MEDICAL STAFF RULES AND REGULATIONS
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ARTICLE I

GENERAL

1.1. Definitions:

The definitions that apply to the Medical Staff Bylaws also apply to these Rules and Regulations.

1.2. Delegation of Functions:

Unless otherwise provided, when an administrative/leadership function is to be carried out by a member of Hospital management, by a Medical Staff member, or by a Medical Staff committee, the individual, or the committee through its chair, may delegate performance of the function to one or more designees.

1.3. Medical Students and Residents:

Rules applicable to students and residents are set forth in a separate policy(s) or manual(s).

ARTICLE II

ADMISSIONS, ASSESSMENTS AND CARE, TREATMENT AND SERVICES

2.1. Admissions:

(a) Only members of the Medical staff with specific privileges will be able to admit patients to the Hospital.

(b) The ARNP or PA is authorized as a proxy for their supervising physicians to enter a patient status order (PSO) as long as the decision to admit has been made by a physician who has admitting privileges at the hospital. Any PSO by an ARNP or PA must be cosigned by such physician prior to discharge.

2.2. Attending Physician:

(a) The identity of the attending physician will be clearly documented in the medical record at all times during the patient’s hospitalization. A note covering the transfer of responsibility will be entered on the order sheet of the patient’s medical record whenever the responsibilities of the attending physician are transferred to another physician. The attending physician will be responsible for verifying the other physician’s acceptance of the transfer.

(b) The attending physician will provide the Hospital with any information that is reasonably necessary to protect the patient, other patients or Hospital personnel from infection, disease, or other harm. The attending physician will also provide the hospital with any information to protect the patient from self-harm.

2.3. Availability and Alternate Coverage:
Physicians will provide professional care for their patients in the Hospital by being personally available, or by making arrangements with a covering physician who is a member of the Medical Staff with the same or comparable clinical privileges sufficient to care for the needs of the physician’s patients, who has agreed to provide coverage in terms of all patient care and treatment.

The attending physician (or his or her covering physician) will personally see his/her patient within 24 hours after admission, as dictated by patient acuity, unless the patient arrives directly from evaluation and admission by the attending physician. Once admitted, the attending physician (or his or her covering physician) must personally see the patient at least daily and more often if the patient is critically ill. The attending physician must document appropriate progress notes in the medical record.

All patients admitted to an adult critical care bed (ICU, SICU, CCU) will require a SMH Intensivist triage, consultation and evaluation within one hour of admission. Patients admitted to the ICU and SICU will require ongoing critical care management by the SMH Intensivist. For patients admitted to the CCU, the SMH Intensivist will determine after initial consultation, if continued Critical Care management is required.

Any patient who is intubated or on continuous BiPAP for 48 hours or longer will additionally require pulmonary consultation and management.

Normal Newborns must be examined and a note must be documented within 24 hours of birth. An additional note in preparation for discharge of a newborn is necessary if the stay is greater than 24 hours. All newborns staying more than 36 hours must be examined, and a note documented at least every other day throughout their entire stay, regardless of the reason for their remaining. Newborns in the Neonatal Intensive Care Unit (NICU) are under the primary care of the Neonatology Service.

Where an unacceptable delay is anticipated in connection with an emergent condition, the attending or consulting physician will notify the relevant care unit, explain the delay and request a stat visit by an alternate physician with appropriate privileges at the Hospital.

If an attending physician is not available, the Chief Executive Officer or the President of the Medical Staff will have the authority to call another member of the Medical Staff to attend to the patient.

2.4. Continued Hospitalization:

All members of the Medical Staff are required to abide by the Hospital’s utilization review plan, including appropriateness of admission, reason for continued stay, use of resources, and plans for hospital care.

The attending physician will provide whatever information may be requested by the Care Coordination Department with respect to the continued hospitalization of a patient, including:

1. An adequate record of the reason for continued hospitalization (a simple reconfirmation of the patient’s diagnosis is not sufficient);

2. The estimated period of time the patient will need to remain in the Hospital; and
(3) Plans for post-hospital care.

This response will be provided to the Care Coordination Department within 24 hours of the request. Failure to comply with this requirement will be reported to Chief Executive Officer (or his/her designee) for appropriate action.

(c) If the Care Coordination Department determines that a case does not meet the criteria for continued hospitalization, written notification will be given to the attending physician. If the matter cannot be appropriately resolved, the Chief Executive Officer (or his/her designee) will be notified.

(d) Multiple occurrences of a physician’s non-compliance with the Hospital’s utilization management plan will be referred to the Hospital’s Utilization Review Committee (also known as the Hospital’s Utilization Management Committee) for appropriate review and action. See SMH IP Procedure 3380.

ARTICLE III

MEDICAL RECORDS

3.1. General:

(a) The attending physician will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

(b) Only authorized individuals may make entries in the medical record.

(c) Medical record entries must be entered electronically when and where the Electronic Medical Record (“EMR”) is available and implemented. When the EMR is unavailable, all handwritten entries will be legible. All entries must be timed, dated and authenticated in written or electronic form.

3.2. Access and Retention of Record:

(a) The Hospital will retain medical records as set forth in Hospital and/or Baptist Health South Florida (“BHSF”) policy.

