MEDICAL STAFF BYLAWS, POLICIES, AND RULES AND REGULATIONS OF SARASOTA MEMORIAL HOSPITAL - VENICE

MEDICAL STAFF RULES AND REGULATIONS

Approved by Physician Advisory Committee
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ARTICLE I

DEFINITIONS

Unless otherwise indicated, the terms used in all of the Medical Staff documents are defined in the Medical Staff Glossary.

ARTICLE II

ADMISSIONS, ASSESSMENTS AND
CARE, TREATMENT AND SERVICES

2.A. ADMISSIONS

(1) A patient may only be admitted to the Hospital, or designated as "observation status," by order of a Practitioner who is granted admitting privileges.

(2) Except in an emergency, all inpatient medical records will include an admitting diagnosis on the record prior to admission. In the case of an emergency, the admitting diagnosis will be recorded as soon as possible, and no later than ***24 hours*** after admission.

(3) Patients will be admitted based on the following order of priority:

(a) **Emergency/Trauma/Critical Care** – includes patients in an emergency medical condition or in active labor who require hospitalization.

(b) **Urgent/Direct** – includes non-emergency patients whose admission is considered imperative by the Admitting Practitioner.

(c) **Routine/Pre-operative** – includes scheduled elective and pre-operative admissions involving all services.

(4) The Admitting Practitioner will provide the Hospital with any information concerning the patient that is necessary to protect the patient, other patients or Hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

2.B. ADMISSIONS THROUGH THE EMERGENCY DEPARTMENT

(1) All emergency cases brought to the Hospital who are unassigned with or without physician preference shall be assigned to a physician based on the Emergency Department on-call schedule.

(2) If an unassigned patient who is evaluated by the Emergency Department requires admission, the patient will be assigned to the appropriate on-call physician.

2.C. OBSERVATION STATUS

(1) Observation status is an outpatient status meant to be used as a period of diagnosis and/or treatment prior to or in lieu of an inpatient admission.

(2) All patients placed in observation status must be seen by the Admitting Practitioner or a Responsible Practitioner within the observation period and a history and physical examination completed.

2.D. RESPONSIBILITIES OF ATTENDING PRACTITIONER

(1) The Attending Practitioner will be responsible for the following while in the Hospital:

(a) the medical care and treatment of the patient while in the Hospital, including appropriate communication among the individuals involved in the patient's care (including personal communication with other physicians where possible);

(b) being personally available (or arranging an alternate Practitioner who has appropriate clinical privileges to care for the patients) to provide professional care for his or her patients in the Hospital;

(c) rounding on his or her patients as frequently as necessary based on the patient's condition, with special attention to patient's deterioration in person or via technology-enabled two-way communication and evaluation. Daily rounding is encouraged unless the Attending Practitioner documents an exception that supports the need for continued hospitalization but less frequent patient visits;

(d) the prompt and accurate completion of the portions of the medical record for which he or she is responsible;

(e) communicating with the patient's third-party payor, if needed;

(f) providing necessary patient instructions;

(g) responding to inquiries from Utilization Review professionals regarding the plan of care in order to justify the need for continued hospitalization;

(h) responding to Medicare/Medicaid quality of care issues and appeal denials, when appropriate; and

(i) performing all other duties described in these Rules and Regulations.

(2) At all times during a patient's hospitalization, the identity of the Attending Practitioner (or his or her alternate or covering physician) will be clearly documented in the medical record. Whenever the responsibilities of the Attending Practitioner are transferred to another physician outside of his or her established coverage arrangement, a note covering the transfer of responsibility will be entered in the patient's medical record. The Attending Practitioner will be responsible for verifying the other physician's acceptance of the transfer and updating the Attending Practitioner screen in the electronic medical record ("EMR").

(3) If the Attending Practitioner does not participate in an established coverage arrangement with known alternate coverage and will be unavailable to care for a patient for longer than 24 hours, the Attending Practitioner will document in the medical record the name of the Medical Staff member who will be assuming responsibility for the care of the patient during his or her unavailability. The Attending Practitioner will be responsible for (i) verifying the other physician's acceptance of the transfer, and (ii) notifying Medical Staff Services and the Emergency Department, if applicable, of his or her absence and who will cover for him or her.

(4) If the Attending Practitioner is unavailable and alternate coverage has not been arranged, the relevant Department Chairperson, the Chief of Staff, the CMO/ACMO, or the administrator on call will have the authority to call on the on-call physician or any other member of the Medical Staff to attend the patient.

2.E. EVALUATION OF PATIENTS IN THE HOSPITAL

(1) All Practitioners will comply with the following patient care guidelines regarding the evaluation and assessment of patients:

(a) **Patients Admitted to the ICU** – must be evaluated by an admitting physician, or upon consultation with the attending physician, by the critical care team within ***two hours*** of decision to admit patient to an ICU bed, unless the patient's condition requires that a Practitioner see him or her sooner; and

(b) **All Other Inpatient Admissions/Observation Patients** – must be evaluated by a Practitioner within ***24 hours*** of admission to the Hospital (or more quickly based upon (i) the acute nature of the patient's condition or (ii) a requirement for a particular specialty as recommended by the MEC and approved by the Board).

(2) Any visit by an Advanced Practice Professional who is acting on behalf of his or her Admitting Practitioner will be carried out under the rules outlined in Article 8 of the Medical Staff Credentials Policy.

2.F. CONTINUED HOSPITALIZATION

(1) The Attending Practitioner will provide whatever information may be requested with respect to the continued hospitalization of a patient, including:

(a) an adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient);

(b) the estimated period of time the patient will need to remain in the Hospital; and

(c) plans for post-hospital care.

This response will be provided within 24 hours of the request. Failure to comply with this requirement will be reported to the Department Chairperson and/or the Chief of Staff for review and appropriate action.

