# LARGO MEDICAL CENTER

# MEDICAL STAFF ORGANIZATIONAL PLAN

# RULES AND REGULATIONS

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## MEDICAL STAFF STANDING COMMITTEES
## RULES AND REGULATIONS
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## ARTICLE I - DEFINITIONS

The following definitions shall apply to terms used in this Medical Staff Organizational Plan Rules and Regulations:

### DEFINITIONS

The following terms shall have the meanings as set forth below, unless the context clearly indicates otherwise. Some of the terms defined below are not capitalized when used throughout these Rules and Regulations.

Administration: The executive members of the Hospital staff, including the Chief Executive Officer (CEO), Chief Operating Officer (COO), Chief Financial Officer (CFO) and Chief Nursing Officer (CNO).

Administrator: The individual appointed by Corporate Management to act on behalf of the Hospital in the overall management of the Hospital. The administrator holds the title of Chief Executive Officer (CEO) of the Hospital. In the event of his/her absence, the CEO may select a designee to temporarily serve in the role of administrator.

Adverse Action: An action that adversely affects an individual's Medical Staff membership or clinical privileges. An adverse action shall entitle the individual to the procedural rights afforded by the Fair Hearing Plan, except as provided in these Rules and Regulations. An adverse action shall include a denial or termination of Medical Staff membership, or a denial, reduction, or termination of clinical privileges.

Allied Health Professional (AHP): An individual, other than those defined under "Physician," who provides direct patient care services in the Hospital under a defined degree of supervision, exercising judgment within the areas of documented professional competence and consistent with applicable law. AHPs are designated by the Board to be credentialed through the Medical Staff system and are granted clinical privileges as either a dependent or independent healthcare professional as defined in these Rules and Regulations. AHPs are not eligible for Medical Staff membership. The Board has determined the categories of individuals eligible for clinical privileges as an AHP are physician assistants (PA), certified registered nurse anesthetists (CRNA) and advanced registered nurse practitioners (ARNP).

Applicant: An individual who has submitted a Complete Application for appointment, reappointment or clinical privileges.

AOA: American Osteopathic Association. The AOA serves as the primary certifying body for doctors of Osteopathic Medicine (D.O), and is the accrediting agency for all osteopathic medical colleges and health care facilities.

Approved School: (a) a medical school in the United States or Canada, accredited by the Liaison Committee on Medical Education of the American Medical Association, or (b) a medical school approved by the American Osteopathic Association, or (c) a medical school approved by the Educational Council for Foreign Medical Graduates, or (d) a dental school approved by the American Dental Association.

Board Certification: A designation for a physician who has completed an approved educational training program and an evaluation process including an examination designed to assess the knowledge, skills and experience necessary to provide quality patient care in that specialty. Board certification shall be from an American Board of Medical Specialties (ABMS) Member Board or from the American Osteopathic Association (AOA) or from the American Board of Podiatric Surgery (ABPS) if the applicant is a podiatrist, or from the American Board of Oral/Maxillofacial Surgeons (ABOMS) if the applicant is an oral surgeon.

Board Admissible, Eligible or Qualified: shall be defined by the applicable Board but shall require that the applicant for appointment or the appointee is actively pursuing board certification, has applied to take the Board Examination and that his application has been approved and has not expired. The applicant for appointment or the appointee must complete the certification process within three years.

Board of Directors:. The individuals elected by the shareholders for the Corporation (or selected or appointed by the Partnership) to hold ultimate responsibility for the Hospital and are the governing body of the Corporation (or Partnership), sometimes herein referred to as the "Directors."

Board of Trustees: As used herein, the Board of Trustees is the local governing body of the Hospital, delegated specific authority and responsibility, and appointed by the Board of Directors. It is the "governing body" as described in the standards of The Joint Commission (TJC) and the Medicare Conditions of Participation. The Board of Trustees may also be referred to as the "Trustees" or the "Board" unless otherwise specifically stated.

Bylaws: The Bylaws of the Medical Staff, unless otherwise specifically stated.

Certification: The procedure and action by which a duly authorized body evaluates and recognizes (certifies) an individual as meeting predetermined requirements.

Chief of Staff: A member of the active Medical Staff who is elected in accordance with the Bylaws to serve as chief officer of the Medical Staff of this Hospital.

Chief Executive Officer (CEO): Person to whom the Board of Trustees delegates the full-time authority and responsibility for the operation of the Hospital. When used in these Rules and Regulations, Chief Executive Officer shall mean Chief Executive Officer or his designee.

Clinical Privilege/Privilege: The permission granted by the Board to appropriately licensed individuals to render specifically delineated professional, diagnostic, therapeutic, medical, surgical, dental, or podiatry services with the approval of the Board.

Complete Application: An application for either initial appointment or reappointment to the Medical Staff, or an application for clinical privileges, that has been determined by the applicable Medical Staff Department Chairperson, the Credentials Committee, the Medical Executive Committee and/or the Board to meet the requirements of the Bylaws. Specifically, to be complete the application must be submitted in writing on a form approved by the Medical Executive Committee and the Board, and include all required supporting documentation and verifications of information, and any additional information needed to perform the required review of qualifications and competence of the applicant. Specific to applications or requests for clinical privileges, it shall not be complete unless it includes supporting evidence of competence for each of the privileges requested and proof that the applicant meets the criteria for each of the privileges requested.

Contract Practitioner: A Practitioner providing care or services to Hospital patients through a contract or other arrangement with the Hospital.

Corporation: Largo Medical Center, Inc.

CPCS: The Clinical Patient Care System, used to electronically document patient care.

Criminal Conviction: Conviction of, or a plea of guilty or *nolo contendere* for, any felony or misdemeanor related to the practice of a health care profession, Federal Health Care Program fraud or abuse, third-party reimbursement, or controlled substances.

Data Bank: The National Practitioner Data Bank (NPDB) implemented pursuant to the HCQIA.

Days: Calendar days, unless otherwise noted.

Dentist: An individual, who has received a doctor of dental surgery or a doctor of dental medicine degree and has a current, unrestricted license to practice dentistry.

Dependent Healthcare Professional: An individual who is permitted both by law and by the Hospital to provide patient care services under the direction or supervision of an independent practitioner, within the scope of the individual's license, and in accordance with individually granted clinical privileges if the dependent practitioner is an AHP.

Department: A clinical grouping of members of the Medical Staff in accordance with their specialty or major practice interest, as specified in the Bylaws.

Director of Medical Education: An osteopathic physician at an institution that has the authority and responsibility for oversight and administration of internship and residency programs.

Disruptive Conduct: Conduct which adversely impacts the operation of the Hospital, affects the ability of others to get their jobs done, creates a "hostile work environment" for hospital employees or other individuals working in the Hospital, or begins to interfere with the disruptive individual's own ability to practice competently. Such conduct may include rude or abusive behavior or comments to staff members or patients, negative comments to patients about other physicians, nurses or other staff or about their treatment in the Hospital, threats or physical assaults, sexual harassment, refusal to accept medical staff assignments, disruption of committee or departmental affairs, or inappropriate comments written in patient medical records or other official documents.

Educational Commission for Foreign Medical Graduates (ECFMG): The ECFMG, through a series of exams, assesses whether physicians graduating from Medical schools outside the United States and Canada are ready to enter U.S. residency and fellowship programs that are accredited by the Accreditation Council for Graduates Medical Education (ACGME).

Ex Officio: Serves as a member of a body by virtue of an office or position held, and unless otherwise expressly provided, means without voting rights.

Fair Hearing Plan: The fair hearing plan as approved by the MEC and Board and incorporated into the Bylaws.

Federal Health Care Program: Any plan or program that provides health benefits, whether directly, through insurance, or otherwise, which is funded directly, in whole or in part, by the United States Government or a State health care program (with the exception of the Federal Employees Health Benefits Program). The most significant Federal health care programs are Medicare, Medicaid, Blue Cross Federal Employee Program (FEP)/Tricare/Champus and the Veterans programs.

Fellow: A physician in an AOA approved subspecialty residency program that is beyond the requirements for eligibility for first board certification in the discipline and who are either registered with or licensed by the State of Florida.

Fifth Pathway: The Fifth Pathway permits qualifying students who have completed four years of medical training at the Universidad Autonoma de Guadalajara (UAG) to return to the United States and enter a year of supervised clinical training at a U.S. Medical School with an approved Fifth Pathway Program. This is offered as an alternative to ECFMG certification.

Good Standing: The term "good standing" means a staff member who, during the current term of appointment, has maintained qualifications for Medical Staff membership in an assigned staff category, is not in arrears in dues payment or the completion of medical records, and has not received a suspension or restriction of membership or privileges.

Governing Body: The Board of Trustees of the Hospital, which has been delegated specific authority

and responsibility, and appointed by the Board of Directors.

Graduate Medical Education (GME): The second phase of medical education which prepares physicians practice in a medical Specialty. GME focuses on the development of clinical skills and professional competencies and on the acquisition of detailed factual knowledge in a medical specialty.

GSA List: The General Service Administration's List of Parties Excluded from Federal Programs.

HCQIA: The Health Care Quality Improvement Act of 1986, 42 U.S.CS. §11101 et seq.

HIPPA: The Health Insurance Portability and Accountability Act of 1996 is a Federal Law at 45 C.F.R. 160,162, 164 which includes The Standards for Privacy of Individually Identifiable Health Information ("Privacy Standards") developed to provide Federal Standards for the protection of health information that is used and disclosed by Hospitals, Healthcare Providers, Health Plans, Healthcare Clearing Houses ("Covered Entities") and their "Business Associates". The Privacy Standards provide certain rights to patients for the control of access to and disclosure of their personal protected health information. At the same time, the Privacy Standards establish obligations of Covered Entities for the protection of their patient's health information. For purposes of meeting these obligations, the Hospital has established an Organized Health Care Arrangement with its Medical Staff and Allied Health Professional Staff. Under this Arrangement, Medical Staff members and Allied Health Professionals who have not opted out of the Arrangement, in writing, have agreed to abide by Hospital policies and procedures related to the Hospital's legal responsibilities under the Privacy Standards.

Healthcare Professional: An individual licensed, certified, or registered by the State, or otherwise permitted, through virtue of completion of a course of study and possession of skills in a field of health, to provide health care to patients.

Hospital: Largo Medical Center Inc. d/b/a Largo Medical Center 201 14th Street Southwest, Largo Florida 33770, d/b/a Sun Coast Hospital an affiliate of Largo Medical Center, 2025 Indian Rocks Road, Largo Florida 33774. As the term is used in the Bylaws/Rules and Regulations, it shall mean all of the facilities, services, and locations licensed or accredited as part of the Hospital, which is an organization inclusive of the Medical Staff.

House Staff: Includes Interns, Residents and Fellows who are in a graduate training program that is approved by a nationally recognized accrediting body, approved by the U.S. Department of Education; and who are permitted to participate in patient care under the direction of an appointee of the Medical Staff and who are either registered with or licensed by the State of Florida. This definition excludes Medical Students.

Independent Healthcare Professional: An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges.

Ineligible Person: Any individual who: (1) is currently excluded, suspended, debarred, or ineligible to participate in any Federal health care program; or (2) has been convicted of a criminal offense related to the provision of health care items or services and has not been reinstated in a Federal health care program after a period of exclusion, suspension, debarment, or ineligibility.

Intern: An Intern is a graduate of a school of Osteopathic Medicine who is in the first year of postdoctoral training at an AOA accredited internship program.

License: An official or a legal permission, granted by a competent authority, usually public, to an individual to engage in a practice, an occupation or an activity otherwise unlawful.

License Status: Indicates the status of the physician's medical license, which is issued by the state medical board. The most common status categories are:

- active—full and unrestricted license to practice medicine
- inactive—physician is not practicing, but reserves the right to activate their license in the future
- expired—no longer valid for use
- revoked—disciplinary action prohibits the practice of medicine
- restricted—board imposed limitation on the practice of medicine

Licensure: A legal right that is granted by a governmental agency in compliance with a statute governing the activities of a profession.

Licensed Independent Practitioner (LIP): An individual who is permitted by both the applicable state law(s) and by the Hospital to provide patient care services without direction or supervision, within the scope of the individual's license and in accordance with individually granted clinical privileges. These are individuals who are designated by the State and by the Hospital to provide patient care independently. The Board has determined that the categories of individuals eligible for clinical privileges as a LIP are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), clinical psychologists (CP) and podiatrists (DPM).

Medical Executive Committee (MEC): The Medical Executive Committee of the Medical Staff, unless otherwise specifically stated.

Medical Staff: The Medical Staff is the term referring to the Practitioners designated by the Board to be eligible for Medical Staff membership and who are credentialed and privileged to provide professional healthcare services. The Board has determined that the categories of Practitioners eligible for Medical Staff membership are physicians (MD or DO), maxillofacial/oral surgeons (DMD), dentists (DDS), Clinical psychologists (CP) and podiatrists (DPM).