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

(c) Information from, or copies of, records may be released only to authorized individuals in accordance with federal and state law and Hospital and/or BHSF policy.

(d) Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research after such projects are approved by the Baptist Health South Florida Institutional Review Board (IRB). Such access shall be consistent with preserving the confidentiality of personal information concerning the individual patients.
Unauthorized access and/or removal of charts from Hospital premises may be grounds for suspension of the member for a period of time determined by the Medical Executive Committee.

3.3. Content of Record:

(a) Medical records will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.

(b) Medical record entries will be legible, complete, dated, timed, and authenticated in electronic or written form by the person responsible for providing or evaluating the service provided, consistent with the Hospital’s and/or BHSF’s policies and procedures.

(c) All medical records will contain the information outlined in this paragraph, as relevant and appropriate to the patient’s care. This documentation will be the joint responsibility of the attending physician and the Hospital’s staff:

(1) Identification data, including the patient’s name, sex, race, ethnicity, address, date of birth, and name of authorized representative;

(2) Patient’s language and communication needs;

(3) Evidence of informed consent when required by Hospital policy and, when appropriate, evidence of any known advance directives;

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

(5) Emergency care, treatment, and services provided to the patient before his or her arrival and any pertinent forms;

(6) Admitting history and physical examination;

(7) Conclusions or impressions drawn from the history and physical examination;

(8) Diagnosis, diagnostic impression, or conditions (Except in an emergency, all inpatient medical records will include a provisional diagnosis on the record prior to admission. In the case of an emergency, the provisional diagnosis will be recorded as soon as possible.);

(9) Chief complaint or reason(s) for admission of care, treatment, and services;

(10) Goals of the treatment and treatment plan;

(11) Diagnostic and therapeutic orders;

(12) Diagnostic and therapeutic procedures, tests, and results;
(13) Progress notes made by authorized individuals;
(14) Assessment and reassessments, and plan of care revisions;
(15) Response to care, treatment, and services provided;
(16) Consultation reports;
(17) Allergies to foods and medicines;
(18) Medications ordered or prescribed;
(19) Medications administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);
(20) Known home medications being taken by the patient, including over-the-counter drugs, and herbal preparations;
(21) Medications dispensed or prescribed on discharge;
(22) Relevant diagnoses/conditions and/or observations established during the course of care, treatment, and services;
(23) Complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;
(24) Discharge summary with outcome of hospitalization, disposition of case, and provisions for follow-up care;
(25) Final discharge/diagnosis;
(26) Whether the patient left against medical advice, if applicable; and
(27) A record of any organ or tissue donation.

(d) The medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies and medications, as outlined in this paragraph, for patients receiving continuing ambulatory care services. This documentation will be the joint responsibility of the attending physician and the Hospital’s staff:

(1) Known significant medical diagnoses and conditions;
(2) Known significant operative and invasive procedures;
(3) Known adverse and allergic drug reactions;
(4) Known home medications, including over-the-counter drugs, and herbal preparations; and
(5) Whether the patient left against medical advice.
Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the attending physician and the Hospital’s staff:

(1) Time and means of arrival;
(2) Record of care prior to arrival;
(3) Results of the medical screening examination;
(4) Home medications, including over-the-counter drugs, and herbal preparations;
(5) Conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care (including prescriptions and referrals when applicable);
(6) Whether the patient left against medical advice, if applicable; and
(7) A copy of any information made available to the practitioner or medical organization providing follow-up care, treatment or service.

3.4. History and Physical:

(a) A complete medical history and physical examination must be performed and documented in the patient’s medical record within 24 hours after admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services). The scope of the medical history and physical examination will include, as pertinent:

(1) Patient identification;
(2) Chief complaint;
(3) History of present illness;
(4) Review of systems;
(5) Personal medical history, including medications, allergies and previous surgeries;
(6) Family medical history (including cultural family history, if applicable);
(7) Social history, including signs of abuse, neglect, addiction or emotional/behavioral disorder, and cognitive and psychosocial data, which will be specifically documented in the physical examination and any need for restraints will be documented in the plan of treatment;
(8) Physical examination, to include pertinent findings in those organ systems relevant to the presenting illness and comorbidities;
(9) Medical treatment plan; and
(10) Admitting diagnosis and/or provisional diagnosis.
If a medical history and physical examination has been completed within the 30-day period prior to admission or registration, a copy of this report may be used in the patient’s medical record, provided that the patient has been evaluated within 24 hours after the time of admission or registration (but in all cases prior to surgery or an invasive procedure requiring anesthesia services). The update of the history and physical examination must reflect any changes in the patient’s condition since the date of the original history and physical or state that there have been no changes in the patient’s condition.

When the history and physical examination is not performed or recorded in the medical record before a surgical, diagnostic operative or invasive procedure, the operation or procedure will be canceled unless the attending physician states in writing that an emergency situation exists. If it is an emergency situation and a history and physical has been dictated but has not been transcribed, there will be a statement to that effect in the patient’s chart, with an admission note by the attending physician. Such admission note must be documented immediately prior to surgery (same day as surgery) and will include, at a minimum, an assessment of the patient’s heart rate, respiratory rate and blood pressure. In the event that an emergency department patient requires emergency surgery, the history and physical performed by the emergency department physician may be accepted.

