6/2014

OCALA REGIONAL
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OCALA HEALTH

MEDICAL STAFF RULES AND REGULATIONS

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ARTICLE 1: ADMISSIONS AND DISCHARGE OF PATIENTS

1. The Hospital shall accept patients for care and treatment.

2. A patient may be admitted to the Hospital services only by a member of the Medical Staff. All practitioners shall be governed by the official admitting policy of the Hospital. Note: Duly licensed and qualified podiatrists will be permitted to admit patients for ulcers, gout, and other approved conditions within the scope of his/her services.

3. The attending staff shall be responsible for the medical care and treatment of each patient in the Hospital and for the prompt completeness and accuracy of reports describing the condition. It will be his/her responsibility to inform the referring practitioner and the patient's family of the patient's condition. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of responsibility and its acceptance shall be entered on the order sheet of the medical record.

   If a patient requests that the relationship between the physician and patient be dissolved, the attending physician will continue care of the patient until another physician can be found.

4. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis is given, valid reason for admission is stated and the hospital's approved Utilization Review criteria has been met.

5. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and the Administration of the Hospital that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart within TWENTY-FOUR (24) hours of admission.

6. After evaluation by the ED physician, if further evaluation and/or admission is felt necessary, the transfer of responsibility for this management occurs upon acceptance by the on-call physician.

   When evaluation a patient in the Emergency Department, the Emergency Department physician will follow the following protocol:

   - For patients with a relationship with a primary care physician, the Emergency Department physician will first call the patient’s primary care physician, who will then assume the responsibility to evaluate the patient and direct specialty care as appropriate. Where the Emergency Department physician concludes that delay in specialty care constitutes a clinical risk to the patient, the Emergency Department physician will call the specialist on call, informing the primary care physician at the first opportunity.(09/27/06)

   - The admitting/discharging physician or his/her covering physician is responsible for the patient 30 –days following discharge if re-admitted unless the patient leaves AMA then it is the responsibility of the on-call physician. (08/27/08)

   - For unattached patients, the Emergency Department physician will have the discretion to call the physician on call for general medicine, or another on call specialist, based upon the clinical needs of the patient. (09/27/06)

   - In the event of disagreement concerning who is responsible to come to the Emergency Department to provide evaluation and treatment or admit the patient, **the decision of the Emergency Department physician shall be considered final,** and binds on-call physicians to respond. Disagreements will be examined later, in a case study format, to

improve communication and decision making for the future. Where physicians feel there has been an abuse of discretion they may bring these to the attention of the Medical Director of the Emergency Department, the Chief of Service, or the President of the Medical Staff.(09/27/06)

For patients who are critically ill and admitted or to be admitted to critical care services, the admitting physician is required to physically assess the patient and direct further management within (6) six hours. This responsibility may be delegated to a specialist/consultant, but the admitting physician must contact the consultant directly to request that this occur within a (6) six hour timeframe. (06/28/06)

7. The pre-admission coordinator or admitting clerk will admit patients on the basis of the following order of priorities:

   a. EMERGENCY ADMISSION life or limb threatening - usually specified by attending emergency department physician.

   b. URGENT ADMISSIONS requires admission within TWENTY-FOUR (24) hours.

   c. ELECTIVE admittance at this time is optional. This area is very broad and includes the following any scheduled elective surgeries.

   d. PREOPERATIVE ADMISSIONS This includes all patients already scheduled for surgery. If it is not possible to handle all such admissions, the priority will be determined on the basis of the day and hour that the patient was scheduled. The rescheduled patient and his/her physician will be notified immediately.

   e. ROUTINE ADMISSIONS This will include elective admissions involving all services.

SECTION 1: OUTPATIENT OBSERVATION ADMISSIONS

A. Observation services are those services, including use of a bed and periodic monitoring by a hospital=s nursing or other staff, which are reasonable and necessary to evaluate an outpatient=s condition and determine the need for a possible admission to the hospital as an inpatient. Observation services usually do not exceed 24 hours.

B. Patients will be accepted in the Hospital for outpatient observation under the following conditions.

   1. Patient will be assigned a room on the unit of service which they require, dependent on census bed availability.

   2. Patient=s stay should not exceed 24 hours. A physician should not substitute outpatient observation services for medically appropriate inpatient admissions.

C. The following types of services are NOT covered as observation services:

   1. Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient or a physician.

   2. Services which are covered under Part A or as part of another Part B benefit, such as services which are defined as ambulatory surgical center (ASC) payment rates or patients who undergo outpatient diagnostic testing.

SECTION 2: PATIENT BED TRANSFERS

A. Transfer priorities shall be as follows:

1. ED to appropriate patient bed.
2. From Intensive Care Units to general care areas.
3. Routine In house.
4. Outside new admissions.

B. When transfer of a psychiatric patient is not possible, the patient may be admitted to the hospital, and, as a temporary measure, special nursing care is provided.

C. No patient will be transferred without such transfer being approved by the responsible physician.

SECTION 3: PRE-ADMISSION/UTILIZATION REVIEW

The Case Management Department conducts pre-admission review of all urgent and elective Medicare/Medicaid hospital admissions (and other commercial insurance companies requiring pre-admission certification for hospitalization).

A. Assess the medical necessity of the patient's planned hospitalization before admission, using appropriate ISD criteria .

B. Contacts the attending physician regarding additional medical information needed for appropriate review of the case.

C. Refers all cases which do not meet medical necessity criteria to a physician advisor who serves on the Utilization Management Committee for a final decision.

D. The attending practitioner is required to document the need for admission and for continued hospitalization in accordance with the hospital's Utilization Management Plan. This documentation must contain:

- Adequate progress notes stating plan of treatment, the reason for admission and for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient. Note: The Utilization Review Committee requires documentation by the attending physician justifying the necessity for continued hospitalization of any patient beyond the twelve days or longer, including an estimate of the number of additional days of stay and the reason therefore. The documentation must appear in the progress note section of the medical record within TWENTY-FOUR (24) hours. Failure to comply with this policy will be brought to the attention of the Executive Committee for action.
- The estimated period of time the patient will need to remain in the hospital.
- Plans for post hospital care; and,
- Every patient is to be visited at least daily by the attending physician or the attending=s covering physician. In any case where this does not happen, the Department Chief of the attending practitioner should be notified immediately. Progress notes should be written at each visit and should reflect any change in condition and continued need for hospitalization.

SECTION 4: DISCHARGE ORDERS

Patients shall be discharged only by written order of the attending physician.

1. The patient's attending physicians should be notified of any patient's concern and desire for early discharge.

2. The physician should make a determination about the safety of such a request. A health care professional should advise the patient of potential risk associated with early release from the hospital. This discussion should be documented.

3. Progress notes should reflect the mutual decisions reached.

4. Patients insisting on leaving the hospital without treatment and/or against medical advice should sign a Release From Responsibility for Discharge form. The form should become a permanent part of the patient's medical record.

SECTION 5: HOSPITAL DEATHS

In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee. The Nursing Shift Supervisor has the authority to pronounce death, as defined in hospital policy.

A. The body should only be moved by order of the physician. However, pronouncement implies an order to move the body to the morgue.

B. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the Medical Staff.

C. Policies with respect to release of the dead bodies shall conform to local law.

D. It shall be the duty of all staff members to secure autopsies, when appropriate.

E. The Medical Staff, with the appropriate hospital staff, shall develop and use criteria that identifies deaths in which an autopsy should be considered.