Medical Staff Office: The Hospital employee(s) or contractor assigned the responsibility for processing applications for Medical Staff appointments, reappointments, and requests for clinical privileges, and for maintaining documents related to the credentialing process. Medical Staff Office responsibilities are assigned by Administration and the Hospital employee(s)/contractor who works in the Medical Staff Office is accountable to Administration. The documents maintained by the Medical Staff Office are the property of the Hospital.

Medical Staff, Organized: The Organized Medical Staff is the body of those individuals who, as a group, are responsible for establishing the bylaws and rules and regulations, and policies for the Medical Staff at large and for overseeing the quality of care provided by all Medical Staff members. The Organized Medical Staff is limited to Practitioners who are Medical Staff Members in the Active category of membership and have therefore been granted the rights to vote, to be a member of a Medical Staff committee, and to hold office in the Organized Medical Staff.

Medical Staff Year: The period from May 1 to April 30 of each year.

Medical Student: an individual who is completing his/her third and fourth year of medical education.

Medico-Administrative Practitioner: A Practitioner who is under contract, employed by, or otherwise engaged by the Hospital on a full time or part time basis, whose responsibilities may be both administrative and, if permitted by State law, clinical in nature. Clinical duties may relate to direct medical care of patients and/or supervision of the professional activities of individuals under such Practitioner's direction.

Member: A Practitioner who has been granted and maintains Medical Staff membership and whose membership is in good standing pursuant to the Bylaws.

Membership: The approval granted by the Board to a qualified Practitioner to be a member of the Medical Staff of the Hospital.

Non-Privileged Practitioner: Those individuals who are licensed to order specific tests and services but who are not medical staff members or practitioners with clinical privileges for practice within this Hospital.

OIG Sanction Report: The HHS/OIG List of Excluded Individuals/Entities.

Oral and Maxillofacial Surgeon, Qualified: An individual who has successfully completed a postgraduate program in oral and maxillofacial surgery accredited by a nationally recognized accrediting body approved by the U. S. Department of Education.

Peer: An individual from the same discipline (for example, physician and physician, dentist and dentist) and with essentially equal qualifications.

Peer Review: The concurrent or retrospective review of an individual's performance of clinical professional activities by peer(s) through formally adopted written procedures that provide for adequate notice and an opportunity for a hearing of the Healthcare Professional under review. With reference to Practitioners and Allied Health Professionals, written procedures for peer review are part of the Bylaws.

Physician: An individual who has been educated and trained in the practice of medicine, and who holds a current license as a Doctor of Medicine (MD) or Doctor of Osteopathy (DO).

Podiatrist: An individual who holds a current license as a Doctor of Podiatric Medicine (PM).

Privileges: Authorization granted by the Board to an individual to provide specific patient care services in the Hospital within defined limits, based on the individual's license, education, training, experience, competence, health status, judgment and individual character. Privileges shall be setting-specific, meaning that the privileges granted shall be based not only on the applicant's qualifications, but also a consideration of the Hospital's capacity and capability to deliver care, treatment, and services within a specified setting.

Qualified Medical Person or Personnel: In addition to a physician, Qualified Medical Persons may perform a Medical Screening Examination. Individuals who have demonstrated current competence in the performance of Medical Screening Examinations, and who are functioning within the scope of his or her license and policies of the Hospital, have been approved by the Board as Qualified Medical Personnel: Physician Assistants in the Emergency Room, Advanced Registered Nurse Practitioners (ARNP), Psychiatric Social Worker or Registered Nurse in Psychiatric Services.

Practitioner: An individual who practices medicine.

Proctor/Proctoring: Clinical proctoring is an objective evaluation of a Practitioner's actual clinical competence by a monitor or proctor who represents the Medical Staff and is responsible to the Medical Staff.

Provisional Status: A physician's first year of Active Staff Category.

Qualified Physician: A Doctor of Medicine (MD) or a Doctor of Osteopathy (DO) who, by virtue of education, training and demonstrated competence, is granted clinical privileges by the Hospital to perform specific diagnostic or therapeutic procedure(s) and who is fully licensed to practice medicine.

Registration: The process in which a person licensed to practice by a federal or state authority has such a license recorded or registered.

Residency Program: the unit of specialty education, comprising a series of graduated learning experiences in GME, designed to conform to the program requirements of a particular specialty.

Residents: A physician at any level of GME in a program accredited by the American Osteopathic Association.

Rules and Regulations: The Rules and Regulations of the Medical Staff including those of its Departments as approved by the MEC and Board of Trustees.

Sponsoring Institution: The institution that assumes the ultimate responsibility for a program of GME.

Staff: Unless otherwise specifically stated, the Medical Staff of this Hospital.

State: The State in which the Hospital operates and is licensed to provide patient care services, which is Florida.

Supervising Physician: the teaching staff member who is responsible for supervising all clinical activities of a resident and/or medical student.

Supervision, Direct: by a supervising physician of a resident physician means to be physically present in the same general area with the ability to observe all or part of the procedure and to communicate with the resident.

Supervision, Indirect: by a supervising physician of a resident physician means to be generally aware of the resident's activities or of the medical procedure, to be available to the resident physically or by telecommunication and to provide follow-up review of the resident's activities or of the medical procedure.

Teaching Faculty: Consists of Board Certified or Board eligible licensed physicians (DO or MD) who have been appointed by the Medical Education Committee of Largo Medical Center to teach, supervise and direct medical students (MS-3 and MS-4), Interns (PGY I), Residents (PGY I-V) and Fellows.

Telemedicine: Medical practice is defined as any contact that results in a written or documented medical opinion and affects the medical diagnosis or medical treatment of a patient. Telemedicine is the practice of medicine through the use of electronic communication or other communication technologies to provide or support clinical care at a distance. The Joint Commission and the American Telemedicine Association define telemedicine as the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care, treatment and services.

## CONSTRUCTION OF TERMS AND HEADINGS

All pronouns and any variations thereof in these Rules and Regulations shall be deemed to refer to the masculine, feminine, or neuter, singular or plural, as the identity of the person or persons may require, unless the context clearly indicates otherwise.

# ARTICLE II – MEDICAL STAFF COMMITTEES

## PART A: MEDICAL STAFF COMMITTEES AND FUNCTIONS

### Section 1: CANCER CONTROL COMMITTEE

(a) Composition:

The Cancer Control Committee is a standing committee and provides program leadership with duties as described in the "Standards of the Commission of Cancer, Volume I", The American College of Surgeons.

The Cancer Control Committee composition is multidisciplinary to include:

Surgery
Medical Oncology
Radiation Oncology
Diagnostic Radiology
Pathology
Cancer Liaison Program
Administration
Nursing
Social Services
Quality Improvement
Cancer Registry
Other special representatives as appropriate to institution.

(b) Duties:

The committee develops and evaluates annual goals and objectives for the clinical, educational, and programmatic endeavors related to cancer care; promotes a coordinated multi-disciplinary approach to patient management; ensures that educational and consultative concern conferences are available to the Medical Staff and Allied Health Professionals; and ensures that educational and consultative cancer conferences cover all major sites and related issues.

(c) Meetings, Reports, and Recommendations:

The Cancer Committee meets at least quarterly and the medical direction is provided by the Cancer Committee Chairman. Administrative management is provided by the Cancer Program Coordinator. Objective studies are conducted under appropriate peer review mechanism.

### Section 2: CRITICAL CARE COMMITTEE

(a) Composition

The Critical Care Committee shall consist of at least five (5) active staff appointees, representing different medical and surgical specialties and services. One (1) representative from Hospital Management, the Nursing Director of Critical Care, Medical Director of Pulmonary Services, and representatives from the Critical Care Units shall serve on this committee. Other medical staff members appointed by the Chief of Staff and healthcare professionals as appointed by the Chief Executive Officer may serve as resource personnel for the committee. The chairperson will be appointed by the Chief of Staff.

(b) Duties

The duties are:

(1) monitor the appropriateness and quality of care provided in the areas utilized for Critical Care;

(2) periodically review, and when necessary, recommend policies and procedures pertaining to the Critical Care areas, training and performance of their personnel, administration of patient care, and provision and maintenance of equipment and technology;

(3) recommend quality improvement activities and efforts within the Critical Care area;

(4) advise the education department in development of educational programs;

(5) assign tasks and responsibilities to committee members, in order to identify and resolve patient care problems and improve the delivery of patient care.

(c) Meetings, Reports and Recommendations

The Critical Care Committee will meet at least quarterly, or more often if necessary, to accomplish its duties; shall maintain a permanent record of its findings, proceedings, and actions; and shall make a written report of its recommendations after each meeting to the Medical Executive Committee, the Chief Executive Officer and the Board.

Documentation of the performance of this function shall be reflected in the appropriate committee minutes.

Section 3: CARDIOVASCULAR MEDICINE COMMITTEE

(a) Composition:

The Cardiovascular Medicine Committee shall be a standing hospital committee and shall be composed of multidisciplinary representation of the Medical Staff and the Hospital CEO or designee. The physician members shall be representative from specialties concentrating in vascular medicine specifically Cardiovascular Medicine and Cardiology. Other representatives may be consulted by the Committee as necessary.

(b) Duties

The duties are:

The Cardiovascular Medicine Committee shall be responsible for planning, maintaining and oversight of all cardiac and cardiovascular procedures conducted within the Hospitals. Establish and maintain a planned, systematic approach to performance measurement, assessment and improvement of all vascular services. It will be a policy and decision making body for all aspects of cardiac and cardiovascular procedures.

(1) review and monitor the quality of medical care at the Hospital;

(2) review and make recommendations to the Quality Coordinating Council concerning medical care improvement efforts and the medical care section of the Hospitals quality /performance improvement plan;

(3) make recommendations to the Quality Coordinating Council concerning those clinical issues that should be addressed through a multi-disciplinary approach;

(4) recommend quality improvement activities and efforts between appropriate Medical Staff clinical sections and hospital departments;

(5) conduct patient care evaluation studies and make appropriate recommendations for follow up and/or corrective action;

(6) review aggregate outcome data quarterly for medical clinical systems.

(7) Evaluate requests for new equipment for vascular procedures and advise Administration on justification of purchase or other types of acquisition of such equipments.

(8) Review findings from external surveys and reviews and advise Hospital on participation in new accreditation programs, i.e. TJC disease specific program, HCA's Clinical Cardiovascular Management Network, and Vascular Lab Accreditation.

(9) Advise Hospital Administration on business strategies relating to vascular services including review of operating expenses and trends, volume changes and appropriate community education and screening programs.

(10) The Committee may also serve as a resource to other Hospital and Medical Staff Committee.

(c) Meetings, Reports and Recommendations

(1) The Cardiovascular Medicine Committee will meet at least quarterly, or more often if necessary, to accomplish its duties; shall maintain a permanent record of its findings, proceedings, and actions; and shall make a written report of its recommendations after each meeting to the MCEC and SCEC and the Medical Executive Committee.

(2) Documentation of the performance of this function shall be reflected in the appropriate committee minutes.

**Section 4: INFECTION CONTROL WORK GROUP**

Results of duties involved in surveillance, prevention and controlling of Hospital-acquired infections are reported to the Infection Control Nurse, and are to:

(a) maintain surveillance of Hospital infection potentials;

(b) identify and analyze the incidence and cause of all infections;

(c) develop and implement a preventive and corrective program designed to minimize infection hazards;

(d) supervise infection control in all phases of the Hospital's activities;

(e) act upon recommendations related to infection control received from the Chief of Staff, the Board and other Staff and Hospital committees;

(f) maintain a permanent record of all activities relating to infection control. Documentation

of the performance of this function shall be reflected in appropriate committee minutes at least quarterly.

## Section 5: GRADUATE MEDICAL EDUCATION COMMITTEE

(a) Composition

The Graduate Medical Education Committee shall consist of the Chief Academic Officer & Director of Clinical Services (Chair), Academic Officer, Administrative Director of Graduate Medical Education (as ex-officio member), all Residency Program Directors, all Fellowship Program Directors, Chief Administrative Resident, and a representative from Administration (as ex-officio members)**.**

(b) Duties

(1) The duties of the Graduate Medical Education Committee are:

(2) To provide oversight of the Graduate Medical Education program at Largo Medical Center.

(3) To inform and discuss among Teaching Faculty leadership, Administration and House Staff, the business of Graduate Medical Education and its programs

(4) To gain formal consensus on medical education initiatives.

(5) To assist the Chief Academic Officer and Administrative Director of Graduate Medical Education in the planning, development, organization, implementation and supervision/evaluation of high-quality pre and post-doctoral medical education programs. This encompasses the planning, development and operational issues of the Department of Graduate Medical Education and its programs.

(6) To communicate with and make recommendations to the Board of Trustees.

(7) To review documents related to the clinical competence and performance of each intern and resident; evaluate the adequacy of the teaching rotations and the medical education programs in total.

(8) To provide effective communication to the organized medical staff through minutes and monthly reports to the Medical Executive Committee by the Chief Academic Officer.

(9) It is the charge of the Committee to assist the Chief Academic Officer in developing a curriculum and methods of evaluation of the educational experience of the House Staff during the academic year.