(2) If a determination is made that a case does not meet the criteria for continued hospitalization, written notification will be given to the Hospital, the patient, and the Attending Practitioner. If the matter cannot be appropriately resolved, the CMO/ACMO will be consulted.

ARTICLE III

MEDICAL RECORDS

3.A. GENERAL

A medical record will be prepared for every individual evaluated and treated at the Hospital. Each Practitioner who is involved in the care of a patient will be responsible for the timely and accurate completion of the portions of the medical record that pertain to the care he or she provides.

3.B. MEDICAL RECORD ENTRIES

3.B.1. Entries:

(a) The following individuals are authorized to document in the medical record:

(1) Admitting Practitioners, Attending Practitioners, Consulting Practitioners, Advanced Practice Professionals, and other Responsible Practitioners;

(2) nursing providers, including registered nurses ("RNs") and licensed practical nurses ("LPNs");

(3) other licensed or certified health care professionals involved in patient care, including, but not limited to, physical therapists, speech therapists, occupational therapists, respiratory therapists, pharmacists, dieticians, social workers, and case managers;

(4) other health care providers who have access to the medical record pursuant to their job description (e.g., aides and assistants);

(5) volunteers functioning within their approved roles;

(6) residents and students in an approved professional education program who are involved in patient care as part of their education process if that documentation is reviewed and countersigned by the student's supervisor, who must also be authorized to document in the medical record; and

(7) non-clinical and administrative staff, as appropriate, pursuant to their job description.

(b) Electronic entries will be entered through the EMR and/or Computerized Provider Order Entry ("CPOE") in accordance with Hospital policy, Computerized Physician Order Entry (CPOE) 00.MD.44.

(c) Handwritten medical record entries will be legibly recorded in blue or black ink whenever the use of paper-based documentation is appropriate (i.e., an emergency situation or when the EMR or CPOE function is not available) or has been otherwise approved by the Hospital (e.g., documentation of informed consents or short stay forms).

(d) All entries, including handwritten entries, must be timed, dated and signed.

(e) Any documentation changes to a medical record that occurs after a health care event greater than two days post discharge shall be considered a late entry. See Hospital Policy, Documentation Changes to Patient Medical or Electronic Health Records 00.ADM.36. Late Entry: A late entry is defined as a pertinent entry written after a health care event (greater than 2 days post discharge or as defined in hospital rules and regulations).

(f) Any entry in the medical record should be clear, concise, and objective. Practitioners should avoid editorializing in the medical record of a patient or entering extraneous comments or criticisms about a patient, a patient's family, or the care provided by other Practitioners or Hospital personnel.

3.B.2. Entries by an Advanced Practice Professional:

When making entries in the medical record, an Advanced Practice Professional will (1) identify him/herself as an Advanced Practice Professional, and (2) identify his/her supervising physician. When required by state law or his or her written supervision or collaborative agreement, the supervising physician will countersign entries by an Advanced Practice Professional within 15 days.

3.B.3. Authentication:

(a) Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the EMR or CPOE.

(b) The Practitioner will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital policy, Authentication of Medical Records 00.ADM.32.

(c) Signature stamps are not an acceptable form of authentication for written orders and other medical record entries unless, in accordance with the Rehabilitation Act of 1973, the Practitioner has a physical disability and can provide proof to a CMS contractor of his or her inability to provide his or her signature due to his or her disability.

3.B.4. Symbols and Abbreviations:

(a) Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used.

(b) The Medical Staff will periodically review the unapproved abbreviations and/or symbols list and an official record of unapproved abbreviations will be kept on file.

3.B.5. Clarity and Completeness:

All entries in the medical record shall be clear and complete so that other members of the health care team are able to understand the entry and the author's intentions.

3.B.6. Correction of Errors:

(a) When a dictated or electronic entry requires correction, the author shall dictate or enter an electronic addendum to the initial entry. Any error made while entering an order in the CPOE should be corrected by entering another order.

(b) Handwritten entries in the medical record will be corrected by making a single line through the original entry and making any necessary addition/correction. Any addition/correction will be timed, dated and initialed by the author.

3.B.7. Copying and Pasting/Carry Forward:

Copying and pasting (or carrying forward) from a prior note in the EMR is permissible so long as the posted note is properly updated (i.e., the Practitioner has verified that the information is accurate for the patient in question and has included any documentation showing the differences and the needs of the patient for each visit or encounter).

3.B.8. Permanent Filing of Medical Records:

A medical record will not be permanently filed until it is completed by the Responsible Practitioner, or it is ordered filed by the HIM Department under the direction of the MEC. No Practitioner will be permitted to complete a medical record on an unfamiliar patient in order to permanently file that record except in rare circumstances, and only when approved by the MEC.

3.C. OWNERSHIP, RETENTION, AND ACCESS TO RECORDS

3.C.1. Ownership of Records:

Medical records are the physical property of the Hospital. Original medical records may only be removed from the Hospital in accordance with federal or state laws.

3.C.2. Retention of Records:

The Hospital will retain medical records in accordance with Hospital policy, Medical Record Preservation 01.ADM.05.

3.C.3. Access to Records:

(a) Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and the Hospital's Health Insurance Portability and Accountability Act ("HIPAA") policy.

(b) A patient or his or her duly designated representative may receive copies of the patient's completed medical record, or an individual report, pursuant to the Hospital's HIPAA policies.

(c) Access to all medical records of patients for bona fide study and research will be made in accordance with Hospital policy, Authorization Policy and Form to Release Protected Health Information 00.ADM.11, applicable federal and state law, and in a manner that preserves the confidentiality of personal information concerning the individual patients.