A history and physical that was performed by a physician who is not credentialed at the Hospital may be used if an individual who has been granted privileges by the Hospital to perform histories and physicals: (i) reviews the non-credentialed physician’s history and physical examination document; (ii) determines that the content of the history and physical is compliant with the Hospital’s requirements for histories and physicals; (iii) obtains any missing information through further assessment; and (iv) updates information and findings as necessary.

A history and physical examination is not required for outpatient services that do not require sedation, including but not limited to: pap smear, phlebotomy, dressing changes, proctoscopy, non-invasive diagnostic radiology, counseling and therapy, and wound care and procedures performed in the Wound Center.

An outpatient history and physical short-form, containing the chief complaint or reason for the procedure, relevant history of the present illness or injury, and the patient’s present clinical condition/physical findings, may be used for ambulatory or same day procedures as approved by the Medical Executive Committee.

The following individuals may perform and record history and physical examinations:

1. Community Associate Staff, Associate Staff, and Active Staff members of the Medical Staff.
2. House Physicians, as defined by Florida law.
3. Oral surgeons who admit patients without underlying health problems and have been granted such privileges.
4. Dentists and podiatrists admitting patients for surgery must select a Medical Staff member with appropriate privileges to do a history and physical examination and
follow the patient; provided, however, that podiatrists treating wound care patients may perform and record the history and physical examination; and

(5) Advanced Registered Nurse Practitioners (“ARNPs”) and Physician Assistants (“PAs”), as long as supervised properly by the Medical Staff member employing them. A Medical Staff member who employs and supervises an ARNP or PA must see the patient and perform at least a brief history and physical examination, recording in the chart all important findings, conclusions and recommendations within 24 hours. Alternatively, a brief statement of full concurrence may be recorded and dictated by the supervising physician within 24 hours.

3.5. Progress Notes:

(a) Progress notes will be entered at the time of observation by the attending or consulting physician, or his or her covering physician. Progress notes may also be entered by ARNPs, PAs, or allied health professionals, as permitted by his/her clinical privileges or scope of practice. The progress note shall sufficiently document ongoing patient care and the involvement of the attending or consulting physician in the management of the patient, and allow for continuity of care. When appropriate, each of the patient’s clinical problems should be clearly identified in the progress notes and correlated with specific orders, as well as results of tests and treatments.

(b) Progress notes will be entered electronically where available and be legible, dated, timed, and authenticated by an attending physician at least daily for all patients who have been admitted to the Hospital.

3.6. Authentication:

(a) Authentication means to establish authorship by signature, printed name, time and date, and may include computer entry using a unique electronic signature code or written signatures when the EMR is not available. Signature stamps are not an acceptable form of authentication for written orders/entries that are made when the EMR is unavailable.

(b) The member will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents in accordance with Hospital and/or BHSF policy.

(c) A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

3.7. Informed Consent:

It shall be the responsibility of the appropriate physician to obtain informed consent, in accordance with Hospital’s Interdepartmental Procedure: IP No. 3220, “Legal Authorization for Treatment and Consents,” for all patients undergoing operative and other diagnostic and therapeutic procedures or treatments that place the patient at risk.
ARTICLE IV

MEDICAL ORDERS

4.1 General:

(a) Whenever possible, orders shall be entered directly by the ordering practitioner into the computerized physician order entry system (“CPOM”). When CPOM is unavailable, orders should be documented on appropriate forms as approved by the Hospital.

(b) All orders will be dated, timed, and authenticated at the time of ordering by the prescribing member. Orders will be entered clearly, legibly, and completely.

(c) Orders which are illegible, unclear, incomplete, or improperly entered will not be carried out until they are clarified with the ordering member (or his or her designee).

(d) All orders for diagnostic studies will include the pertinent clinical indications.

(e) Drugs and biologicals are addressed in the relevant pharmacy policies, and may only be ordered by Medical Staff members and other authorized individuals with clinical privileges at the Hospital.

(f) The use of the terms “renew,” “repeat,” “resume,” and “continue” with respect to previous medication orders is not acceptable.

(g) Orders for “daily” tests will state the number of days, except as otherwise specified by protocol, and will be reviewed by the ordering physician at the expiration of such time frame unless warranted sooner. If it is to be continued at the end of the stated time, any order that would be automatically discontinued requires reentry in the same format in which it was originally recorded.

(h) Orders for all medications and treatments will be under the supervision of the attending physician and will be reviewed by that physician in a timely manner to assure discontinuance when no longer needed.

(i) Pharmacist may substitute a medication or its generic equivalent unless the physician orders “No Substitutions”.

(j) Medication orders require name, strength or concentration, frequency of use, route, duration, rate of infusion and parameters for titration. In addition, PRN orders require indication for use.

(k) All medication orders will clearly state the administration times or the time interval between doses. If not specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols. When medication or treatment is to be resumed after an automatic stop order has been employed, the orders that were stopped will be reentered.

