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ARTICLE I
ADMISSION

Section 1. Who May Admit Patients.

Patients may be admitted to the hospital only by practitioners who have been appointed to the medical staff and who have privileges to do so. Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient or a person seeking necessary medical care, or for any reason cannot be admitted to the hospital, the hospital or attending physician, or both shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. Except in an emergency, no patient shall be admitted to the hospital unless a provisional diagnosis has been stated. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible. Physicians should not admit patients with diagnoses that are not in their purview to manage.

Section 2. Admitting Physician's Responsibilities.

Each admitted patient shall be the responsibility of a physician member of the medical staff, who has provided an order to admit the patient signed within 24 hours of admission. The admitting practitioner shall be responsible for providing the hospital with any known information concerning the patient as may be necessary to protect the patient or hospital personnel from infection, disease, or other harm, and to protect the patient from self-harm. In the case of a group practice, the admission sheet shall clearly show the name of the attending physician. Such attending physician shall be responsible for the medical care and treatment, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring medical staff member and to relatives of the patient. The intended transfer of a patient to the care of another attending physician shall first be verbally communicated to, and requires approval from, the attending physician accepting such patient transfer. Following such approval, a note describing this transfer of responsibility shall be entered in the progress notes and on the orders sheet of the medical record.

The attending physician or designee must see their patients on a daily basis. When a physician hands off patient care to a partner or a covering physician, detailed clinical information must be shared to adequately summarize the patient's clinical condition. Minimum shared information should include a description of patient's overall clinical status, any significant lab values, results of recent procedures, and any other information necessary to ensure continuity of patient care.

Section 3. Alternate Coverage.

Each medical staff member shall provide assurance of immediate availability of adequate professional care for his/her patients in the hospital by being available or having available an alternate medical staff member with whom prior arrangements have been made and who has clinical privileges at the hospital sufficient to care for the patient. Failure to meet the above requirements may result in loss of clinical privileges. A medical staff member who will be unavailable shall, by notification to the Emergency Room or on the order sheet of the charts of each of his/her patients, indicate the name of the physician who will be assuming responsibility for the care of his/her patients during his/her absence.
Section 4. Priorities for Admission.

In any case in which a patient requires admission, the physician shall first contact the Direct Admit Nurse department to ascertain whether there is an available bed. The Direct Admit Nurse office will admit patients on the basis of the following order of priorities:

a. Emergency Admission - This category includes those patients who could not be reasonably cared for on an outpatient basis without substantial increased risk of mortality or increased significant morbidity and for whom an admission cannot be scheduled. Within 48 hours following an emergency admission, the attending physician shall furnish to the Utilization Management Committee/Physician Advisory Board a signed, sufficiently complete documentation of need for this admission, if requested.

b. Urgent Admissions - This category includes non-emergency patients for whom a prolonged delay of admission will increase the risk of mortality of morbidity. The patient will be promptly called when a bed becomes available; such patients should be admitted within 24-48 hours. Urgent admissions may be reviewed as necessary by the Utilization Management Committee/Physician Advisory Board to determine the priority when such admissions for a specific day are not possible. This category includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of Surgery may decide the urgency of any specific admission.

c. Routine Admissions - This category includes elective admissions involving all services.

If there is any question concerning the admission of a patient, the Chief of the Medical Staff shall determine the necessity for, or deferment of, the admission.

Section 5. Emergency Admissions.

Medical staff members admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff that the admission was a bona fide emergency. A patient to be admitted on an emergency basis who does not have a private physician may select any medical staff member in the applicable department or service to attend to him. Where no such selection is made or the physician selected does not elect to see the patient, the physician on call for the service will be assigned to the patient.

Section 6. Continued Hospitalization.

The attending physician is required to routinely document the need for continued hospitalization after specific periods of stay as defined by the UR plan. This statement must contain:

a. An adequate written record of a working diagnosis for continued hospitalization. A simple confirmation 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.

Upon request of the Utilization Management Committee/Physician Advisory Board, 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 reasons therefore. This report must be submitted within 24 hours of receipt of such request. Failure to comply with this policy will be brought to the attention of the Executive Committee for appropriate action. Any patient remaining in the hospital over 2 months is monitored by the Utilization Management Committee/Physician Advisory Board and by the Chief Executive Officer.
ARTICLE II
MEDICAL ORDERS

Section 1. General Requirements.
   a. Orders must be written clearly, legibly and completely. Orders that are illegible or improperly written will not be carried out until they are verified by the nurse with the ordering physician. These clarifications will be recorded as telephone orders for physician signature.
   b. Only black or blue ballpoint pens should be used when writing orders.
   c. Orders must include date and time written.
   d. Only approved abbreviations, signs and symbols shall be used in the medical record.
   e. When giving telephone orders, nurse is required to write down the order and read it back to the practitioner.
   f. All orders written for “daily” labs and x-rays (without a specific number of days indicated) will be automatically stopped every 3 days; if such studies are to be continued, they must be re-ordered.
   g. All previous orders are HELD when patients go to surgery.
   h. All orders will be completely rewritten when a patient is transferred to or from a specialty care unit.
   i. Medication orders must include patient name, name of drug, dosage, route, and frequency.
   j. PRN orders must include patient name, name of drug, dosage, route, frequency and clinical indication if more than one indication exists.
   k. No abbreviations, signs or symbols may be used in recording the patient’s final diagnosis or any notable complication.
   l. Blanket reinstatements of previous orders for medications are not acceptable; e.g., “resume home meds is not acceptable.” All orders are reviewed when patient is transferred.

Section 2. Who May Write Orders.

Members of the medical staff and allied health practitioners shall have the authority to write orders as permitted by their Florida license, approved clinical privileges, and scope of practice. All orders must be entered in the patient's record and dated. The responsible member of the medical staff shall sign them. Orders written by allied health practitioners as permitted by their license and approved clinical privileges/protocol must be countersigned within 24 hours by their attending physician.

Section 3. Telephone Orders.

Verbal orders will not be accepted. Physician or LIP shall write all orders in the medical record. Telephone orders for medication and treatment shall be accepted only under urgent circumstances when it is impractical for such orders to be given in written manner by the responsible practitioner. Telephone orders shall be taken only by qualified personnel who shall transcribe the orders in the proper place in the medical record of the patient. The order shall include the date, time and signature of the person taking the order.

Acceptance of a telephone order is limited to only the following personnel, with noted restrictions:
   a. A physician, dentist or podiatrist with clinical privileges at this hospital;
   b. A registered nurse employed at this hospital;
   c. A licensed practical nurse employed at this hospital;
   d. A pharmacist employed at this hospital who may transcribe telephone orders pertaining to drugs;

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e. A physical, speech or occupational therapist/assistant employed at this hospital who may transcribe telephone orders pertaining to therapy regimens;

f. A radiology technician employed at this hospital who may transcribe a telephone order from a physician requesting a radiology procedure be performed.

g. A respiratory therapist employed at this hospital that may transcribe telephone orders pertaining to respiratory therapy treatments;

h. A clinical dietician employed at this hospital who may transcribe telephone orders pertaining to nutritional therapy regimens;

i. A licensed physician assistant advanced registered nurse practitioner, or clinical pharmacist with approved clinical privileges at this hospital may take telephone orders from their supervising physician but these orders must be countersigned by their supervising physician within 24 hours.

Section 4. Orders for Specific Procedures.

a. All requests for x-ray and EKG examination shall contain a pertinent statement of the reason for the procedure. An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series. This rule does not apply to orders written for patients while in the ICU's.

b. All orders for therapy shall be entered in the patient’s record and signed by the physician.

c. Therapeutic diets shall be prescribed by the attending physician in written orders on the patient’s chart.

ARTICLE III- CONSULTATIONS

Section 1. Who May Give Consultations.

Any qualified member of the medical staff with clinical privileges in this hospital can be asked for consultation within his/her area of expertise. Consultation by physicians associated in the same office, for recommended consultations, should be avoided insofar as possible. In circumstances of grave urgency, or where consultation is recommended by the rules of the hospital, the Chief of Staff or the appropriate department chairman shall at all times have the right to call in a consultant or consultants.

Section 2. Consult Notification Procedure.

All requests for consultation must contain a pertinent statement of the reasons for the consultation and must be directed to a specific physician. The ordering physician shall personally call the consultant when seeking an immediate response for clinical or other reasons. The nursing and secretarial staff will not be responsible for calling “stat” consults.

All other consultation requests shall be considered routine and should be called personally by the requesting physician. If this is not possible, all consults will be called by the nursing personnel caring for the particular patient at the time the consult is ordered. The nurse should be aware of the clinical rationale for the consultation and have knowledge of the patient’s clinical condition.
For consults ordered after regular office hours:

1. The ordering physician will call the consultant at the time of the order and explain the case and need for consultation, or
2. The ordering physician will specifically write that the consult is “routine-call the consultant in the AM.” In this case, the nurse caring for the patient will personally call the consultant with the reason for the consultation.

Section 3. Recommended Consultations.