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

ARTICLE IV

CONTENT AND TIMELINESS OF MEDICAL RECORD DOCUMENTATION

4.A. CONTENT OF MEDICAL RECORD

4.A.1. General Requirements:

All medical records for patients receiving an evaluation or treatment in the Hospital or at an ambulatory care location will document the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the Responsible Practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, race, ethnicity, and name of authorized representative;

(b) for patients receiving psychiatric care, their admission status (i.e., voluntary or involuntary commitment);

(c) patient's language and communication needs, including preferred language for discussing health care;

(d) evidence of informed consent when required by Hospital policy, Written General Consent for Treatment and Notice of Privacy Practices 00.RSK.00 and, when appropriate, evidence of any known advance directives and/or resuscitation orders (i.e., DNR);

(e) records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

(f) emergency care, treatment, and services provided to the patient before his or her arrival, if any;

(g) admitting history (i.e., date, source and type of admission) and physical examination and conclusions or impressions drawn from the history and physical examination;

(h) allergies and sensitivities;

(i) reason(s) for admission of care, treatment, and services;

(j) diagnosis, diagnostic impression, or symptoms;

(k) goals of the treatment and treatment plan;

(l) diagnostic and therapeutic orders, procedures, tests, and results;

(m) progress notes made by authorized individuals;

(n) medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, titration parameter, as applicable, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

(o) consultation reports;

(p) operative and/or high risk procedure reports and/or notes;

(q) any applicable anesthesia evaluations;

(r) response to care, treatment, and services provided;

(s) relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

(t) reassessments and plan of care revisions;

(u) any complications or unfavorable reactions to medications and/or treatments; and

(v) discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, medications dispensed or prescribed on discharge, and if the patient left against medical advice.

4.A.2. Emergency Care:

In addition to any of the applicable general requirements outlined in Section 4.A.1, the medical records of patients who have received emergency care will contain the information outlined in this section, as relevant and appropriate to the patient's care. This documentation will be the joint responsibility of the Responsible Practitioners and the Hospital:

(a) identification data, including the patient's name, sex, address, date of birth, and name of authorized representative;

(b) patient's language and communication needs, including preferred language for discussing health care;

(c) time and means of arrival;

(d) record of care prior to arrival;

(e) medications, including current medications, over-the-counter drugs, and herbal preparations;

(f) pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his or her arrival at the Emergency Department;

(g) results of the medical screening examination, including significant clinical, laboratory, and radiographic findings;

(h) treatment given, if any;

(i) conclusions at termination of treatment, including final disposition, condition, instructions for follow-up care, and any changes in medications;

(j) if the patient left against medical advice; and

(k) a copy of any information provided to the health care provider or facility providing follow-up care, treatment, or services.

4.A.3. Progress Notes:

(a) Progress notes will be entered by the Attending Practitioner or designee for all hospitalized patients in accordance with the rounding requirements outlined in Section 2.D(1)(c) of these Medical Staff Rules and Regulations and as needed to reflect changes in the status of a patient in an ambulatory care location.

(b) Progress notes will be understandable, dated, timed, and authenticated. When appropriate, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

4.A.4. History and Physical:

The requirements for histories and physicals, including general documentation and timing requirements, are outlined in Article 9 of the Medical Staff Bylaws.

4.A.5. Consultation Reports:

(a) Consultation reports will be completed within 24 hours and documented in an EMR-generated note or dictated note, or a legible written note when the EMR is unavailable. The consultation report will contain the date and time of the consultation, opinions based on relevant findings, and recommendations by the Consulting Practitioner.

(b) When non-emergency operative procedures are involved, the Consulting Practitioner's report will be recorded in the patient's medical record prior to the surgical procedure.

4.A.6. Medical Orders:

Medical orders will be entered/written and documented in the medical record in accordance with Article 5 of these Rules and Regulations.

4.A.7. Informed Consent:

Informed consent will be obtained and in accordance with Hospital policy and documented in the medical record

4.A.8. Operative or High-Risk Procedure Reports:

An operative or High-Risk procedure report must be dictated or written in accordance with Article 7 of these Medical Staff Rules and Regulations.

4.A.9. Anesthesia Care Record:

Appropriate notes regarding the anesthesia care provided will be inserted into the patient's medical record on appropriate paper or electronic forms.

4.A.10. Diagnostic Reports:

All diagnostic reports shall be included in the completed medical record. These reports may be filed in the medical record or may appear in an electronic version in the EMR.

4.B. TIMELINESS OF DOCUMENTATION

Failure to complete medical records shall be addressed in accordance with Hospital Policy, Record Completion and Physician Notification Process 01.MD.46 and may result in automatic relinquishment of appointment and clinical privileges. Relinquishment shall continue until all delinquent records are completed and reinstatement accomplished in accordance with the above Policy. Failure to complete medical records that caused relinquishment within the time required by the above Policy shall result in automatic resignation from the Medical Staff or Advanced Practice Professional Staff, as applicable.

ARTICLE V

MEDICAL ORDERS

5.A. GENERAL

(1) Orders will be entered directly into the EMR by the ordering Practitioner utilizing the CPOE, except when the use of written or paper-based orders has been approved by the Hospital (e.g., an emergency situation or when the EMR or CPOE function is not available). Orders ***cannot*** be communicated by text message or Voalte. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient's EMR as soon as possible, and no later than the time of discharge.

(2) All orders (including verbal/telephone orders) must be:

(a) dated and timed when documented or initiated;

(b) authenticated by the ordering Practitioner, with the exception of a verbal order which may be countersigned by another Practitioner who is responsible for the care of a patient. Authentication must include the time and date of the authentication*; and

(c) documented clearly and completely. Orders which are improperly entered will not be carried out until they are clarified by the ordering Practitioner and are understood by the appropriate health care provider.

* Orders entered into the EMR are electronically authenticated, dated, and timed.