F. There is a system for notifying the appropriate member of the Medical Staff when an autopsy is being performed as defined by hospital policy.

G. An autopsy may be performed only with a written consent, signed in accordance with State Law.

H. All autopsies shall be performed by the hospital pathologist, or by his delegate.

I. Provisional anatomic diagnoses shall be recorded on the medical record within SEVENTY-TWO (72) hours and the complete protocol should be made a part of the record within SIXTY (60) days.

SECTION 6: ADMISSION AND DISCHARGE OF PSYCHIATRIC/SUICIDAL PATIENTS

A. The hospitals provide for the acute medical management, including treatment and stabilization, of patients admitted with psychiatric emergencies, such as suicide-attempt or acute substance overdose. The admitting physician shall be responsible for giving such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever his/her patients might be a source of danger from any cause whatsoever.

B. For the protection of the patient, and the medical and hospital staffs, the hospital requires immediate evaluation by a licensed, qualified physician, who is a member of the Medical Staff, to determine the possible need(s) for:

1. Suicide precautions, including constant supervision and other means necessary to prevent harm to self or others;

2. Involuntary custody, to include SEVENTY-TWO (72) hours following medical treatment and stabilization of the condition leading to admission as required by the Florida Baker Act;

3. Evaluation and treatment recommendations, including the time frame for such evaluation and recommendations, by a Psychiatrist or Mental Health Professional with medical staff privileges; and

4. Referral to private or public community resources addressing the patient's psychiatric and/or psychosocial needs.

C. If voluntary custody is instituted, in accordance with the Florida law or unless the involuntary custody has been terminated by a mental health professional as permitted by Florida law, the patient will be transferred to the appropriate Baker Act-receiving facility upon determination by the attending physician that the medical condition that led to admission to the hospital has been stabilized. Transport of the patient will be accomplished as required by Florida law.

SECTION 7: PATIENTS REQUIRING RESTRAINTS

A. Restraints or seclusion may be used on a patient for the protection of self and/or others. Trained professional staff may initiate the use of soft restraints when the attending physician is not present; however, an order must be obtained from the attending physician within TWELVE (12) hours. Verbal orders must be co-signed by the physician within TWENTY-FOUR (24) hours. Orders must include the reason for restraint and/or seclusion and the expected behavior exhibited by the patient for release from the restraints/seclusion. Orders for restraints will be based upon individual assessed and are not to exceed TWENTY-FOUR (24) hours. The order for restraints will include date and time of application. Clinical justification for use, type of restraint used, release from restraints criteria and the time restraint order expires.

B. For patients who require SEVENTY-TWO (72) hours of continuous restraint or four separate episodes within a seven day period, consideration should be given to a team meeting between the attending physician and the nursing staff.

ARTICLE 2: MEDICAL RECORDS

SECTION 1. GENERAL GUIDELINES

A. An adequate medical record shall be maintained for each individual who is evaluated or treated in the hospital, whether as an inpatient or as an outpatient. This includes all patients in Outpatient Surgery, the Emergency Department, Outpatient Observation, Outpatient Testing, and in any Offsite Facilities. The contents of each medical record shall be pertinent, current, and shall include information required for completion of birth, death and still birth certificates, and may at a minimum contain as appropriate the following: identification data, which includes the patient's name, address, date of birth, sex and the name of any legally authorized representative; the patient's legal status, for patients receiving mental health services; medical history, including the chief complaint; details of the present illness; relevant past, social, and family histories (appropriate to the patient=s age); and an inventory by body system; a summary of the patient's psychosocial needs, as appropriate to the patient's age; a report of relevant physical examinations; a statement on the conclusions or impressions drawn from the admission history and physical examination; a statement on the course of action planned for the patient for this episode of care and of its periodic review, as appropriate; the record and findings of the patient=s assessment and reassessment; evidence of known advance directives; diagnostic and therapeutic orders; evidence of appropriate informed consent; clinical observations, including the results of therapy; evidence of medications and dosages ordered and administered; any adverse drug reaction; a copy of Florida EMS Report, if the patient was delivered to the hospital by ambulance; progress notes made by the medical staff and other authorized staff; consultation reports; preoperative diagnosis; reports of operative and other invasive procedures, listing primary surgeon/assistants and describing complications, reactions, length of time, techniques, findings, tissues removed or altered, postoperative diagnosis; documentation of intraoperative anesthesia given and pre/ postanesthesia evaluations; tests, and their results;

reports of any diagnostic and therapeutic procedures, such as pathology and clinical laboratory examinations and radiology and nuclear medicine examinations or treatments; ancillary testing reports; records of request for organ donation, donation and receipt of transplants or implants; final diagnoses and procedures; discharge planning evaluation, any referrals/communications made to external or internal care providers and to community agencies; conclusions at termination of hospitalization; clinical resumes and discharge summaries, or a final progress note or transfer summary; discharge instructions to the patient or family; certifications of transfer of the patient between hospitals as required by Florida law; and when performed, results of autopsy. (7/28/10)

B. When computer keys are used to authorize, the individual signs a statement signifying he/she alone will use the code (statement on file).

C. All clinical entries in the patient's medical records shall be legible, dated, timed and authenticated in written or electronic form by whoever is responsible for ordering or providing the service. (7/28/10) Provider must have a legible signature, or print their name under the signature. (8/22/12)

D. Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations is documented within hospital policy.

E. All previous records shall be available for use by the attending practitioner on readmission of any patient.

F. A medical record shall not be permanently filed until it is completed by the responsible practitioner. In the event a record cannot be completed due to physician illness, relocation, death, etc. the record will be referred to Utilization Management Committee and Performance Improvement Council for retirement. If the record has been approved for filing by the aforementioned Committees appropriate forms will be completed and filed within the medical record indicating this action.

SECTION 2: ACCESS TO INFORMATION

A. The medical record is the property of the hospital and is maintained for the benefit of the patient, the Medical Staff, and the hospital. **T**he information contained in the medical record belongs to the patient and the patient is entitled to the protected right of information. All patient care information shall be regarded as confidential and shall be made available to only authorized users. The hospital is responsible for safeguarding both the record and its informational content against loss, defacement, tampering and from use by unauthorized individuals.

B. Each member of the Medical Staff with access to the hospital medical records agrees to comply with the information security policies of the hospital set forth in the Information Security Agreement, System Access Authorization and Connectivity Agreement. Such policies include maintaining passwords and Personal Identification Numbers (PIN), which allow access to computer systems and equipment, in strictest confidence and not disclosing passwords and/or PIN with anyone, at any time, for any reason. Each member of the Medical Staff and privileged practitioner understands that the records of the patients maintained are confidential and that access to such records should be limited to those who have a need-to-know in order to provide for care of the patient. Failure to comply with the information security policies of the Hospital may result in termination of access to computer systems, paper or other health information records, resulting in the initiation of corrective action as specified in these Bylaws, Rules and Regulations. Loss of medical staff membership or limitation, reduction, or loss of clinical privileges for any reason may be grounds to terminate access to the system immediately and without notice to the practitioner.

C. Personal Identification Number (PIN) shall be used to authenticate entries only after the PIN owner, who is the author of the entry, has reviewed the entry. Another form of authentication after review of entry may be signature per Medical Staff Rules and Regulations.

D. Each member of the medical staff shall have access to previous hospital records of patients he/she is treating on an outpatient basis as per HIPAA regulations and hospital policy. At the time of readmission, all appropriate previous records will be made available for the use of the attending and consulting staff responsible at the time of and for the duration of the admission.