1. Consultation is recommended in all non-emergency cases whenever requested by patient or his/her family or in all cases in which, in the judgment of the attending physician:
   a. The patient is not a good medical or surgical risk,
   b. The diagnosis is obscure after ordinary diagnostic procedures have been completed.
   c. There is doubt as to the best therapeutic measures to be used,
   d. Unusually complicated situations are present that may require specific skills of other practitioners.
   e. The patient exhibits severe symptoms of mental illness or psychosis.
2. Consultation by a Pediatrician is recommended for all pediatric admissions to the ICUs, age 12 and under.
3. The attending practitioner is responsible for requesting consultation when indicated and for calling in a qualified consultant. Requests for a consultation shall be entered on the order sheet in the medical record, along with the pertinent statement of the reason for the consultation, the name of the specific physician being consulted, and the time-frame in which the consultant may respond to the consultation request.
4. Additional requirements for consultation may be established by the medical staff as needed.
5. If a nurse employed by the hospital has any reason to doubt or question the care provided to a patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of the nursing supervisor. The nursing supervisor, if unable to resolve the issue with the physician in question, may refer the matter to the Chief of Staff or his/her designee. The Chief of Staff or his/her designee may bring the matter to the attention of the chairman of the department in which the practitioner in question has clinical privileges. In all situations that require it, the chairman of the department may himself request a consultation after appropriate discussion with the attending practitioner.
6. It is the duty of medical staff, through the Credentials Committee, the appropriate department chairman, and the Executive Committee to make certain that members of the medical staff request consultations when needed.


Each consultation report should contain a written opinion and recommendations by the consultant that reflects, when appropriate, an actual examination of the patient and the patient’s medical record. This report shall be made a part of the patient’s medical record. A limited statement, such as “I Concur” does not constitute an acceptable consultation report. When operative procedures are involved, the consultation note shall be recorded prior to the operation, except in emergency situations so verified on the record. The consultation report shall contain the date and time or the consultation and the signature of the consultant.
Section 5. Psychiatric Consultations.

Psychiatric consultation should be obtained for all patients who have attempted suicide, have taken a chemical overdose, and who are emotionally ill, or become emotionally ill while in the hospital. Appropriate referrals will be made for those patients who suffer alcoholism or drug abuse. Evidence that appropriate referrals or consultations have at least been offered to such patients should be documented in the medical record.

ARTICLE IV
EMERGENCY SERVICES

1. All Appointees to the Active Staff and other staff categories defined in the Bylaws, rules and regulations shall be required to accept call assignments on the Emergency Service roster within their designated medical/surgical areas of practice on a rotating basis. The Medical Staff Services Department shall be responsible for preparing and distributing daily and monthly schedules for Emergency Service call assignments following consultation with affected practitioners.

2. A practitioner on-call for Emergency service or for his/her own private patients shall be required to promptly respond to the Emergency Department by telephone within thirty (30) minutes when notified to do so. Practitioners’ on-call shall be required to carry portable pagers or be routinely available at pre-designated telephone numbers at all times while on-call for emergency purposes. A request to respond to the ED or L&D may come from anyone designated as qualified to perform a medical screening exam. BM/SHHS has designated the following practitioners as qualified to perform a medical screening exam: physicians, nurse practitioners, physician assistants and L&D registered nurses.

3. Practitioners scheduled on Emergency Service call shall be personally responsible for arranging alternate coverage with another practitioner with appropriate privileges in the event he/she cannot be available during any time period scheduled to be on-call and shall notify the Emergency Department and/or answering service of such alternate coverage.

4. Practitioners who refuse to come into the emergency room, or return pages shall face disciplinary action as follows:
   a) First occurrence will generate letter to practitioner outlining their duties to cover the ER;
   b) Second occurrence will generate letter and requiring practitioner to attend Medical Executive Committee meeting to discuss problem;
   c) Third occurrence would be grounds for immediate suspension based on the imminent danger to patients from lack of a covering physician, and initiate due process for reportable action to the National Practitioner Data Bank.

5. All patients registering within the Emergency Department on an unscheduled basis shall be seen by a physician prior to their disposition.

6. ED physician will assess patients sent to ED in event emergent action is needed in the absence of the PMD. If a PMD is referring a patient, the ED MD will do an initial assessment and assist the PMD in the administration of his or her orders. The Emergency Department Physician (EDP) may initiate evaluation of each patient who has been registered within the ED for more than one (1) hour. A physician on Emergency Service call shall not be permitted to refuse care when requested by the EDP on duty to attend or consult on a patient.
7. The EDP on duty shall be primarily responsible for the stabilization of all patients registered within the ED for treatment, including the determination of appropriate consultants. The EDP shall maintain this responsibility until such consultant is engaged, or the patient is transferred to the care of another physician or acute-care facility.

8. An appropriate medical record shall be maintained on every patient receiving emergency medical services. The ED record shall include at least the following information:
   a. Adequate patient identification data.
   b. Information concerning the time of arrival and how transported to the hospital.
   c. Pertinent history and physical examination of the injury or medical complaint, including details relative to first aid or emergency care rendered prior to arrival at the hospital, history of allergies and current medications recently taken by the patient.
   d. Description of clinical observations and findings, and laboratory and x-ray reports if ordered.
   e. Diagnosis.
   f. Condition of the patient on discharge, transfer or admission to the hospital.
   g. Final disposition, including instructions provided to patient and/or family relative to follow-up care.

9. The ED record shall be signed by the EDP and/or private physician in attendance that shall be responsible for its accuracy. ED records shall be incorporated in the patient's previous inpatient records if such records exist.

10. The EDP attending to a patient who has presented for emergency treatment shall consult with the private physician of record when admission or transfer of the patient to another facility appears necessary. If there is disagreement between the EDP and the private physician regarding such disposition of the patient, the private physician shall be responsible for coming to the Emergency Department to independently evaluate the patient to make the final determination. In such cases, the private physician shall complete and sign the ED record or dictate a complete progress note.

11. A private physician shall be authorized to refer patients to the Emergency Department to be seen personally. In such cases, it is the responsibility of the private physician to notify the ED nursing staff of such referral and inform them of any instructions or orders that may need to be administered pending his/her arrival. In these cases, and such orders notwithstanding, the referring physician shall be required to see the patient within one (1) hour of patient arrival to the ED.

11. Any patient presenting to the Emergency Department, whether by self-referral or otherwise, shall be treated by the EDP on duty if the patient's condition is judged to be critical or requiring immediate attention.

12. All transfers of patients from the Emergency Department to other facilities shall conform to these Rules and Regulations, and current State and Federal laws. The responsible physician shall assure that transfers are documented on appropriate Hospital forms and incorporated in the ED record.

13. The patient referral electronic document faxed to the physicians’ offices from the E.D. is provided to the physician for informational purposes only. It does not describe the creation of an appointment in behalf of the patient, nor a duty on the part of the physician to provide care to the described patient. It remains the obligation and responsibility of the patient to contact the office of the physician to schedule an appointment, as recommended. It further remains the responsibility of the patient to satisfy any and all administrative requirements for intake into the physician’s practice as may be applied. No assurances have been provided to the patient at the time of discharge from the ED. The patient has been provided the name and phone number of this physician, with the understanding that the patient must contact the office of the physician if the appointment is to
become scheduled. The sole purpose of the electronic document is to facilitate the exchange of relevant clinical information between physicians, and hence continuity of care, should the patient comply with the recommendation for ongoing or follow-up care provided by hospital personnel at the time of discharge following BMC emergency department evaluation.

**ARTICLE V**

**CRITICAL CARE**

As determined by the Medical Staff Leadership, a Critical Care Committee of the Medical Staff may be formed to provide physician leadership for special care units such as recovery rooms, intensive care units of all kinds, step-down units, coronary care units, etc.

The Committee shall be composed of:

1. The MICU, SICU, CVICU and AHDU Medical Directors,

2. Physician members from each of the following specialties (if not already represented by the Medical Directors):
   - Anesthesiology, Pulmonary Medicine, Nephrology, Cardiology, Cardiothoracic Surgery,
   - Neurosurgery, Neurology, General Surgery, and Internal Medicine as appointed by the Chief of Staff, and

3. Appropriate nursing, respiratory therapy, pharmacy, and other hospital staff representatives. The Chairmanship shall be appointed the Chief of Staff.

The SICU, MICU, CVICU, and AHDU shall each be directed by an active member of the Surgery and Medical Departments appointed by their respective department chiefs. The MICU Director shall also serve as Medical Director for the Step-down Unit.

The SICU, MICU, CVICU and AHDU Medical Directors will assure that the quality, safety and appropriateness of patient care services provided are reviewed and evaluated on a regular basis. Each Medical Director will assist in implementing policies in a consulting capacity, when necessary. In consultation with the responsible physician, each Medical Director helps to make decisions for disposition of patients when patient load exceed optimal operational capacity. In the absence of the Medical Director, a qualified designee will be available.

All patients admitted to Intensive Care Units must be seen by their attending physician or the physician covering for their attending physician (exclusive of the ER physician) within a reasonable period of time dependent upon the condition of the patient.

**ARTICLE VI**

**DELIVERY ROOM**

Section 1. Admission.

Obstetrical patients may be admitted on a 24-hour basis via the Emergency Room or Admissions Office. Nursing personnel shall notify the attending physician when the patient is admitted. No maternity patient shall be denied a bed because of the presence of gynecological patients in the unit. If necessary, gynecological patients shall be transferred to other areas of the hospital.
Section 2. Required Laboratory Procedures.

Hematocrit, Serology, Rh and Type laboratory procedures must be done prior to admission and recorded on the prenatal records.

Section 3. Vaginal Examinations.

Vaginal examinations are to be performed by labor room nurses in the following cases:

a. Upon admission of all patients to the labor area and prior to the notification of the physician unless contraindicated as noted below; and

b. When indicated to immediately determine the patient’s progress in labor, e.g., change of fetal heart sounds, pushing with contractions.

Vaginal examinations are not to be performed by the labor room nurses, unless specifically directed by the attending physician, in incidents of questionable bleeding, with or without pain.