(3) All orders must be reconciled when a patient is transferred from one level of care to another (e.g., from a procedural area to the floor, the floor to the ICU, etc.). In addition, medication orders will be reconciled in accordance with Section 5.C below.

(4) When required by state law or his or her written supervision or collaborative agreement, orders issued by an Advanced Practice Professional will be countersigned/authenticated by his or her supervising physician.

5.B. ORDERS FOR TESTS AND THERAPIES

(1) Orders for inpatient tests and therapies will be accepted, to the extent permitted by their license and clinical privileges, from:

(a) members of the Medical Staff;

(b) Advanced Practice Professionals; and

(c) Life Link

(2) Orders for "daily" tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering Practitioner at the expiration of this time frame unless warranted sooner. At the end of the stated time, any order that would be automatically discontinued will be reentered in the same format in which it was originally recorded if it is to be continued.

(3) Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may also be ordered by Practitioners who are not affiliated with the Hospital in accordance with Hospital policy, Outpatient Orders 00.ADM.28.

5.C. ORDERS FOR MEDICATIONS

(1) All medication orders will clearly state the administration times or the time interval between doses and the indications for use when appropriate. Each dose of medication shall be recorded in the medical record of the patient and properly signed after the medication has been administered. If not specifically prescribed as to time or number of doses, the medications will be controlled by protocols or by automatic stop orders as described in Section 5.G of these Rules and Regulations. See Hospital policy, Administration of Medications 00.PAT.13.

(2) All orders for medications administered to patients will be:

(a) periodically reviewed by the prescriber to assure appropriateness;

(b) reviewed when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

(c) reviewed by a Hospital pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). Pharmacist review is not required when Licensed Independent Prescriber is present and controlling the ordering and administration.

(3) The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medication orders is not acceptable.

(4) The use of "conditional" orders are permissible only if they include the specific parameters and time period needed to meet the "condition" and activate or release the order.

(5) All PRN orders (i.e., as necessary medication orders) must be qualified by either specifying time intervals or the limitation of quantity to be given in a 24-hour period. All PRN medications must specify the indications for use.

(6) Titration orders may be used so long as the following are specified:

(a) medication name and route;

(b) initial or starting rate of infusion (e.g., dose/min);

(c) incremental units the rate can be increased or decreased and frequency for incremental doses;

(d) maximum range (dose) of infusion; and

(e) objective clinical endpoint for the titration (e.g., RASS score, CAM score, etc.).

(7) Advanced Practice Professionals may be authorized to issue medication orders as specifically delineated in their clinical privileges. If required by the Advanced Practice Professional's written supervision agreement, any such order will be countersigned in accordance with Section 3.B.2 of these Rules and Regulations.

5.D. VERBAL ORDERS

(1) A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering practitioner and a delay in accepting the order could adversely affect patient care.

(2) All verbal orders will be entered into the EMR and include the date and time of entry into the medical record, identify the names and titles of the individuals who gave, received, and implemented the order, and include the full signature of the individual who accepted the order. Verbal orders will then be authenticated with date and time by the ordering practitioner or another practitioner who is responsible for the care of the patient, as authorized by Hospital policy, Telephone and Verbal Orders-Receiving and Documenting 00.PAT.32 and state law.

(3) The ordering practitioner, or another practitioner who is responsible for the patient's care in the Hospital, will countersign all verbal orders (both in person and by telephone) promptly, as described in the CMS Conditions of Participation (i.e. performed readily and immediately).

(4) For verbal orders, the complete order will be verified by having the person receiving the information record and "read-back" the complete order as the order is entered and alert checking is completed in the EMR. This will serve to eliminate

any errors related to sound-alike drugs and other common discrepancies in transmission and acceptance of verbal orders.

(5) Personnel qualified to receive and record telephone/verbal orders are outlined and in accordance with Hospital policy, Telephone and Verbal Orders – Receiving and Documenting 00.PAT.32.

5.E. STANDING ORDERS, ORDER SETS, AND PROTOCOLS

(1) The MEC and the Hospital's nursing and pharmacy departments must review and approve any standing orders, order sets, and protocols (collectively, "standing orders") that permit treatment to be initiated by an individual (for example, a nurse) without a prior specific order from the Attending Practitioner. All standing orders will identify well-defined clinical scenarios for when the order is to be used.

(2) The MEC will confirm that all approved standing orders are consistent with nationally recognized and evidence-based guidelines. The MEC will receive confirmation that such standing orders are reviewed by the Departments and are consistent with evidence based medicine at least annually.

(3) If the use of a standing order has been approved by the MEC, treatment may be initiated (i) by a nurse or other authorized individual acting within his or her scope of practice who activates the order; or (ii) when a nurse enters documentation into the medical record that triggers the standing order.

(4) When used, standing orders must be dated, timed, and authenticated promptly in the patient's medical record by the individual who activates the order or by another Responsible Practitioner.

(5) The Attending Practitioner must authenticate the initiation of each standing order after the fact, with the exception of those for influenza and pneumococcal vaccines, which may be administered per Hospital policy, Influenza Vaccinations Adults and Pediatrics 01.PAT.31, after an assessment for contraindications. See also Standards for Development, Revision, Review and Deletion of Electronic Orders, Order Sets, Protocols and Standing Orders with Medications 00.MD.43.

5.F. SELF-ADMINISTRATION OF MEDICATIONS

Self-administration of medications without the direct supervision of a licensed nurse, physician/provider, or respiratory therapist is not allowed unless in accordance with Hospital Policy, Self-Administration of Medications by Patients 129.062/126.202.

5.G. STOP ORDERS

(1) Medication stop orders shall be implemented as indicated except for those orders which have:

(a) a specified number of total doses to be administered; or

(b) a specified time period for doses to be administered.