E. Unauthorized release of information from hospital records is grounds for summary suspension of the Staff member per Medical Staff Bylaws. Unauthorized release includes printing of documents and re-release of these documents to others who do not have appropriate access.

F. All Radiology films, pathology specimens, microscopic slides, photographs, videotapes and photographic slides are the property of the Hospital. Under no circumstances may any of these items be removed for legal purposes without prior approval of the Chief Executive Officer or designee.

G. Removal of original documents, such as radiology films, pathology specimens, microscopic slides, photographs, videotapes, and photographic slides may occur with the written consent of the patient. Records may be removed from the hospital only in accordance with a court order, subpoena, or statute, or for transport to the HIM Shared Services Center, or other similar centralized location designated in accordance with HCA policy regarding Health Information Management systems, for processing. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Administrator. Unauthorized removal of original documents from the Hospital is grounds for automatic suspension of the Staff member as per the Medical Staff Bylaws.

H. Access to all medical records of all patients shall be afforded to members of the Medical Staff for bonafide study and research, consistent with preserving the confidentiality of personal information concerning the individual patient. All such projects shall be approved by the Executive Committee of the Medical Staff, with the agreement of the Chief Executive Officer, and Board of Trustee approval, before records can be studied. Subject to the discretion of the Chief of Staff, former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.

ARTICLE 3: INPATIENT MEDICAL RECORD

SECTION 1: HISTORY AND PHYSICAL EXAMINATION

A. The medical history of the patient shall include the chief complaint; details of the present illness, including when appropriate, assessment of the patient's emotional, behavioral, and social status; relevant past, social, and family histories appropriate to the age of the patient; a summary of the patient's psychosocial needs; and an inventory by body systems. The physical examination report reflects a comprehensive current physical assessment.

B. A complete admission history and the results of the physical examination shall be documented within TWENTY-FOUR (24) hours of admission. In cases where the physician dictates the H&P, an admission note shall be documented and provide any pertinent information regarding the patient's history and physical, the admitting diagnosis, any coexistent disease together with a statement of the conclusions or impressions drawn from this information, and a statement of the course of action planned for the patient while in the hospital.

C. Pre-operative or previous H&P's may be utilized under the following conditions:

- The H&P was performed within 30 days prior to admission;
- An appropriate assessment, which should include a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H&P or to address any areas where more current data is needed, was completed within 24 hours of admission and prior to any operative/invasive procedure;

D. The report of the history and physical is authenticated by a physician or, when appropriate, by a qualified oral and maxillofacial surgeon member of the Medical Staff, or a midwife (operating under approved protocols).

E. When the medical record fails to document a current history and physical examination prior to surgery or prior to any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

SECTION 2: ORDERS

A. All orders for treatment shall be in writing or electronically entered. (3/27/13)

1. A verbal order shall be considered to be in writing or electronically entered (3/27/13) if dictated to a duly authorized person functioning within his/her sphere of competence. Verbal orders must be dated and timed at the time they are taken. They must be authenticated in written or electronic form by the person (identified by name and discipline) who is responsible for ordering, providing or evaluating the service provided within 48 hours and may be authenticated by another practitioner responsible for the care of the patient. (10/24/07)

2. Verbal orders for restraints and DNR require authentication of the LIP responsible for the order within TWENTY-FOUR (24) hours.

3. Persons duly authorized to accept verbal orders within their scope of practice include nurses, physician assistants(P.A.), pharmacists, registered dieticians, neurophysiologists,

physical therapists, physical therapist assistants, occupational therapists, Medical Social Worker, Radiologic Technicians and respiratory therapists. Unit secretaries may accept diet or activity orders. (07/25/07)

B. A practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, and signed by the practitioner.

C. The transfer of a patient from one physician's service to another shall be accomplished by a written or electronic (3/27/13) order of the attending physician. The physician to whom the patient is transferred shall acknowledge his/her acceptance in the patient record. The admitting physician shall be responsible for the dictation of the history and physical. The attending physician at time of discharge will be responsible for the dictation of the discharge summary.

SECTION 3: INFORMED CONSENT:

A. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission and is valid for the duration of hospitalization. General consent on admission cannot be used in lieu of informed consent for medical or surgical procedures that require informed consent. Informed consent is required for all invasive procedures or for any procedure involving a substantial risk to the patient, including administration of blood and blood products and anesthesia. Additionally, consent from the next of kin is required in all autopsy and organ donor cases.

B. The practitioner who actually plans to perform the procedure in question has the responsibility to inform the patient of the diagnosis, the nature and the purpose of the proposed treatment, the risks and consequences of the proposed treatment, the probability that the proposed treatment will be successful, feasible treatment alternatives, the prognosis if the proposed treatment is not given any professional or business relationship with another healthcare provider or institution that might suggest a conflict of interest and to obtain the informed consent.

C. Where there is no evidence of an informed consent in the medical record, the practitioner should be notified, and the procedure/treatment should not be performed until the informed consent is obtained, unless such action would be harmful to the patient in the practitioner=s judgment.

D. Informed Consent must be obtained at the time of the procedure. Each procedure requires its own informed consent.

E. Only a mentally competent person, over the age of majority, or an emancipated minor, may consent to his/her treatment. When the patient is an unmarried minor, only the patient's parent or legal guardian may consent to treatment. If a patient has been declared mentally incompetent, or is an incapacitated adult, the patient's legal guardian, or other person equally authorized to consent for the patient, must consent to treatment. In the case of a life threatening illness or injury, life saving treatment may be rendered without the expressed consent of the patient, parent or guardian. The patient, parent and guardian should be informed as soon as possible following treatment, and the reason that consent was no obtainable must be documented in the medical record.

F. Should a second operation, of a different nature than the first, be required during the patient's stay in the hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be scheduled at the same time and performed by the same surgeon, each may be described and consented to on the same form. If these procedures are to be performed by different physician, then separate consent forms (one for each physician involved) must be obtained.

G. Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

SECTION 4: PROGRESS NOTES

Pertinent progress notes shall give a chronological report of the patient's course in the hospital and reflect any change in condition and the results of treatment. They shall be written daily at each visit by the physician and/or the physician assistant/ARNP who are credentialed to do so, and whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders and the results of tests and treatments. Progress notes should reflect the need for continued hospitalization, should be legible if handwritten, dated and signed. (6/2014)

SECTION 5: REPORTS OF PROCEDURES, TESTS AND THEIR RESULTS

A. All diagnostic and therapeutic procedures are recorded and authenticated in the medical record.

B. The attending physician authenticates and records a preoperative diagnosis prior to surgery.

C. Operative reports shall contain a description of the findings of surgery, the technical procedures used, any complications, the specimens removed, any estimated blood loss, the post-operative diagnosis, and the name of the primary surgeon and any assistants. (7/28/10)

D. Operative reports shall be written (or dictated) immediately following surgery. The completed operative report is authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

E. If any delay in dictation or transcription is anticipated, a comprehensive, operative, progress note is entered in the medical record immediately after surgery to provide pertinent information for use by those involved in the patient's care.

F. Reports of pathology and clinical laboratory examinations, radiology, nuclear medicine, cardio-pulmonary, and neuro-physiology examinations or treatment, anesthesia records, etc., are completed promptly.