(10) It is the charge of the Committee to review the initiatives, actions and recommendations of the Chief Academic Officer and each respective Program Director.

(11) To actively participate in the evaluation of interns and residents.

(12) To evaluate the performance of Teaching Faculty members, in accordance with membership criteria and House Staff evaluations of teaching services; and recommend action for reappointment of faculty and appointment of new faculty.

(13) To actively participate in the selection and appointment of interns; and in the approval process for resident candidates, recommended by each respective Program Director.

(14) To have a working understanding of the funding mechanisms of Graduate Medical Education, as it pertains to Medicare DGME and IME reimbursement under a limited FTE resident cap.

(15) To evaluate the performance of teaching affiliate institutions and outside rotations as it pertains to meeting the needs of the medical students, internship, residency and fellowship programs.

(16) To oversee the effectiveness and quality of the Graduate Medical Education program and its Teaching Faculty; the academic progress and competence of the House Staff, and the competitiveness of the program on a statewide and national scale.

(17) To provide oversight of the safety and quality of patient care, treatment and services provided by House Staff and to ensure that supervision requirements are met by Teaching Faculty, in accordance with Hospital By-Laws, Medicare Rules and Regulations, Joint Commission and the AOA.

(18) To oversee the implementation of the Due Process and Grievance Appeals Procedure, if necessary.

(19) The Committee will communicate periodically with the Hospital's Medical Executive Committee and the Board of Trustees about the performance of it's students/interns/residents, regarding patient safety issues and quality of care provided. The Committee will ensure that all supervising physicians possess clinical privileges commensurate with their supervising activities.

(c) Meetings

The Committee shall meet on a monthly basis with a minimum of ten meetings per year and as often as necessary to conduct the required business of the Graduate Medical Education Program. A permanent record of the Committee's proceedings, actions, findings and recommendations will be maintained by the Department of Graduate Medical Education and submitted to the Medical Executive Committee and Board of Trustees.

**Section 6: LIBRARY COMMITTEE**

(a) Composition

The library committee shall consist of the Director of Graduate Medical Education, multidisciplinary representatives who frequently use the Medical Library, additional members of the medical staff representing the Departments of Internal Medicine, Family Medicine, and Surgery, the Administrative Director of Graduate Medical Education, nursing department and administration.

(b) Duties

The duties of the Library Committee shall be:

(1) Develop immediate and long term goals, support a realistic annual budget and make recommendations for the acquisition and deletion of books, journals, clinical and

management literature, practice guidelines, internal and external information systems, audiovisual materials and other resources to the library to meet the Hospital's informational, educational and when appropriate research related needs.

(2) Assist the medical librarian or any other person in charge of the professional library to establish rules and regulations for the use of the library.

(3) To assure information and resources are authoritative and up to date and encompass literature/knowledge based information used to support clinical, management decision making performance improvement activities, staff education, patient and family education and research as appropriate.

(4) To approve guidelines, policies and procedures for the appropriate organization and management of the library.

(5) To conduct a needs assessment annually and utilize this information in planning the services, resources and systems of knowledge based information.

(c ) Meetings

The committee shall meet at least annually. A permanent record of the committee's proceedings, actions, findings and recommendations will be maintained and submitted to the Medical Executive Committee.

**Section 7: MEDICAL ETHICS COMMITTEE**

The Medical Ethics Committee of the Hospital shall function in an advisory and educational capacity as a standing committee of the Board of Trustees. All decisions rendered by the Medical Ethics Committee shall be advisory only and shall be forwarded to Administration for consideration by the Board of Trustees.

(a) The Ethics Committee shall function only to consider, hear, and advise on cases related to patients of or in the Hospital, or their families/surrogates seeking advice.

(b) An ethics consult may be requested, as needed, through the Risk Manager or the Ethics and Compliance Officer.

(c) No impaired physician or other Allied Health Professional case will be considered for consultation by the Ethics Committee. Quality of Care issues shall be referred to Peer Review.

(d) The Ethics Committee shall meet on an as needed basis, or ~~bi-~~annually to consider issues and/or review of current policies and procedures.

(e) The Ethics Committee may be convened upon the request of the following individual(s):

1. Patient
2. Patient's Family/Surrogate
3. Administration
4. Physician
5. Employee
6. Other Allied Health Professional

(f) The following procedure shall be followed for requests for consultation by the Ethics

Committee:

1. Nursing - through the Director of Nursing or her designee.
2. Medical Staff - through the Medical Executive Committee
3. Patient Family - through the Medical Executive Committee (most likely to be forwarded from the Social Services Department of the Hospital).
4. Employees (through the Human Resources Department)

(g) A report of the recommendation of the Ethics Committee may be filed in the Patient Medical Record and shall be recorded in the Ethics Committee Minutes.

(h) Composition:

The Medical Ethics Committee shall consist of the following recommended members, which shall be subject to change at the Direction of the Board of Trustees of the hospital:

1. Two physicians who are members of the Medical Staff
2. One clergy member
3. Case Management Employee
4. One representative from the Board of Trustees (as needed)
5. Chief Nursing Officer or designee
6. CEO of the hospital or designee (as needed)
7. Risk Manager or designee
8. Human Resources Director or designee (as needed)
9. Nurse

Upon request for consultation involving a patient, either the Chief Nursing Officer or the Risk Manager (or designee) will review the medical record and obtain input from involved parties. That individual will clarify the facts and determine if the question/issue can be resolved by application of hospital policy and/or by regulations.

If not, the ethical question/issue is discussed with the Chairman of the Medical Ethics Committee (or designated Medical Ethics Committee member). If the Chairman/designee determines that the issue warrants consideration by the Medical Ethics Committee, a meeting will be called at the earliest availability of the members. The Chairman may consult with members by telephone if the urgency of the issue does not permit time to convene the Committee in person. All issues and the outcomes referred to the Chairman will be reviewed by the Committee at the next meeting. All cases will be reviewed at the annual Committee meeting.

**Section 8: MEDICAL and QUALITY REVIEW COMMITTEES**

Each quality review committee shall monitor and evaluate medical care on a retrospective, concurrent and prospective basis in all major clinical activities, including its specialty subsections and services. This monitoring and evaluation must at least include:

(a) the identification and collection of information about important aspects of patient care provided in the clinical section;
(b) the identification of the indicators used to monitor the quality and appropriateness of the important aspects of care; and
(c) evaluation of the quality and appropriateness of care.

Medical Staff ‘s leadership role in performance improvement includes review of:
(a) Medical assessment and treatment of patients;
(b) Use of medications;
(c) Use of blood and blood components;
(d) Use of operative and other procedures;

(e) Efficiency of clinical practice patterns;
(f) Significant departures from established practice patterns;
(g) Patient safety issues.

Medical staff's participant role in performance improvement includes review of:

(a) Education of patients and families;
(b) Coordination of care with others;
(c) Accurate, timely, and legible completion of medical records.

Peer review activities are covered under Quality Resources peer review policy and procedure titled, "Medical Staff Performance – Peer Review".

**Section 8.1: MEDICAL CARE EVALUATION COMMITTEE**

(a) Composition:

The Medical Care Evaluation Committee shall consist of at least five (5) Active Staff appointees, each of whom represent different medical specialties and services and Interns/Residents appointed by COS. One (1) representative from Hospital management and the Director of Quality Resources, Risk Manager, Director of Nursing, or their designees, shall each serve on the committee, *ex officio*, without vote. Other Medical Staff members as appointed by the Chief of Staff and health care professionals as appointed by the Chief Executive Officer may serve as resource personnel for the committee. The chairperson will be appointed by the Chief of Staff.

(b) Duties:

The Medical Care Evaluation Committee shall function as the medical quality assurance review committee and assist the Board in fulfilling its responsibilities for patient care evaluation and assessment as required by law, regulation, and accreditation and regulatory agencies. Specifically, the committee shall:

(1) review and monitor the quality of medical care at the Hospital;

(2) review and make recommendations to the Quality Coordinating Council concerning medical care improvement efforts and the medical care section of the Hospitals quality /performance improvement plan;

(3) make recommendations to the Quality Coordinating Council concerning those clinical issues that should be addressed through a multi-disciplinary approach;

(4) recommend quality improvement activities and efforts between appropriate Medical Staff clinical sections and hospital departments;

(5) assign tasks and responsibilities to clinical sections and Staff committees and/or individuals in order to identify and resolve patient care problems and institutional waste and duplication;

(6) conduct patient care evaluation studies and make appropriate recommendations for follow up and/or corrective action;

(7) review blood transfusions for proper utilization. Each actual or suspected transfusion reaction shall be evaluated and a report completed. The evaluation of blood use should include a review of the amount of blood requested, the

amount used, and the amount of wastage;

(8) review aggregate outcome data quarterly for medical clinical systems.

**8.1.1 BLOOD USAGE REVIEW**

On behalf of the Medical Staff, Medical and Surgical Care Evaluation Committees blood usage review will be performed on an ongoing basis to continuously improve the appropriateness and effectiveness with which blood and blood components are used.

(i) Blood usage review includes the review of all categories of blood and blood components in the hospital through the use of screening criteria to identify single cases or patterns of cases that require more intensive evaluation; and/or through intensive evaluation of a single case or of a group of cases. Screening criteria are predetermined by the Medical Staff and may apply to either one specific category of blood or blood component or to several categories of blood or blood components. When screening or intensively evaluating any category of blood or blood component, an adequate number of cases is included.

(ii) Blood usage review includes the intensive evaluation of all confirmed transfusion reactions, the approval of policies and procedures relating to the distribution, handling, use, and administration of blood and blood components, the review of the adequacy of transfusion services to meet the needs of patients, and the review of ordering practices for blood and blood components.
iii) Relevant results from the blood usage review are used primarily to study and improve processes that affect the appropriate and effective use of blood and blood components.

(9) monitor the appropriateness, quality of patient care and patient safety;

(10) develop, review, and recommend policies and procedures as appropriate concerning emergency care and the functioning of the Emergency Center;

(11) make recommendations concerning environmental and equipment improvements and enhancements for emergency medicine services at the Hospital;

(12) serve as consultant to medical, nursing and support services personnel; and

(13) periodically review, and, when necessary, recommend policies and procedures pertaining to the specialty care units, training and performance of their personnel, administration of patient care and provision and maintenance of equipment and technology.

(13) Review and analyze clinical medical system outcome data and make recommendations as needed.

(c) Meetings, Reports and Recommendations:

(1) The Medical Care Evaluation Committee shall meet at least quarterly or more often as necessary to accomplish its duties, shall maintain a permanent record of its findings, proceedings and actions and shall make a written report of its recommendations after each meeting to the Medical Executive Committee, the Chief Executive Officer and the Board of Trustees.

(2) The Medical Care Evaluation Committee shall report (with or without recommendation) to the appropriate section chief and/or the Medical Executive Committee for its consideration for appropriate action any situation involving questions of patient care and treatment, case management, professional ethics, infraction of Hospital or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff, which is specifically related to the functions of the committee as set forth in Section 2 of this Part and any other applicable Hospital policy.

(3) Blood Usage Review will provide written reports of conclusions, recommendations, actions taken, and the results of actions taken at least quarterly to the Medical Executive Committee, and to other individuals and committees as appropriate

**Section 8.2: SURGICAL CARE EVALUATION COMMITTEE**

(a) Composition:

The Surgical Care Evaluation Committee shall consist of at least five (5) Active Staff appointees, each of whom represent different surgical specialties and services, the Hospital pathologist and Interns/Residents appointed by COS. One (1) representative from Hospital management and the Risk Manager, Director of Quality Resources, Director of Nursing, and Director of Surgical Services, Director of Outpatient Treatment Center, and other designees, shall each serve on the committee, *ex officio,* without vote. Other Medical Staff members as appointed by the Chief of Staff and health care professionals as appointed by the Chief Executive Officer may serve as resource personnel for the committee. The Chairman will be appointed by the Chief of Staff.

(b) Duties:

The Surgical Care Evaluation Committee shall function as the surgical quality assurance review committee and assist the Board in fulfilling its responsibilities for patient care evaluation and assessment as required by law, regulation, and accreditation and regulatory agencies. Specifically, the committee shall:

(1) review and monitor the quality of surgical, anesthesia, pathology, dental and podiatric care at the Hospital;

(2) review and make recommendations to the Quality Coordinating Council concerning surgical care improvement efforts and the surgical care section of the Hospitals quality/performance improvement plan;

(3) make recommendations to the Quality Coordinating Council concerning those clinical issues that should be addressed through a multi-disciplinary approach;

(4) recommend quality/performance improvement activities and efforts between appropriate Medical Staff clinical sections and Hospital departments;

(5) assign tasks and responsibilities to surgical clinical sections and staff committees and/or individuals in order to identify and resolve patient care problems and institutional waste and duplication;

(6) conduct patient care evaluation studies and make appropriate recommendations for follow up and/or corrective action;

(7) review blood transfusions for proper utilization. Each actual or suspected

transfusion reaction shall be evaluated and a report completed. The evaluation of blood use should include a review of the amount of blood requested, the amount used, and the amount of wastage;

(8) review aggregate outcome data quarterly for surgical clinical systems.