(l) Orders entered by a pharmacist, under the authorization of the Hospital’s or BHSF’s Pharmacy & Therapeutics Committee and the Medical Executive Committee, do not need to be cosigned/authenticated by a physician.
Physicians, PAs, ARNPs and CRNAs are responsible for reconciling medications on admission, transfer to different levels of care, post-Op, and at discharge. (See SMH IP Procedure 2590, Medication reconciliation across the continuum of care).

4.2. Telephone Orders:

(a) All telephone/verbal orders must be made, received and implemented in accordance with Administrative Interdepartmental Policy: IP No. 2460, “Verbal/Telephone Orders.”

(b) An order via telephone for medication or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the prescribing member. Verbal orders should only be used when circumstances do not permit the prescriber to leave the patient bedside.

(c) All telephone orders will include the date and time of entry into the medical record and will identify the names of the individuals who gave, received, and implemented the order.

(d) For telephone orders, the complete order will be verified by having the person receiving the information “read-back” the complete order and obtain the full name of the ordering physician.

(e) Telephone/verbal orders must be cosigned/authenticated, timed and dated by the ordering physician or another practitioner who is responsible for the care of the patient no later than 30 days after the patient’s discharge, with the exception of emergency psychiatric treatment and restraint/seclusion orders, which must be authenticated within 24 hours.

4.3. Standing Orders/Protocols and Order Sets:

(a) The Medical Executive Committee will review and approve any standing orders/protocols and pre-printed order sets to be utilized in caring for patients at South Miami Hospital.

(b) When using a standing order/protocols approved by the Medical Executive Committee, the nurse may initiate treatment and notify the physician as soon as possible in order to avoid delay in patient care. Standing orders/protocols need to be authenticated by a Medical Staff member as soon as possible.

(c) Pre-printed orders require Medical Staff member authentication prior to initiating treatment.

(d) Orders for home care or durable medical equipment must be signed by the ordering physician (not allied health professionals) prior to discharge. Allied health professionals shall not order home care or durable medical equipment.
ARTICLE V
CONSULTATIONS

5.1. General:

(a) Any individual with clinical privileges at the Hospital may be requested to provide a consultation within his or her area of expertise, and these individuals will respond appropriately as a condition of their Medical Staff appointment.

(b) The attending physician will be responsible for requesting consultations when indicated for the appropriate care of a patient. In addition to documenting the reasons for the consultation request in the medical record, the attending physician will make reasonable attempts to personally contact the consulting physician in order to provide the clinical history and the specific reason for the consultation request.

(c) ARNPs/PAs may not initiate or call consults without specific approval from the supervising physician. Absent such specific approval, consults are to be initiated/called by their supervising physician.

(d) The consulting physician must generally respond within 24 hours and, in the case of a critical care consultation, within 12 hours of the request, unless the patient’s condition requires that the physician complete the consultation sooner. In urgent/emergent situations, the physician is required to respond within 30 minutes.

(e) A consultation is considered complete after the consultant has completed the assessment and proposed a documented plan in the medical record.

(f) If a nurse employed by the Hospital has any reason to doubt or question the care provided to any patient or believes that an appropriate consultation is needed and has not been obtained, after having a conversation with the attending physician that nurse will notify his or her nursing supervisor who, in turn, will contact the attending physician. The nursing supervisor may then bring the matter to the attention of the clinical service chief of the member in question. Thereafter, the clinical service chief or President of the Medical Staff may request a consultation after discussion with the attending physician.

(g) The President of the Medical Staff or the appropriate clinical service chief will at all times have the right to call in a consultant or consultants in circumstances of grave urgency, or where consultation is required by these Rules and Regulations, or where a consultation requirement is imposed by the Medical Executive Committee.

5.2. Content of Consultation Report:

(a) Each consultation report will be completed in a timely manner and will contain an opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and pertinent findings and the patient’s medical record. A statement, such as “I concur,” will not constitute an acceptable consultation report. The consultation report will be made a part of the patient’s medical record.

(b) When non-emergency operative procedures are involved, the consultant’s report will be recorded in the patient’s medical record prior to the surgical procedure, and when emergency operative procedures are involved, the consultant’s report will be recorded in
the patient’s medical record no later than immediately after the surgical procedure. In either case, the consultation report will contain the date and time of the consultation, an opinion based on relevant findings and reasons, and the authentication of the consultant.

5.3. Recommended Consultations:

Except in emergencies, a consultation is recommended in all cases in which, in the judgment of the attending physician:

(a) the case is a major surgical case where the patient is a poor candidate for the operation or treatment or is at risk of perioperative medical complications;

(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) in clinical situations where specific skills and knowledge are outside the expertise of the attending physician;

(e) unusually complicated situations are present that may require specific skills of other members of the Medical Staff;

(f) the patient exhibits severe symptoms of mental illness or psychosis;

(g) the patient or family, or the patient’s legal representative if the patient is incompetent, requests a consult; or

(h) a consult is indicated for the clinical specialty in admission to special care units.

Additional recommendations for consultation may be established by the Hospital as appropriate.