SECTION 6: CONSULTATIONS

A. Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinions, and his/her recommendations. A limited statement such as "I concur" does not constitute an acceptable consultation. When operative procedures are involved, the consultation note shall, except in emergency situation so verified in the record, be written (or dictated) prior to the operation. Consultations shall be performed in a timely manner.

SECTION 7: DISCHARGE SUMMARY

A. A discharge summary shall be dictated on all inpatient medical records.
Exceptions:

- For patient stays under (48) forty eight hours, a final progress note may serve as the discharge summary and must contain the outcome of hospitalization, the case disposition and any provisions for follow-up care.
- Normal newborns, uncomplicated obstetrical deliveries, uncomplicated surgery or invasive procedures requiring a stay of less than 48 hours (biopsies, areteriogram,

etc.), routine blood transfusions, and routine chemotherapy. In these cases, a final detailed progress note will suffice.

B. The summary should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient on discharge, discharge diagnosis and any specific instructions given to the patient concerning physical activity, medication, diet and follow-up care.

C. The condition of the patient on discharge is stated in terms that permit a specific measurable comparison with the condition on admission, avoiding the use of vague relative terminology, such as "improved."

D. In the event of death, a summation statement is added to the record either as a final progress note or as a separate resume. The final note indicates the reason for admission, the findings and course in the hospital, and the events leading to death.

E. A copy of the Discharge Summary will be forwarded to the clinician responsible for continued care.

SECTION 8: NECROPSY REPORT

When a necropsy is performed, provisional anatomic diagnoses are recorded in the medical record within THREE (3) days, and the complete protocol is made part of the record within SIXTY (60) days.

SECTION 9: ORAL SURGERY AND DENTAL RECORDS

A. A patient admitted for dental care is a dual responsibility involving both the dentist and a physician member of the Medical Staff.

B. Dentists' responsibilities:

1. A detailed dental history justifying hospital admission.

2. A detailed description of the examination of the oral cavity and preoperative diagnosis. Note: Qualified oral surgeons who admit patients without medical problems may perform the history and physical examinations on those patients in lieu of a physician staff member, if they have such privileges.

3. Outpatient dental surgery cases requiring the use of local anesthesia shall show documentation in the medical record of the dental history and physical by the dentist or oral surgeon. Outpatient dental surgery cases requiring general anesthesia shall show documentation in the medical record of the history and physical obtained by the physician member of the Medical Staff or by the qualified surgeon.

4. All general anesthesia for dental patients must be administered by a physician anesthesiologist who will be responsible for reviewing and approving immediate post-operative orders.

5. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed.

6. Progress notes as pertinent to the patient's oral condition.

7. Clinical resume (or summary statement).

C. Physician's responsibilities:

1. All dental patients admitted to the hospital must have a medical evaluation by a physician member of the medical staff within 24 hours from time of admission.

2. Medical history pertinent to the patient's general health except where an oral surgeon has been granted clinical privileges (based on his qualifications) to record the pertinent medical history him/herself.

3. A physician examination to determine the patient's condition prior to anesthesia and surgery.

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

D. The discharge of the patient shall be on written order of the dentist member of the Medical Staff.

SECTION 10: PODIATRIC RECORDS

A. A patient admitted for podiatric care is a dual responsibility involving both the podiatric and a physician member of the Medical Staff.

B. Podiatrists' responsibilities:

1. A detailed podiatric history justifying hospital admission.

2. A detailed description of the examination of the foot and preoperative diagnosis.

3. Outpatient podiatric surgery cases requiring the use of local anesthesia shall show documentation in the medical record of the podiatric history and physical by the podiatrist. In addition to the podiatric history and physical, outpatient podiatric surgery cases requiring general anesthesia, conscious sedation, or regional anesthesia shall show documentation of a history and physical appropriate to adequately address the risks associated with anesthesia. This history and physical may be done by the podiatrist in conjunction with a complete anesthesia assessment by the Anesthesia Department.

4. All general, conscious sedation, or regional anesthesia for podiatry patients must be administered by a member of the Anesthesia Department who will be responsible for reviewing and approving immediate post-operative orders.

5. A complete operative report, describing the findings and technique.

6. Progress notes as pertinent to the patient's podiatric condition.

7. General orders for the patient's preoperative and post-operative care, including orders for diet and activity.

8. Clinical resume (or summary statement).

C. Physician's responsibilities:

1. All podiatric patients admitted to the hospital must have a medical evaluation by a physician member of the medical staff within TWENTY-FOUR (24) hours from the time of admission.

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

3. A physician examination to determine the patient's condition prior to anesthesia and surgery.

4. Any medical orders (i.e., medication orders).

D. The discharge of the patient shall be on written order of the podiatric member of the Medical Staff.

SECTION 11: ANESTHESIA RECORDS

A. The pre-anesthesia evaluation is documented in the medical record and includes information concerning the choice of anesthesia and the surgical procedure anticipated; reference to the use of general, spinal, or other regional anesthesia; the patient's previous drug history, other anesthetic experiences and any potential anesthetic problems.

B. The post-anesthesia follow-up must be documented with reference to the presence or absence of anesthesia related complications.

C. Each post-anesthesia note specified by the date and time.

ARTICLE 4: OUTPATIENT MEDICAL RECORD

SECTION 1: OUTPATIENT OBSERVATION DOCUMENTATION

A. A physician order shall be required to admit the patient to an Outpatient Observation bed.

B. The admission note shall include the reason for admission, the patient's past, history, a systems review, results of a physical examination, a plan of care and, as appropriate to the age of the patient, a summary of the patient's psychosocial needs.

C. The Outpatient Observation record shall include applicable orders for patient care; observation or progress notes; written and signed discharge order; and a discharge note to include instructions to patients with mention of the patient's condition on discharge.

D. When patients stay 24 hours or longer due to medical necessity, the progress note shall reflect the need for continued observation.

SECTION 2: OUTPATIENT INVASIVE DIAGNOSTIC AND THERAPEUTIC PROCEDURE DOCUMENTATION

A. A history and physical must be performed pre-operatively on all patients undergoing outpatient invasive diagnostic or therapeutic procedures for which monitored anesthesia care or sedation analgesia will be performed.(09/27/06) The referring physician, the attending physician, or an assistant authorized by state law to perform an examination may perform the history and physical.

A physician history and physical is not required for patients undergoing outpatient invasive diagnostic or therapeutic procedures in which no anesthesia or only topical analgesia will be performed. (01/20/2010)

B. Pre-operative Evaluation: the following elements must be documented in the medical record and reviewed by the surgeon prior to performing the procedure:

1. Evidence of the patient=s informed consent, including confirmation of the surgical site, when appropriate;

2. A pre-operative diagnosis and/or indications/symptoms supporting the clinical justification for the procedure;

3. List of current medications and dosage for each;

4. Known allergies/medication reactions;

5. Existing co-morbid conditions, if any, and

6. Consultation, if required, providing surgical clearance.

C. An assessment of anesthesia risk considerations and a plan for anesthesia must be completed prior to administration of anesthesia, when anesthesia is performed.

D. In cases where a history and physical is required, the scope of the history obtained should reflect the indications for and risks associated with the planned procedure. This information may be recorded in the operative note/report. In cases where the physician opts to include this information in the operative note, an admission note shall be documented to provide pertinent information regarding the patient's history and physical, the admitting diagnosis, any coexistent disease together with a statement of the conclusions or impressions drawn from this information, and a statement of the course of action planned for the patient while in the hospital.

