

SHANDS at Lake Shore

Rules & Regulations

ABBREVIATIONS:

1. Only symbols and abbreviations, which have been approved by the Medical Staff and appear on the current list of accepted abbreviations should be used in the medical records.
2. The Medical Staff shall review the list of abbreviations and shall update this list appropriately.

ADMITTING:

1. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis has been stated and the consent of the hospital admission department secured. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.
2. Physicians admitting patients (hereinafter called the Attending Physician) shall be held responsible for giving such information on the order sheet as may be necessary to assure the protection of others from patients who are a source of danger from any cause whatsoever.
3. The Administrator of the hospital with the approval of the Chief of each Medical Staff Service shall have prepared on a regular monthly basis a list of On-Call Physicians who shall have responsibility for the emergency patients in the medical specialties offered by SHANDS at Lake Shore, Inc. The determination of the scope of medical specialties offered at SHANDS at Lake Shore, Inc. and the On-Call areas of responsibility for individual medical staff members shall be the responsibility of the Administrator and the Executive Committee of the Medical Staff.
4. Patients presenting to the Emergency Service who must be admitted and who do not have a pre-selected Attending Physician shall be attended by the Staff member who is On-Call or by a staff member who accepts referral. This physician will be notified in accordance with his instructions provided to the Emergency Services

staff. Patients who have a pre-selected physician shall be admitted to that physician's service with his permission.

5. A pertinent history and physical examination shall be recorded within 24 hours of admission and as soon as conditions permit for an emergency admission. A history and physical examination pertinent to the planned treatment is required for outpatients when anesthesia, deep or moderate sedation is administered. The history and physical shall include, but is not limited to, patient identification, date, chief complaint, history of present illness, family history, psychosocial history, review of pertinent physical systems, physical examination, current medication and allergies.
6. If a history and physical examination has been performed by a Medical Staff member within seven (7) days before admission, or thirty days (30) for an outpatient procedure requiring anesthesia, deep or moderate sedation, a legible copy of the report may be used in the patient's medical record; provided any significant changes that may have occurred are recorded at the time of admission for the procedure. If a non-credentialed physician has performed a history and physical, then the history and physical must be reviewed by a physician and a note of concurrence entered into the medical record. If an inpatient is readmitted within (7) days of discharge, the history and physical in the medical record may be used provided that any significant changes that have occurred are recorded at the time of admission.
7. A physician or an Oral Maxillofacial Surgeon who is a member of the medical staff must do the history and physical. Dentists are responsible for the part of their patients' history and physical examination that related to dentistry. Podiatrists are responsible for the part of their patients' history and physical examination that related to podiatry. The medical evaluation and risk assessments of these patients are the responsibilities of a qualified staff physician.
8. When the history and physical examination, including the pre-procedure diagnosis and required laboratory tests are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be

detrimental to the patient's health. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of procedure.

9. Assigned service patients include all patients who, for any reason, do not have or do not express a choice of physician. They shall be assigned to the members of the Active Medical Staff On-Call for the appropriate service duty at the time and assigned to the service indicated by the illness of the patient in the opinion of the Emergency Service Physician. In the event of transfer of care or if consultation is required by another physician, this transfer or consultation shall be to the Staff member actively assigned to service duty at that time. The On-Call Physician responsible for patient care shall not place himself so as not to be able to respond to a telephone request from the Emergency Service within thirty (30) minutes or to be unable to physically attend the patient in need of care within a reasonable amount of time. Specific services in the hospital may make rules more specific in limiting for physician response time.
10. The Attending Physician responsible for an inpatient shall not place himself so as not to be able to respond to a telephone request from the nursing service within thirty (30) minutes or be unable to physically attend the patient in need of care within a reasonable amount of time. Specific services in the hospital may make rules more specifically defining physician response time for inpatient situations.
11. In a case of admission or readmission of a service patient, the On-Call physician may not refuse responsibility due to the patient having been under the care of another On-Call Attending Physician at the previous admission. This rule shall not apply in cases where physician delay has resulted in a change in On-Call responsibility prior to the service patient being seen by an Attending Physician.

ATTENDING RESPONSIBILITY:

1. Every patient admitted to the hospital or retained temporarily in the hospital for observation or outpatient services shall have a specific member of the Medical Staff identified as the Attending Physician. No patient may be retained in the hospital outside the Emergency Service without such a physician being identified.

