

SHANDS AT STARKE

MEDICAL STAFF RULES AND REGULATIONS

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Section I – Admission and Discharge of Patient

1. A patient may be admitted to the hospital and treated only by practitioners who have been duly appointed to the Medical Staff and who have appropriate privileges. A patient to be admitted who does not have a practitioner shall be assigned to a member of the Active Medical Staff on duty.
2. A member of the Medical Staff of the hospital shall be responsible for the medical care and treatment of each patient in the hospital, for timely completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring practitioner and/or a legal representative of the patient. Whenever these responsibilities are transferred to another Staff member, a note documenting the transfer of responsibility shall be entered on the order sheet of the medical record. The note shall be signed dated and timed.
3. Except in an emergency, no patient shall be admitted to the hospital until after a provisional diagnosis or valid reason for admission has been stated. Such diagnosis shall be written in the medical record as soon as possible.
4. The admitting clerk will admit patients on the basis of a written physician's order. The patient status is determined by utilizing the Case Management Protocol.
5. The admitting physician shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatever.
6. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by hospital policy. The documentation must contain:
 - a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
 - b. The estimated period of time the patient will need to remain in the hospital.
 - c. Plans for post hospital care.
7. Patients shall be discharged only on a written order of the attending practitioner. Should a patient leave the hospital against the advice of the attending practitioner or prior to proper

discharge, a notation of the incident shall be made in the patient's medical record. The patient shall also be requested to sign a form stating that he/she is leaving against medical advice.

8. Upon discharge, a discharge/death summary shall be dictated for all inpatients, except for those hospitalized for less than 48 hours and with only minor problems (as defined by the responsible physician) and observation patients. In these cases a final progress note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the dictated summary. The summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to patient and/or family, i.e., instructions relating to physical activity, medication, diet and follow-up care. All summaries shall be reviewed and approved by the responsible attending physician.
9. Medical records of discharged patients are to be completed promptly, preferably before the patient leaves the facility but no longer than thirty (30) days following the date of discharge.
10. It shall be the responsibility of the attending practitioner to discharge his/her patients as early in the day as is reasonably possible.
11. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his/her designee within a reasonable time. The body shall not be released until an entry has been made and signed on the medical record of the deceased by a member of the Medical Staff.

Section II – Medical Records

1. The attending practitioner shall be responsible for the preparation of a complete and legible medical record for each patient. Its content shall be pertinent and current. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. This record shall include at least the following information, as appropriate:
 - the patient's name;
 - address;
 - date of birth;
 - the name of any legally authorized representative; for patient's receiving mental health service;
 - patient's legal status;
 - emergency care provided to the patient prior to arrival, if any;
 - the record and findings of the patient's assessment;
 - a statement of the conclusions or impressions drawn from the medical history and physical examination;
 - the diagnosis or diagnostic impression;
 - the reason(s) for admission or treatment;
 - the goals of treatment and the treatment plan with episodic review as appropriate;
 - evidence of known advance directives;
 - evidence of informed consent when appropriate;
 - reports of operative and other procedures, tests and their results;
 - progress notes made by the medical staff and other authorized individuals;
 - all reassessments, when necessary;
 - clinical observations;
 - the response to the care provided;
 - consultation reports;
 - medications ordered or prescribed during treatment or upon discharge;
 - all relevant diagnoses established during the course of care;
 - conclusions at the termination of hospitalization;
 - discharge summaries, or a final progress note or transfer summary;
 - discharge instructions to the patient or family;
 - any referrals and communications made to external or internal care providers and to community agencies;
 - results of autopsy, when performed.

2. A pertinent history and physical examination shall in all cases be dictated within twenty-four (24) hours after admission of the patient and as soon as conditions permit for emergency admissions. In addition, a pertinent history and physical examination is required prior to the performance of

any invasive procedure (whether inpatient or outpatient), or when anesthesia or conscious sedation is administered if the practicing physician deems the procedure places the patient at significant risk, and for outpatients who are observation patients. The attending physician shall confirm and countersign the history and physical examination documented by other health care professionals with privileges to perform these activities.

- a. The history and physical shall contain the following:
 - Date of admission
 - Admission diagnosis
 - History of present illness (include mental status)
 - Past medical history
 - Past surgical history
 - Family history
 - Medications
 - Allergies
 - Review of systems
 - Physical examination
 - Laboratory results
 - Impression/Plan

- b. If a history and physical examination (H & P) has been performed within seven (7) days before admission, or thirty days (30) for an outpatient procedure, a legible copy of the report may be used in the patient's medical record. Documentation of significant changes that have occurred or that no changes are identified is recorded at the time of admission.

- c. A credentialed physician must review a history and physical that has been performed by a non-credentialed physician and a note of concurrence entered into the medical record.

- d. If an inpatient is readmitted within seven (7) days of discharge, the history and physical in the medical record may be used provided that any significant changes that have occurred are recorded at the time of admission.

3. No anesthesia shall be given, nor invasive/significant risk procedure started, until the history and physical examination, pre-procedure diagnosis and indicated laboratory/diagnostic tests, are on the chart, unless the attending practitioner documents in the Medical Record that delay would be detrimental to the patient's health. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of procedure.

4. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems

will be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatment. Progress notes shall be written at least daily on each patient.

5. Operative/procedure reports shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed and the postoperative diagnosis. Operative/procedure reports shall be dictated or written immediately following surgery for outpatients as well as inpatients, and authenticated and filed in the medical record as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note, containing the same elements indicated above is entered in the patient's medical record immediately.
6. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, and the consultant's opinion and recommendations. This report shall be made a part of the patient's record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.
7. All entries in the medical record shall be legible, accurately dated, timed and authenticated by the author of the entry. Only those healthcare professionals who are employed by, or contract with Shands HealthCare, or are credentialed by the Shands HealthCare Board are authorized to make entries into the medical record.
 - a. General requirements:
 - 1) All entries should be written legibly.
 - 2) The date and time of each entry will be included.
 - 3) The signature and title of the author will follow all entries.
 - 4) Entries will contain essential information only, recorded in scientific and professional manner.
 - 5) Non-physician authors will limit their subjects to those within their area of training.
 - 6) The patient's name and medical record number should appear on each page.
 - 7) The medical record must be left intact at all times and errors should be left in the chart but lightly cross out in such a way that they remain legible. Corrections should be entered, dated, timed and signed by the editor. Erasures and the use of ink eradicator are not permissible.
 - b. Co-Signatures:
 - 1) Co-signature of a medical record signifies an acknowledgement by the co-signer that the entry was made. It implies concurrence with the statements or conclusions contained in the entry.

- 2) If there is significant disagreement with the conclusion of the author, the co-signer should record such conclusions or expand on the entry as appropriate.
8. Symbols and abbreviations should be used only when they have been approved by the Medical Staff and in compliance with Hospital policy. An official record of approved abbreviations is kept on file in the record room.
9. Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, dated, timed and signed by the responsible practitioner at the time of discharge of all patients. This will be deemed equally as important as the actual discharge order.
10. A discharge summary including plans for continuing care shall be written or dictated by the attending physician on all medical records of patients hospitalized over forty-eight (48) hours. The Medical Staff shall identify exceptions (observation patients), and for these, a final summation-type progress note shall be sufficient. The summary should recapitulate concisely the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to patient and/or family, *e.g.*, instructions relating to physical activity, medication, diet, and follow-up care.
11. In all circumstances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.
12. Written consent of the patient or appropriate alternate decisionmaker is required for release of patient information to persons not otherwise legally authorized to receive this information. Release of patient information shall be made in accordance with Hospital policy.
13. Original records may be removed from the hospital only in accordance with a proper court order or subpoena, or as otherwise permitted by law and hospital policy. All records are the property of the hospital and shall not be taken away without permission of the Administrator. Unauthorized removal of charts from the hospital is grounds for disciplinary action in accordance with the Medical Staff Policy on Appointment and Reappointment.
14. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is attended by the same practitioner or by another.
15. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed and signed by the practitioner.

16. Medical records of discharged patients are to be completed promptly, preferably before the patient leaves the facility, but no longer than thirty (30) days following the date of discharge. Incomplete patient records will be available in the Medical Record Department.
17. Failure to complete medical records as required may be cause for disciplinary action including the suspension of clinical privileges as provided for in the Medical Staff's Policy on Appointment and Reappointment.
18. A medical record shall not be permanently filed until the responsible practitioner completes it. If the responsible practitioner is unavailable for completion of the record and no other physician is adequately familiar with the care to allow completion of the record, it will be presented to the Executive Committee for closure.

Section III – General Conduct of Care

1. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission (except in emergency situations when the patient cannot sign and there is no one else available to sign on her/his behalf.) The admitting office should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall be the practitioner's obligation to obtain proper consent.
2. All orders for treatment shall be in writing. A verbal or telephone order may be taken and transcribed by an RN, LPN, Respiratory Therapist, Physical Therapist, Pharmacist or Clinical Dietitian functioning within his/her scope of practice. The order will be dated, timed and signed by the person receiving the order. The practitioner giving the verbal or telephone order shall authenticate date and time such orders within forty-eight (48) hours. Failure to authenticate verbal/telephone orders in a timely manner shall be brought to the attention of the Administrator for proper action.
3. All medications are administered by or under the supervision of appropriate licensed personnel, in accordance with applicable law.