(2) The medication stop order policy shall apply to those drugs as defined by the Pharmacy and Therapeutics Committee.

(3) The ordering Practitioner shall be notified in advance of the impending expiration of an order through the patient's medical record. The Practitioner shall renew as a continuing order, renew with indicated stop time or number of doses, change the order by completely rewriting, or discontinue the order.

(4) Drug orders shall not be stopped until there is documented evidence that the ordering Practitioner has been contacted, is aware of the impending expiration of the order, and has had an opportunity to determine if administration of the drug is to be stopped, continued, or altered. Orders may be renewed by telephone.

5.H. ORDERS FOR DRUGS AND BIOLOGICALS

(1) Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

(2) All orders for medications and biologicals will be dated, timed and authenticated by the Responsible Practitioner, with the exception of influenza and pneumococcal vaccines, which may be administered per Hospital policy, Influenza Vaccinations Adults and Pediatrics 01.PAT.31, after an assessment for contraindications. Verbal or telephone orders will only be used in accordance with these Rules and Regulations.

5.I. ORDERS FOR RADIOLOGY AND DIAGNOSTIC IMAGING SERVICES

(1) Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital or in accordance with the Hospital's policy, Outpatient Orders 00.ADM.28, on accepting orders for outpatient services from Practitioners who are not otherwise affiliated with the Hospital.

(2) Orders for radiology services and diagnostic imaging services must include: (i) the patient's name, date of birth, proof of insurance (and authorization for the exam if insurance requires), and accurate telephone number; (ii) the name of the ordering

individual; (iii) the radiological or diagnostic imaging procedure orders; including the appropriate ICD-10 code and (iv) the reason for the imaging service.

5.J. ORDERS FOR RESPIRATORY CARE SERVICES

(1) Respiratory care services may be ordered by a qualified and licensed Practitioner who is responsible for the care of the patient.

(2) Orders for respiratory care services must include as applicable: (i) the patient's name; (ii) the name and electronic or written signature of the ordering individual; (iii) the type, frequency, and, if applicable, duration of treatment; (iv) the type and dosage of medication and diluents; and (v) the oxygen concentration or oxygen liter flow and method of administration.

5.K. RESUSCITATION ORDERS

The administration or withholding of resuscitative measures for patients shall be followed in accordance and as defined in Hospital Policy, Code Blue Classification and Do Not Resuscitate (DNR) Orders 00.PAT.02

5.L. DISCHARGE ORDER

Patients shall be discharged in accordance with Article 11.

ARTICLE VI

CONSULTATIONS

6.A. REQUESTING INPATIENT CONSULTATIONS

(1) Requests for consultations shall be ordered in the EMR by a Requesting Practitioner (including Advanced Practice Professionals) and in accordance with the following communication guidelines:

- **STAT Consults** – For STAT consults, the Requesting Practitioner (who must be a physician) will personally speak with the Consulting Practitioner (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the emergent consultation.

- **ASAP Consults** – For ASAP consults (e.g., "urgent," "today," or similar terminology), the Requesting Practitioner (who may be a physician or another member of the care team) will personally speak with the Consulting Practitioner (face-to-face or by telephone) to provide the patient's clinical history and the specific reason for the urgent consultation.

- **Routine Consults** – In addition to entering the reasons for the consultation request in the EMR, the Requesting Practitioner (who may be a physician or another member of the care team) will make reasonable attempts to personally contact the Consulting Practitioner to discuss all routine consultation requests.

(2) Failure by a Requesting Practitioner to follow the communication guidelines described in this Section may be reviewed through the appropriate Medical Staff policy.

6.B. RESPONDING TO INPATIENT CONSULTATION REQUESTS

(1) Any member of the Active Staff can be asked for an inpatient consultation within his or her area of expertise. Members who are requested to provide an inpatient consultation will respond to the request either in person, via telephone, or via other technology-enabled direct communication (i.e., Voalte or other EMR communication). In either case, the Consulting Practitioner is expected to respond in accordance with the following patient care guidelines:

(a) **STAT Consults** – must be completed within ***two hours*** of the request, unless the patient's condition requires that the Consulting Practitioner complete the consultation sooner;

(b) **ASAP Consults** – must be completed within ***12 hours*** of the request, unless the patient's condition requires that the Consulting Practitioner complete the consultation sooner;

(c) **Routine Consults** – must be completed within ***24 hours*** of the request or within a time frame as agreed upon by the Requesting Practitioner and the Consulting Practitioner.

(2) The Consulting Practitioner may ask an Advanced Practice Professional with appropriate clinical privileges to examine the patient, gather data, order tests, and generate other documentation to help facilitate the consultation. However, an evaluation by an Advanced Practice Professional will not relieve the Consulting Practitioner of his or her obligation to personally see the patient.

(3) When providing a consult, the Consulting Practitioner will review the patient's medical record, brief the patient on his or her role in the patient's care, and examine the patient in a manner consistent with the requested consult. Any plan of ongoing involvement by the Consulting Practitioner will be directly communicated to Requesting Practitioner.

(4) Failure to respond to a request for a consultation in a timely and appropriate manner will be reviewed under the appropriate Medical Staff policy.

(5) Practitioners who wish to refuse consultation are responsible for finding alternate coverage. If they are unable to do so, then the Chief of Staff or the appropriate Department Chairperson can appoint an alternate Consultant.

(6) Once the Consulting Practitioner is involved in the care of the patient, the Requesting Practitioner and Consulting Practitioner are expected to review the patient's medical record on a regular basis to assure continuity of care until such time as the Consulting Practitioner has signed off on the case or the patient is discharged.

(7) A Requesting Practitioner who believes that an individual has not responded in a timely and appropriate manner to a request for a consultation may discuss the issue with the CMO, the Chief of Staff, or the appropriate Department Chairperson.