2. The Attending Physician at the time of the patient discharge from the hospital shall be the physician responsible for the completion of the medical record. The Attending Physician of record shall have complete responsibility for the management of the patient in the hospital.
3. In the case of transferring the Attending Physician responsibility for a patient from one physician to another, the physician transferring and the physician receiving the patient must state this fact in writing in the patient's chart. This may take the form of a verbal order dictated as described in the rules and regulations. Each physician should sign his respective order. Until both such orders have been recorded, no transfer of Attending Physician responsibility shall have occurred.
4. Requests from the Attending Physician for consultation should be in writing or typed from dictation and should be signed by the physician requesting it. The request must include the reason the consultation is needed. No physician shall be expected to provide a consultation without first being given the reason the consultation is requested. The Attending Physician shall expend every effort to personally communicate this reason to the consultant.
5. It shall be the duty of each Attending Physician to establish fail-safe primary and alternate methods of telecommunications to allow the prompt response to the request for assistance from a member of the hospital staff when that physician has the On-Call Physician responsibility for his service or when he is the Attending Physician for an inpatient. At the request of the Administrator, each Attending Physician shall provide appropriate documentation of these modes of telecommunication.
6. If the On-Call Physician or the Attending Physician for an inpatient has made an arrangement to have his service covered by another physician, it shall be the responsibility of the Attending Physician with the primary responsibility to communicate this substitution to the Shands at Lake Shore Receptionist prior to the beginning of the substitution. At that time the Shands at Lake Shore Receptionist should be informed of when the individual physician will resume his own responsibilities. No other substitution such as informing the Emergency Room nurses or the floor staff shall be acceptable in communicating this substitution of

responsibilities. If the substitution of responsibilities is done in a systematic way, the provision of a monthly calendar listing of the responsible physician for coverage to the Administrative offices, Emergency Department and Patient Care Units shall be deemed necessary to satisfy this reporting requirement.

7. Patients admitted to the Intensive Care Unit will be seen by the Attending physician within eight hours if the Attending Physician or the Emergency Room Physician has initially screened that patient. The Attending Physician will see patients who have not been screened by a physician that day within two hours of admission to the Intensive Care Unit.

AUTOPSIES:

1. Autopsies shall be performed upon consent from the deceased patient's next of kin or other legally competent person by a certified Pathologist or under his supervision. Obtaining such consent is the responsibility of the Attending Physician or his physician designate. Provisional autopsy diagnosis will be recorded in the patient's medical record within 72 hours and final diagnosis within 60 days.
2. The Medical Staff, with other appropriate hospital staff, shall develop and use criteria that identify deaths in which an autopsy should be performed. Such criteria include:
 - a) Interesting conditions which will enlighten both the attending physician and/or medical staff as well as family members.
 - b) Deaths in which no definitive diagnosis and/or cause of death are established and occur during hospital stay.
 - c) Death during or following surgery or invasive procedures.
 - d) Death related to pregnancy or delivery.
 - e) All perinatal or pediatric deaths.
 - f) All medical examiner cases must be autopsied.

Findings from autopsies shall be used as a source of clinical information in quality assurance activities.

CONSULTATIONS:

1. The status of consultant is determined on the basis of an individual's training, experience and competence. A consultant must be well qualified to give an opinion in the field in which that opinion is sought. Members of the Medical Staff shall agree to render consulting services regardless of the patient's ability to pay when requested by a member of the Medical Staff. In cases when consultation is required by the hospital rules, whether private or service cases, Staff Members shall render such consultation upon request.
2. A satisfactory consultation includes examination of the patient and the record. A written opinion signed by the consultant must be included in the medical record. When operative procedures are anticipated, the consultation note except in an emergency shall be recorded in the chart prior to the operation.
3. The patient's Attending Physician is responsible for requesting consultations when the patient's need exceeds the physician's privileges. It is the duty of the Medical Staff, through its Chiefs of Service and Executive Committee, to make certain that members of the staff do not fail in the matter of calling consultants as needed.
4. Routine consultation (such as x-ray examination, electrocardiogram interpretation, and tissue examination) shall be deemed to fulfill the definition of satisfactory consultation when the written report of the consultant appears in the chart.
5. When the Attending Physician responsibility for a service patient has been assigned through the On-Call process, the responsibility for consultation in a service area rests with the On-Call physician in the service area responsible at the time the order was written.