E. The scope of the physical examination should include the risks determined by the anesthesia assessment and plan. This information may be recorded in the operative note/report. The examination must include at a minimum:

1. Sedation Analgesia:
- (a) Assessment of mental status;
- (b) An examination specific to the procedure to be performed and any co-morbid conditions; and
- (c) Examination of the heart and lungs by auscultation.
- (d) This information may be recorded in the operative note.

2. ** General, Spinal, or Epidural Anesthesia:
- (a) Assessment of mental status;

(b) An examination specific to the procedure to be performed and any co-morbid conditions; and
(c) A complete physical examination.
(d) ** Pre-procedure notes are required on patients undergoing spinal or general anesthesia and must include an anesthesia examination by a person, qualified to administer anesthesia, including the anesthesia planned and the risk of anesthesia.
(e) Combinations of anesthesia types reflected above require a physical relevant to the highest level of anesthesia administered.
(f) Consent for anesthesia

F. Pre-operative diagnostics:

1. Testing relevant to the patient=s health status and appropriate to the planned procedure and facility standards should be completed.

2. All abnormal results must be addressed pre-operatively as appropriate.

G. Surgical Note/Report: must be completed immediately post-operative **and** must contain description of indications, findings, any complications, any estimated blood loss, procedures, and pathology report if applicable. (7/28/2010)

H. Documentation of post-operative discharge and education may be included in the operative note/report and must include:

1. Interventions for and explanations of complications which occurred peri-operatively.

2. Statement of medical stability by a physician or a post-operative anesthesia evaluation performed in accordance with policies and procedures approved by the Medical Staff.

3. Care arrangements and to whom released or notation of transfer to another care setting, and

4. Instructions to include diet, activity, medications, follow-up visits, and any other information pertinent to the patient=s medical condition.

SECTION 3: OUTPATIENT TREATMENT - SAME DAY CARE

A. Outpatient treatment may include same day care for blood transfusions, injections, therapeutic antibiotic treatment, and chemotherapy. The following elements must be entered into the medical record and reviewed by a registered nurse prior to initiation of outpatient treatment:

1. Attending physician=s orders for the planned treatment;

2. Clinical diagnosis and/or diagnostics/indication/symptoms supporting the clinical justification for the planned treatment (for blood transfusion this includes the patient=s hemoglobin and/or hematocrit);

3. Evidence of the patient=s informed consent, when appropriate;

4. List of current medications and dosage for each;

5. Known allergies/medication reactions;

6. Existing co-morbid condition; and

7. A nursing assessment completed in accordance with facility standards.

B. The attending physician is responsible for maintaining any other information necessary to support the clinical justification for the ordered treatment in the patient=s office record.

C. Discharge documentation may be completed by the registered nurse responsible for the patient=s in-hospital care based on the attending physician=s written orders.

D. If unplanned overnight observation stay is required for patient=s receiving same day care, an order supporting the clinical justification for observation and a history and physical appropriate to an observation stay must be entered into the medical record by the attending physician. Discharge documentation appropriate for observation stay is then required.

ARTICLE 5: INCOMPLETE AND DELINQUENT RECORDS

SECTION 1: GENERAL POLICIES

A. Medical records of discharged patients shall be completed in so far as possible at the time of discharge, including final diagnoses and procedures, and discharge summaries.

B. Following a quantitative analysis by Health Information Management, the patient's record will be made available to the physician for completion purposes.

C. All medical records shall be completed within 30 calendar days post discharge. After notification, if a staff member fails to complete such records within the specified timeframe, a temporary suspension of all privileges may be imposed automatically by the Medical Executive Committee. Such suspension shall be effective as of the first day after the expiration of the specified timeframe and shall continue until the medical records in question are satisfactorily completed. With exception of emergency care, for which only the practitioner is qualified and available to render, and the care of the patients already hospitalized at the time of suspension, such temporary suspension shall include all admitting and clinical privileges, as well as, scheduling of elective operations, and assisting at elective operations. Unverified emergency admissions shall not be used to bypass such restriction. The suspended practitioner shall not attend patients admitted by another member unless he is the only practitioner available for a specific emergency consultation. A practitioner who sustains two suspensions in any one quarter will be referred for appearance before the Medical Executive Committee for discussion and resolution of the matter.

D. At one year advancement, applicants having one instance of suspension, advancement to be deferred for six months.

At reappointment, applicants having one suspension will result in a one year appointment.

ARTICLE 6: PHARMACY AND THERAPEUTICS

SECTION 1: INPATIENT PRESCRIBING

1. NEW ORDERS: All drug orders must be electronic (3/27/13) or written clearly, legibly, and completely on the patient's order sheet. Individuals who prescribe/order medications are authorized legally and through the granting of clinical privileges to do so. A direct copy of the patient's order sheet must be sent to Pharmacy to obtain the drugs. The copy of the order sheet must have the following legible information:

   a. The patient's Addressograph information.

   b. The patient's room number.

   c. The complete name of each drug ordered.

   d. The dosage form, dose size and strength of each drug.

   e. Directions for administration of each drug, including route and frequency.

   f. Signature of the physician.

   g. The date and time the order was written or electronically entered. (3/27/13) (01/26/12)

2. REWRITE ORDERS: Anti-infectives (IM,IV); Toradol (IV, IM,); Heparin/Coumadin, Steroids (IM, IV) must be reordered, discontinued; or changed by the physician every FIVE DAYS. Oxytoxics are dispensed only for the exact number of doses, prescribed by the physician and new orders must be written for each new dose or doses given. Any change in a previously existing order requires a new complete order to be written. (7/25/07)

3. NARCOTICS PRESCRIBING: Narcotics for inpatients are ordered in the routine manner. These drugs will be provided to the nurse as a sign out stock. The stock on the nursing unit can only be used for inpatients and must not be given to patients or employees to take home.

4. INVESTIGATIONAL DRUGS: Investigational drugs are those drugs which have not been released by the Federal Food and Drug Administration for general use and are not available commercially. Such drugs are used only under the direct supervision of the chief investigator who retains contact over the use and distribution of the drug in Ocala Regional Medical Center. Physicians desiring to use investigational drugs in the Hospital must comply with Federal Regulations mandating the presentation of his/her protocol to an Institutional Review Board approved by the FDA. Only after approval of an IRB Approved by the FDA will the use of such drugs be considered.

5. DISCHARGE PATIENT PRESCRIBING: Prescriptions written or electronically entered (3/27/13) for patients being discharged from the Hospital should be given to the patient. Patient will be instructed to take the prescriptions to his community pharmacist for filling.

ARTICLE 7: GENERAL RULES REGARDING SURGICAL CARE

SECTION 1: RULES AND REGULATIONS FOR THE SURGICAL SUITE

1. The use of the operating room facilities is restricted to those active staff physicians, oral surgeons, dentists and podiatrists with appropriate surgical privileges.

2. SCHEDULING OF PROCEDURES:

A. Order of Priority

1. Procedures designated as emergencies

2. Procedures designated as urgent

3. Elective procedures

DEFINITIONS:

Emergency - when delay would constitute threat to life and/or limb.

Urgent - when a procedure should be performed within TWELVE (12) hours.

B. Assignment of priority will be made by the operating room supervisor after consultation with the attending physician, and, if necessary, with the Director of Anesthesia or his designate, and the Chief of Surgery. Loss of Priority -- tardiness, without good cause by the attending surgeon will constitute grounds for loss of priority.