5.4. Mental Health Consultations:

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

5.5. Surgical Consultations:

Whenever a consultation (medical or surgical) is requested prior to surgery, a notation from the consultant, including relevant findings and reasons, appears in the patient’s medical record. If a relevant consultation is not available for review, surgery and anesthesia will not proceed.
ARTICLE VI

SURGICAL SERVICES

6.1. Pre-Procedure Protocol:

(a) The physician who will perform the surgery or procedure is responsible for documenting in the medical record: (i) the provisional (pre-operative clinical) diagnosis and the results of any indicated diagnostic tests; (ii) a properly executed informed consent; (iii) a complete history and physical examination (or completed outpatient history and physical short-form, as appropriate) prior to transport to the operating room, except in emergencies; (iv) a description of the proposed procedure and whether it is emergent in nature; and (v) NPO status, if applicable. If the above information is not available, in a non-emergent situation, the responsible nurse will notify the physician that preparation for surgery, including pre-medication, will not begin until all proper entries are recorded in the medical record. If this delay causes a change to be made to the surgery schedule, the operation will be rescheduled to the next available time.

(b) In the case of an emergency, the physician will take the following steps before starting the surgery or procedure: (i) document that a delay would be detrimental to the patient, and (ii) make a note in the medical record indicating the patient’s condition prior to the induction of anesthesia and start of surgery or the procedure.

(c) In an emergency situation involving a minor or unconscious patient, in which consent cannot be immediately obtained from parents, guardian, or next of kin, these circumstances should be explained in the patient’s medical record.

(d) The following will also occur before an invasive procedure or the administration of anesthesia occurs:

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

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

(3) the responsible physician is in the Hospital; and

(4) the procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in Hospital protocol.

6.2. Post-Procedure Protocol:

(a) For every procedure performed in an operating/procedural suite and/or under sedation, a progress note containing the following information will be entered in the medical record immediately after the procedure by each physician performing a procedure:

(1) pre-operative diagnosis;

(2) post-operative diagnosis;

(3) procedures performed;
(4) findings at surgery and/or intervention;
(5) specimen(s) removed;
(6) estimated blood loss;
(7) packs, tubes, or drains left in place, prosthetic devices, grafts, tissues, transplants or device implanted;
(8) fluid replacement;
(9) type of anesthesia;
(10) complications; and
(11) name of primary surgeon(s)/assistant surgeon(s) and intra-operative consultants.

This post operative/procedure note must be promptly timed, dated and signed by the surgeon prior to the patient being discharged from the PACU and entering the next level of care and shall be made part of the patient’s current Medical Record.

(b) A full operative procedure report for these invasive procedures will be completed by the physician(s) performing the procedure or the fellow, within 24 hours after the procedure, and authenticated by the physician. The report will record:

(1) the patient’s name and hospital identification number;
(2) pre- and post-operative diagnoses;
(3) date and time of the procedure;
(4) the name of the surgeon(s) and assistant surgeon(s) responsible for the patient’s operation;
(5) procedure(s) performed and description of the procedure(s);
(6) a statement regarding the indications or justification for the performance of the operation/procedure;
(7) description of the specific surgical tasks that were conducted by practitioners other than the primary attending physician;
(8) findings;
(9) estimated blood loss;
(10) any unusual events or complications, including blood transfusion reactions and the management of those events;
(11) the type of anesthesia/sedation used and name of the member providing anesthesia;
(12) specimen(s) removed, if any;

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

(14) authentication from the surgeon.

(c) A patient admitted for dental care is a dual responsibility involving a dentist and/or oral surgeon and a physician. The dentist/oral surgeon shall be responsible for:

(1) performance of the dental history and examination upon admission, subject to Section 3.4 of these Rules and Regulations;

(2) a detailed description of the examination of the oral cavity and pre-operative diagnosis;

(3) a complete operative report, describing the findings and techniques;

(4) progress notes as are pertinent to the oral condition;

(5) the discharge of the patient; and

(6) in cases of extraction of teeth, clearly documenting the number of teeth and fragments removed and sending all tissue, including teeth fragments, to the pathologist for examination.

The physician shall be responsible for the following:

(i) medical history pertinent to the patient’s general health and physical examination to determine the patient’s condition prior to anesthesia and surgery; and

(ii) supervision of the patient’s general health status while hospitalized.

(d) A patient admitted for podiatry procedures is a dual responsibility involving a podiatrist and a physician. The podiatrist shall be responsible for:

(1) performance of the podiatric history examination upon admission, in accordance with Section 3.4 of these Rules and Regulations;

(2) a detailed description of the examination and pre-operative diagnosis;

(3) a complete operative report, describing the findings and techniques;

(4) progress notes as are pertinent to the podiatric condition; and

(5) the discharge of the patient.

The physician shall be responsible for the following:

(i) medical history pertinent to the patient’s general health and physical examination to determine the patient’s condition prior to anesthesia and surgery; and
supervision of the patient’s general health status while hospitalized.

**ARTICLE VII**

**ANESTHESIA SERVICES**

7.1. General:

Anesthesia” means general or regional anesthesia, monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia or minimal or moderate sedation (all patients receiving minimal or moderate sedation will be monitored and evaluated before, during, and after the procedure by an anesthesiologist, certified registered nurse anesthetist and/or a qualified member (per his/her delineation of privileges) in accordance with Hospital policy/procedure.