Section 4. Scheduling Delivery.

a. The attending physician must be named when the case is scheduled and is responsible for the care of his/her patients, including those of the nurse midwives.

b. When the attending physician or nurse midwife has been informed that a patient is in active labor, it is his/her responsibility to be present for the delivery.

c. If the patient is attempting a vaginal birth after C-Section (VBAC), a cesarean delivery must be available within 30 minutes of decision to operate and a physician who is capable of performing a C-section and evaluating labor should be readily available.

Section 5. Identification.

Hospital means of patient identification shall be attached to the mother and newborn infant before they are removed from the delivery or operating room.

Section 6. Medical Records.

Complete medical records must accompany the patient to the delivery room. Obstetrical records should include all prenatal information. The prenatal records may be a legible copy of the attending practitioner’s office record transferred to the hospital upon admission but an interval admission note must be written that includes any subsequent changes in the physical findings. All procedures shall be fully dictated or written in the patient’s chart by the attending physician within 24 hours after delivery.

Section 7. Attire.

Anyone entering the caesarean section suite must be properly attired in the approved suit and footwear. Hair, nose and mouth shall be covered.

Section 8. Call Rosters.
a. Two separate department call schedules are maintained for members of the Department of OB/GYN. One call roster is for Obstetrics and the second roster for Gynecology.

b. By previous definition, the GYN patient is any non-pregnant or pregnant patient less than 12 weeks gestation presenting to the Emergency Room or Labor and Delivery. Twenty weeks or more is considered obstetrical and may be treated in Labor and Delivery or the ER.

c. When on either call list, it is the responsibility of the physician on call to advise, evaluate and/or treat any patient presenting themselves to the ER or Labor and Delivery not already a private patient of a member of the OB/GYN Department.

d. In addition, it is their responsibility to treat any patient referred by the Emergency Room physician or a private physician.

e. It is the responsibility of the physician on call to assure coverage if he is not available and notify the Medical Staff office, ER and Labor and Delivery respectively as necessary.

f. All obstetrical patients not expressly a private patient of a member of the Department of OB/GYN are the complete and sole responsibility of the physician on call.

ARTICLE VII- NURSERY AND CARE OF NEWBORN

Section 1. On-Call Roster.

A physician on-call schedule shall be posted in the nursery to ensure that a physician is available at all times to come to the hospital immediately and deal with emergency situations. All physicians with Pediatric privileges will participate in Nursery and Pediatrics call in accordance with the Medical Staff Bylaws. All physicians with restricted Nursery privileges will nonetheless participate in Nursery call, except that a physician with full Nursery privileges shall be posted on back-up call. Physicians with Pediatric privileges who also participate in the Medicine ER call shall be permitted to take ½ calls for Medicine and ½ call for Pediatrics.

Section 2. Examinations.

All newborn infants shall have a complete physical examination by a physician within 24 hours of admission to the nursery, and the results of the examination shall be recorded in the infant's medical record. A physician shall examine any infant who displays abnormal signs and symptoms any time as soon as possible. Every newborn infant shall be examined by his/her attending physician within one day prior to discharge, and the findings shall be recorded in the infant's medical record.

Section 3. High Risk Infants.

The physician to be in charge of the infant and the nurse in charge of the nursery shall be notified when the delivery of a potentially high-risk infant is expected. Continuity of care for all infants and especially for high-risk infants to be initiated in the delivery area, with constant observation of newborns for distress. The term "high risk infant" means any infant who, on the basis of socioeconomic, genetic, or pathophysiologic history prior to delivery or on the basis of findings in the newborn period, manifests or is likely to manifest persistent and significant signs of distress. This includes but is not limited to the following:
a. Any infant with a birth weight below 2,000 grams or of less than 34 weeks gestation and any other low birth weight or premature infant who shows abnormal signs.
b. Any infant showing persistent and significant signs of illness. This includes those with respiratory distress, congenital anomalies, tumors, jaundice, seizures, infections, metabolic distress, or other conditions that pose an immediate threat to neonatal survival.
c. Any infant with serious feeding difficulties, excessive lethargy or instability of body temperature.
d. Any infant requiring major surgical procedures.

Section 4. Identification.
The identification of each infant and his/her mother shall be carefully checked again at the time of discharge from the hospital. Infants discharged or transferred to another nursery or hospital shall be carefully identified.

Section 5. Birth Certificates.
Birth certificates are the responsibility of Women’s and Children’s Services and must be completed within 72 hours of the birth.

Section 6. Transportation of Infants.
Care for the protection of the infant shall be taken when transporting the newborn to the nursery from the delivery room. Transfer of distressed infants to the nursery shall be done in such a manner as to minimize heat loss and to insure adequate oxygenation.

Section 7. Prophylaxis Against Gonorrheal Ophthalmia.
Prophylaxis against gonorrheal ophthalmia with erythromycin ointment shall be carried out as soon as the condition of the infant permits.

Section 8. Consultations.
A consultation with a qualified medical staff pediatrician is required in any instance of:
   a. An APGAR score of 5 points or less at 1 minute after birth or 7 points or less at 5 minutes after birth;
   b. Respiratory distress or atelectasis;
   c. Generalized cyanosis;
   d. Jaundice of any type;
   e. Blood dyscrasias or anemia;
   f. Persistent vomiting;
   g. Persistent diarrhea;
   h. Delay in voiding or passage of meconium;
   i. Neurological abnormalities of any type;
   j. Congenital heart disease;
   k. Any congenital defects that interfere with function or that are disfiguring;
   l. Staphylococcal infections or other infections;
   m. Dermatitis of any type;
n. Whenever the diagnosis is obscure.

Section 9. Medical Records.

Every newborn shall be examined at the time of delivery and the following noted on the medical record:

a. Condition at birth including APGAR score or its equivalent;
b. Time of sustained respirations;
c. Any physical abnormalities or pathological states; or
d. Any evidence of distress.

The record of the newborn infant shall accompany him from the place of delivery to the nursery and be immediately available to nursery personnel. In addition to the information listed above, this record shall also include information concerning prenatal history, course of labor, delivery, and drug administration to mother and infant, relevant condition of the mother, procedures performed on the infant in the delivery room, complications of any type, and other facts and observations. A complete medical record for every newborn should include the following information:

a. Obstetrical history of mother's previous pregnancies;
b. Descriptions of complications of pregnancy or delivery;
c. List of complicating maternal disease;
d. Drugs taken by mother during pregnancy, labor and delivery;
e. Duration of ruptured membranes.
f. Maternal antenatal blood serology, rubella titer, blood typing, Rh factors, and where indicated, a Coombs test for maternal antibodies.
g. Complete description of progress of labor including reasons for induction and operative procedures, if any, signed by the attending physician or his/her authorized delegate.
h. Anesthesia, analgesia, and medications given to mother and infant.
i. Condition of infant at birth, including the one- and five-minute APGAR score or its equivalent, resuscitation, time of sustained respirations, details of physical abnormalities, pathological states observed, and treatments given before transfer to the nursery.
j. Any abnormalities of the placenta and cord vessels.
k. Date and hour of birth, birth weight and length, and period of gestation.
l. A written verification of eye prophylaxis.
m. Report of initial physical examination, including any abnormalities signed by the attending physician or his/her authorized delegate.
n. Discharge physical examination, including head circumference and body length, unless previously done, recommendations, and signature of the attending physician or his/her designate.
o. A listing of all diagnoses since birth, including discharge diagnosis.
p. Specific follow-up plans for care of infant.
ARTICLE VIII
SURGICAL CARE

Section 1. Operating Room Committee.

As determined by Medical Staff Leadership, an Operating Room Committee of the Surgery Department may be formed. Members are appointed by the Chief of Surgery composed of representatives of different surgical specialties, anesthesia, nursing service, and hospital administration. The committee may meet, as circumstances require reviewing the function, within the surgical area, and recommend to the Surgery Department additions or changes in policy when indicated.

Section 2. Scheduling Surgery.

a. The presence of the operating surgeon in scrubs and the patient in the operating room is required at the scheduled time for surgery. The operating surgeon must be named when the case is scheduled and is responsible for the surgical care of the patient before, during and after the operation. In no case shall anesthesia be started until the operating surgeon is present in the hospital. Operating time will be released promptly when a case is canceled.

b. Procedures must be designated on the schedule with the name of the patient, age and diagnosis. Cases requiring frozen sections should be posted as such at the time the case is scheduled.

Section 3. Pre-operative /Pre-procedure Patient Assessment.

a. A pre-operative/pre-procedure patient assessment will be documented and include review of applicable history, physical exam, and documented lab/x-ray/ test results deemed necessary and appropriate by the physician based on patient’s medical condition and clinical diagnosis as set forth in the Bylaws I.

b. All documentation requirements will be followed as set by the various licensing and accreditation organizations.

Section 4. Surgical Records.

Except in emergency situations where the patient’s life is in jeopardy, the following data shall be recorded in the medical record prior to surgery or the operation shall be canceled:

a. Verification of identity of patient
b. Medical history and supplement information regarding drug sensitivities and other pertinent facts
c. General physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery
d. Provisional diagnosis
e. Laboratory test results if deemed necessary
f. Consultation reports if indicated
g. A signed hospital informed consent obtained by the surgeon and signed by the patient. Should a second operation be required during the patient’s stay in the hospital, a second consent specifically worded shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they shall be described and consented to on the
same form. In addition to the hospital’s consent form, physicians may include a copy of their own consent form in the Medical Record.

h. Radiology reports if deemed necessary.

i. Dental or podiatric radiology reports, if applicable.

j. Procedure reports, if applicable, i.e., cardiac catheterization, bronchoscopy, endoscopy, Swan Ganz insertions, etc.

The patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report received. In an emergency situation, the attending surgeon shall write a note in the medical record on the patient’s condition. If the history and physical have been dictated but not yet entered in the chart, an admission note and statement to that effect may be entered in the chart by the physician.

All operations performed shall be fully described by the operating surgeon who shall record at least the following information immediately following procedure defined as upon completion of operation or procedure and before patient is transferred to next level of care:

1. Name of primary surgeon and assistants;
2. Procedure performed;
3. Findings;
4. Estimated blood loss;
5. Specimens removed;
6. Postop diagnosis.

**Section 5. Anesthesia Rules and Regulations.**

a. The anesthesiologist shall verify that there has been a recent preoperative physical examination with appropriate laboratory data, if deemed necessary, in the clinical record on all patients referred to him. The pre-anesthesia evaluation must include appropriate documentation of pertinent information relative to the choice of anesthesia and the surgical procedure anticipated. This evaluation must include the patient’s previous drug history, other anesthetic experience, any potential anesthetic experience, and any potential anesthetic problems.

b. The anesthesiologist or CRNA shall review the patient’s condition immediately prior to the induction of anesthesia.

c. A record shall be maintained of all events taking place during the induction of, maintenance of an emergence from anesthesia, including the dosage and duration of all anesthetic agents, other drugs, intravenous fluids, and blood or blood fractions.

d. The findings of pre-anesthesia physical examination by a physician shall be recorded before surgery. A post-anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia within 48 hours after surgery.

**Section 6. Recovery Room.**

a. Post-operative orders must be written by the surgeon or his/her designate before the patient leaves the operating room department. The patient will be discharged from the recovery room based on criteria established by the anesthesiologists.

b. At least one registered nurse shall be on duty in the Recovery Room whenever the room is occupied. Additional personnel shall be provided to meet the needs of each patient.
Section 7. Dental Patients.

A patient admitted for dental surgery is the dual responsibility of the attending dentist and a physician member of the medical staff.

Dentist’s Responsibilities:

1. A detailed dental history justifying hospital admission;
2. A detailed description of the examination of the oral cavity and preoperative diagnosis;
3. A complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, except teeth and tooth fragments, shall be sent to the pathologists for examination at the discretion of the dentist;
4. Progress notes pertinent to the oral condition;
5. Clinical summary or statement;
6. Discharge order

Physician’s Responsibilities:

1. Medical history pertinent to the patient’s general health;
2. A physical examination to determine the patient’s condition prior to anesthesia and surgery;

An anesthesiologist or CRNA must be present in the operating suite for the administration of anesthesia. Dentists appointed to the medical staff shall be available for inpatient consultations as requested by other medical staff members.

Section 8. Podiatric Patients.

Podiatrist’s Responsibilities:

1. A detailed history and physical exam justifying hospital admission conducted by either the podiatrists credentialed to perform H&P or by a physician (M.D. or D.O.) who holds an appointment to the medical staff;
2. A detailed description of the examination of the foot and pre-operative diagnosis;
3. A complete operative report, describing the findings and technique used. All tissue shall be sent to the pathologist for examination;
4. Pertinent progress notes;
5. Clinical summary of statement;
6. Discharge order.

Section 9. Operating Room Records.

a. A roster of physicians, dentists and podiatrists currently possessing surgical privileges with a delineation of the surgical privileges of each shall be maintained by the Medical Staff Services Department and available on the hospital intranet.
b. There shall be an on-call schedule of physicians established and posted in the Emergency Room.
c. Operating room records and copies shall be provided and maintained on a current basis. The operating room register sheets shall contain the date of each operation, name and number of the
Section 10. Attire.

Anyone entering the Operating Room suite will wear appropriate surgical attire as outlined in the OR Policy D-3, Surgical Services Dress Code.

Section 11. Pathology Report.

All tissues removed during a surgical procedure (unless specifically exempted as listed below) shall be properly labeled and sent to the laboratory for examination by the pathologist who shall determine the extent of examination necessary for diagnosis. The specimen must be accompanied by pertinent clinical information, including its source and the pre-operative and post-operative surgical diagnosis. The pathologist shall sign the report, which becomes a part of the patient’s medical record.

**Exempt Surgical Specimens** - It is not required that the following specimens removed during a surgical procedure be sent to Pathology for examination, however, they may be sent at the discretion of the surgeon: Orthopedic Hardware, Placentas, Stapes, Foreskin (patients less than 10 years of age), Teeth, Urinary Calculi, Foreign Bodies, Life Ports, Pacemakers, Cataract Lens, Discs from Discectomy, Nasal Septal Cartilage, Rib from Thoracotomy Exposure.

Section 12. Incident Reports.

When an incident occurs in the Operating Room, a report must be made at once to the Operating Room Supervisor or his/her designee, and contain the following information: Time, place and circumstances of the incident, persons involved, any witnesses, condition of patient, and signature of person submitting the report. This report will be reviewed by the appropriate medical staff representative in conjunction with the Risk Manager with recommendation and/or follow-up as deemed necessary.

**ARTICLE IX**

**MEDICAL RECORDS**

Section 1. General Rules.

The attending physician shall be responsible for the preparation of a complete medical record for each patient under his/her care. Its contents shall be pertinent and current. A single attending physician shall be identified in the medical record as being responsible for the patient. The admitting physician is identified as the individual who gave the admission order and this is not subject to revision. A physician's routine orders, when applicable to a given patient shall be reproduced in detail on the order sheet of the patient's record, but must be dated and signed by the attending physician. Only the abbreviations, signs and symbols approved by the Medical Staff Executive Committee shall be used in the medical record.

Section 2. Authentication.

All clinical entries in the record shall be dated and authenticated by the person making the entry. A single signature on the face sheet of a record shall not suffice to authenticate the entire record. Each entry must be individually authenticated. The responsible physician shall in any case, sign the diagnosis.
A complete medical record shall include but not be limited to:

a. Identification data

b. Date of admission and discharge

c. Order for admission authenticated by the attending or admitting physician within 24 hours of patient being admitted

d. History, including:
   1) Chief complaint
   2) Details of present illness
   3) Relevant past, social and family histories, and concerns
   4) Current medications and previous medication hypersensitivities
   5) Allergies

e. Provisional admitting diagnosis

f. Physical examination to minimally include head, neck, heart, lungs, abdomen, neurological, extremities and any other additional physical assessment relevant to the diagnosis or intended procedure.

g. Diagnostic and therapeutic orders

h. Evidence of appropriate informed consent

i. Clinical observations, progress notes, nursing notes, consultation reports

j. Reports of procedures, tests and results (when applicable):
   1) Preoperative diagnosis and operative report
   2) Pathology reports
   3) Clinical laboratory examination reports
   4) Radiology and nuclear medicine examination and treatment reports
   5) Anesthesia records

k. Final diagnosis, condition on discharge or transfer summary, or discharge note

l. Autopsy report, when performed

m. Relevant nutritional and functional status

Lab tests and x-ray results as part of this medical record may be accepted from outside sources provided:

a. The outside lab and/or source of ionizing radiation is licensed by the Department of Health and Rehabilitative Services and/or adheres to the requirements of current Florida statutes to assure the quality and accuracy of results;

b. The diagnostic x-ray procedures are conducted or interpreted by a Board Certified or Board Eligible Radiologist;

c. The specimens or reports are available for review by the hospital’s radiologist or pathologist to justify the need for surgery.
Results of lab tests and/or diagnostic X-rays performed prior to admission by the attending physician may be dictated into the patient's history and physical and accepted in lieu of lab tests and/or X-rays required upon admission.

Section 4.  History and Physical.

A medical history and physical exam will be completed and documented as set forth in the Bylaws.

The admitting physician will be notified by applicable hospital personnel within two working days after failure to record the history and physical. If not recorded within the next working day, the medical record will be considered delinquent.

Section 5.  Progress Notes.

Progress notes made by the medical staff should give a pertinent chronological report of the patient's course in the hospital. Progress notes shall be legible, recorded and dated at the time of observation, and shall contain sufficient content to insure continuity of care if the patient is transferred. Wherever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients and those where there is difficulty in diagnosis and management of the problem. Pertinent progress notes shall also be made by other such individuals who have been granted these clinical privileges and specified professional personnel.

Section 6.  Operative Reports.

Operative notes shall be dictated or written in the medical record immediately after surgery and shall contain a description of the findings, the technical procedures used, the specimens removed, the post-operative diagnosis and the name of the primary surgeon and any assistants. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. A handwritten operative progress note should be entered in the medical record in a timely fashion after surgery in order to provide pertinent information for use by any practitioner who is required to attend the patient. The attending physician will be notified by applicable hospital personnel one working day after failure to record the operative note and if not completed within the next working day, the medical record will be considered delinquent.

Section 7.  Discharge Summaries.

a. All relevant diagnoses as well as all operative procedures performed shall be recorded using acceptable disease and operative terminology. The diagnoses shall be recorded and signed by the attending physician.

b. A clinical discharge and transfer summary shall be included in the medical records of all patients except those with minor problems who require less than a 48-hour period of hospitalization, normal newborn infants and uncomplicated obstetrical deliveries. A final progress note may be substituted for the discharge summary for those patients, which should include any instructions given to the patient or family.

c. The discharge and transfer summary shall include 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 the patient or family, as pertinent. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission.
d. When preprinted instructions are given to the patient or family, the record should so indicate and a copy of the instruction sheet used should be on file in the medical record department. The attending physician shall authenticate all summaries.

e. A medical record shall not be permanently filed until it has been completed by the responsible attending physician or is retired by the Medical Staff Executive Committee.