C. Effective utilization of the operating suite and other Hospital facilities will be of prime consideration in the scheduling of elective procedures.

D. The operating room supervisor or designate must be notified and approved granted in the event of a schedule change. It will be his/her responsibility to notify the involved physicians in the event of such a change. It shall be the responsibility of the attending physician to contact the physician whose case is "bumped."

E. Information required to schedule will include the name of the attending physician, patient's name, clearly defined operative procedure, telephone number, date of birth, diagnosis admission time and estimated length of time of the procedure. The time and date of scheduling will be a factor in the determination of priority.

SECTION 2: REQUIREMENTS PRIOR TO ANESTHESIA AND SURGERY

A. Identification of patient - by name, hospital number, attending physician's name, and hospital room number.

B. Preoperative evaluation and documentation.

1. The history and physical examination of a non-emergent in-patient must be completed prior to anesthesia and surgery. In an emergency, information concerning the patient=s emergent condition and surrounding circumstances must be documented in the progress notes. The out-patient surgery chart must have a dictated or hand written history and physical or have a short form history and physical on the chart prior to anesthesia and surgery. An admission note shall include any pertinent information regarding the patient's history and physical, the admitting diagnosis, and any coexistent disease together with a statement of the conclusions or impressions drawn from this information. When the medical record fails to document a current history and physical examination prior to surgery or prior to any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending practitioner states in writing that such delay would be detrimental to the patient.

2. Timing and type of pre-op testing as indicated by the patient=s current medical history and proposed surgical procedure should be completed within thirty (30) days prior to the patient=s admission.

3. Informed consent must be obtained from the patient, or from a person authorized to grant consent for the patient before each medical or surgical procedure to be performed, including administration of blood and blood products and anesthesia. The exception to this would be in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The requirements for preoperative laboratory work, etc., may also be waived in these circumstances. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record.

   The physician who actually plans to perform the procedure in question has the responsibility to inform the patient of the diagnosis, the nature and purpose of the proposed treatment, the risks and consequences of the proposed treatment, the probability that the proposed treatment will be successful, feasible treatment alternatives, and the prognosis if the proposed treatment is not given. the consent form must be on the chart before the administration of the operative medication and surgery.

   Where there is no evidence of an informed consent in the medical record, the physician should be notified, and the procedure/treatment should not be performed until the informed consent is obtained by the physician, unless such action would be harmful to the patient in the physician's judgment.

4. DAILY SCHEDULE STARTING TIME will be 7:30 unless other arrangements are agreed upon by all the involved parties.

5. All previous orders are canceled when patients go to surgery.

6. Outpatient Surgery Documentation

A. A history and physical is required regardless of the type of anesthesia planned or given, as well as, when no anesthesia is given. Requirements for the H&P include:

- The H&P was performed within 30 days prior to the outpatient surgery;

-An update note addressing the patient's current status and any changes in the patient's status is completed prior to the outpatient procedure;

-If the patient is undergoing anesthesia, this update may be completed by the Anesthesiologist during the preanesthesia assessment, which will include a complete physical systems review; otherwise it will be completed by the surgeon.

The history must at a minimum include documentation of the indications or symptoms for surgical procedure; current medications and dosages; any known allergies, including medication reactions; and existing co-morbid conditions, if any.

The history must be in the medical record prior to surgery. The extent of documentation required in the physical examination is to be reflective of the type of anesthesia planned and/or given according to the following:

1. No anesthesia, or topical, local, or regional block:

    a. Assessment of mental status; and
    b. An examination specific to the procedure proposed to be performed, and any co-morbid conditions.

2. Conscious sedation:

    a. A and b above; and
    b. Examination of the heart and lungs by auscultation

3. General, spinal, epidural anesthesia:

    a. A, b, above; and
    b. Assessment and written statement about the patient's general condition.
    c. Consent for anesthesia. Note: Anesthesia combinations requires a physical relevant to the highest level of anesthesia provided (i.e. local with conscious sedation requires a physical as described for Conscious sedation).

    Note: Anesthesia combinations require a physical relevant to the highest level of anesthesia provide (i.e., local with Conscious sedation requires a physical as described for Conscious sedation.)

B. Pre-operative Diagnostics:

1. Testing relevant to the patient=s health status and;
2. Appropriate to the planned procedure and facility standards should be completed.
3. All abnormal results must be addressed pre-operatively as appropriate.

C. Surgical Note/Report: must be completed immediately post-operative and must contain description of indications, findings, procedures, and pathology report if applicable.

D. Documentation of post-operative discharge and education may be included in the operative note/report and must include:

1. Interventions for and explanations of complications, which occurred peri-operatively.

2. Statement of medical stability by a physician or a post-operative anesthesia evaluation performed in accordance with policies and procedures approved by the Medical Staff.

3. Care arrangements and to whom released or notation of transfer to another care setting, and

4. Instructions to include diet, activity, medications, follow-up visits, and any other information pertinent to the patient's medical condition.

7. CARE AND TRANSPORT OF PATIENTS - Trained personnel will be in attendance of the patient at all times, and will accompany the patient to the recovery room. Upon discharge from the recovery room, the recovery room nurse will accompany the patient to the room and remain with the patient until post-operative vital signs are taken by the floor nurse.

8. Infection Control shall be practiced as per policy. See Infection Control specific - OR/Anesthesia.

9. State and Federal regulations involving conductivity and environmental control will be observed.

10. Radiation safety procedures as recommended by the Director of Radiology will be followed.

11. Written, signed, informed, surgical & anesthesia consent shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. The requirements for preoperative laboratory work, etc., may also be waived in these circumstances. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record.

12. When a patient requires a major operation that is not included in the privileges of the attending practitioner, then the patient must be transferred to the care of a designated qualified surgeon. The transfer shall be accomplished by an Order of Transfer by the attending practitioner on the patient record. The surgeon to whom the patient is transferred shall acknowledge his acceptance of the patient on the patient record. It is also required that the surgeon indicate on the record that the patient has been examined prior to surgery and shall list the diagnosis, contemplated surgery, and indications. This information shall be on the patient's record before the patient is taken to surgery, except in an emergency. Upon sufficient recovery of the patient following surgery, the care of the patient may be transferred back to the original practitioner. Transfer orders shall be the same as listed above.

13. ANESTHESIA RECORDS

A. The pre-anesthesia evaluation is documented in the medical record and includes information concerning the choice of anesthesia and the surgical procedure anticipated; reference to the use of general, spinal, or other regional anesthesia; the patient's previous drug history, other anesthetic experiences, and any potential anesthetic problems.

B. The post anesthesia follow-up must be documented with reference to the presence or absence of anesthesia related complications.

C. Each post anesthesia note specifies the date and time.

D. Except in emergency cases, the patient should be seen prior to coming to the operating room suite.

E. Informed consent for anesthesia is obtained prior to administration.

14. Tissue

All tissues removed in the operation with the exception of the following shall be sent to the Hospital pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis.

(a) Cataracts
(b) Teeth
(c) Metallic Implants
(d) Prosthesis
(e) Screws, Nails, Plates
(f) Intraocular lens
(g) Sutures
(h) Pacemaker Batteries
(i) Adipose tissue from Liposuction
(j) Foreskin - Newborn only
(k) Arthroscopic Shavings

Some specimens requiring only identification could be designated by the surgeon. The authenticated report shall be made a part of the patient's medical record. The weight of the adipose tissue from a liposuction procedure will be documented in the medical record before the tissue is disposed.