(a) General or deep Anesthesia must be administered only by the following qualified members who have been granted the appropriate clinical privileges:

- a qualified anesthesiologist;

- a certified registered nurse anesthetist (“CRNA”), who is under the supervision of the operating surgeon or of an anesthesiologist who is immediately available if needed; or

- an anesthesiologist’s assistant, who is under the supervision of an anesthesiologist who is immediately available if needed.

(b) An anesthesiologist is considered “immediately available” when needed by a CRNA under the anesthesiologist’s supervision only if he/she is physically located within the same area as the CRNA (e.g., in the same operative suite, or in the same labor and delivery unit, or in the same procedure room, and not otherwise occupied in a way that prevents him/her from immediately conducting hands-on intervention, if needed).

(c) Because it is not always possible to predict how an individual patient will respond to minimal or conscious sedation, a qualified member with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

(d) General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7.2. Pre-Anesthesia Procedures:

(a) The pre-anesthesia evaluation must be performed by an individual qualified to administer anesthesia within 48 hours immediately prior to any inpatient or outpatient surgery or procedure requiring anesthesia services. At a minimum, the pre-operative anesthetic evaluation of the patient will include:

(1) a review of the medical history, including anesthesia, drug and allergy history;
(2) an interview, if possible, preprocedural education, and examination of the patient;

(3) patient’s condition prior to induction of anesthesia;

(4) notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);

(5) any potential anesthesia problems identified that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access);

(6) development of a plan for the patient’s anesthesia care; and

(7) any additional pre-anesthesia evaluations that may be appropriate or applicable (e.g., stress tests, additional specialist consultations).

The elements of the pre-anesthesia evaluation in (1) through (3) must be performed within the 48-hour time frame. The elements in (4) through (7) must be reviewed and updated as necessary within 48 hours, but may be performed during or within 30 days prior to the 48-hour time period.

(b) The patient will be reevaluated immediately before induction in order to confirm that the patient remains able to proceed with care and treatment.

7.3. Monitoring During Procedure:

(a) All patients will be monitored during the procedure and/or administration of anesthesia at a level consistent with the potential effect of the procedure and/or anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient’s physiological status.

(b) All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:

(1) name and Hospital identification number of the patient;

(2) the name of the practitioner who administered anesthesia and, as applicable, any supervising physician;

(3) name, dosage, route and time of administration of drugs and anesthesia agents;

(4) the technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

(5) IV fluids;

(6) blood or blood products, if applicable;

(7) time-based documentation of vital signs, as well as oxygenation and ventilation parameters;
(8) continuous recordings of patient status, noting blood pressure, heart and respiration rate; and

(9) any complications or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment and status upon leaving the operating room.

7.4. Post-Anesthesia Evaluations:

(a) A post-anesthesia evaluation will be completed and documented in the patient’s medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area. Where post-operative sedation is necessary for the optimum care of the patient, the evaluation can occur in the PACU/ICU or other designated recovery area. For outpatients, the post-anesthesia evaluation must be completed prior to the patient’s discharge. The evaluation should not begin until the patient is sufficiently recovered so as to participate in the evaluation, to the extent possible, given the patient’s medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient’s inability to participate will be made in the medical record.

(b) The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

(1) respiratory function, including respiratory rate, airway patency, and oxygen saturation;

(2) cardiovascular function, including pulse rate and blood pressure;

(3) mental status;

(4) temperature;

(5) pain;

(6) nausea and vomiting; and

(7) postoperative hydration.

Depending on the specific surgery or procedure performed, additional types of monitoring and assessment may be necessary.

(c) Patients will be discharged from the recovery area by a qualified member or according to approved criteria. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

(d) Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult/designee.

(e) When surgical or anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information
about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

ARTICLE VIII

RESTRAINTS, AND SECLUSION

8.1. Restraints:

Hospital uses restraint only when it can be clinically justified or when warranted by patient behavior that threatens the physical safety of the patient, staff, or others. Restraint is not used as a means of coercion, discipline, convenience or staff retaliation. Restraints are used only when less restrictive interventions are ineffective which includes alternatives to restraint. The least restrictive form of restraint that protects the physical safety of the patient, staff or others will be used. Restriction will be discontinued at the earliest possible time, regardless of the scheduled expiration of the order. All restraint orders must be made, received and implemented in accordance with the following policies: Administrative Interdepartmental Policy, IP No. 2420, “Restraint for Violent or Self Destructive Behavior.”; Administrative Interdepartmental Policy, IP No. 2410, “Restraint for Non-violent / Non self-destructive Behavior Purposes”; and Administrative Policy No. 913, “Use of Restraint”.

8.2. Seclusion:

Hospital does not use seclusion.

ARTICLE IX

EMERGENCY SERVICES

9.1. General:

The Hospital has written policies, referenced below, concerning the provision of emergency care in accordance with the federal Emergency Medical Treatment and Active Labor Act (EMTALA) and state laws.