6.C. RECOMMENDED CONSULTATIONS

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

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

(2) The Chief of Staff, the CMO, and the appropriate Department Chairperson shall each also have the right to call in a Consulting Practitioner where a consultation is determined to be in the patient's best interest.

6.D. MENTAL HEALTH CONSULTATIONS

A mental health consultation and treatment will be requested for and offered to all observation and inpatients who have engaged in self-destructive behavior (e.g., attempted suicide, chemical overdose) or who are determined to be a potential danger to themselves or others. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made will be documented in the patient's medical record.

6.E. SURGICAL CONSULTATIONS

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the Consulting Practitioner, including relevant findings and reasons, must appear in the patient's medical record. If a relevant consultation has not been communicated, surgery and anesthesia will not proceed, unless the surgeon states in writing that an emergency situation exists.

6.F. CRITICAL CARE CONSULTATIONS

A consult with a Critical Care specialist is required at the time of admission to an Adult Critical Care Unit for all patients unless the patient is in a "stepdown" bed status or waiting availability of a non-critical care bed.

ARTICLE VII

PROCEDURAL SERVICES

7.A. GENERAL

Criteria has been established in accordance with the Hospital policy, Preoperative Admission Criteria, Patient Assessment and Preparation for Surgery 139.0201.

7.B. PRE-PROCEDURAL PROCEDURES

Except in a documented emergency situation, the following will occur before an operative or high-risk procedure or the administration of anesthesia occurs:

(1) the Proceduralist or Surgeon is in the Hospital;

(2) The following documents will have been entered into the medical record either prior to starting the procedure or prior to transporting the patient to the procedure room in accordance with policies specific to the procedural areas:

(a) the provisional diagnosis and the results of any relevant diagnostic tests;

(b) the signed attestation of consent completed by the Proceduralist; and

(c) a complete and appropriately updated history and physical examination (or completed short-stay form, as appropriate);

(3) the anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

(4) pre-procedural education, treatments, and services are provided according to the plan for care, treatment, and services;

(5) a pre-anesthesia evaluation is performed; and

(6) the procedure site is marked and a “time out” is conducted, as described in and in accordance with the Hospital policy, Correct Patient, Procedure and Site Verification 01.PAT.18.

7.C. POST-PROCEDURAL PROCEDURES

(1) Immediate Post-Operative Note (IPON). An IPON must be entered in the medical record ***immediately*** after an operative procedure* and before the patient is transferred to the next level of care by the Proceduralist or other authorized Advanced Practice Professional and if required, cosigned within 24 hours.

The IPON will include:

(a) the names of the physician(s) responsible for the patient's care and physician assistants;

(b) the name and description/technique of the procedure(s) performed and any complications (if encountered);

(c) findings, where appropriate, given the nature of the procedure;

(d) type of anesthesia administered;

(e) estimated blood loss, when applicable or significant;

(f) specimens removed;

(g) grafts or implants (may indicate where in chart for detail); and

(f) pre-operative and post-operative diagnosis.

*For purposes of this Article, "operative procedures" includes not only surgical operations, but also other procedures, including Cath Lab procedures, EP Lab procedures, Endoscopy procedures, Pathology procedures, and bedside procedures, etc.

(2) Full Operative or High Risk Procedure Report. A full operative or high risk procedure report must be dictated or entered ***within 24 hours*** after an operative procedure. The operative procedure or high risk procedure report shall include:

(a) the patient's name and hospital identification number;

(b) pre- and post-operative diagnoses;

(c) date and time of the procedure;

(d) the name of the Attending Practitioner(s) and assistant surgeon(s) responsible for the patient's operation;

(e) procedure(s) performed and description/technique of the procedure(s);

(f) description of the specific surgical tasks that were conducted by Practitioners other than the Attending Practitioner;

(g) findings, where appropriate, given the nature of the procedure;

(h) estimated blood loss, where applicable;

(i) any unusual events or any complications, including blood transfusion reactions and the management of those events;

(j) the type of anesthesia/sedation used and name of the Practitioner providing anesthesia;

(k) specimen(s) removed and disposition, if any;

(l) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any); and

(m) the signature of the Attending Practitioner.

(3) A Structured Operative Note may serve as both IPON and Full Operative Report, provided all required elements are present.

(4) Cancelled Procedures. If an operative procedure is cancelled after a patient is prepared for surgery, the Attending Practitioner will enter a progress note describing the reason for cancelling the procedure (e.g., because of the patient's condition or other unforeseen circumstances) as well as a description of any specific surgical tasks that were performed prior to cancelling the procedure (e.g., the procedure was cancelled prior to the administration of anesthesia or after the procedure has been started).

7.D. PATHOLOGY REPORTS AND DISPOSITION OF SURGICAL SPECIMENS

(1) All significant surgical specimens removed during an operative procedure shall be properly labeled, packaged in preservative as designated, identified in the operating room or procedural area as to patient and source, and sent to the Hospital pathologist, who will determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including the pre-operative and post-operative surgical diagnoses. See Hospital policy, Specimen Preparation and Handling for Operative and Other Invasive Procedures 01.PAT.24.

(2) The pathologist will document the receipt of all surgically removed specimens and sign the pathology report, which shall become part of the patient's medical record. The pathology report will be filed in the medical record within 24 hours of completion.

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

ARTICLE VIII

ANESTHESIA SERVICES

8.A. GENERAL

(1) Anesthesia may only be administered by the following qualified Practitioners:

(a) an anesthesiologist;

(b) an M.D. or D.O. who has been granted clinical privileges to administer anesthesia in a specific patient care area or for a specific procedure; and

(c) a CRNA who is supervised by an on-site operating Practitioner or an anesthesiologist who is immediately available;

(2) "Anesthesia" means general or regional anesthesia, monitored anesthesia care or deep sedation, including epidurals, spinals, and other nerve blocks. "Anesthesia" does not include topical or local anesthesia, minimal or moderate ("conscious") sedation.