**See Section 8.2.1 – Blood Usage Review**

(9) conduct a comprehensive review to examine justification of surgery performed, whether tissue was removed or not, and to evaluate the acceptability and the quality of the procedure chosen. Specific consideration shall be given to cases involving complications and to the agreement or disagreement of the pre-operative and post-operative (including pathological) diagnoses. Written reports shall be maintained reflecting the results of all evaluations performed and actions taken;

(10) review and recommend all surgical forms proposed for inclusion in the permanent medical record;

(11) monitor the appropriateness, quality of patient care and patient safety;

(12) serve as consultant to surgical, nursing and support services personnel; and

(13) periodically review, and, when necessary, recommend policies and procedures pertaining to the surgical care units, training and performance of their personnel, administration of patient care and provision and maintenance of equipment and technology.

(14) Review and Analyze clinical surgical system outcome data and make recommendations as needed.

(c) Meetings, Reports and Recommendations:

(1) The Surgical Care Evaluation Committee shall meet at least quarterly, or more often if necessary, to accomplish its duties, shall maintain a permanent record of its findings, proceedings and actions and shall make a written report of its recommendations after each meeting to the Medical Executive Committee, the Chief Executive Officer, and the Board.

(2) The Surgical Care Evaluation Committee shall report (with or without recommendation) to the appropriate section chief and/or the Medical Executive Committee for its consideration for appropriate action any situation involving questions of patient care and treatment, case management, professional ethics, infraction of Hospital or Medical Staff Bylaws, policies or rules, or unacceptable conduct on the part of any individual appointed to the Medical Staff, which is specifically related to the functions of the committee as set forth in Section 2 of this Part and any other applicable Hospital policy.

(3) Blood Usage Review will provide written reports of conclusions, recommendations, actions taken, and the results of actions taken at least quarterly to the Medical Executive Committee, and to other individuals and committees as appropriate.

## Section 9: MEDICAL RECORDS COMMITTEE

(a) Composition

The Medical Records Committee shall consist of at least five (5) active staff appointees, representing different medical and surgical specialties and services. Hospital representation will be provided by the Director of Health Information Management, Risk Manager, Director of Quality_Improvement, Director of Nursing and other members of Health Information Management as needed. The chairperson will be appointed by the Chief of Staff. House staff may serve on this committee.

(b) Duties - The duties involved in assuring the maintenance of patient medical records that are complete, timely and clinically pertinent are to:

(1) review and evaluate medical records to determine that they:

- properly describe the condition and progress of the patient, the therapy provided, the results thereof, and the identification of responsibility for all actions taken;
- are sufficiently complete at all times so as to facilitate continuity of care and communications between all those providing patient care services in the Hospital and throughout the continuum of care ;
- meet the standards of patient care usefulness and of historical validity required by the Staff and by acknowledged authorities, including JCAHO; and
- are adequate in form and content, to permit patient care evaluation and quality maintenance activities to be performed;

(2) review Staff and Hospital policies, Rules and Regulations relating to medical records including medical records completion, forms, formats, filing, indices, storage and availability, and recommend methods of enforcement thereof and changes thereto;

(3) act upon recommendations from committees responsible for patient care evaluation, quality maintenance and monitoring functions;

(4) provide liaison with Hospital administration and the medical records professionals in the employ of the Hospital on matters relating to medical records practice.

(c) Meetings, Reports, and Recommendations

(1) The Medical Records Committee shall meet at least quarterly, or more often if necessary, to accomplish its duties; shall maintain a permanent record of its findings, proceedings, and actions; and shall make a written report of its recommendations after each meeting to the Executive Committee, the Chief Executive Officer and the Board.

(2) Documentation of the performance of this function shall be reflected in the appropriate committee minutes.

**Section 10: PHARMACY AND THERAPEUTICS COMMITTEE**

(a) Composition

The Pharmacy and Therapeutics Committee shall consist of at least five (5) active staff appointees, representing different medical and surgical specialties and services and Interns/Residents as appointed by COS. Members shall consist of representation from Administration, Nursing, Quality Resources, Pharmacy, Laboratory, Clinical Dieticians-Food Services, and adhoc members from other departments/ services as needed. The chairperson will be appointed by the Chief of Staff.

(b) Duties - The duties involved in developing and maintaining surveillance over Medication Management policies and practices are to:

(1) assist in the formulation of policies regarding the evaluation, appraisal, use, safety procedures and all other matters relating to medications in the Hospital;

(2) make recommendations concerning medications to be stocked on the nursing units and by other services;

(3) review and revise periodically a formulary for use in the Hospital;

(4) review reported medication reactions, food and drug interactions, medication errors and recommend corrective action;

(5) review data relative to medication effectiveness, side effects and new drugs or uses, and disseminate such information as needed;

(6) prepare a quarterly report, consisting of statistical data involving medication reactions and medication errors, their probable courses and actions taken to resolve problems and follow-up action to assure the resolution of problems;

(7) establish standards concerning the use and control of Investigational drugs and of research in use of recognized drugs;

(8) perform medication usage evaluation functions;

(9) Assess annually the Medication Management function, with emphasis on the notable strengths and weaknesses, and to develop recommendations for opportunities for improvement;

(10) perform such other duties as assigned by the Chief of Staff.

(c) Meetings, Reports and Recommendations

(1) The Pharmacy and Therapeutics Committee shall meet at least quarterly, or more often if necessary, to accomplish its duties; shall maintain a permanent record of its findings, proceedings, and actions; and shall make a written report of its recommendations after each meeting to the Medical Executive Committee, the Chief Executive Officer and the Board. Recommendations will require Medical Executive Committee and administrative approval prior to implementation.

(2) Documentation of the performance of this function shall be reflected in the appropriate committee minutes.

**Section 11: RESOURCE MANAGEMENT REVIEW COMMITTEE**

(a) Composition

The Resource Management Review Committee shall consist of at least five (5) active staff appointees, representing different medical and surgical specialties and services. One (1) representative from Hospital Management, the Director of Case Management, Director of Nursing, and representatives from Case Management, Critical Care Units and the Emergency Room shall serve on this committee. Other medical staff members appointed by the Chief of Staff and healthcare professionals as appointed by the Chief Executive Officer may serve as resource personnel for the committee. The chairperson will be appointed by the Chief of Staff. House staff may serve on this Committee.

(b) Duties

(1) The duties shall include performing utilization review functions as required by the Hospitals' utilization review plan.

(2) Resource Management functions shall include the creation of criteria and length of stay monitoring mechanisms designed to meet the requirements of JCAHO, peer review organizations, requirements of health maintenance organizations and others;

(3) A written Utilization Review plan shall be developed and reviewed at least annually.

(4) Use of non-physician personnel in those activities not requiring medical judgment shall be encouraged to the greatest extent possible.

(c) Meetings, Reports and Recommendations

(1) The Resource Management Review Committee will meet at least quarterly, or more often if necessary, to accomplish its duties; shall maintain a permanent record of its findings, proceedings, and actions; and shall make a written report of its recommendations after each meeting to the Executive Committee, the Chief Executive Officer and the Board.

(2) Documentation of the performance of this function shall be reflected in the appropriate committee minutes.

(c) Meetings, Reports and Recommendations

(1) The Resource management Review Committee will meet at least quarterly, or more often if necessary, to accomplish its duties; shall maintain a permanent record of its findings, proceedings, and actions; and shall make a written report of its recommendations after each meeting to the Executive Committee, the Chief Executive Officer and the Board.

(2) Documentation of the performance of this function shall be reflected in the appropriate committee minutes.

**PART B – OTHER COMMITTEES**

**Section 12: SAFETY COMMITTEE**

The purpose of the Safety Committee shall be to manage a comprehensive safety program that will obtain the participation of employees in improving and maintaining safe conditions and practices within all buildings and grounds of the hospital for employees, patients, visitors,

volunteers and medical staff members. The program shall meet with The Joint Commission, State, Federal and local regulatory requirements; and shall interface with external agencies to promote community safety. All employees shall participate in the Safety Management Program. Volunteers and medical staff shall participate in pertinent aspects of the Safety Management Program. The Employee Safety Officer will communicate with the medical staff through quarterly reports to the Medical Executive Committee, articles in the Physician's newsletter and participation, as needed with medical staff committees and members. The medical staff shall comply with hospital safety policies and procedures as approved by the Board of Trustees. The scope of the Safety Management Program is defined to include the following:

* Safety and Security
* Life Safety
* Fire Safety
* Hazardous Materials and Waste Management
* Emergency Management and Operations
* Utilities
* Medical Equipment

**Section 13: AD HOC REVIEW COMMITTEES**

The Medical Executive Committee may, by resolution and upon approval of the Board, without amendment of this manual, establish ad hoc committees to perform one (1) or more Staff functions. In the same manner, the Medical Executive Committee may, by resolution and upon approval of the Board, dissolve or rearrange committee structure, duties or composition as needed to better accomplish Medical Staff functions. Any function required to be performed by this manual that is not assigned to a standing or special committee shall be performed by the Medical Executive Committee.

# ARTICLE III - RULES AND REGULATIONS

## PART A: ADMISSION AND DISCHARGE OF PATIENTS

I. The Hospital may admit general medical/surgical patients for care and treatment. A neuropsychiatric patient who is judged to be a danger to himself or to others shall be transferred to an appropriate inpatient psychiatric facility as soon as his medical condition permits. The Hospital will perform outpatient surgery on ages 12 years and older who meet ASA Classification 1 or 2. Pediatrics is defined as an individual who has not achieved their eighteenth birthday. Pediatric patients who present to the Emergency Department will be stabilized and transferred to a facility that provides pediatric services.

2. A patient may be admitted to the Hospital only by a member of the Medical Staff in good standing.

   A patients' initial assessment is conducted in accordance with the Hospital-wide policy/procedure titled, "Patient Assessment/Reassessment". During the initial assessment, a member of the Medical Staff and/or Case Management will be alerted to any signs of potential abuse and if abuse is suspected, will comply with established Hospital policy/procedure. Licensed independent practitioners can refer to Hospital-wide policy/procedure related to abuse, which are placed strategically throughout the Hospital for easy access.

3. Members of the Medical Staff shall be responsible for the medical care and treatment of their patients, which shall include prompt accurate completion of the medical record. Physicians shall be required to provide necessary instructions to patients and/or patient's representatives as well as for transmitting reports of the condition of the patient to the referring practitioner, to the patient and/or to the patient's representative. Whenever these responsibilities are transferred to another staff physician, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

4. 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, such statement shall be recorded on the medical record as soon as possible.

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

6. Practitioners admitting emergency cases shall be prepared to justify to the Medical Executive Committee and the administration of the Hospital that the said emergency 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 medical record as soon as practical after admission.

7. A patient who needs to be admitted on an emergency basis and who does not have a private physician may select any physician in the applicable service to attend him. Where no such selection is made, a member of the Active or Associate Staff on call in the specialty will be assigned to the patient, on a rotation basis, where possible. The chief of each clinical department shall provide a schedule of assignments.

8. In the event of an emergency situation involving a patient whose attending physician cannot be contacted for appropriate care, the Chief of Staff, the chief of the department concerned or the Chief Executive Officer shall have the authority to call any member of the Active or Associate Staff to provide emergency care. A physician who will be unavailable for over 24 hours should, on the order sheet of the chart of each of his

patients, indicate in writing the name of the physician who will be assuming the responsibility for the care of the patient during his absence. Such an order will not be required in the situation of recognized medical partnerships, group practices or on-call coverage groups.

9. Patients will be transferred to a different level of care only upon physicians order.

10. The admitting physician will be held responsible for giving to the charge nurse or designee of the appropriate nursing unit such information as may be necessary to ensure the protection of the patient from self harm and to ensure protection of others whenever such patients might be a source of danger or require isolation.

11. Precautions are to be taken in the care of potentially emotionally ill patients (including those patients who are suicidal, alcoholic or having drug abuse problems) for the protection of patients, nursing staff, Medical Staff and the Hospital as follows:

    (a) If possible, the patient shall be referred to another institution where suitable facilities are available.

    (b) Any patient known or suspected to be suicidal in intent shall be admitted to the Hospital and shall remain there until appropriate psychiatric consultation is obtained or if clinically evaluated to not need the level of critical care, the patient may be placed on the Medical/Surgical Telemetry Unit with a Certified Nursing Assistant or Sitter until appropriate psychiatric consultation is obtained.

    (c) Patients with alcohol or drug abuse problems will be referred to the appropriate facility as deemed necessary by the attending physician.

    (d) Refer to Baker Act policy/procedure for specific patient protocol.

12. Admission to Critical and Progressive Care Units

    If any question as to validity of admission to, or discharge from, the Critical Care or Progressive Care Unit should arise, that decision is to be made through consultation of the attending physician with the chairman of the Critical Care Committee.