9.2. Medical Screening Examinations:

A medical screening examination will be performed, within the capability of the Hospital, on all individuals who come to the Hospital requesting examination or treatment to determine the presence of an emergency medical condition. Medical screening examinations are to be performed in accordance with: South Miami Hospital Departmental Policy SMH-3020-009, “Medical Screening (EMTALA)” and South Miami Hospital Departmental Policy SMH 2630-420, “Obstetrical Triage (OB Triage); Care of the patient in”. The latter two policies are incorporated herein by this reference. These policies, approved by the Board of Directors, set forth, among other things, who is qualified to perform a medical screening examination. SMH 3020-009 states that medical screening examinations are to be performed by a physician or by other appropriate personnel under the supervision of a physician (to the extent permitted by applicable law) to determine if an emergency medical condition exists. As for obstetrical patients, SMH 2630-420 states that Registered Nurses in Labor and Delivery are qualified and
approved to perform medical screening examinations of obstetrical patients for pregnancy related complaints, in accordance with the procedures set forth in the policy.

9.3. On-Call Responsibilities:

It is the responsibility of the scheduled on-call physician (including consultants and attending, and contracted admitting panelists) to respond to calls from the Emergency Department. Unless otherwise stated in the relevant on-call agreement with the Hospital, the scheduled on-call physician shall: (a) generally respond by telephone to a page or telephone call regarding a request for services at the Emergency Department within thirty (30) minutes of receipt of such page or telephone call; and (b) if necessary, be present at the Emergency Department ready to provide the relevant physicians services to the patient(s) within a medically reasonable time-frame as determined through consultation with the Emergency Department physician. In the event of a difference of opinion between the Emergency Department physician and the scheduled on-call physician regarding the medically reasonable time-frame for the scheduled on-call physician’s physical presence at the Emergency Department, the determination of the Emergency Department physician will be controlling and will be recorded in the medical record.

ARTICLE X

DISCHARGE PLANNING AND DISCHARGE SUMMARIES

10.1. Who May Discharge:

(a) Patients will be discharged only upon the order of the attending physician. Should a patient insist on leaving the Hospital against medical advice, or without proper discharge, a notation of the incident will be made in the patient’s medical record, and the patient will be asked to sign the Hospital’s release form.

(b) At the time of discharge, the attending physician will review the record for completeness, state the principal and secondary diagnosis (if one exists) and authenticate the entry.

(c) The Attending physician is responsible for reviewing and discussing the relevant consultant notes, and obtaining any necessary clearance from consultants on the case.

10.2. Identification of Patients in Need of Discharge Planning:

(a) The attending physician will evaluate the patient to identify those patients whom the lack of adequate discharge plan is likely to result in an adverse impact on the patient’s health. The following factors need to be taken into consideration: the patient’s functional status and cognitive ability; the type of post-hospital care that the patient requires, and whether such care requires the services of health care professionals and/or facilities; the availability of the required post-hospital health care services to the patient; and the availability and capability of family and/or friends to provide follow-up care at the home.

(b) The attending physician will commence discharge planning at an early stage of the patient’s hospitalization (preferably, at admission). In the event that a patient is transferred to another hospital, any pertinent information concerning the identification of the patient’s post-hospital needs should be included in the medical record that is transferred with the patient. The attending physician should reevaluate the needs of patients on an ongoing basis and prior to discharge, as the patient’s needs may change. It
is the attending physician’s responsibility to identify all discharge needs for the appropriate transition of care.

10.3. Discharge Planning:

(a) The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient’s identified needs after hospitalization, and will be documented in the patient’s medical record.

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

10.4. Discharge Summary:

(a) A concise, dictated discharge summary will be prepared by the member of the Medical Staff discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another member of the Medical Staff who agrees to assume such responsibility. All discharge summaries will include the following and must be completed within 30 days of discharge:

1. reason for hospitalization;
2. significant findings;
3. procedures performed and care, treatment, and services provided;
4. reconciled list of medications;
5. adverse and allergic drug reactions;
6. condition and disposition at discharge;
7. instructions/information provided to the patient and family, as appropriate; and
8. provisions for follow-up care.

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

(c) In addition to the attending physician (or such other member of the Medical Staff who assumed the attending physician’s discharge summary responsibilities), the discharge summaries may be completed by residents, advanced registered nurse practitioners, nurse midwives, or physician assistants, but must be authenticated by the responsible attending physician (or such other member of the Medical Staff who assumed the attending physician’s discharge summary responsibilities).

10.5. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, 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 will so state in writing and the statement will become a part of the permanent medical record of the patient.

Once a discharge order is written, it can only be rescinded if the patient has unmet medical needs or the discharge would be considered unsafe. The physician clearly documents the support of the rescinded discharge.

10.6. Discharge Instructions:

The discharge planning process is a collaborative process that includes the patient, the care givers and the Hospital’s staff.

(a) The attending physician, with the Hospital’s staff, will provide the patient with information regarding post-discharge options, what to expect after discharge, and instruction and training on how to provide care post-discharge.

(b) Upon discharge, the patient will be provided with clear instructions concerning what to do when concerns, issues or problems arise, including who to call and when they should seek emergency assistance.

(c) Upon discharge, the patient and/or those responsible for providing continuing care will be given written discharge instructions.

(d) The attending physician, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient’s needs after discharge, when indicated.