DISCHARGE:

1. Patients shall be discharged only on order of the Attending Physician or his designee.
2. Appropriate discharge planning shall normally be a part of the regular admission procedure instituted by the Attending Physician at the time of admission.

3. When pre-printed discharge instructions are given to the patient or family, the medical record shall so indicate and a sample of the instruction sheet then in use shall be filed in the patient's chart.
4. The Attending Physician at the time of the patient's discharge shall have the responsibility of preparing a discharge summary which shall accurately recapitulate the reasons for hospitalization, significant findings, procedures performed and treatment rendered, condition of the patient at discharge, and specific instructions given to the patient and/or family including limitations on physical activity, medication, diet and follow-up care.
5. In the event of the death of a hospitalized patient, it is the duty of the patient's physician to immediately pronounce the patient dead. At the physician's request, the Emergency Department physician or Patient Care Coordinator may pronounce the patient dead. In the case of an expected death such consultation may be arranged in advance at the discretion of the Attending Physician.

CLINICAL PRIVILEGES FOR DENTISTS:

Surgical procedures performed by dentists shall be under the overall supervision of the Chairperson of the Surgery Service. A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the medical staff before dental surgery shall be scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization. The dentist shall be responsible for the dental care of the patient, including the dental history and dental physical examination as well as elements of the patient's record relating to dental care. Dentists may write orders within the scope of their license and consistent with the medical staff rules and regulations and in compliance with the hospital and medical staff bylaws.

CLINICAL PRIVILEGES FOR ORAL SURGEONS:

A medical history and physical examination of the patient shall be made and recorded by a physician who holds an appointment to the medical staff before oral surgery shall be

scheduled for performance, and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization.

CLINICAL PRIVILEGES FOR PODIATRISTS:

Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairperson of the Surgery Service. A medical history and physical examination of the patient shall have taken place and been recorded in the medical record by a physician who holds an appointment to the medical staff before podiatric surgery shall be performed and a designated physician shall be responsible for the medical care of the patient throughout the period of hospitalization. The podiatrist shall be responsible for the podiatric care of the patient, including podiatric history and the podiatric physical examination as well as all elements of the patient's record relating to podiatric care. The podiatrist may write orders within the scope of his/her license and consistent with the medical staff rules and regulations and in compliance with the hospital and medical staff bylaws.

CLINICAL PRIVILEGES FOR INTERNS AND RESIDENTS:

Residents and Interns shall not hold appointments to the medical staff, and shall not be granted specific clinical privileges. Residents and Interns shall be permitted to exercise only those privileges set out in training protocols and recommended by the Credentials Committee to the Medical Executive Committee and approved by the Board.

DRUGS:

1. Medications will be administered only upon the written order of an authorized member of the Medical Staff or other individuals who have been granted clinical privileges to write medication orders in accordance with the Medical Staff Rules and Regulations.
2. Verbal orders for medications may be accepted within the scope of practice only by a Registered Nurse, Licensed Practical Nurse, Registered Pharmacist, Physician's Assistant, Physical Therapist, or Respiratory Therapist and must be validated by the prescribing practitioner within forty-eight hours.

3. Physician's Assistants (PA's) may not write orders without direct contact with the physician. An order written by a PA shall bear the PA's signature, the physician's name and a notation of the means of communication.
4. All orders are cancelled on a patient going to surgery, or after transfer to or from the ICU unit. New medication and treatment orders must be written.
5. When an order begins with "Post-Op Orders" or "Postpartum Orders", discontinue all previous medications unless they are rewritten.
6. On all units a pharmacist will check the profiles of patients whose length of stay has reached a multiple of fourteen (14) days, verify that all current medications appear to still be indicated. The pharmacist will document in the pharmacy's computer system (patient level ASO note) that "A medication review has been completed". If changes are recommended, the pharmacist will consult with the appropriate physician before documentation is completed.
7. All orders are cancelled at discharge. The only drugs to be dispensed at discharge are limited to a three-day supply of TB medications as mandated by OSHA.

As far as possible, the use of generic medications shall be encouraged and the use of proprietary remedies avoided. When such proprietary remedies are ordered for private patients by the Attending Physician, they will be secured if, in the opinion of the Pharmacist, an adequate substitute cannot be provided.