Section 8. Entries in the Medical Record.

It is the policy of Bay Medical Center that the following individuals are authorized to make entries into the medical record:

1. Members of the medical staff shall have the authority to make entries in the medical record as defined by their appointment to the Bay Medical Center medical staff.

2. Qualified health care practitioners as recognized by and defined in the Medical Staff Rules & Regulations may document in the medical record in accordance with their approved clinical privileges.

3. Clinical personnel who are documenting information on the evaluation and progress of the patient's care may make entries into the medical record. This objective documentation should reflect any significant or pertinent findings, along with entries regarding the patient's care and course of treatment.

4. Admitting or registration personnel are authorized to make entries into the medical record. This also includes those individuals making entries regarding any legal activities, e.g., signatures on consent forms.

5. Students participating in approved training programs are authorized to make entries into the medical record.

6. Refer also to the policy on telephone orders in the Medical Staff Rules and Regulations.

Section 9. Completion of Medical Records/Fine System.

Delinquent Medical Records

It is the policy of the Medical staff to ensure timely completion of medical records. Incomplete records can compromise patient care and impede accurate and timely billing. Incomplete medical records also violate both Joint Commission accreditation standards and CMS Conditions of Participation (CFR 482.24(c)(2)(viii)) which mandate that all medical records must be complete within 30 days of discharge or outpatient care. The elective and emergency admitting privileges of any Medical staff appointee, except with respect to those patients already in the hospital, shall be automatically suspended for failure to complete medical records, in accordance with the following provisions.

Each medical record shall be completed within 23 days following discharge. A staff appointee who has not completed his or her medical records within 16 days after discharge shall be notified by the Medical Records department that the record is considered past due.

If the medical record is not completed within 23 days of discharge the staff appointee’s elective and emergency admitting privileges shall be deemed an automatic suspension. The appointee will be notified in writing by Medical Records of the status change. The appointee shall be responsible for arranging for his/her on-call coverage obligations. Any scheduled elective surgeries or procedures in the OR, Cardiac Cath Lab, Endoscopy or any other appropriate areas must be rescheduled. If the appointee...
has a patient in the hospital at the time of the relinquishment or privileges, the appointee may continue to care for that patient. Upon completion of the incomplete records, the appointee privileges will be reinstated by the CEO or his designee during regular business hours.

If the medical record continues incomplete for an additional seven days following discharge (day 30), a second written notice shall be sent by the Medical Records department advising the staff appointee that he/she must transfer their in-house patients, cancel any scheduled surgeries or procedures, and delegate on call coverage to another medical staff member.

A medical staff appointee whose privileges have been automatically suspended for incomplete medical records three times within a 12 month period or who has failed to complete any single chart within 14 days (37 days post discharge) will be reported to the Executive Committee. The Committee may require appointee to appear before the Committee or automatically impose an additional fourteen day suspension of all clinical privileges, and/or initiate a professional review based on patient care, which could result in the revocation of appointment and clinical privileges at the hospital. Failure of the appointee to attend MEC meeting if requested will result in a fourteen day relinquishment of all clinical privileges and corrective action.

1. If a Medical staff appointee is subject to five episodes of automatic suspension of privileges within a 12 month period, the individual’s staff appointment shall either lapse immediately, or within appropriate time for patient care transfer responsibilities. Department of Medical Staff Services will be responsible for notification to individual.

2. Documentation of automatic suspension status of medical records will be included in appointee’s reappointment profile.

3. Appointee will not be placed on automatic suspension status while on vacation or out of town. However, the appointee must complete his or her delinquent records within 72 hours of return. It is the appointee’s responsibility to notify the Medical Records department prior to leave and declare a date of return for exemption to apply.

4. Extraordinary personal circumstances will be dealt with on a case by case basis with the CEO or Department Chief of their designee.

ARTICLE X
INFORMED CONSENT

Policy:

All inpatients require a Bay Medical Center Conditions of Admission form when admitted for service to the hospital. In addition, patients having surgical or special procedures performed require a Request and Consent for Treatment/Procedure form to be completed.

The Request and Consent for Treatment/Procedure form should be utilized for all surgical procedures performed, as well as other procedures considered, in the judgment of the attending physician, to present significant medical risk(s) to the patient. It is the responsibility of the physician to obtain appropriate informed consent. This specifically requires that the patient, or an individual who may legally consent for the patient, must understand the nature of the procedure or treatment, the medically acceptable alternative procedures or treatments, the substantial medical risks and hazards inherent in the proposed treatment and the significant medical risks associated with refusal.

Procedure:

Bay Medical Staff Rules and Regulations
(12/9/2014)
Section 1. Responsibility for Obtaining Informed Consent for Treatment/Procedures

a. It shall be the responsibility of the practitioner to obtain Consent for Treatment/Procedure from patients in the following circumstances:

1) The surgeon shall obtain the patient's consent to any surgical procedure to be undertaken, including ambulatory surgery;

2) The physician performing the procedure shall obtain the patient's consent to all non-routine or high-risk medical procedures;

3) The anesthesiologist or CRNA shall obtain the consent of the patient to the administration of anesthesia; and

4) The obstetrician/gynecologist or Certified Nurse Midwife shall obtain the patient's consent to vaginal delivery.

b. The Consent for Treatment/Procedure form must be signed by the patient or their representative. Except in emergencies, a failure to include a completed consent form in the patient's chart prior to the performance of the procedure shall automatically cancel the procedure.

c. Whenever the patient's condition prevents the obtaining of consent, every effort shall be made, and documented, to obtain the Consent for Treatment/Procedure of the patient's legal representative prior to the procedure or surgery.

Section 2. Adults.

a. A mentally competent adult, 18 years of age or over, may sign his/her own consent.

b. Lack of competence to consent to treatment may result from a patient's unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as to treatment. When a court has declared the patient incompetent, a consent form signed by the court-appointed guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the patient, in non-emergent cases, the issue of competency must be resolved before consent can be obtained. When questions arise, the attending physician should promptly confer with the administrator on-call. The hospital will make every effort to assist the physician in obtaining the required consent and providing information relative to these matters. However, it is the ultimate responsibility of the attending physician to comply with the informed consent requirement.

c. Consent of spouse, child or another relative of a patient is most often useless unless that person has been deemed the legal guardian of the patient. However, if such party is available, it is advisable that they function and sign as a witness to the obtaining of the informed consent.

d. A mentally competent adult has the right to refuse recommended treatments and procedures. If a competent adult refuses a treatment or procedure, the patient should write, "I refuse the above treatment" above their signature on a consent form. The physician and hospital should not be held responsible for any ill effects that have been explained to the patient as a likely result from such refusal.
e. For guidance in unusual circumstances, the physician involved in obtaining informed consent should contact the administrator on call.

Section 3. Minors.

a. Any minor (under 18 years of age) except emancipated minors (see below) admitted to the hospital for care must have the signature of at least one parent on the permit. When both parents are present, both signatures should be obtained. In case of separation or divorce of parents, the legal custodian of the minor is required to consent. If reasonable doubt exists as to the legal custody, or there is apparent disagreement between the parents as to the procedure to be performed, the administrator on call should be contacted. Exceptions to this requirement are:

i. An unwed, pregnant minor may consent to the performance of medical or surgical care or services relating to her pregnancy. No other consent is required. Section 743.065, Florida Statutes (2009)

ii. An unwed, minor mother may consent to the performance of medical or surgical care or services for her child. No other consent is required. Section 743.065, Florida Statutes (2009)

iii. A minor may consent to confidential examination and treatment for any sexually transmissible disease. Section 384.30, Florida Statutes (2009)

iv. A minor may consent to voluntary substance abuse impairment services. Section 397.601, Florida Statutes (2009)

v. A minor who is married or who has been married may consent to medical treatment as an adult. Section 743.01, Florida Statutes (2009)

b. An emancipated minor (under 18 years of age) may sign his/her own consent. An emancipated minor is a minor who has established a permanent home separate from its parents, who has become completely self-supporting and whose parents pay none of its financial obligations. Emancipation is a question of fact dependent upon the circumstances of each case. Factors considered relevant on the question of emancipation are: economic independence and freedom from parental control, intelligence, maturity, training and general adult conduct. Of these, economic independence and freedom from parental control are the most important. If a question arises, the physician responsible for obtaining the informed consent should contact the administrator on call.

c. Consent may be obtained from a legally appointed guardian.

d. Consent for wards of the Juvenile Court may be given by the judge on advice of the physician.

e. Consent obtained from foster parents who have not been appointed legal guardian for the minor involved is most often useless. If the legal guardian or parent is unavailable to provide consent, contact the administrator on call.

f. In all unusual circumstances, and circumstances not covered above, the physician responsible for obtaining consent should contact the administrator on call.

Section 4. Emergency Consents.
In emergencies, the regular procedure regarding consents in a non-emergency situation shall be followed unless the consent cannot be immediately obtained.

a. **Adults** - When an adult who has been injured in an accident or who is suffering from an acute illness, disease or condition, is unconscious or otherwise unable to communicate adequately, or appears to be incompetent, and there is no person reasonable available who is legally authorized to sign the consent; emergency care or treatment may be rendered to the adult if, within a reasonable degree of medical certainty, delay in initiation of emergency medical care or treatment would endanger the health or physical well-being of the patients.