13. When a patient is admitted to a Critical Care/Progressive Care Unit and his condition is unstable, he shall be seen by the attending or consulting physician within two hours of admission. If the patient is stable, he shall be seen by the attending or consulting physician within eight hours of admission to the unit.

14. Upon request of the Resource Management Review Committee, the attending physician must provide written justification of the necessity for continued hospitalization of any patient, 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. Failure to comply with this policy shall be brought to the attention of the Medical Executive Committee for possible corrective action.

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

16. In the event of the death of a patient while in the Hospital, the deceased shall be pronounced dead by the attending physician or his designee in accordance with hospital policy. Exceptions shall be made in those instances of incontrovertible and irreversible

terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Hospital and staff policies with respect to bodies of deceased persons shall conform to local and state laws.

17. It is recommended that all unexplained deaths, except Medical Examiner's cases, occurring in the Hospital have an autopsy performed, unless refused by next-of-kin, in accordance with State Law. All autopsies shall be performed by the Hospital pathologist, or by a physician delegated this responsibility. Provisional diagnosis shall be recorded on the medical record within 48 hours and the complete protocol made a part of the medical record within one month of the death of the patient.

    (a) The indications (criteria) for autopsies are outlined within a laboratory policy.

## PART B: CONSULTATIONS

1. Consultations shall be ordered, except in extreme emergencies, under the following conditions:

    (a) where the diagnosis is obscure after ordinary diagnostic procedures have been completed;

    (b) where there is doubt as to the choice of therapeutic measures to be utilized;

    (c) in unusually complicated situations where specific skills of other physicians may be needed;

    (d) in any instances in which the patient exhibits severe psychiatric symptoms;

    (e) when requested by the patient or his family;

    (f) when required by the policy of a special care unit.

2. Psychiatric consultation and treatment will be required for all patients who have attempted suicide or have taken a chemical overdose; that such services were at least recommended must be documented in the patient's medical record.

3. Consultations in Critical Care units are required for:

    (a) Pulmonary management of patients on ventilators shall be by physicians credentialed specifically for those privileges.

4. Reports of consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. When operative procedures are involved, the consultation note shall, except in emergency situations so stated in the record, be recorded prior to the operation. Any qualified physician with clinical privileges in the Hospital may be called for consultation. The consultant must be qualified to give an opinion in the field in which his opinion and consultation are sought. The physician responsible for the care of the patient shall be responsible for judgments as to the serious nature of the illness and the question of doubt as to diagnosis and treatment.

5. Urgent consultations shall be done within a 12 hour period upon personal notification by the attending physician. STAT cases shall be done immediately upon personal notification of the consultant by the attending physician.

## PART C: DISPOSITION OF IMAGING EXAMS AND RECORDS

1. All Imaging exams and records are a portion of the patient's permanent Hospital record and shall remain the property of the Hospital.

2. Release of records is authorized only to patients or staff physicians with appropriate identification, with records released being utilized for patient care.

3. Digitally acquired images will be stored in accordance with State Law and/or the American College of Radiology recommendations which ever is greater.

## PART D: EMERGENCY SERVICES

1. Members of the Medical Staff shall accept responsibility for care in accordance with Emergency Department policies and procedures.

2. The medical director of the Emergency Department shall have the overall responsibility for emergency care, subject to the authority of the Board.

3. Emergency Department policies and procedures shall be approved by the director of the Emergency Department, the Medical Executive Committee of the Medical Staff and the Board.

4. At least one emergency physician shall be in the Hospital and immediately available for rendering emergency patient care twenty-four (24) hours per day, seven (7) days per week.

5. The patient's private physician shall be called in accordance with emergency department policies and procedures. The emergency physician shall recommend to the admitting physician whether inpatient or observation status is more appropriate for the care of the patient.

6. A patient to be admitted on an emergency basis will be given the opportunity to select a member of the Active or Associate Staff to be responsible for the patient while in the Hospital. If a dentist or podiatrist is selected by the patient, a physician shall be selected to assume the medical responsibility for the patient.

   Where no selection is made or where the selected physician does not assume responsibility for care of the patient for some reason, the patient shall be assigned to the on-call physician.

7. If a patient needs to be admitted to the Hospital, in the judgment of the emergency physician, either for observation or for further treatment, the patient shall be admitted in the name of the patient's physician or the physician on-call. If, in the judgment of the emergency physician, the patient's condition requires continuing attention, the emergency physician shall continue to accept responsibility for the patient until the assigned physician assumes responsibility for the patient. The assigned physician is considered to have assumed responsibility for the patient when the assigned physician comes to the Hospital or the patient has been accepted by the admitting physician and transferred from the Emergency Department.

   The assigned physician shall come to the Hospital as promptly as possible if requested by the emergency physician.

   (a) A physician or a Qualified Medical Person may perform medical screening examinations. Individuals in the following professional categories who have demonstrated current competency in the performance of medical screening examinations and who are functioning within the scope of his/her license and policies of the Hospital and have been approved by the Hospitals Board of Trustees. Qualified Medical Personnel includes Physicians, Physician Assistants and/or Nurse Practitioners.

   (b) Patients desiring a specific physician will be referred to that physician or to the physician covering for him.

   (c) In cases when patients have their own physician, but his area of expertise is not required, that physician or the physician covering for him will be contacted to determine the consulting physician to be used.

   (d) In cases when patients do not have a personal physician, they will be assigned by the Emergency Room physician to the on-call physician. It will then be the responsibility of that physician to obtain whatever other consultants are deemed necessary.

   (e) The on-call physician shall respond within 30 minutes of being called.

   (f) A diligent effort will be made to contact the patient's personal physician; however, if this cannot be accomplished within 30 minutes, the Emergency Room physician will refer the patient to the on-call physician in the needed specialty. In the event the on-call physician cannot be reached or respond within the thirty minute time period, the Emergency Room physician shall contact other physicians in that specialty for the purpose of securing their services for the patient. A documented report of the incident will be forwarded to the Medical Executive Committee for their review and appropriate action.

   (g) In the event a physician cannot take call when scheduled, it is his/her responsibility to identify an alternate and to arrange for the alternate to cover in his/her absence, and to notify Hospital administration of the alternate's coverage. The alternate must be an appointee of the Medical Staff and hold clinical privileges appropriate to cover the call schedule.

8. An appropriate Emergency Department record or log shall be kept listing every person who presents himself or is brought to the Emergency Department for

treatment or care and a notation concerning treatment or transfer. An appropriate Emergency Department medical record shall be kept for every patient receiving emergency service and shall be available through the Medical Records Department. The emergency service medical record shall include:

(a) adequate patient identification;
(b) information concerning the time of the patient's arrival and by whom transported;
(c) pertinent history of the injury or illness, including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital and history of allergies;
(d) description of significant clinical, laboratory and X-ray findings;
(e) diagnosis including condition of patient;
(f) treatment given and plans for management;
(g) condition of the patient on discharge or transfer; and

(h) final disposition, including instructions given to the patient or his family relative to necessary follow-up care.

9. Each patient's emergency medical record shall be signed by the physician in attendance, whom shall be responsible for its clinical accuracy.

10. A copy of the Emergency Department medical record shall accompany patients being admitted as inpatients.

11. The director of the Emergency Department shall coordinate the review of Emergency Department records with the responsible Medical Staff committee.

12. Procedures of a major complexity or of extended duration may not be done in the Emergency Department, but rather shall be done in the operating room or department designated for the necessary procedure.

13. The emergency physician shall arrange for an interpretation of X-rays by a Staff radiologist and comparison of initial and final X-ray interpretations. In cases where an X-ray interpretation of the radiologist is different from that initially made by the emergency physician, the radiologist shall notify the emergency physician and/or the patient's private physician as soon as possible, and copies of the radiologist's report shall be made available to the emergency physician and the patient's private physician.

14. Patients with conditions whose definitive care is not within the scope of services provided by the Hospital shall be referred to an appropriate facility when, in the judgment of the attending physician, the patient's condition permits such a transfer. No patient shall be arbitrarily transferred and arrangements will be made with the receiving hospital or physician. A copy of pertinent medical records shall accompany the transfer. The Hospital's procedures and applicable State and Federal regulations for patient transfers to other facilities shall be followed. In particular, all transfers will comply with EMTALA and State of Florida's Agency for Health Care Administration.

15. The director of the Emergency Department shall make certain that Emergency Department procedures are properly coordinated with the Hospital's disaster plan, especially as they pertain to the care of mass casualties.

16. The director of the Emergency Department shall provide for monthly patient care evaluation concerning the quality and appropriateness of patient care.

## PART E: ETHICAL CONDUCT

1. All physicians shall refrain from fee splitting or other inducements relating to patient referral.

2. Each member of the Medical Staff shall provide for continuous care of his patients.

3. Each member of the Medical Staff shall refrain from delegating the responsibility for diagnosis or care of hospitalized patients to a medical or dental physician who is not qualified to undertake the responsibility.

4. Each member of the Medical Staff shall seek consultations whenever necessary.

5. All incidents reported to Agency for Health Care Administration (AHCA), the Department of Health (DOH) or The Joint Commission (TJC) in which a physician's name is mentioned shall be brought to the physician's attention by the Hospital CEO or his representative.

6. All clinical entries in the patient's medical record shall be legible, and accurately dated, timed and authenticated by signature. The physician should legibly print their name under their signature.

7. All members shall comply with hospital policies regarding patients' rights and organizational ethics.

## PART F: GENERAL CONDUCT OF CARE

I. General Consent Form
A general consent form, signed by or on behalf of every patient admitted to the Hospital, shall be obtained at the time of admission. When so notified, it shall (except in emergency situations) be the physician's obligation to obtain proper consent before the patient is treated in the Hospital. In addition to the patient's general consent to treatment, specific consent forms documenting that the patient has been informed of the risks inherent in, benefits of and possible alternatives to any special treatment or surgical or special procedures shall be signed by, or on behalf of, every patient undergoing such special treatment, procedures or surgery. The physician performing the procedure may also sign the consent form.

2. Orders:

   (a) All orders for treatment shall be in writing. All orders need to be authenticated, dated and timed by the prescribing physician.

   (b) A verbal order shall be considered to be in writing if dictated to a licensed nurse, licensed pharmacist, licensed physicians assistant, registered dietician, radiology technician, nuclear medicine technician, licensed physical therapist or licensed respiratory therapist and only verbal orders within their scope of practice.

3. Referrals:

   (a) In addition, verbal orders pertaining to evaluations and for referrals for Home Health Care, discharge to home or a nursing care facility, can be

written by hospital Case Managers, subsequent to consultation with the appropriate nursing personnel. Case Managers will consist of Registered Nurse, Licensed Practical Nurse, Social Worker and Accredited Record Technician. All verbal orders and all orders dictated over the telephone shall be signed by the appropriate authorized person to whom dictated with the name of the physician per his or her own name.

(b) All verbal/phone orders including critical lab values must be written down and "read-back" to assure that the information is accurate.

4. Hazardous Orders:

(a) All Hazardous Orders must be authenticated and dated within twenty-four (24) hours. Hazardous Orders are defined as:

Chemotherapy
Restraints
Investigational Drugs
Do Not Resuscitate (DNR) order and/or
Comfort Measures Only (CMO) orders

5. The physician's orders must be written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until rewritten or understood by the nurse. It is recommended to clearly print all medication names within orders.

6. New orders are to be written after the patient has undergone surgery. Orders written prior to surgery will no longer be in effect, and must be rewritten to assure continuation.

7. All preprinted orders shall be reviewed and revised as appropriate annually and shall be reviewed by the Medical Record Review Committee and the appropriate Medical Staff Department.

8. All drugs and medications administered to patients shall be FDA-approved and may be referenced in the latest edition of: Clinical Pharmacology, the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or A.M.A. Drug Evaluations. Herbal or other non-approved (FDA) supplement use is prohibited by Policy/Procedure H.32 – Herbal and Alternative Products. Drugs for bona fide clinical investigation may be exceptions. These shall be used in full accordance with the State of Principles involved in the Use of Investigational Drugs in Hospitals and all regulations of the Food and Drug Administration (FDA). Refer to Policy/Procedure H.14 – Investigational Drugs. Selected Medications, as recommended by the Pharmacy & Therapeutics Committee and approved by Medical Executive Committee, may be discontinued within the Policy/Procedure H.13 – Stop Orders.

9. If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and had not been obtained, he/she shall call this to the attention of his/her supervisor who in turn shall refer the matter to the attention of the Director of Nursing, Assistant Chief Nursing Officer and/or the Chief Nursing Officer.

10. All patients undergoing procedures who undergo Sedation and/or Anesthesia care shall have care administered in accordance with Policy/Procedure# K-14.

## PART G: GRADUATE MEDICAL EDUCATION PROGRAM

### 1. GENERAL INFORMATION

(a) **Identification** – All Medical Students and House Staff (interns, residents, and fellows) must wear Largo Medical Center badges at all times while on duty. Medical Students and House Staff not wearing their badge are not allowed on patient care areas. Students wear short lab coats, Interns, Residents and Fellows wear long lab coats.