(3) Pre-anesthesia evaluations, procedural monitoring and post anesthesia care will be performed in accordance with Hospital policy, Preoperative Admission Criteria, Patient Assessment, and Preparation for Surgery 139.0201; Anesthesia Care and Intraoperative Monitoring 139.0501; Admission Discharge Criteria PACU 139.1603

8.B. POST ANESTHESIA EVALUATIONS

In all cases, a post-anesthesia evaluation will be completed and documented in the patient's medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

8.C. DIRECTION OF ANESTHESIA SERVICES

Anesthesia services will be under the direction of a qualified doctor of medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate clinical privileges and who is responsible for the following:

- planning, directing and supervising all activities of the anesthesia service; and
- evaluating the quality and appropriateness of anesthesia patient care.

ARTICLE IX

PHARMACY

9.A. GENERAL RULES

(1) Orders for drugs and biologicals are addressed in the Medical Orders Article.

(2) Adverse medication reactions and errors in administration of medications will be immediately documented in the patient's medical record and reported to the Attending Practitioner, the director of pharmaceutical services, and, if appropriate, to the Hospital's quality assessment and performance improvement program.

(3) The pharmacy may substitute an alternative equivalent product for a prescribed brand name when the alternative is of equal quality and ingredients, and is to be administered for the same purpose and in the same manner.

(4) All drugs and medications will be administered in accordance with the Policies and Procedures of the Pharmacy and Therapeutics Committee. A Hospital Formulary shall be developed by the Pharmacy and Therapeutics Committee. All investigational drugs must be reviewed and approved in accordance with the Policies and Procedures of the Institutional Review Board and shall only 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.

(5) Information relating to medication interactions, therapy, side effects, toxicology, dosage, indications for use, and routes of administration will be readily available to members of the Medical Staff, Advanced Practice Professionals, and other Hospital personnel.

9.B. PATIENT'S OWN MEDICATION

If a patient brings his or her own medications to the Hospital, these medications shall not be administered unless the Attending Practitioner has entered an order for their administration. If the medications are not ordered by the Attending Practitioner, they shall be packaged, sealed and sent home with the patient's personal representative or other person identified by the patient on admission. Otherwise, such medications will be kept in a secure area such as the Hospital pharmacy or in Security for 30 days or until the patient's discharge, at which time such medications will be returned to the patient or given to the patient's legal representative. Controlled substances as listed in the Controlled Substances, Drug, Device and Cosmetic Act except as otherwise described in policy shall not be returned to the patient without approval of the Attending Practitioner.

9.C. STORAGE AND ACCESS

(1) In order to facilitate the delivery of safe care, medications and biologicals will be controlled and distributed in accordance with Hospital policy, Medication Storage and Compliance Monitoring 126.203/129.007; Administration of Medications 00.PAT.13 consistent with federal and state law.

(a) All medications and biologicals will be kept in a secure area, and locked unless under the immediate control of authorized staff.

(b) Medications listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1970 will be kept locked within a secure area.

(c) Only authorized personnel may have access to locked or secure areas.

(2) Abuses and losses of controlled substances will be reported, in accordance with applicable federal and state laws, to the individual responsible for the pharmaceutical service, and to the President.

ARTICLE X

EMERGENCY SERVICES – QUALIFIED MEDICAL PERSONNEL

10.A. MEDICAL SCREENING EXAMINATIONS

1. Medical screening examinations, within the capability of the Hospital, will be performed on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Qualified Medical Personnel ("QMP") who can perform medical screening examinations within applicable Hospital policies and procedures are defined as:

    (a) Emergency Department:

        (i) members of the Medical Staff with clinical privileges in Emergency Medicine;

        (ii) other Active Staff members; and

        (iii) appropriately credentialed Advanced Practice Professionals.

    (b) Labor and Delivery:

        (i) members of the Medical Staff with OB/GYN privileges;

        (ii) Certified Registered Nurse Midwives with OB privileges; and

        (iii) Registered Nurses who have achieved competency in Labor and Delivery and who have validated skills to provide fetal monitoring and labor assessment.

ARTICLE XI

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

11.A. WHO MAY DISCHARGE

(1) Patients will be discharged only upon the order of the Attending Practitioner or another Practitioner acting as his or her designee.

(2) At the time of discharge, the discharging physician will review the patient's medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

(3) 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, and the patient shall be asked to sign an "Against Medical Advice" form.

11.B. DISCHARGE PLANNING

(1) Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission. The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The Responsible Practitioner is expected to participate in the discharge planning process.

(2) Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

11.C. DISCHARGE SUMMARY

(1) A concise discharge summary will be prepared by the Practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another Practitioner who agrees to assume this responsibility. All discharge summaries will include the following and must be completed as soon as possible and no later than ***30 days*** after discharge:

(a) reason for hospitalization;

(b) significant findings;

(c) procedures performed and care, treatment, and services provided;

(d) final diagnosis and the patient's condition and disposition at discharge;

(e) information provided to the patient and family, as appropriate;

(f) provisions for follow-up care; and

(g) discharge medication reconciliation.

(2) A short stay form may be used to document the discharge summary for routine obstetrics admissions, a patient discharged from antepartum service, a patient admitted for less than 48 hours, and a newborn services short admission for less than 48 hours. A final summary progress note, antepartum discharge summary, newborn discharge summary or short stay summary form will be completed.

(3) If the discharge summary is prepared by an Advanced Practice Professional, the Attending Practitioner will authenticate and date the discharge summary to verify its content.