In such cases, two (2) licensed physicians on the involved service(s) who have found, in competent medical judgment, that procedure is immediately necessary shall certify in the patient’s record that immediate emergency medical care or treatment was necessary for the patient and cite the reason(s) that appropriate consent was not obtained. A person reasonably available who is legally authorized to sign the consent should be notified as soon as possible after the emergency care or treatment is administered. Although not required by law, even in an emergency, an attempt should always be made to obtain the informed consent of an adult next-of-kin accompanying the patient.

In the event that the delay reasonably anticipated to be caused by an attempt to obtain a second certification could, within a reasonable degree of medical certainty, jeopardize the life, health or safety of the patient, emergency care treatment may be administered without the second opinion.

b. **Minors** - Emergency care or treatment may be rendered to any minor who has been injured in an accident or who is suffering from an acute illness, disease or condition if, within a reasonable degree of medical certainty, delay in initiation of emergency medical care or treatment would endanger the health or physical well-being of the minor. This section applies only when parental consent cannot be immediately obtained for one of the following reasons:

i. The minor’s condition has rendered him unable to reveal the identity of his/her parents, guardians or legal custodian and such information is unknown to any person who accompanied him/her to the hospital, or

ii. The parents, guardians or legal custodian cannot be immediately located by telephone at their place of residence or business. *Section 743.064, Florida Statutes (2009)*

In such cases two licensed physicians on the involved service(s) shall certify in the patient’s record that immediate emergency medical care or treatment was necessary for the patient and cite the reason(s) that appropriate consent was not obtained. The parents, guardians or legal custodian shall be notified as soon as possible after the emergency care or treatment is administered. Although not required by law, even in an emergency, an attempt should always be made to obtain the informed consent of any adult next of kin accompanying the minor. In the event that the delay reasonably anticipated to be caused by an attempt to obtain a second certification could, within a reasonable degree of medical certainty, jeopardize the life, health or safety of the patient, emergency care treatment may be administered without the second opinion.

For guidance and assistance in unusual circumstances, the physician responsible for obtaining informed consent should contact the administrator on call.

**Section 5. Non-English Speaking Patients.**
When informed consent is obtained from non-English speaking patients, an interpreter should be present in the room at the time the physician imparts the information required and obtains the appropriate informed consent. The translator will then sign as a witness to the consent obtained.

Section 6. Incompetent Patients.

Lack of competence to consent to treatment may result from a patient’s unconsciousness, the influence of drugs or intoxicants, mental illness, or other permanent or temporary impairment of reasoning power. The essential determination to be made is whether the patient has sufficient mental ability to understand the situation and make a rational decision as to treatment. When a court has declared a patient incompetent, a consent form signed by the court-appointed guardian shall be obtained. In cases where no court has previously assessed the mental capacity of the particular patient involved, the consent of the patient (if possible) and the patient’s next of kin shall be obtained.

Section 7. Unusual Cases.

Where questions arise or unusual circumstances occur not clearly covered by these Rules and Regulations regarding patient consent, the attending physician shall promptly confer with hospital administration concerning such matters. The hospital will make every effort to assist the physician in obtaining the required consent and providing information relative to such matters. However, it is the ultimate responsibility of the attending physician to satisfy himself that he has complied with the requirements contained in these Rules and Regulations.

Section 8. Release of Medical Records.

Written consent of the patient on the form prescribed by the hospital is required for release of medical information to those not otherwise authorized to receive this information.

ARTICLE XI
PHARMACY

Section 1. General Rules.

a. All drugs and medications administered to patients shall be listed in the hospital formulary approved by the Medication & Nutrition and Executive Committees and/or the latest editions of the U.S. Pharmacopoeia National Formulary, American Hospital Formulary Service, or the AMA Drug Evaluations reference guide.

b. Drugs and medications prescribed for bona fide clinical investigations, research purposes or experimental use must be approved by the Hospital’s Institutional Review Board, and administered thereafter in accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all applicable regulations of the Federal Drug Administration.

c. Medications will only be administered by medical staff appointees (physicians, dentists and podiatrists) granted privileges at the hospital; registered nurses, practical nurses, respiratory therapists, physical therapists, and radiology technicians licensed by the State of Florida employed by the hospital, all of whom have demonstrated or provided documentation of qualifications to administer medications in accordance with the policies of the Pharmacy, Respiratory Therapy, Hyperbaric Medicine, Physical Therapy, Radiology, and Nursing Departments.
d. Pharmacy or nursing personnel under urgent circumstances may prepare intravenous solutions with additives, diluted, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual. Each drug dose shall be recorded in the medical record of the patient and properly signed after the drugs have been administered.

Section 2. Patient’s Own Drugs.

If patients bring their own drugs to the hospital, these drugs shall not be administered unless the attending physician has written an order for their administration. If the attending physician does not order the drugs, they shall be packaged, sealed and returned to the patient at the time of his/her discharge from the hospital.

a. Ordering physicians shall evaluate the patient’s home medications prior to prescribing them to be continued during the hospital stay. Each such medication to be continued must be singly reviewed with and approved by the ordering physician prior to its listing on the Physician’s order form. The nursing staff may utilize electronic resources made available by the facility (e.g. Lexicomp) to verify the patient’s home medications if they are to be used during the hospitalization. Pharmacy will be contacted for further verification if required.

b. Disposition of patient’s own medications if not ordered by the physician:

1. Medications may be identified, packaged, sealed and sent home with the patient’s family or representative; or

2. Medications may be packaged, sealed and stored in the Pharmacy in accordance with Pharmacy/Nursing Medication policies.

Section 3. Medication Errors; Adverse Reactions.

Any medication error or apparent drug reaction shall be reported immediately to the physician who ordered the drug. Any occurrence of an apparent drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible, in order to notify everyone treating the patient throughout the duration of the hospitalization of this drug sensitivity and thereby prevent a recurrence of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the physician and to the manager of pharmaceutical services.

Section 4. Legible Prescription Law.

According to Florida Statutes, Section 456.2, written prescriptions are required to:

a. Be legibly printed or typed.

b. Contain the name of the prescribing practitioner, the name and strength of the drug prescribed, the quantity of the drug prescribed in both textual and numerical formats, and the directions for the use of the drug.

c. Be dated with the month written out in textual letters.

d. Be signed by the prescribing practitioner on the day when issued.
ARTICLE XII
DISCHARGE

Section 1. Who May Discharge.
Patients shall be discharged only on telephone or written order of the attending physician. Should a 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, and the patient shall be asked to sign the hospital’s release form.

Section 2. Discharge Planning.
Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. Discharge planning shall include, but need not be limited to, the following:

a. Appropriate referral and transfer plans;
b. Methods to facilitate the provision of follow-up care; or
c. Information to be given to the patient or his/her family or other persons involved in caring for the patient on matters such as the patient's condition; his/her health care needs; the amount of activity he should engage in; any necessary medical regimens including drugs, diet, or other forms of therapy; sources of additional help from other agencies; and procedures to follow in case of complication.

Section 3. Transfer of Patients.
A patient shall not be transferred to another medical care facility unless there is an accepting physician at the other medical facility and prior arrangements for admission to that facility have been made. Clinical records of sufficient content to insure continuity of care shall accompany the patient.

Section 4. Discharge of Minors and Incompetent Patients.
Any individuals who cannot legally consent to his/her own care shall be discharged only to the custody of parents, legal guardian, and person standing in “loco parentis” or another responsible party unless otherwise directed by the parent, guardian or court order. If the parent or guardian directs that discharge be made otherwise, that individual shall so state in writing and the statement shall become a part of the permanent medical record of the patient.

Section 5. Autopsies and Disposition of Bodies.

a. The remains of any deceased patient, including a fetal death or a neonatal death, shall not be subjected to disposition until death has been officially pronounced. Death certificates are the responsibility of the attending physician and must be completed in accordance with state law or at birth in the case of a fetal death.

b. The medical staff shall attempt to secure consent for meaningful autopsies. Medical staff approved autopsy criteria include: (1) unexpected deaths based on clinical diagnosis, (2) obstetrical, neonatal, and pediatric deaths, and (3) death at any age in which an autopsy would disclose a known or suspected illness which may have a bearing on survivors or recipients of transplant organs. An autopsy may be performed only with proper consent in accordance with the laws of the State of Florida. The hospital pathologist or designee shall
perform all autopsies. The Chief Pathologist shall establish departmental policy and procedure outlining the methodology by which the attending physician or other interested medical staff are notified when an autopsy is being performed.

Section 6. Medical Examiner Cases.

a. Florida Statute #406 requires notification of the Medical Examiner's office in the event when any person dies in this state as follows:

   1. Of criminal violence
   2. By accident
   3. By suicide
   4. Suddenly, when in apparent good health
   5. Unattended by a practicing physician or other recognized practitioner
   6. In any prison or penal institution
   7. In police custody
   8. In any suspicious or unusual circumstance
   9. By criminal abortion
  10. By poison
  11. By disease, constituting a threat to public health
  12. By disease, injury or toxic agent resulting from employment

b. It is the responsibility of the attending physician to contact the Medical Examiner concerning any hospital deaths related to the above. The time interval between onset of the disease or injury and death is not important. The Medical Examiner will decide if his/her office has jurisdiction on the case and will arrange for transport of the body for necropsy. The attending physician should not request permission for autopsy from the family.

c. A Xerox copy of all medical records should be forwarded with the body when requested by the Medical Examiner. All medical devices and tubing should be left in-site during transport of the body.

ARTICLE XIII
GUIDELINES FOR DETERMINATION OF BRAIN DEATH

Section 1. Preamble.

Florida law recognizes two (2) methods for determining death.

First, the cardiopulmonary definition (irreversible cessation of circulatory and respiratory functions as determined in accordance with accepted medical standards) has long been accepted as a matter of common law in this State.