15. Dental staff documentation responsibilities: Please refer to Medical Records Section 11.

16. Podiatric Staff Documentation responsibilities: Please refer to Medical Records Section 12.

ARTICLE 8: CARE OF PATIENTS

SECTION 1: CONSULTATIONS

1. Any qualified practitioner with clinical privileges in this hospital can be called for consultation within his area of expertise.

2. Consultation should be considered in the following situations:

A. When the patient is not a good risk for an operation or treatment.

B. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

C. When an emergency procedure is contemplated on a minor or unconscious person where informed consent is not obtained.

D. When a patient is incapacitated and unable to communicate a health care decision, a second physician shall document incompetence.

E. When a physician determines a patient=s condition is terminal and is contemplating withdrawal of life prolonging procedures, a second physician must verify the patient=s condition, per state statutes.

F. When there is doubt as to the choice of therapeutic measures to be utilized.

G . In complicated situations where specific skills of other practitioners are needed.

H. When requested by the patient or patient=s family.

3. The attending practitioner is primarily responsible for requesting consultation with a qualified specialist when unusual problems are encountered and required when special procedures beyond the training or privileges of the attending physician are indicated in the care of the patient. Written authorization will be provided to permit another physician to attend or examine his patient except in an emergency. Consultations shall be performed in a timely manner.

4. Physicians accepting appointment to the Medical Staff should see consultations when requested by an attending physician. If a physician refuses or cannot see a consult, they must personally contact the attending physician to explain the circumstances regarding the refusal.

SECTION 2: TELEMEDICINE

1. The following lists of clinical services are appropriately delivered by LIPs that have gone through the credentialing process through the medium of Telemedicine:

A. Radiology (01/28/09)
B. Neurology (July 2010)

2. ARTICLE 9: EMERGENCY SERVICES

SECTION 1: ER CALL COVERAGE REQUIREMENTS

1. The emergency room call timeframe default for all specialties is 20 years, unless the specialty members taking call agree upon a lesser number of years, with a majority vote, and providing there is adequate ED coverage for that specialty. If the majority of any specialty do decide on a shorter number of years, the specialty must submit the decision to the Medical Executive Committee for final approval. (02/22/06)

2. While serving in an on-call capacity members of the Medical Staff are required to respond to the emergency room for on-call needs within 30 minutes. (03/26/08)

SECTION 2: EMERGENCY SERVICES AREA

1. The Medical Staff shall adopt a method of providing medical coverage in the emergency services area. This shall be in accord with the Hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care.

2. The duties and responsibilities of all personnel serving patients within the emergency area shall be defined in a procedure manual relating specifically to this outpatient facility. The contents of such a manual shall be developed by a multi specialty committee of the Medical Staff, including representatives from nursing service and Hospital administration. When approved by the Medical Staff and by the Governing body, it shall be appended to this document.

   COMMENT:

   Written policies concerning the extent of treatment to be carried out in the emergency service shall be determined by the Medical Staff and approved by the Governing Body. Written procedures should be reviewed at least annually and approved by the Executive Committee of the Medical Staff and by the clinical services involved.

3. An appropriate medical record shall be kept for every patient receiving emergency service and be incorporated in the patient's hospital record, if such exists. The record shall include:

   A. Adequate patient identification.

   B. Information concerning the time of the patient's arrival, means of arrival and by whom transported.

   C. Pertinent history of the injury or illness including details relative to first aid or emergency are given the patient prior to his/her arrival at the Hospital.

   D. Evidence of a Medical Screening Examination.

      1. Description of significant clinical, laboratory and roentgenologic findings.

      2. Diagnosis.

      3. Treatment given.

   E. Condition of the patient on discharge or transfer.

   F. Final disposition, including instruction given to the patient and/or his/family, relative to necessary follow up care.

4. Each patient's medical record shall be signed by the practitioner in attendance who is responsible for it's clinical accuracy.

5. There shall be ongoing monitoring of emergency room medical records by the Staff and by appropriate clinical services to evaluate the quality of emergency medical care. Reports shall be submitted to the appropriate committee including the Medical Staff each month.

   COMMENT: These medical records should first be reviewed for their adequacy as documents. If the contents reasonably reflect what has transpired, the review committee can then utilize them for medical care evacuation purposes and refer selected clinical situations to the applicable services for definitive review. In addition, the records of all patients dying within TWENTY-FOUR (24) hours of admission to the emergency service should routinely be reviewed.

6. There shall be plan for the care of mass casualties at the time of any major disaster, based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. It shall be developed by a committee which includes at least ONE (1) member of the Medical Staff, the Director of Nursing services or designee, and a representative from Hospital administration. When approved by the Medical Staff and Governing body, the plan shall be appended to this document.

7. The disaster plan should make provision within the Hospital for:

   A. Availability of adequate basic utilities and supplies including gas, water, food and essential medical and supportive materials.

   B. An efficient system of notifying and assigning personnel.

   C. Unified medical command under the direction of a designated physician (the chairman of the committee or designated substitutes).

   D. Conversion of all usable space into clearly defined areas for efficient triage, for patient observation, and for immediate care.

   E. Prompt transfer, when necessary, and after preliminary medical or surgical services have been rendered, to the facility most appropriate for administering definitive care.

   F. Those patients who require life support will be evacuated after ambulatory and non-ambulatory patients.

   G. A special disaster medical record, such as an appropriately designed tag, that accompanies the casualty as he is moved.

   H. Procedures for the prompt discharge or transfer of patients in the Hospital who can be moved without jeopardy.

   I. Security is stationed outside Triage area.

      Plant Operations will assist Security if additional help is required.

      Ocala Police will also assist in certain emergency situations (i.e., excluding city-wide disasters).

   J. Assignment of public relations liaison duties to a qualified individual. Advance arrangements with communications media will help to provide organized dissemination of information.

8. All physicians shall be assigned to posts (either in the Hospital or in the auxiliary Hospital, or in mobile consulting stations) and it is his/her responsibility to report to his/her assigned stations. The Chief of the clinical services in the Hospital and the Chief Executive Officer of the Hospital will work as a team to coordinate activities and directions. In case of evacuation of patients from one section of the Hospital to another, or evacuation from Hospital premises, the Chief of the clinical services during the disaster will authorize the movement of patients. All policies concerning direct patient care will be a joint responsibility of the Department Chiefs and the Chief Executive Officer of the Hospital. In their absence, the Deputy Chiefs and alternate in administration are next in line of authority respectively.

9. The disaster plan should be rehearsed at least twice a year, preferably as part of a coordinated drill in which other community emergency service agencies participate. The drills, which should be realistic, must involve the Medical Staff, as well as administrative, nursing and other Hospital personnel. Actual evacuation of patient's drills is optional. A written report and evaluation of all drills should be made.

ARTICLE 10: CRITICAL CARE UNITS

SECTION 1: OBJECTIVES

To provide highly technical, specialized designated areas designed for critically ill patients requiring the clinically competency and advanced knowledge of nursing services and support personnel.

SECTION 2: UNIT MEDICAL DIRECTORS

A. The Medical Director of MICU will be appointed by the Chief of Medicine and will serve a two year term. The Medical Director's assignee will perform the duties of Director in his/her absence.

B. The Medical Director of SICU will be appointed by the Chief of Surgery and will serve a two year term. The Medical Director's assignee will perform the duties of Director in his/her absence.