11.D. DEATH SUMMARIES

A death summary shall be documented in the event of an inpatient death, regardless of the length of the patient's stay in the Hospital. The death summary shall include date of admission, admitting and final diagnoses, reason for hospitalization, significant findings, course of treatment, events leading to death, and the date and exact time of death.

11.E. DISCHARGE OF INCOMPETENT PATIENTS AND MINORS

Any individual who lacks decision-making capacity, is legally incompetent, or is a minor shall be discharged only to the custody of the designated surrogate or proxy decision maker. If the designated surrogate or proxy decision maker directs that discharge be made otherwise, he or she shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

ARTICLE XII

HOSPITAL DEATHS AND AUTOPSIES

12.A. DEATH CERTIFICATES

(1) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the Attending Practitioner, an Advanced Practice Professional, or 2 RN's within a reasonable time frame. Death certificates are the responsibility of the Attending Practitioner and will be completed within ***24 hours*** of when the certificate is available to the responsible Practitioner Physician and in accordance with state law.

(2) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person.

(3) The Attending Practitioner (or his or her designee) will notify the coroner/medical examiner of any cases considered by law to be a coroner/medical examiner's case.

12.B. AUTOPSIES

(1) No autopsy shall be performed without written consent of a relative or legally authorized agent. Such consent must be documented in the medical record.

(2) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient's death. If permission is refused, this must be documented in the medical record.

(3) All autopsies shall be performed by the Hospital pathologist or by a Practitioner delegated this responsibility by the Hospital pathologist. Provisional anatomic diagnoses shall be recorded on the medical record and the complete protocol should be made part of the record within sixty (60) days after the autopsy.

(4)

12.C. POTENTIAL ORGAN AND TISSUE DONORS

It is the policy of the Hospital to identify potential organ and tissue donors and to offer the relatives or legally authorized agents of every medically suitable deceased patient, the opportunity to donate. All Medical Staff members and residents will cooperate fully in this effort.

ARTICLE XIII

MISCELLANEOUS

13.A. ORIENTATION

All new members of the Medical Staff will be provided an overview of the Hospital and its operations. As a part of this orientation, the Medical Records Department and Medical Staff Services will orient new members as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties.

13.B. SELF-TREATMENT AND TREATMENT OF FAMILY MEMBERS, COLLEAGUES, AND CO-WORKERS

13.B.1. Self-Treatment:

(a) Practitioners are strongly discouraged from treating themselves, except in an emergency situation or where no viable alternative treatment is available.

(b) Practitioners should never write prescriptions for controlled substances for themselves.

13.B.2. Guidelines for Treatment of Immediate Family Members, Colleagues, and Co-Workers:

(a) Generally, Practitioners should refrain from the following activities in the Hospital:

(1) admitting or consulting on immediate family members (i.e., a parent, spouse, child, or anyone else residing in the same household); or

(2) being involved in the care of a family member with complex or potentially serious symptoms or diagnoses.

When considering these guidelines, factors such as the availability of other Practitioners to provide the needed care, patient acuity, and the patient's right to direct his/her own medical care should also be considered.

(b) Practitioners should never write prescriptions for controlled substances for family members.

(c) As it relates to colleagues and co-workers in the Hospital, Practitioners should refrain from:

(1) treating any individual without first performing an appropriate assessment and creating a proper medical record; or

(2) writing a prescription for any individual in the absence of a formal practitioner-patient relationship.

13.C. INFECTION PRECAUTIONS

All Practitioners will abide by Hospital infection control policies.

13.D. HIPAA REQUIREMENTS

All Practitioners will:

(1) adhere to the security and privacy requirements of HIPAA, meaning that only a Responsible Practitioner may access, utilize, or disclose protected health information; and

(2) complete any applicable HIPAA compliance and privacy training that is required by the Hospital.

13.E. TREATMENT OF SEXUAL ASSAULT VICTIMS

The appropriate medical attention and treatment shall be provided to victims of sexual assault through:

(1) such gynecological, psychological, and medical services as are needed by the victim;

(2) the administration of medical examinations, tests, and analysis required by law enforcement personnel in the gathering of evidence required for investigation and prosecution; and

13.F. CHILD ABUSE, NEGLECT CASES, AND VULNERABLE ADULTS

The Hospital shall maintain a policy that every staff member has an affirmative duty to report any actual or suspected case of child abuse, abandonment, or neglect, and act as a liaison between the Hospital and Department of Children and Family Services office which is investigating the suspected abuse, abandonment, or neglect.

13.G. NEW OR EXPANDED CLINICAL PROGRAMS/SERVICES

The Chief Medical Officer in coordination with the Chief of Staff and Chief Operating Officer will be responsible for identifying those new or expanded clinical services programs which will be presented to the Medical Executive Committee for review and input.

13.H. PUBLIC HEALTH POLICIES

In the event that the federal or state government enacts public health policies (e.g., quarantining during a pandemic), all Practitioners agree to abide by such policies and actions when recognized by the Hospital.

13.I. TELEHEALTH IN THE CASE OF AN EMERGENCY

While efforts will be made to include telehealth privileges within the relevant core of all specialties, in the event of an emergency, the Hospital may permit currently credentialed and privileged Practitioners to provide care to their patients via telehealth on a temporary basis, without the need for any additional credentialing or privileging. The MEC may be consulted to determine which services would be appropriate to be delivered in this manner.

ARTICLE XIV

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 10 of the Medical Staff Bylaws.

ARTICLE XV

ADOPTION

These Rules and Regulations are adopted and made effective upon approval of the Sarasota County Public Hospital Board, superseding and replacing any and all other bylaws, rules and regulations, policies, manuals of the Medical Staff, or the Hospital policies pertaining to the subject matter thereof.

Adopted by the MEC on: Physician Advisory Committee, July 23, 2020

Approved by the Board on: December 21, 2020