(b) **Teaching Staff** - Membership to the teaching faculty is governed by "Criteria for Primary Teaching Staff" approved by the Department of Medical Education.

(1) <u>Membership</u> - Medical staff members have the option of not participating in the teaching program without jeopardizing their appointment or privileges. The training program does not prohibit medical staff members from writing orders.

(2) <u>Supervisor</u> - Members of the Teaching Faculty are responsible for the supervision of Medical Students and House Staff. The "House Staff Manual" contains a defined process for supervision by a licensed independent practitioner with appropriate clinical privileges of each participant in the graduate education program(s) in carrying out patient care responsibilities. The supervision of House Staff is evidenced by compliance with the signature requirements. *Supervising physicians must date and time the H&Ps to ensure timely adherence to regulations.* However, the supervising physician may change any statement made in the medical record by a House Staff member by drawing a single line through the entry and initialing the change.

(c) **Scope of Practice/Credentialing in Clinical Competency** - The mechanisms to determine the scope of services provided by an individual House Staff member, the required supervision, and the clinical competence of House Staff is outlined in House Staff Manual and in the logs.

(d) **Committees**

(1) **Medical Education Committee** - The Education Committee is responsible for the oversight of the Medical Education Program. The Graduate Medical Education Committee is comprised of the Chief Academic Officer & Director of Clinical Services (Chair), Administrative Director of Graduate Medical Education, all Residency Program Directors, all Fellowship Program Directors, Director of Pediatrics, Chief Administrative Resident, and a representative(s) from Administration. The Education Committee meets at least quarterly and communicates on pertinent medical education issues to the Medical Staff via the Director of Medical Education who is a member of the Medical Executive Committee. The Education Committee provides copies of meeting minutes to the Medical Executive Committee and to the Board of Trustees. The Committee also makes annual recommendations to the Board of Trustees relevant to the contracting and promotion of new Interns and

Residents.

(e) Specific curriculum and procedural responsibilities within the scope of each respective intern, resident's postdoctoral training program are detailed in the House Staff Manual, and House Staff Competency Assessment and Credentialing Manual, as updated on an annual basis.

2. **MEDICAL STUDENTS**

(a) **Definitions** - a Medical Student is a third or fourth year student in a college of Osteopathic Medicine or a college of Medicine. Medical Students may not refer to themselves or be referred to as "Doctors or Physicians". Medical Students are under the direct supervision of the attending physician or resident physician. The duties and supervision of Medical Students are governed by the "Medical Student Manual" which is approved by the Department of Medical Education and the Medical Executive Committee.

(b) **Identification** – All Medical Students must wear Largo Medical Center badges at all times while on duty. Medical Students not wearing their badge are not allowed on patient care areas. Students wear short lab coats.

(c) **Signature** - Medical Students shall sign progress notes that they write with their name followed by "M.S.III or IV," whichever applies.

(d) **Authorized Activities – Medical Students may -** perform and write history and physicals for education purposes only. Such history and physicals may be placed in a separate section of the chart but will not be a permanent part of the medical record.

(e) **Prohibitions –** Medical Students may not initiate, give, write, transcribe or accept verbal orders or orders of any kind. Medical Student may not write order in the patient chart or write prescriptions. *Medical Students writing in the medical record must sign and print: student name, MSIII or IV.* Medical Student may not perform any procedures on a patient unless directly supervised by an Attending or Resident.

3. **HOUSE STAFF -** The term "House Staff" includes Interns, Residents and Fellows. House Staff are governed by the "House Staff Manual", the Competency Assessment Book, and by job descriptions which are approved by the Department of Medical Education and the Medical Executive Committee. These documents more fully describe the duties and supervision of House Staff while they are acting in their capacities as such. House Staff also are governed by applicable portions of the Medical Staff Bylaws, Rules and Regulations and policies/procedures. Medical Students, Interns, Residents and Fellows will not be privileged as Medical Staff physicians and are not members of the Medical Staff. They will be monitored by a Physician with staff privileges at Largo Medical Center who is a member of the Teaching Faculty.

(a) **Interns (PGY I)**

(1) **Definition -** An Intern is a graduate of a school of Osteopathic Medicine who is in the first year of postdoctoral training at an AOA accredited rotating traditional internship program; employed

by the hospital.

(2) **Identification -** Interns shall wear easily visible identification as an "Intern" whenever they are on duty.

(3) **Signature** - Interns shall sign handwritten chart entries and dictated reports with their name followed by PGY I."

(4) **Authorized Activities - Interns may:**

(a) Supervises and directs decisions of medical students.
(b) Can perform initial assessment, actively participates in all aspects of patient care, including H&P's, diagnostic and therapeutic planning, procedures, and writing orders; and orders require countersignature by the attending physician. If a H&P is performed by an Intern, it must be authenticated by the attending physician.
(c) All procedures must be done under direct supervision of attending physician.
(d) Interns may complete any portion of the medical record.
(e) History and Physicals, Operative Reports and Discharge Summaries must be signed by the attending physician; who must document: review of chief complaint and past medical history; and agree with the assessment and plan and have discussed with the Intern.
*(f)* Interns may write orders, which must be countersigned by the Attending. *These orders must be countersigned by the Attending prior to following the order.*
(g) Interns and Residents may give and transcribe verbal orders; however, Interns and Residents may not initiate DNR order or orders to withhold or to withdraw life-prolonging procedures.
(h) Write progress notes, which require countersignatures including but not limited to: admit, diagnostic and therapeutic planning, and pre-surgical progress notes, in accordance with Medical Education policy.
(i) The immediate, handwritten, post-surgical note requires a countersignature by the Attending.

(4) **Prohibitions - Interns may not:**

(a) Initiate DNR orders or orders to withhold or to withdraw life-prolonging procedures.
(b) Be or sign as the Informing Physician on Consent forms.
(c) Serve as Consulting Physicians for any purpose.

(b) **<u>Residents</u> (PGYI-V)**

(1) **Definition** - A Resident in an osteopathic teaching hospital is a physician who has completed an AOA-accredited internship program and has progressed to the second to the fifth postdoctoral year(s) of training in an AOA-accredited Residency Program; employed by hospital.

(2) **Identification** - Residents and Fellows shall wear easily visible identification, which identifies them as a "Resident" whenever they are on duty. Residents shall sign all their handwritten entries in the

medical record with their name followed by "their PGY level".

(3) **Authorized Activities - Residents may:**

2nd Year Residents (PGY-II):

(a) Supervises PGY-I and students.
(b) May initiate common diagnostic studies and therapeutic interventions prior to presentation to attending physician.
(c) Decisions regarding invasive procedures must be discussed with attending physician prior to initiation.
(d) History and Physicals, Operative Reports and Discharge Summaries must be signed by the attending physician; who must document: review of chief complaint and past medical history; and agree with the assessment and plan and have discussed with the Resident.
(e) Residents may write orders. These orders may be followed immediately and must be countersigned.
(f) Write progress notes, which require a countersignature, in accordance with Medical Education policy.
(g) May take verbal orders.

3rd Year Residents and Higher (PGY-III, IV, V):

(a) Supervises PGY-I and II.
(b) May initiate common diagnostic studies and therapeutic interventions prior to presentation to attending physician.
(c) May also initiate more sophisticated diagnostic studies and therapeutic interventions with attending physician approval.
(d) Must discuss all cases with attending physician prior to disposition of decisions and changes in therapeutic regimens.
(e) History and Physicals, Operative Reports and Discharge Summaries must be countersigned by the attending physician; who must document: review of chief complaint and past medical history; and agree with the assessment and plan and have discussed with the Resident.
(f) Residents may write orders. These orders may be followed immediately and must be countersigned.
(g) May take verbal orders.
(h) May write progress notes, which require a countersignature, in accordance with Medical Education policy.

(4) **Prohibitions - Residents may not:**

(a) Initiate DNR orders or orders to withhold or withdraw life-prolonging procedures.
(b) Be or sign as the informing Physician on Consent forms.
(c) Serve as a Consulting Physician.
(d) Residents without a valid Florida License and DEA may not write and provide to patients any prescriptions that have not been previously countersigned by the Attending physician

(c) **Fellows**

(1) **Definition:** Fellows are residency-trained, board-eligible or board certified physicians in their residency specialty; employed by the hospital, and in an AOA-accredited subspecialty training program at Largo Medical Center. The Fellow must be licensed in Florida; and

must meet the prerequisites for the basic standards for sub-specialty training as required by the relevant osteopathic specialty or sub-specialty college. Fellows are engendered with additional qualifications, as follows:

(2) **Identification** - Fellows shall sign all their handwritten entries in the medical record with their name followed by "Fellow and/or PGY level."

(3) **Authorized Activities - Residents may:**

(a) The Fellow must be licensed in Florida.
(b) The Fellow must meet the pre-requisites for the Basic Standards for subspecialty training as required by the relevant subspecialty College of the American Osteopathic Association.
(c) The Fellow is empowered with all the responsibilities of a Senior Resident (PGY II, IV, V), in accordance with Medical Education policy, as specified above.
(d) The Fellow, similar to the Residents, must participate in Competency Assessment and credentialing processes established by the Fellowship program and Medical Education policies.

**PART H: IMAGING SERVICES**

1. The department shall carry out the functions and directives specified in the Medical Staff Bylaws concerning purposes and functions of the departments insofar as applicable to the practice of radiology at the Hospital.

2. All X-ray reports are to be included in the patient's medical record within twenty-four (24) hours after being dictated by the radiologist and all reports are to be signed before the permanent record is filed.

3. Appropriate protection aprons are to be worn by any personnel within any X-ray room in which X-rays are exposed or a fluoroscopy procedure is being performed.

4. Imaging personnel will make every effort to avoid holding patients for Radiography examinations in accordance with the As Low As Reasonably Achievable (ALARA) Policies.

5. All requests for radiology and nuclear medicine service must include information from the requesting physician justifying the need for the examination(s) requested.

6. All imaging services will be provided only on the order of a licensed physician, podiatrist, or dentist, within their scope of practice.

7. All females between thirteen (13) and fifty (50) years of age are shielded during any procedure not involving the pelvic region.

   Direct fetal area exposure exams and Nuclear Medicine studies are to be done only if one of the following criteria are met:

   (a) Within ten (10) days of the onset of menses. Date must be permanently recorded.

(c) Patient has had a hysterectomy, tubal ligation or a current negative pregnancy test on record.

(d) The attending physician is aware that the patient does not meet the above criteria but feels the benefits outweigh the risks. This must be permanently recorded.

8. A staff physician shall be within the department and/or immediately available during the administration of contrast media. After hours coverage may be provided by the Emergency Room physicians, if necessary.

9. All ultrasound, nuclear medicine, MRI, CT and radiographic examinations shall be interpreted by a Staff radiologist and a written report rendered.

10. Imaging examinations shall be interpreted by a Staff radiologist within twenty-four (24) hours of presentation to the Staff radiologist.

11. If there are significant abnormal findings of an imaging study requiring prompt medical attention, the Staff radiologist will notify the attending physician or appropriate person.

12. A Staff radiologist will be available twenty-four (24) hours a day, seven (7) days a week for emergency radiographic examinations.

## PART I: SPECIAL PROCEDURES

1. Scheduling: All imaging procedures must be scheduled. Elective special procedures should, if possible, be scheduled at least twenty-four (24) hours in advance with the patient's name, age, birth date, phone number, address, examination to be done, date examination is requested, valid history and physical, brief indications of the examination, tentative diagnosis, and name of referring physician. Emergency special procedures shall have priority over all other scheduled radiographic procedures.

## PART J: MEDICAL RECORDS

l. The management and coordination of the patient’s care, treatment and services should be documented in the patient’s medical record by all physicians who care for the patient. A complete and accurate medical record is maintained on all patients assessed, cared for, treated and serviced. This record shall include identification data, chief complaint(s), personal medical and surgical history, family history, history of present illness, body systems review, physical examination, plan for hospital care, special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis, progress notes, final diagnosis, condition on discharge, discharge instructions, discharge summary or clinical resume and autopsy report (when performed).

2. **General Statement** - A complete admission history and physical examination on each patient must be written or dictated within twenty-four (24) hours of admission (but prior to surgery or invasive procedures). This report shall include, at a minimum, the following elements:

<u>History Section:</u>
Reason for Admission/ Indication for Procedure
Patient History (past, social/family documentation only if relevant)
Current Medications
Allergies

Physical Section:
HEENT
Cardiovascular
Respiratory
Abdomen
Neurological
Extremities
GU System (if applicable)
Conclusion/Impression
Treatment Plan
Date that the H&P was completed.

An abbreviated or shortened history and physical may be recorded either in writing or typed form for a patient whose stay is less than forty-eight (48) hours. This report should address all of the required elements noted above.