C. The Medical Director of CVICU will be appointed by the Chief of Surgery and will serve a two year term. The Medical Director's assignee will perform the duties of Director in his/her absence.

D. The Medical Directors will designate a qualified physician to preside as the Medical Director of the specific Critical Care Unit in his/her absence. The physician designee will perform the duties as the Medical Director and will be available for administrative and consultative decisions when the Medical Director is unavailable.

E. The Medical Directors will be responsible for implementing policies established by the Medical Staff for the continuing operation of the unit.

F. The Medical Directors shall be responsible for making triage decisions, in consultation with the attending physician responsible for the patient, for disposition of patients when there are no ICU beds available and a critically ill patient requires admission.

G. The Medical Directors will assure that the quality, safety, and appropriateness of patient care services provided within the specialized Critical Care Units are monitored and evaluated on a regular basis and that appropriate actions based on the findings are taken.

SECTION 3: CONSULTATIONS

Consultation with a qualified specialist is recommended when unusual problems are encountered, and required when special procedures or level of care beyond the training of privileges of the attending physician that are indicated in the care of the patient. The attending physician may request any consultant of his/her choosing. Consultations shall be performed in a timely manner. The admitted patient for surgery will remain the responsibility of the attending physician until such time an order is written to transfer service to the consulted surgeon by the attending physician and the consulted surgeon accepts the service.

SECTION 4: STANDING ORDERS FOR MICU, AND SICU, CVICU

Critical Care Units are staffed with personnel qualified to provide the necessary therapeutic measures. The critical care nurse continually refines his/her practice by participating in ongoing educational activities. In addition to basic preparation, the critical care nurse acquires clinical competency and an advanced knowledge of psychosocial, physiological and therapeutic components specific to the care of the critically ill.

In the absence of a physician and in an urgent or emergency life threatening situation, registered nurses in the Critical Care Units shall have the following standing orders:

A. Administer oxygen and insert oral airways, ABGs for impeding respiratory distress, non-invasive SaO_2 monitoring PRN.

B. Maintain an intravenous access on all admitted patients and start an infusion of D5W liter in a critically ill patient.

C. Begin cardiopulmonary resuscitation, per standards and guidelines of American Heart Association, in a cardiac or respiratory arrest.

D. Will follow the therapy outlined for arrhythmias in the Routine Arrhythmias Management Orders of Ocala Regional Medical Center.

E. Institute Cardiac/Respiratory Arrest protocols, as outlined in policy, following the guidelines of Advanced Cardiac Life Support (ACS), per standards of the American Heart Association, in a cardiac or respiratory arrest. (Which includes the pharmacological therapies, defibrillation/cardioversion process and external transcutaneous pacing)

F. Institute measure for patients with high risk for skin breakdown (i.e., mechanically ventilated/poor cardiac output) to include liquid tears, lacra lube, and triple care.

G. Implementation of a standing order must be documented and authenticated in the patient's medical record.

ARTICLE 11: GENERAL RULES REGARDING DIVISION OF FEES

The Medical Staff is forbidden the practice of Division of Fees under any guise whatsoever.

ARTICLE 12: HOSPITALIST MEDICINE SERVICES (07/22/09)

SECTION 1: OBJECTIVES

A. To define practice within the hospitals that constitutes Hospitalist Medicine Services
B. To establish the general rules for Hospitalist Medicine Services

SECTION 2: HOSPITALIST MEDICINE PRACTICE

For purposes of establishing practice expectations for Hospitalist Medicine Services, Hospitalist Medicine is considered to include any physician who:

1. Admits and/or cares for the patients of another physician other than group shared call arrangements and admissions resulting from Emergency Department Call coverage that has not been reassigned;
2. Accepts or solicits re-assignment of Emergency Department Call days that he/she would not otherwise be responsible for.

SECTION 3: GENERAL RULES FOR HOSPITALIST MEDICINE SERVICES

A. When on call, the Hospitalist will respond to calls from the Emergency Departments within thirty (30) minutes. When on duty as an attending physician, the Hospitalist will respond to calls from the Critical Care Units within thirty (30) minutes and medical-surgical units within sixty (60) minutes.
B. When on call, the Hospitalist may not determine that the patient requires transfer to another acute care facility without first examining the patient to determine if the clinical condition of the patient warrants transfer. It is expected that the Hospitalist will assist in communicating the clinical condition of the patient to the receiving physician in cases where transfer is warranted. EXCEPTION: in cases where the Emergency Department Physician determines that there is an emergent need for transfer based on patient's need for care or service not provided or available at the Hospitals, he/she will initiate the transfer process while awaiting the arrival of the Hospitalist.
C. In admissions occurring up until 7pm the Hospitalist should examine patients who are new to his/her service on the day of admission . In admissions occurring after 7pm the Hospitalist should examine the patient by noon the following day. EXCEPTION: in admissions where the Emergency Department Physician communicates the need for the patient to be seen sooner.
D. The Hospitalist should provide his/her patients with a formal introduction and description of his/her role as the Attending Physician; the use of a business card with a picture for patients and families is encouraged.
E. Specialty consultations generally should not be ordered until the admitting Hospitalist has examined the patient to determine if consultation is warranted by the patient's clinical condition. EXCEPTION: in cases where the Emergency Department Physician determines that there is an clear need for specialty consultation, he/she will initiate the consultation while awaiting the arrival of the Hospitalist. The reason for the consultation should be clearly documented in the medical record.
F. When specialty consultations are required, it is the responsibility of the Hospitalist to act effectively as the Attending Physician to assure communication and coordination of care with responsible management of resources.
G. Transfer of Attending Physician Responsibilities:

1. In order to achieve optimal coordination of care and patient satisfaction every effort should be made to limit the number of Hospitalists that attend during a patient admission. The maximum number for Hospitalists acting as the managing physician of record should not exceed three (3) per week.
2. When more than one Hospitalist does act as a patient's attending physician there must be a formal hand-off communication to transfer attending physician responsibilities.
3. Hand-off communication should be managed in a manner that avoids:

- disruption of the communication between the patient and family, consultants, and other members of the care team;
- redundancy of care; and
- delays in patient discharge

H. Medical Records

1. A comprehensive History and Physical will be completed within 24 hours of admission. Dictation of reports is encouraged.
2. Progress notes will be complete and legible.
3. Discharge summaries should be dictated within 24 hours of discharge, transcribed within 24 hours of dictation, and forwarded to the Primary Care Physician or other provider designated for follow-up care within 72 hours of discharge.
4. The Hospitalist will respond in a timely manner to documentation queries from HIM, Quality/Risk Management, and Case Management/Utilization Review.

I. Communication with Subscribing Primary Care Physician

1. The Hospitalist will notify the patient's Primary Care Physician within 24 hours of admission unless he/she is already aware of the patient's admission.
2. In cases where the patient's admission is complex and close follow-up will be required, the Hospitalist will notify the Primary Care Physician by phone within 24 hours of patient discharge.

CERTIFICATION OF ADOPTION AND APPROVAL

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Approved and Adopted by the Medical Staff of Ocala Regional Medical Center and West Marion Community Hospital on January 20, 2010.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on January 27, 2010.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on July 28, 2010.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on January 26, 2011.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on February 23, 2011.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on April 27, 2011.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on January 26, 2012.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on August 22, 2012.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on March 27, 2013.

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Approved and Adopted by the Board of Ocala Regional Medical Center and West Marion Community Hospital on June 25, 2014.