EMERGENCY:

1. Individual medical records are to be maintained on each patient seen in the Emergency Room. They are to be dated, properly completed and signed by the Attending Physician at the time of the treatment. The records are to be appropriately filed. All allergies of the patient are to be prominently noted on the record.
2. No elective surgery such as removal of moles and cysts will be done in the Emergency Room except:
 - a. Physically handicapped patients who need specialized facilities or treatment available only at the hospital.

- b. Non-emergency orthopedic cases requiring cast changes and x-rays difficult to accomplish in a physician's office may be scheduled after prior consultation with the Emergency Service.

HOSPITAL VISITS:

1. All hospitalized patients must be seen daily by their Attending Physician or by a physician providing coverage for the attending. Daily progress notes must be written in the chart of each patient. The Chief of the appropriate service will report those physicians who do not comply with this to the Executive Committee for corrective action and this information shall be included in the credentialing process for consideration of reappointment to the medical staff.

MEDICAL RECORDS:

1. The Attending Physician shall be held responsible for the preparation of a complete medical record for each patient. This record shall include:
 - the patient's name;
 - address;
 - date of birth;
 - the name of any legally authorized representative; for patient's receiving mental health service;
 - patient's legal status;
 - emergency care provided to the patient prior to arrival, if any;
 - the record and findings of the patient's assessment;
 - a statement of the conclusions or impressions drawn from the medical history and physical examination;
 - the diagnosis or diagnostic impression;
 - the reason(s) for admission or treatment;
 - the goals of treatment and the treatment plan with episodic review as appropriate;
 - evidence of known advance directives;
 - evidence of informed consent when appropriate;
 - reports of operative and other procedures, tests and their results;
 - progress notes made by the medical staff and other authorized individuals;
 - all reassessments, when necessary;
 - clinical observations;
 - the response to the care provided;
 - consultation reports;

- medications ordered or prescribed during treatment or upon discharge;
- all relevant diagnoses established during the course of care;
- conclusions at the termination of hospitalization;
- discharge summaries, or a final progress note or transfer summary;
- discharge instructions to the patient or family;
- any referrals and communications made to external or internal care providers and to community agencies;
- results of autopsy, when performed.

1. No medical record shall be filed until it is complete, except on the order of the Continuous Quality Improvement Committee.
2. Only physicians and their credentialed designees are allowed to perform and dictate the history and physical examinations required for patients admitted to the hospital.
3. All medical records are the property of the hospital and shall not be taken away from the premises except in accordance with court order, subpoena or statute. In case of readmission of a patient, all previous records shall be available for the use of the Attending Physician. This shall apply whether the same physician or another attends the patient.
4. Free access to all medical records of patients shall be afforded to Staff Physicians in good standing for bona fide study and research, provided that no personal information concerning the individual patients is disclosed.
5. Operative reports shall be recorded in the medical record immediately after surgery and shall contain a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis, and the name of the primary surgeon and any assistants. The completed operative report shall be authenticated by the surgeon and filed in the medical record department as soon as possible after surgery. When a transcription and/or filing delay is anticipated, a comprehensive operative progress note is to be entered in the medical record immediately after surgery to provide pertinent information for use by any individual who is required to attend to the patient.
6. All medical records shall be completed and in the Medical Record Department within 30 days of discharge of the patient. Failure to satisfy this requirement for completion of the medical record shall invoke the voluntary relinquishment of

elective admitting and consultative clinical privileges as defined by Article VI, Section 7 (g) of the Policy on Appointment, Reappointment and Clinical Privileges for SHANDS at Lake Shore, Inc. Under extenuating circumstances involving an individual physician, at the discretion of the Executive Committee this time limit shall be suspended until said circumstances are found to no longer apply.