Second, Section 382.009, Florida Statute, provides an alternative method for determining death in those cases in which a person's respiratory and circulatory functions are maintained by
artificial means of support so as to preclude a determination that those functions have ceased. This alternative method is commonly referred to as Brain Death. Advancements in medical science have resulted in an increased reliance on the Brain Death standard for determining death due to the frequency with which cardiopulmonary functions are artificially maintained.

It is the policy of the medical staff to preserve and enhance human life and to insure medical care to all patients in accordance with currently accepted reasonable medical standards. When a patient is brain dead, however, opportunities arise to enhance the standard of living for many others through the donation of organs by donor candidates. The purpose of these guidelines is to establish the criteria and procedures for determining Brain Death in order to enhance human life for all patients while facilitating the donation of organs to recipients in need.

The determination of Brain Death at Bay Medical Center shall be made in accordance with the criteria contained in these guidelines, Florida Statutes and currently accepted reasonable medical standards in the community in those cases where cardiopulmonary functions are artificially maintained. In all other cases, death shall be determined pursuant to the traditional, common law criteria.

Section 2. Historical and Clinical Evaluations.

In all cases, the proximate cause of the coma must be determined in order to insure the absence of remedial or reversible conditions. The following conditions or causative factors can complicate the determination of death on the basis of neurological criteria:

a. Toxic and metabolic disorders;
b. Sedative - hypnotic drugs;
c. Paralytic agents;
d. Hypothermia;
e. Hypotension; and
f. Surgically remedial conditions

The clinical examination of the patient must be carried out carefully taking into consideration all available historical data and should rule out any of the conditions or causative factors listed above.

Section 3. Physical Examination Criteria.

The Brain Death Method may determine the occurrence of death where there is the irreversible cessation of the functioning of the entire brain, including the brain stem. The following criteria must be documented by physical examination:

a. Coma and apnea must co-exist, with complete loss of consciousness, vocalization and volitional activity.

b. Absence of brain stem function as defined by:

i. Mid-position or fully dilated pupils which do not respond to light;
ii. Absence of spontaneous eye movements, oculocephalic and caloric precipitation movements;
iii. Absence of movement of bulbar musculature including facial and or pharyngeal musculature on a central basis;
iv. Absence of corneal reflex, gag, cough, and sucking and rooting reflexes;
v. Absence of respiratory movements with the patient off the respirator. Apnea testing using endotracheal oxygen catheter and standardized method can be performed but it is done after criteria are met.

c. The patient must not be significantly hypothermic or hypotensive for age.

d. Flaccid tone and absence of spontaneous or induced movements, excluding spinal cord mediated movements such as reflex withdrawal or spinal myoclonus, should exist.

e. The patient should remain consistently brain dead throughout the observation and testing. All physical criteria shall exist and be documented by at least two (2) separate clinical examinations. The expert examination shall be no sooner than six (6) hours after the time of terminal irreversible event or initial exam. In the event the patient’s clinical condition is determined to have resulted initially from hypoxia (i.e., cardiopulmonary arrest), the second examination shall be no sooner than forty-eight (48) hours after the first examination.

Section 4. Diagnosis of Brain Death with a View to Organ Transplantation.

The diagnosis of brain death with regard to the removal of organs requires two clinical assessments, with the following minimum intervals:

a. A period of observation of six (6) hours in adults and children over the age of five (5) years, if the cause of the coma is known, if there is no intoxication and if the patient’s condition cannot be explained by metabolic parameters. Also, there must be no suspicion of an infection of the nervous system, especially a polyradiculitis cranialis. In addition, there must be no relevant effect of CNS-sedative drugs given in the course of resuscitation or to facilitate transport of the patient.

b. A period of observation of twenty-four (24) hours in children under the age of five (5) years, if the cause of coma is known, if there is no suspicion of intoxication and if the condition cannot be explained by metabolic parameters. Also, there must be no suspicion of an infection of the nervous system, especially a polyradiculitis cranialis. Here too, there must be no relevant effect of CNS-sedative drugs.

c. A period of observation of forty-eight (48) hours in adults and children, if the cause of the coma is not known and if metabolic and toxicological investigations cannot be carried out.

The periods of observation defined under B and C may be shortened for the purposes of organ transplantation surgery, only if the absence of any cerebral circulation has been provided by cerebral angiography. The waiting time must never be less than six (6) hours.

Section 5: Exceptions.

These guidelines shall not be utilized to determine Brain Death if the following conditions exist:

a. Pregnancy

b. Infants less than seven (7) days old.

Section 6: Alternative Tests.

The following tests are not required in all cases but shall be considered as possible confirmatory tests in appropriate cases.
a. Electroencephalogram (EEG).
   The EEG, if performed, shall be conducted over a thirty (30) minute period using
   standardized techniques for Brain Death determination.

b. Angiography.
   A technically satisfactory Cerebral Radionuclide Angiography that demonstrates arrest of
   carotid circulation at the base of the skull and absence of intracranial arterial circulation
   can be confirmatory of Brain Death.

Section 7: Procedure.

The following procedures shall be observed and documented in all cases:

a. Determination of Brain Death shall be made in accordance with currently accepted
   reasonable medical standards by two (2) physicians licensed under Chapter 458 or Chapter
   459, Florida Statutes. One physician shall be the treating physician, and the expert
   physician shall be a board-eligible or board-certified neurologist or neurosurgeon. Each of
   these physicians shall conduct separate clinical examinations as required and document
   clinical findings and results of all tests.

b. The next of kin of the patient shall be notified as soon as practicable of the procedures to
   determine death pursuant to the Brain Death Method. The medical records of the patient
   shall reflect such notice; if such notice has not been given, the medical records shall
   reflect the attempts to identify and notify the next of kin.

Section 5. Children.

Notwithstanding anything to the contrary in these guidelines, the following additional criteria
shall be observed in the case of a child six (6) years of age and under but older than seven (7)
days:

a. Determination of Brain Death shall be made in accordance with currently accepted
   reasonable medical standards by three (3) physicians licensed under Chapter 458 or
   Chapter 459, Florida Statutes. One physician shall be the treating physician, one shall be a
   board-eligible or board-certified neurologist or neurosurgeon, and the expert shall be a
   board-eligible or board-certified pediatrician. If the treating physician is a board-eligible or
   board-certified pediatrician, then the third physician is not required to have any particular
   area of specialization. All three (3) physicians shall conduct separate clinical examinations
   as required by paragraph seven (B) and document clinical findings and results of all tests.

b. The patient shall remain consistently brain dead throughout the observation and testing.
   All physical criteria listed in Section 3 above shall exist and be documented by at least two
   (2) separate clinical examinations. The second examination shall be no sooner than twenty-
   four (24) hours after the first. In the event the patient's clinical condition is determined to
   have resulted from hypoxia, the second examination shall be no sooner than forty-eight
   (48) hours after the first examination.

ARTICLE XIV
SPECIAL TREATMENT PROCEDURES

It is the policy of the Medical Staff to maintain a leadership role in maintaining a physical, social and
 cultural environment, which limits the use of restraint to clinically appropriate and adequately justified
situations. The Medical Staff adheres to all federal, state, organizational policies, and accrediting agency guidelines appropriate to the safe use of restraint and seclusion.

Restraint is defined as any method (chemical or physician) of restricting an individual’s freedom of movement, including physical activity or normal access to his or her body that (1) is not a usual and customary part of a medical diagnostic or treatment procedure to which the individual or his or her legal representative has consented; (2) is not indicated to treat the individual’s medical condition or symptoms. Or (3) does not promote the individual’s independent functioning. The use of restraint must be in accordance with the order of a physician who is responsible for the care of the patient. If a consulting physician orders restraint or seclusion, the patient’s attending physician must be contacted and informed as soon as possible.

When restraint is used, organization policy and procedures guide appropriate and safe use. Orders and time limits are consistent with such policy and are based on clinical justification guided by clear criteria present in practice guidelines, practice parameters, pathways of care, nationally recognized standards, or other care processes approved by the Medical Staff.

Hospital personnel will ensure that patients in restraint are monitored and each episode of restraint use is documented in the medical record, consistent with organization policy and procedure.

ARTICLE XV
MISCELLANEOUS

Section 1. Reports.

It shall be the responsibility of each appointee to the medical staff to report, in writing, to the President of the Medical Staff or the Chief Executive Officer any conduct, acts or omissions by medical staff members of which he is aware which he, in good conscience, believes to be detrimental to the safety of patients or to the proper functioning of the hospital, or which violate professional ethics.

Section 2. Emergency Management Plan and Disaster Privileges.

The Emergency Management Plan for the care of mass casualties and other disasters shall be reviewed by the Executive Committee or its designee in coordination with the Bay County Medical Society Disaster Committee. Each medical staff member shall be responsible for familiarizing himself with the plan. All medical staff members will be assigned to posts, either in the hospital or elsewhere, and it is their responsibility to report to their assigned stations. The President of the Medical Staff and Chief Executive Officer will work as a team to coordinate activities and give directions. In case of evacuation of patients from one section of the hospital to another or evacuation from hospital premises, the President of the Medical Staff or the Chief Executive Officer, or their respective designees, will authorize the movement of patients.

Disaster privileges may be granted when the Emergency Management Plan has been activated and the hospital is unable to handle immediate patient needs.

Physicians and other medical Licensed Independent Practitioners (LIP’s) who do not possess medical staff privileges may be accepted to work at Bay Medical Center during an emergency or disaster within the scope of their specialty.

