nurse Practitioners with privileges to practice in the Emergency Department of Helen Ellis Memorial Hospital are authorized to perform medical screening examinations on patients who present to the Emergency Department or Emergency Department Fast Track.
2. Advanced Registered Nurse Practitioners, Physician Assistants and Registered Nurses, who are employed by the hospital, are authorized to perform medical screening examinations on women who present to Triage on 8th floor O.B. Unit Triage.
3. Any physician on the medical staff at Helen Ellis Memorial Hospital is authorized to perform medical screening examinations at all locations.
4. The performance of medical screening examinations are subject to division and hospital policies, which may be more (but not less) restrictive than these regulations.

14. ADOPTION

These Rules and Regulations of the Medical Staff have been hereby amended on October 3, 2007 in accordance with the terms of the Medical Staff Bylaws. These Medical Staff Rules and Regulations supersede and replace any and all previous Rules and Regulations.

APPROVED by the Medical Staff on October 3, 2007

By: _____
President

APPROVED by the Board on November 21, 2007

By: _____
Chairman