A dictated or hand written history and physical is required for all patients undergoing surgery or other procedures that places the patient at risk and/or involves the use of sedation or anesthesia

When the history and physical examination is not recorded on the patient record before an operation or any potentially hazardous diagnostic procedure, the procedure shall be cancelled, unless the attending physician states, in writing, that such delay would be detrimental to the patient. A consult note with required components can be utilized to fulfill the H&P prior to a surgical and/or non-invasive procedure requirement, as long as the appropriate specialist completes the consult and the consult contains all of the required minimum elements of an H&P.

If a History & Physical is performed by an Allied Health Professional (ARNP/PA), it must be authenticated by the sponsoring physician.

**Use of Reports Prepared Prior to Current Admission or Surgery** - If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission to the Hospital, such as in the office of a physician staff member, a reasonably durable, legible copy of such reports may be used in the patient's Hospital medical Record. A pre-admission history and physical examination report that is over 24 hours old will be reviewed by the physician who will update the patients condition since it was last assessed noting any changes, or stating no changes. The time frame for the update is twenty-four (24) hours following registration or admission, but prior to surgery. An H&P performed up to twenty-nine (29) days prior to admission must be updated within twenty-four (24) hours following registration or admission. This update will be dated, signed and timed by the physician.

(a) In the event the patient is currently an inpatient and requires surgery or invasive procedure, a complete and legible progress note(s) shall suffice as the updated history and physical examination. The exception to this is the situation in which the patient is admitted as an inpatient and having surgery within the first twenty-four (24) hours of admission. An update to the H&P would be required prior to surgery if an H&P performed prior to admission is being utilized to meet the H&P requirement.

(b) In the event the patient is being admitted for outpatient surgery and utilizing an H&P performed prior to admission, an update to the patient's condition since it was last assessed noting any changes, or stating no

changes is required prior to surgery.

3. When a pertinent history and physical examination has not been recorded prior to surgery or any potentially hazardous diagnostic procedure, the procedure shall be delayed until the history and physical exam is recorded, unless the attending physician states in writing that such delay would be detrimental to the patient.

4. All verbal/telephone orders must be timed, dated and authenticated within forty-eight (48) hours by the prescribing physician or another physician responsible for the care of the patient, even if the order did not originate with him or her.

5. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be carefully defined in the progress notes and correlated with specific orders as well as results of tests and treatments. Progress notes shall be written at least daily on all patients. Failure to comply will be brought to the attention of the Medical Executive Committee for possible corrective action.

6. All consultations shall be considered routine unless stipulated in writing on the patient's order sheet. Consultations shall be performed within a twenty-four (24) hour period and shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I agree or concur" does not constitute an acceptable report on consultation. When operative procedures are involved, the consultation note shall, except in an emergency so verified on the record, be recorded prior to surgery. Any qualified physician with clinical privileges in this Hospital may be called in consultation within the area of his expertise. Urgent consultations shall be done within a twelve (12) hour period upon personal notification by the attending physician. STAT cases shall be done immediately upon personal notification of the consultant by the attending physician.

7. While recognizing the inherent right of any physician to refuse to provide initial professional services, including consultation, to any patient unless specifically ordered to do so by the Medical Executive Committee or the Chief of Staff (acting in his official capacity), it is recommended and strongly urged that all reasonable requests for consultation will be fulfilled by the consultant to facilitate care of the patient without undue delay.

   If, in the opinion of the consultant, the requested consultation is deemed unnecessary or inappropriate, a cancellation order shall be entered on the patient's record by the consulting physician.

8. All clinical entries in the patient's medical record shall be accurately dated, timed and authenticated. This includes legible handwritten signature, faxed handwritten signature, identifiable initials or computer key signature (electronic signature) of the responsible physician.

   Entries into the medical record can be made by any caregiver/practitioner who is currently involved in the patient’s care. This includes, but is not limited to, physicians, nursing, cardiopulmonary therapist, rehab therapist, dietary staff,

   case managers, diagnostic imaging staff, pharmacies, CRNAs, PAs, anesthesia assistant, external Hospital Nurses and external vendors who are actively participating in patient care/procedures (orthotics/implant vendors).

9. Medical Staff use of abbreviations in the medical record must be in accordance with the hospital's policy/procedure. (Please refer to Unacceptable Abbreviation policy/procedure)

10. Final diagnosis or diagnoses shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible physician. This will be on the dictated discharge summary or final progress note.

11. A discharge summary must be completed on all patients admitted to the hospital. This does not include observation and/or outpatient surgery patients. All summaries shall be authenticated by the responsible physician. All discharge summaries shall include patients' recommended activity, diet, medications, appointment following discharge (when appropriate) and specific statement of the patient's general medical/surgical condition.

12. If a formal transfer of service is made to surgery, the surgeon is responsible for completion of the discharge summary. If a formal transfer is not made, the admitting physician is responsible. Transfer of service can only occur during hospitalization and not after patient has been discharged.

13. When a case is lengthy and has both medical and surgical problems, two discharge summaries may be done. The first is to be done by the attending physician and the second one done as an addendum.

14. It will be the policy of the Medical Staff to require signatures for dictated reports, to include: History and Physical, Operative Report, Consultation Report and Discharge Summaries. These reports will be flagged and held deficient in the Medical Records Department until completed.

15. Written consent of the patient is required for the release of the medical information to persons not otherwise authorized to receive this information. This information may only be released by the Health Information Department.

16. Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing. All records are the property of the Hospital and shall not otherwise be taken away. In case of readmission of the patient, all previous records shall be made available for the use of the attending physician. This shall apply whether the patient is attended by the same physician or by another. Unauthorized removal of charts from the Hospital by a physician is grounds for suspension of the physician for a period to be determined by the Medical Executive Committee.

17. Free access to all medical records of all patients shall be afforded to members of the Medical Staff for bona fide study and research consistent with preservation of the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Medical Executive Committee before such records can be studied. Subject to the discretion of the Medical Executive Committee and the Chief Executive Officer, former Medical Staff members may be permitted free access to information from the medical records of their own patients covering all periods during which they attended the respective patients in this Hospital.

18. A medical record shall not be permanently filed until it is completed by the

responsible physician or is ordered to be filed by the Medical Executive Committee under unusual circumstances (such as death or prolonged illness or absence of the responsible physician.)

19. The patient's medical records shall be completed within thirty days from the date of discharge. If the record still remains incomplete on the 31st day, the record will become delinquent. The physician will be notified, by mail, that he/she has delinquent records by the following means:

    - After discharge on the first (1st) Wednesday of the following month (or the following workday if the Wednesday is a holiday) a First Reminder Letter will be mailed to the practitioner identifying their incomplete medical records
    - After discharge on the third (3rd) Wednesday of the following month (or the following workday if the Wednesday is a holiday) a Second Reminder Letter will be mailed to the physician identifying their incomplete as well as their delinquent medical records
    - If by the next Medical Executive Committee that follows (the second week every month) the physician has not completed their delinquent medical records Medical Executive Committee will recommend a Delinquent Notice be sent by certified mail to the physician notifying him/her that they have until the next Medical Executive Committee (30 days) to complete their delinquent records, or they will be placed on temporary suspension.

    If temporary suspension of hospital privileges occurs, the physician will not be able to admit patients, see consultations, perform inpatient or outpatient procedures or to provide any medical management on patients admitted after that date until the delinquent charts have been completed. Temporary Suspension for delinquent medical records does not alleviate the provider from providing emergency department coverage per the hospital call schedule for any continuum of care. Any additional call will not be given to a physician who is on the suspension list.

    A medical record will be considered delinquent in the absence of a dictated or handwritten History and Physical, Discharge Summary, Op or Consult reports, and/or lack of physician signature thirty (30) days after discharge.

20. The attending surgeon is responsible for dictating or handwriting an operative report immediately after surgery. The report must include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, post-operative diagnosis as well as estimated blood loss. The completed operative report is authenticated by the surgeon and placed on the patient's medical records immediately after surgery. When the operative report cannot be placed on the patient's medical record immediately after surgery, a progress note must be entered in the medical record.

21. The original documents (e.g., laboratory or radiology reports or medication administration records) should be in the physician or Allied Health Professional, who has been credentialed to document in the medical record, immediate possession and be visible when it is necessary to transcribe information from one document to another.

## PART K: MISCELLANEOUS

1. The Infection Control physician, through the Chief of Staff or physician members, has the authority to institute any appropriate control measures or studies when it is reasonably felt that danger to patients, visitors or personnel exists.

2. The Risk Management, Utilization Review, Environment of Care and Quality/Performance Improvement Plans of this Hospital, as approved by the Board, shall be adhered to by all practitioners.

3. Policies and procedures governing the use of various facilities of the Hospital, preparation of medical records, specialized forms of treatment, disposal of specimens, etc., when determined and published by authorized committees or the appropriate departments of the Medical Staff and approved by its Medical Executive Committee and the Board, shall be adhered to by all practitioners who are responsible for remaining abreast of all current directives.

4. Policies and procedures referred to in these Rules and Regulations are to be found in the Policy and Procedure Manuals of the Hospital.

5. Members of the Medical Staff are required to notify the CEO in writing of any change in permanent residence, office, or applicable phone within thirty (30) days of the change.

6. Members of the Medical Staff shall inform the Hospital CEO or his designee in writing within thirty (30) days of notification of a quality issue, identified by the PRO (Peer Review Organization), or of notice of a professional liability negligence claim.

7. Members of the Medical Staff shall inform the Hospital CEO immediately and in writing of any disciplinary actions taken by any regulatory or licensing body against the Medical Staff Member which will serve to limit, restrict or otherwise alter the practice privileges of that Medical Staff member.

8. Willful violation of any of these Rules and Regulations may subject the physician or allied health practitioner to disciplinary action.

**PART L: NON-PHYSICIANS**

1. A physician's assistant may provide patient care only if the physician under whose supervision and direction he works is permitted by the department to delegate specified patient services to the physician's assistant and the physician's assistant is permitted to render specified services by the Board of Trustees.

2. A physician shall retain full responsibility and accountability for the conduct and activities of the physician's assistant, including moral and ethical behavior. A physician must provide verification of the credentials of the physician's assistant to the clinical section to which he is assigned. The physician shall also designate members of the Medical Staff assigned to his clinical section who are willing to assume responsibility for supervising the physician's assistant in his absence.

3. Doctoral scientists may write orders for the care of a patient only if the orders are countersigned by the attending physician.

4. A physician who is licensed to practice medicine in another jurisdiction, but not in this state, may participate as an observer in patient care, with the permission of the attending physician and patient. The out-of-state physician must be recommended to, and approved by, the Chief of Staff, or his designee. The physician must accompany the physician making the recommendation, who will be responsible for his activities.

5. Appropriately licensed Allied Health Professionals may be permitted to provide specified patient care services. They will function primarily to provide adjunctive care, in addition to the usual care provided by the physician.

6. A supervising physician will be responsible for the actions of each Allied Health Professional.

**PART M: OTHER**

1. Blood that has been cross-matched and is being held for a patient will be held for three (3) days, at which time the order for the blood will be canceled unless reordered for another three (3) days. Blood will not be released without notifying the appropriate physician.

2. Oxygen and pulmonary services will be administered according to the attending physician's orders and in accordance with the policies and procedures of the Pulmonary Services Department. Orders that vary from the policy and procedures shall be immediately brought to the attention of the ordering physician, and, if necessary, be referred to the Medical Director for resolution.

3. Cardiac telemetry shall require a physician order at least every seventy-two (72) hours for continuation of the monitoring.

4. Consultation request forms for radiology and pathology shall be filled out completely. The attending physician is responsible for providing necessary clinical data. The necessary data may be taken from the order sheet or progress notes by a nurse.

5. Standing orders shall be instituted only after approval of the Medical Executive Committee. Such standing orders and/or instruction sheets shall be reviewed at least annually and/or revised as necessary. All standing orders and/or instruction sheets must be signed, dated and timed by the responsible physician when utilized, as required for all orders for treatment.

6. All members of Medical Staff shall follow the guidelines of the Hospital policy and procedures for Withholding or Withdrawing Life-Prolonging Procedures, in accordance with The Joint Commission standards and Florida Statute Ann. Section 765.0 et seq, and other applicable laws and court decisions.

**PART N: PSYCHIATRIC SERVICES**

1. Every patient receiving psychiatric services in the hospital shall be under the care of a psychiatrist credentialed by the hospital to provide those services.

2. Inpatient psychiatric services at the hospital shall be under the supervision of the Medical Director for the psychiatry Department. The Medical Director shall have met the training and experience requirements by examination by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. This section chief shall monitor and evaluate the quality and appropriateness of psychiatric services and treatment provided by the medical staff.

3. Electroconvulsive therapy (ECT) may only be performed by psychiatrists who have applied for privileges to administer this therapy, who have demonstrated proof of competence and who have been approved for the administration of ECT by the Medical Executive Committee and the Governing Board.

(a) ECT may not be performed without obtaining informed consent for ECT from the patient, his or her legal guardian, or the patient's guardian advocate appointed pursuant to Florida Statute Section 394.4598, if the guardian advocate has been given express authority by the Court to consent to ECT.