The following categories of personnel may administer medications functioning within his/her scope of practice:

- a. R.N. (Registered Nurse)
- b. L.P.N. (Licenses Practical Nurse)
- c. Medical Assistants
- d. Radiology Technologists
- e. Respiratory Therapists

f. Physical Therapists

4. Only drugs in the hospital formulary shall be prescribed, unless otherwise necessary for appropriate patient care.
5. Their attending physician or a physician providing coverage for the attending must see all patients within the hospital daily. The physician must write daily progress notes in the chart of each patient at the time of the visit.
6. The practitioner's orders must be clear, legible and complete. Orders, which are illegible or improperly written, will not be carried out until rewritten and understood by the practitioner responsible for implementing the order. The use of "Renew", "Repeat", and "Continue" orders is not acceptable.
7. A renewal order for narcotics, sedatives, hypnotics, and antibiotics shall be written every seven-(7) days.
8. All previous orders, except Do Not Resuscitate (DNR) orders, are canceled when patients go to surgery. A physician member from the surgical team and an anesthesiologist from the anesthesia team shall discuss the status of a previously written DNR order with the patient and/or surrogate, if one has been appointed, prior to the perioperative period and determine the status of the DNR order during surgery. Appropriate documentation shall be made.
9. Preprinted orders shall be formulated by the Medical Staff and the Quality Committee. They can be changed only by mutual consent of the Medical Staff and the Quality Committee and the latter shall notify all personnel concerned. The attending physician shall sign, date and time these orders.
10. All drugs and medications administered to patients must be listed in the latest edition of the United States Pharmacopoeia, National Formulary, American Hospital Formulary Service, or AMA Drug Evaluation. Drugs for bona fide clinical investigations may be exceptions. The Hospital's Pharmacy and Therapeutics Committee must approve such use.
11. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his/her area of expertise.
12. All requests for radiology services must contain reasonable clinical information from the requesting physician.

13. A pre-anesthesia assessment of each patient for whom anesthesia is contemplated, and a determination that the patient is an appropriate candidate to undergo the planned anesthesia, shall be performed by the individual administering anesthesia within 48 hours prior to the procedure and shall be recorded in the medical record of all patients. The assessment must specifically include information relative to the choice of anesthesia for the procedure(s) anticipated. The pre-anesthesia assessment and choice of anesthesia must be co-signed by the patient's surgeon prior to induction. Immediately prior to induction, an evaluation of the patient is completed and documented.
14. The patient's post-operative status is assessed on admission to and discharge from the post-anesthesia recovery area. If discharge criteria are to be used for patient discharge from post-anesthesia care, the Medical Staff must approve them. Post-operative documentation includes at least a record of vital signs and level of consciousness; medications (including intravenous fluids), blood and blood components; any unusual events or postoperative complications, including drug and transfusion reactions, and the management of those events; identification of who provided direct patient care; the patient's discharge from the post-anesthesia care area including documentation of the responsible physician or indication if discharge was by criteria. In addition, for inpatients, a post-anesthesia follow-up report by the individual who administered the anesthesia shall be written within 48 hours following anesthesia.
15. Elective surgery will be scheduled five days a week, 7:00 a.m. through 3:00 p.m. As appropriate all patients going to surgery shall have a CBC, Basic Metabolic Panel, and a urinalysis done within one (1) week prior to surgery. An EKG is required on all patients above forty (40) years of age. A chest x-ray done within six (6) months is also required. A pertinent history and physical examination, as specified in Section II, paragraph 2 and a pre-operative diagnosis, shall be on the chart.
16. Mentally ill patients, or patients who become mentally ill while in the hospital, shall be transferred to an appropriate physician and hospital. Patients in need of substance abuse treatment shall also be transferred to appropriate facilities.
17. The attending practitioner is responsible for requesting consultation, when indicated, and for calling in a qualified consultant on staff. He/she will provide written authorization to permit another attending practitioner to attend or examine his/her patient, except in an emergency.
18. Dentists are responsible for the part of their patient's history and physical examination that relates to dentistry.
19. Podiatrists are responsible for the part of their patient's history and physical that relates to podiatry.

Section IV – Emergency Service

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the hospital's basic plan for delivery of such services, including the delineation of clinical privileges for all physicians who render emergency medical care. The Medical Staff shall have overall responsibility for all emergency medical care.
2. The duties and responsibilities for all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient department.
3. An appropriate medical record shall be kept for every patient receiving emergency services. The record shall include:
 - a. Adequate patient identification.
 - b. Information concerning the date and time of the patient's arrival, means of arrival and by whom transported.
 - c. Pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his/her arrival to the hospital.
 - d. Description of significant clinical laboratory and radiology findings.
 - e. Diagnosis.
 - f. Treatment given.
 - g. Condition of the patient on discharge or transfer.
 - h. Final disposition, including instruction given to the patient and/or family, relative to necessary follow-up care.
4. Each patient's medical record shall be signed by the practitioner in attendance that is responsible for its clinical accuracy.
5. There shall be a monthly review of emergency room medical records to evaluate quality of emergency medical care. Reports shall be submitted to the Medical Staff at least quarterly.

Section V– Surgical Consents

Written the physician must obtain informed consent from each patient or his/her legal representative for any operative or invasive procedure, or as otherwise required by Hospital policy. The only exception to this rule will be in cases of emergencies where an incapacitated patient is in immediate danger of death or serious bodily harm, and no alternative decision maker can be reached in a timely manner to obtain consent.

Section VII – Pathological Specimens

It shall be the responsibility of the attending physician/surgeon to see that all required specimens are obtained and given to the surgical staff who will in turn have the specimens delivered to the hospitals' pathologist. Written pathology reports will be placed in the patient's chart in a timely manner. The pathologist will determine the extent of examination on all tissue specimens taken during surgical procedures.