7. At the time of discharge of a patient from the hospital, a primary diagnosis and any secondary diagnoses and operative procedures must be written into the chart in the appropriate discharge section.
8. A patient may not be placed in the operating room nor anesthesia commenced until the written record of a complete history and physical examination is present in the chart and the required clinical laboratory procedures are completed and recorded on the chart as well. This rule shall not apply if the Attending Physician states in writing that a delay would be detrimental to the patient. In the case of such an emergency, the use of an interim history and physical must be recorded in the chart within 24 hours of the operative procedure.
9. The Chiefs of each Medical Staff Service shall establish, after consultation with the Service Physicians, written procedures in compliance with JCAHO appropriate to the documentation required for the medical record on Day Stay, Outpatient and 23-Hour Observation Patients.
10. It is the duty of the Attending Physician to assure the legibility of the physician part of the medical record.
11. It is the responsibility of the physician performing the hospital procedure or surgical operation to obtain informed consent.

MEDICAL STAFF BYLAWS:

1. The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each member of the medical staff. The Rules and Regulations will be reviewed and recommendations

for changes shall be made at least biennially. Such changes shall become effective when approved by the MEC and the Board of Directors.

OPERATING ROOM:

1. Surgeons must be in the operating room and ready to commence the operation at the time scheduled. The operating room will be held no longer than 15 minutes after the time schedule except when, in the opinion of the attending Anesthesiologist, there is due cause for the delay.
2. Medical and paramedical personnel in training will be allowed in the operating room and the delivery rooms under supervision of the Attending Physician and/or the operating room supervisor. Resident Physicians and other physicians will be allowed in these areas by invitation of the Attending Physician only in compliance with standard Operating Room Policies. Any individual not properly credentialed through the standard process used at SHANDS at Lake Shore, Inc shall perform no surgery or surgical assistance. Provision for the admission of non-medical or non-paramedical personnel to the restricted areas will not be made except when contingent upon departmental regulations.
3. The Attending Physician shall be responsible for the information in preparation of the document to accompany all tissue removed in operation to the Pathologist with appropriate indications for pathological investigation. The responsibility of delivery of the tissue to the Pathologist shall lie with the operating room supervisor. The containers and documentation will indicate the origin of the tissue, and the name and hospital number of the patient and the date on which the tissues were obtained.
4. The Pathologist shall make such examinations, as he may consider necessary to establish diagnosis of tissues removed by the physician from a patient in the operating room or elsewhere in the hospital. Exceptions include forensic evidence and placentas, unless specifically requested for examination by attending physician. The original of the Pathologist's consultation report will be made a part of the patient's medical record.

PHYSICIAN'S ORDERS:

1. Medical orders for care and treatment of patients are to be given only by credentialed medical staff, ARNPs, CNMs, CRNAs and PAs within the scope of their clinical privileges or protocols as approved by the Shands at Lake Shore Board of Directors.
2. Orders issued by a PA must be co-signed within 24 hours by a physician.
3. All orders for treatment shall be in writing and must include the date of the order and the time given. Such orders must be written clearly, legibly, and completely.
4. Verbal/telephone orders may be dictated to a license or registered health care professional in an emergent situation or when the physician, ARNP, CNM, CRNA, or PA is not present to write the order. All orders dictated over the phone or verbally given must be written down by the recipient, read back to the practitioner and shall be signed and dated in the medical record with a note "T.O _____" "V.O. _____". All orders shall be authenticated and dated within forty-eight hours of receipt, by the practitioner giving the order.

PATIENTS WITH SPECIAL NEEDS:

1. It is the responsibility of the Attending Physician to determine and document the need for appropriate mental health consultations for patients who are emotionally ill, suicidal, or those who are suffering from the results of alcoholism or drug abuse.

TREATING MEMBERS OF IMMEDIATE FAMILY

Physicians generally should not treat themselves or immediate family members*, however there may be occasions where this is acceptable and appropriate. Any physician, who desires to provide treatment to him/herself or a family member at Shands at Lake Shore, must first contact the Chief of his/her assigned department or the President of the Medical Staff. The physician will disclose to the Chief or President the nature of the problem and/or the intended treatment and advise the Chief or President the reason a non-related physician is not providing the care. The Chief or President will offer counsel to the requesting physician, referencing the American Medical Association's Code of Ethics statement on this issue, which is appended to these Rules and Regulations. Documentation of this conversation shall be submitted by the Chairman at his/her earliest

convenience and maintained by Quality Assurance Department. In situations where the physician chooses to proceed with the delivery of care to self or family members, contrary to the advice of the Chief or President, concurrent chart review will be conducted.

**For purposes of this rule, parents, sibling, children (whether natural or by law) and spouses are considered to be immediate family members.*