4. Psychiatric medical records must stress the psychiatric components of the record, including history of findings and treatment for the psychiatric condition for which the patient is hospitalized. An initial psychiatric evaluation shall include a medical history, a record of mental status, note the onset of illness and the circumstances leading to admission, describe attitudes and behavior, estimate intellectual functioning, memory functioning, and orientation, and include an inventory of the patient's assets in descriptive, not interpretive, fashion. Each patient must have an individual, comprehensive treatment plan that must be based on an inventory of the patient's strengths and disability. The record of each patient who has been discharged must have a discharge summary that includes a recapitulation of the patient's hospitalization and recommendations from appropriate services concerning follow up or after care as well as a brief summary of the patient's condition on discharge.

5. Restraints or seclusion shall not be used for punishment, to compensate for inadequate staffing, or for the convenience of staff, and shall be in compliance with all applicable provisions of state and federal law and in compliance with written policies and procedures of the hospital, including Part P of these Rules and Regulations.

6. Only credentialed and appointed physicians, clinical psychologists, licensed clinical social workers, or registered nurses with Masters in Psychiatric Nursing may impose a Baker Act in accordance with Florida statutes. Only credentialed and appointed psychiatrists, emergency department physicians with experience in the diagnosis and treatment of mental and nervous disorders, and clinical psychologists may lift a Baker Act in accordance with Florida statutes.

7. All medical staff members and allied health professionals providing services subject to Florida's Baker Act, Chapter 394, Florida Statutes, are expected to be knowledgeable pertaining to the provisions of the Baker Act and its associated administrative rules, and shall comply with those provisions in conjunction with providing services at the hospital.

8. Initial psychiatric evaluations for patient admitted for psychiatric care are to be performed, documented, and be present on the chart within 24 hours after the patient's arrival at the facility.

9. All admitting physicians with hospitalized patients receiving psychiatric care must respond within 1 hour to calls/pages regarding the condition of care of their patient.

10. Axis I-V shall be recorded upon admission and discharge.

**PART O: PRIVACY PRACTICES (HIPAA)**

Each member of the medical staff, as well as every practitioner or Allied Health Professional with clinical privileges shall be part of the Organized Health Care Arrangement with the Hospital, which is defined in 45 C.F.R. 164.501, which is part of what is commonly known as the HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive health care from more than one healthcare

provider. This arrangement allows the hospital to share information with the Provider and the Provider's office for purposes of the Provider's payment and practice operations. The patient will receive one Notice of Privacy Practices during the Hospital's registration or admissions process, which shall include information about the Organized Health Care Arrangement with the Medical Staff, Practitioners or Allied Health Professionals with clinical privileges.

**PART P: RESTRAINTS AND SECLUSION**

The use of restraints or seclusion within this organization is limited to those situations with adequate appropriate clinical justification and adequate human resources to meet the clinical needs of patients requiring restraint or seclusion as a therapeutic intervention. All patients have basic human rights that must be respected within the limits of safety. The goal is to maintain the patient's dignity and reinforce their self-esteem.

Restraints or seclusion may only be imposed if the restraints or seclusion are imposed to ensure the immediate physical safety of the patient, a staff member, or others, and must be discontinued at the earliest possible time. Restrains or seclusion may be imposed only upon the written order of a physician or other licensed independent practitioner permitted by the hospital to order such restraint or seclusion. Any orders for restraint or seclusion shall be in compliance with all applicable laws and regulations, including but not limited to the provisions of 42 CFR 482.13(e), and the hospital's written policies and procedures pertaining to the use of restraints.

Please refer to policy/procedure titled, "Restraints". This policy/procedure can be located in all nursing areas of the hospital.

**PART Q. SPECIAL CARE UNITS**

I. Special Care Units such as PACU, Critical Care Units and Emergency Department duties and responsibilities are clearly defined in the Plan for Providing Patient Care policy and procedure. This policy/procedure is reviewed and approved by the Medical Executive Committee, the Chief Executive Officer, the Nurse Executive and the Board of Trustees.

2. If the patient's attending physician is not credentialed to perform the following procedures or care for patients with the following conditions, then a consulting physician shall be obtained:

    (a) Renal failure requiring dialysis
    (b) Symptomatic 2nd degree or greater heart block
    (c) Cardiogenic Shock
    (d) Swan Ganz catheter insertion
    (e) Patients requiring temporary pacemakers
    (f) Patients requiring ventilator support for more than forty-eight (48) hours.

**PART R: SURGICAL CARE**

1. Except in emergencies, documentation in the form of a current written History and Physical by a physician must be on the chart prior to surgery.

   Physical and lab studies required prior to surgery, under general, spinal anesthesia, and managed anesthesia care are as follows: A pregnancy test is done on all females under the age of fifty (50), unless there is a history of a surgical hysterectomy or tubal ligation

Appropriate indications for ordering tests include the identification of specific clinical indicators or risk factors (e.g. age, pre-existing disease, magnitude of the procedure). Individual anesthesiologists will order test when, in their judgment, the results may influence decisions regarding risks and management of the anesthesia and surgery. The results of the tests relevant to anesthetic management will be reviewed prior to the initiation of the anesthetic.

2. The primary surgeon shall be in the operating room and ready to commence surgery at the time scheduled.

3. A pre-sedation or pre-anesthesia assessment is performed and documented in the medical record by the anesthesiologist for each patient before beginning moderate or deep sedation and before anesthesia induction. Each patient's moderate or deep sedation care is planned and sedation and anesthesia options and risks are discussed with the patient and/or family prior to administration.

4. All physicians and practitioners performing surgery or invasive procedures are responsible for assuring the surgical site has been marked in accordance with Policy/Procedure #K23 entitled "Patient Safety, Universal Protocol" prior to any surgical or invasive procedure; the physician shall actively participate in a final verification process to confirm the correct patient/procedure and site. This process may be referred to as a "Time Out". See the Universal Protocol noted above.

5. The patients' post-procedure status is assessed and documented by the anesthesiologist on admission to and before discharge from the recovery area. A description of the presence or absence of any complications is also documented.

6. Dental Care

A patient admitted for dental care is the dual responsibility of the dentist and primary physician who holds active medical staff privileges. Surgical procedures performed by dentists shall come under the purview of the Chief of Surgery.

6a. Dentist's responsibilities:

i. Provide to the Hospital the name of the physician who is responsible for medical care and with whom prior arrangements have been made to assume responsibilities listed in 5B below.

ii. A detailed dental history justifying hospital admission.

iii. A detailed description of the examination of the oral cavity and pre-operative diagnosis.

iv. A complete operative report, describing the findings and techniques. In case of extraction of teeth, all tissue, including teeth, shall be sent to the hospital pathologist. The number of teeth removed must be written on the O.R. record.

v. The dentist is totally responsible for the oral and dental care.
vi. Progress notes as are pertinent to the oral condition.
vii. Discharge summary.

6b. Physician's and/or oral surgeon's responsibilities:

i. Medical history pertinent to the patient's general health.

ii. A physical examination to determine the patient's condition prior to anesthesia and surgery.

iii. Supervision of the patient's general health status while hospitalized.

iv. The physician is not responsible for any dental care or consequences thereof.

v. Availability during the performance of a surgical procedure.

7. Podiatric Care

A patient admitted for podiatric care is the dual responsibility of the podiatrist and primary physician who holds active medical staff privileges. Surgical procedures performed by podiatrists shall come under the purview of the Chief of Surgery.

7a. Podiatrist's responsibilities:

i. Provide to the Hospital the name of the physician who is responsible for medical care and with whom prior arrangements have been made to assume responsibilities listed in 6B below.

ii. A detailed history justifying hospital admission.

iii. A detailed description of the examination of the feet and pre-operative diagnosis.

iv. A complete operative report, describing the findings and technique. All tissue removed shall be sent to the Hospital pathologist for examination.

v. Progress notes.

vi. The podiatrist is responsible solely for the care of the feet.

vii. Discharge summary (or summary statement).

7b. Physician's responsibilities.

i. Medical history pertinent to the patient's general health.

ii. A physical examination to determine the patient's condition prior to anesthesia and surgery.

iii. Supervision of the patient's general health status while hospitalized.

vi. Physicians are not responsible for any podiatric care or treatment of feet or consequences thereof.

v. Availability during the performance of a surgical procedure.

8. Admission and discharge of a podiatric or dental patient shall be the responsibility of the attending physician (MD/DO), who must be a member of the Active Staff with appropriate privileges to oversee the general medical care of the patient.

9. Informed surgical consent shall be documented in writing and signed prior to the operative procedure except in those situations wherein the patient's life is in 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 cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be fully explained on the patient's medical record by the attending surgeon. If time permits, a consultation in such instances may be desirable before the emergency operative procedure is undertaken.

10. The anesthesiologist or anesthetist shall maintain a complete anesthesia record that includes evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

11. The attending surgeon shall ensure that all tissues removed (with the exception of those approved by the Medical Executive Committee as not required as specimens submitted to Pathology) shall be sent to the Hospital pathologist, who shall make such examination as he may consider necessary to arrive at a pathological diagnosis. His report shall be made a part of the patient's medical record. Each specimen shall be accompanied by information that includes the preoperative diagnosis, description of tissue and brief pertinent clinical data that the surgeon will complete or cause to be completed.

12. Scheduling of Elective Surgery

    Refer to policy/procedure #701-81-007 titled, “Scheduling Policy – Surgical Services”.

13. Anesthesia may be administered by qualified Nurse Anesthetists certified by the American Association of Nurse Anesthetists, under the direction of an anesthesiologist.

14. Add-On Non-Emergency Cases

    Elective cases will be scheduled so that they may be completed by 3:00 p.m. when the schedule permits. Cases starting after 3:00 p.m. will be placed on a to-follow basis as staffing for that day permits. If a question exists, the Chief of Surgery and/or Chief of Staff will be consulted. Cases that are postponed will be rescheduled for the next day. Physicians who post cases outside of normal elective operating hours should state on the patient's chart their reasons for doing the case at that particular time.

15. Emergency Surgery During Regular Hours

    (a) Criteria

        During the course of a regular work day, the only cases which take priority over the scheduled cases are those which must be done in a life or limb threatening situation, (e.g., severe bleeding, severe cranial pressure, tracheal obstruction, etc.). Emergency surgery, such as an

appendectomy or surgery for an intestinal obstruction, are done as soon as the case can be incorporated into the schedule.

(b) Scheduling

Emergency surgery will be scheduled with the O.R. Director or his/her designee. Acute emergencies will take priority over scheduled procedures of less urgency. It is the responsibility of the surgeon with the emergency case to contact the surgeon having the scheduled case and arrange for release of the O.R. when this is necessary. The remaining schedule will be rearranged at the discretion of the O.R. Director and Anesthesia Department, taking into consideration who booked first, the age and condition of the patient, and the urgency of the procedure.

Emergency cases to be done after regular hours shall be scheduled as soon as possible with the House Supervisor to allow sufficient time to call in the surgery and anesthesia teams and also allow adequate time for pre-operative preparation of the patients. If the possibility arises that a second off-hours team may have to be called, the anesthesiologist shall make this decision. If a disagreement should arise as to the need for a second off-hours team, the Chief of Surgery and/or the Chief of Medical Staff shall be consulted for a final decision.

16. There shall be a Hospital-employed R.N. circulator in the O.R. before any operative procedure begins.

17. If any of the sponge, needle or instrument counts are incorrect, the surgeon shall be notified and the wound and room carefully searched. If the lost sponge, needle or instrument is not found, an X-ray shall be taken of the operative site before the patient leaves the room.

18. Delinquent Medical Records

(a) No surgery bookings will be accepted from physicians who have been suspended for delinquent medical records until such records are complete.

## ARTICLE III

## BOARD APPROVAL AND INDEMNIFICATION

Any Medical Staff officer, committee chairperson, committee member, or individual staff appointee who acts for and on behalf of the Hospital in discharging duties, functions or responsibilities stated in this Medical Staff Organizational Manual shall be indemnified, to the fullest extent permitted by law, when the appointment and/or election of the individual has been approved by the Board.

## ARTICLE IV

## AMENDMENTS

Medical Staff Rules and Regulations and Policies: Subject to approval by the Board, the Medical Executive Committee, acting on behalf of the Medical Staff, shall adopt such Rules and Regulations and Policies. The Rules and Regulations and Policies shall relate to the proper conduct of Medical Staff organizational activities and shall embody the level of practice required of each Staff appointee and individuals with clinical privileges. Such Rules and Regulations and Policies shall not conflict with the Governance Bylaws of the Board of Trustees.

Rules and Regulations of Largo Medical Center Approved and Adopted

Approved and Adopted by the Medical Staff of Largo Medical Center on April 12, 2011

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Chief of Staff

Approved and Adopted by the Board of Trustees of Largo Medical Center on April 26, 2011

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Chairman of the Board

Adopted: 10/28/08,
Revised 8/25/09
Revised 10/27/09
Revised 11/17/09
**REVISED: 05/25/10 – Board approved retroactive date of 01/01/2010**
Revised 4/26/2011