The procedure for credentialing these practitioners for disaster privileges is as follows:

1. An LIP not currently privileged at Bay Medical Center may present to the hospital.
2. All staff should be alerted to direct the LIP to the designated representative from Medical Staff Services Dept. to process and approve emergency privileges on behalf of the CEO and President of the Medical Staff.

3. The LIP must produce any or all of the following: his/her pocket license to practice medicine issued by a state, federal or regulatory agency, a photo ID, the name and telephone number of a hospital where they currently have privileges or have recently practiced, identification indicating the practitioner is a member of a Disaster Medical Assistance Team (DMAT), or identification that he/she has been granted authority to render patient care, treatment, and services in disaster circumstances by a federal, state, or municipal entity.

4. After reviewing the documents, the Medical Staff Services representative must record the date and time of the approval for emergency privileges, the state license number and expiration date, and any other pertinent information and provide the LIP with some type of identification that readily identified them as an LIP granted Disaster privileges.

5. If possible, copies should be made of the license and photo ID and the Florida Medical Board website will be reviewed, if accessible.

6. The Medical Staff Services representative should immediately attempt to contact the facility at which the LIP has recently practiced to verify that they are in good standing and the state medical licensing board to verify the license is active and in good standing. In the event that these calls cannot be completed, emergency privileges may still be issued. The verification process will be initiated as soon as the immediate situation is under control and be completed within 72 hours from the time the volunteer practitioner presents to the organization. If this time frame cannot be met, appropriate documentation will outline attempts and reasons.

7. Wherever possible, the LIP granted emergency privileges will be paired with a credentialed practitioner currently on staff who has a similar specialty. This pairing should be recorded along with the licensing information. By either direct observation or record review, the credentialed practitioner will provide oversight of care, treatment and services provided by the volunteer practitioner.

8. A volunteer practitioner’s privileges, granted under this emergency situation, will be reviewed within 72 hours. Continuation of disaster privileges will be based on information obtained regarding the professional practice of the volunteer. Such privileges may be terminated at any time without reason or cause.

9. Termination of these disaster privileges will not give cause or rights to a hearing or review.

Section 3. Research Activities.

Participation in research projects by medical staff members is encouraged. To ensure adequate compliance with any applicable guidelines and laws, medical staff members shall consult with and obtain the approval of the Institutional Review Board and Chief Executive Officer, or his/her designee, regarding any research projects in which they propose to participate. The Institutional Review Board shall review policy consideration pertaining to medical and/or scientific research projects of the medical staff.

The results of all research projects, clinical, statistical, or otherwise, and all publications written or provided by medical staff members using the name of the hospital must be submitted to the Institutional Review Board for approval prior to any publication. Specific protocols are to be followed in the case of any pharmaceuticals to be used.

Section 4. Outpatient Test Orders by Physicians Not on Medical Staff.
All outpatient tests ordered by physicians who are not members of the medical staff will be performed at the discretion of the Medical Director of each department. Refer to Administrative Policy for criteria.

Section 5. Suspicion of AIDS Diagnosis.

Anytime an AIDS diagnosis is being considered, the Infection Surveillance staff should be notified immediately in order to implement appropriate precautionary procedures.

Section 6. Temporary Active Status.

Consultant or Courtesy medical staff members may cover for a member of the active medical staff for a period not to exceed six weeks per year. During this time of coverage, they must assume the duties and responsibilities of full active membership, i.e., Emergency Room call, meeting attendance, etc. Written notification of intent to provide this coverage must be sent to the Chief Executive Officer or his/her designee, Chief of Service, and President of the Medical Staff at least two weeks prior to the effective date.

Section 7. Fines for Not Attending Meetings.

Active and provisional members of the medical staff who fail to attend 50% of their clinical department meetings and/or 50% of the quarterly medical staff meetings per year shall be fined $100.00 at the end of the medical staff year. These fines will be deposited into the Medical Staff account.

Section 8. Reduction of ER Call.

Medical staff members who have attained the age of 55 or more, and have served as active medical staff members at Bay Medical Center for either 5 or more consecutive years immediately preceding the effective date of the request, 10 or more cumulative years at Active status, or 20 or more cumulative years at Active or Courtesy status, may, at their discretion, request to diminish their Emergency Room call for their discipline. Such requests shall be submitted, in the form of a letter of intent, to Medical Staff Services, at least twelve (12) months in advance of the desired effective date. Medical Staff Services shall send a copy of the letter of intent to all physicians taking Emergency Room call in the same discipline as the requesting physician. After reviewing the request and determining whether that discipline will continue to be adequately covered in the Emergency Room, these physicians shall submit a collective recommendation to the Executive Committee for consideration and approval. The Executive Committee will have the authority, on behalf of the medical staff, to take action as needed on these requests. A physician whose request is granted under this section must, nonetheless, provide coverage for his/her private patients that may present to the Emergency Room.

A physician whose request is denied shall have the right to have his/her request reconsidered annually, or at any time upon the addition of a new staff member taking call for the discipline, prior to that discipline considering or recommending approval of any additional requests. In the event that two or more physicians from the same discipline submit requests within sixty (60) days of each other, the physician with the greatest number of cumulative years as an active member will receive first consideration.

The Executive Committee retains the right to rescind the privilege of reduced call from members of the Active and Courtesy medical staff who have been granted retirement from or reduction in Emergency Room call, should call coverage for unattached patients in a particular discipline become, in the judgment of the Executive Committee, unreasonably burdensome to the remaining staff members taking that call. In consultation with members of the affected discipline, the Executive Committee may also ask the hospital to begin recruitment efforts in this specialty. The Executive Committee may immediately
restore the privilege of reduced Emergency Room call to physicians so affected, individually or in combination, when, in the judgment of the Executive Committee, this is deemed feasible.

**Section 9. Telemedicine Radiology.**

The following preliminary studies may be sent via telemedicine equipment link after normal business hours:

1. Ultrasound
2. Nuclear Medicine
3. CT Scan
4. MRI
5. Plain Radiograph

An Active, Provisional, Courtesy or Reserve status member of the Dept. of Radiology will perform the final interpretation and report of these studies the following morning.

**Section 10. Disruptive Conduct of Medical Staff Members.**

**Purpose:** Bay Medical Center’s Sacred Heart Health System (BMCSHHS) mission is to provide excellent health services in a compassionate, innovative and fiscally responsible environment. The purpose of this Disruptive Conduct Policy is support BMCSHHS’s mission by (i) promoting compassionate patient care in a safe, cooperative, and professional environment and (ii) identifying, preventing, and eliminating conduct that disrupts Medical Staff or BMCSHHS operations.

**Standard of Conduct:** BMCSHHS’s Medical Staff members, employees, and all patients or visitors at Bay Medical Center facilities shall be treated with courtesy, respect and dignity. Medical staff members are expected to conduct themselves in a professional and collegial manner. Medical Staff members who engage in disruptive or unprofessional conduct may be subject to disciplinary action in accordance with the corrective action procedures set forth in this policy or the Medical Staff Bylaws.

**Inappropriate Disruptive Behavior:** Inappropriate behavior includes disruptive, intimidating, disrespectful, offensive, and violent conduct. Examples include the following:

1. Verbal outbursts, such as:
   a. Yelling
   b. Profane or abusive language
   c. Ethnic, racial, sexual orientation, or socioeconomic slurs

2. Physical threats or intimidation, such as:
   a. Throwing objects
   b. Encroaching on personal space
   c. Assault
   d. Harassment (sexual, racial, verbal, physical or visual context)

3. Uncooperative actions, such as:
   a. Refusing to perform assignments, or to participate in committee or departmental affairs on anything but their own terms or to do so in a disruptive manner
   b. Exhibiting impatience with reasonable questions
   c. Reluctance or refusal to answer questions, return phone calls or pages

4. Demoralizing behaviors, such as:
   a. Non constructive criticism, condescending language or voice intonation
   b. Shaming, humiliating, belittling others or imputing stupidity or incompetence
   c. Statements intended to undermine the confidence of staff, patients, or families

5. Inconsiderate behaviors, such as:
   a. Attacks that are personal, irrelevant or go beyond the bounds of fair professional comment
b. Imposing idiosyncratic requirements that unreasonably burden staff and do not increase quality of patient care

c. Impertinent and inappropriate comments written (or inappropriate illustrations drawn) in patient medical records, or other official documents, impugning the quality of care in the hospital or attacking particular physicians, nurses or hospital policy

Rules of Enforcement

1. First occurrence - Incident informally discussed with the specific physician and the President of the Medical Staff or Department Chair.

2. Second occurrence - Repetitive incidents shall be discussed with the specific physician, President of the Medical Staff, Department Chair, and an appropriate member of BMC administration. Written documentation of incidents and behavior should be included.

3. Third occurrence - Possible recommendation to the Medical Executive Committee to initiate a formal investigation (see Article VII Medical Staff Bylaws) and consider final corrective action. Written documentation of additional incidents and behavior should be included.

The above rules are a guide and are not to be strictly construed. In accordance with the Medical Staff Bylaws, the President of the Medical Staff, any Department Chair, the majority of any medical staff committee, the Chief Executive Officer, or the Chairman of the Board may refer any single incident deemed severe or disruptive to the Medical Executive Committee for investigation and appropriate discipline.

Section 11. Catholic Health Care Services Directives.

All Medical staff appointees and others exercising clinical privileges at the hospital shall abide by the terms of the Ethical and Religious Directives for Catholic Health Care Services promulgated by the National Conference of Catholic Bishops. No activity prohibited shall be engaged in by any Medical staff appointees or other person exercising clinical privileges within the Sacred Heart or associated facilities.