(e) When continuing care is needed after discharge, the attending physician, along with the Hospital staff, will provide appropriate information to the other health care providers, including:

   (1) the reason for hospitalization;

   (2) brief description of hospital course of treatment;

   (3) patient’s condition at discharge, including cognitive and functional status and social support needed;

   (4) medication list;

   (5) list of allergies;

   (6) pending laboratory work and test results;

   (7) brief description of care instructions;

   (8) list of follow-up appointments with practitioners, if applicable, which were scheduled prior to discharge; and

   (9) if applicable, referral to potential primary care provider or health clinic.
ARTICLE XI
TRANSFER TO ANOTHER HOSPITAL OR HEALTH CARE FACILITY

11.1. Transfer:

The process for providing appropriate care for a patient, during and after transfer from the Hospital to another facility, includes:

(a) assessing the reason(s) for transfer;
(b) establishing the conditions under which transfer can occur;
(c) evaluating the mode of transfer/transport to assure the patient’s safety; and
(d) ensuring that the organization receiving the patient also receives necessary medical information and assumes responsibility for the patient’s care after arrival at that facility.

11.2. Procedures:

(a) A patient will be transferred to another hospital or facility based on the patient’s needs and the Hospital’s capabilities. The attending physician will take the following steps as appropriate under the circumstances:

1. identify the patient’s need for continuing care in order to meet the patient’s physical and psychosocial needs;
2. inform the patient and his or her family members (as appropriate), in a timely manner, of the need to plan for a transfer to another organization;
3. involve the patient and all appropriate members of the Medical Staff, Hospital staff, and family members involved in the patient’s care, treatment, and services in the planning for transfer; and
4. provide the following information to the patient whenever the patient is transferred:
   (i) the reason for the transfer;
   (ii) the risks and benefits of the transfer; and
   (iii) available alternatives to the transfer.

(b) When a patient is transferred, appropriate information will be provided to the accepting physician/facility, including:

1. brief reason for hospitalization, including working diagnoses and reason for transfer;
2. brief description of hospital course of treatment, including significant findings;
3. summary of the procedures performed and the care, treatment and services provided;
(4) patient condition at discharge, including cognitive and functional status and social support needed;

(5) reconciled medication list;

(6) list of allergies (including food allergies) and drug interaction;

(7) pending laboratory work and test results, if applicable, including information on how results will be furnished; and

(8) copy of patient advance directives, if applicable.

c) When a patient requests a transfer to another facility, the physician will:

(1) explain to the patient his or her medical condition;

(2) inform the patient of the benefits of additional medical examination and treatment;

(3) inform the patient of the reasonable risks of transfer;

(4) request that the patient sign the transfer form acknowledging responsibility for his or her request to be transferred; and

(5) provide the receiving facility with the same information outlined in paragraph (b) above.

11.3. EMTALA Transfers:

The transfer of a patient with an emergency medical condition from the Emergency Department to another hospital will be made in accordance with the Hospital's applicable policies and procedures.

ARTICLE XII

COMMUNICATIONS

12.1. General:

Physician-to-Physician communication occurs preferably face-to-face, or by telephone. Thoughts and plans are memorialized through entries on the patients' records.

12.2. Intermediary:

(a) Physician-to-Physician communication does not utilize a nurse or secretary as an intermediary, except in emergency circumstances (such cases subject to review) and non-urgent consults not related to the admission diagnosis.

(b) Any member that is a physician, dentist, podiatrist or psychologist can, in any circumstance, require direct communication with any other member that is a physician,
dentist, podiatrist or psychologist for the purpose of discussing a patient who is in the
care of both such members (“Direct Physician-to-Physician Communication” or
“DPPC”). A physician, dentist, podiatrist or psychologist cannot refuse to participate in
DPPC, and cannot use an intermediary (e.g., ARNP, PA, nurse, secretary, etc.) for DPPC. Allied Health Professionals must promptly inform their supervising physician if a request for DPPC has been made, so that the supervising physician can directly communicate with the requesting physician, dentist, podiatrist or psychologist.

12.3. Cell Phone Number:

Medical Staff members are to provide the Medical Staff Service Office with their personal cell phone numbers, and when changed, report the new numbers to the Hospital immediately. The Hospital will create a log which will be maintained by the Medical Staff Service Office and may be used by Medical Staff members in emergencies, calling consultations, etc. If any Medical Staff member is unwilling to supply these numbers, he/she is obligated to be available by phone or in person with a promptness equal to that of the compliant Medical Staff members.

ARTICLE XIII

MISCELLANEOUS

13.1. Autopsies:

(a) Autopsies will be secured in accordance with state and local laws. The attending physician must be notified when an autopsy is to be performed.

(b) Authorization for autopsy must be obtained from the parent, legal guardian, or responsible person after the patient’s death. The attending physician must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of the attending physician, an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this must be documented in the medical record.

(c) Any request for an autopsy by the family of a patient who died while at the Hospital will be honored, if at all possible, after consulting with the pathologist. The payment for such autopsies is the responsibility of the patient’s family or legal guardian. Difficulties or questions that arise with such a request will be directed to the Chief Executive Officer or the President of the Medical Staff.

(d) The Medical Staff will be actively involved in the assessment of the developed criteria for autopsies.

13.2. Patient Deaths and Death Certificates:

(a) In the event of a patient death in the Hospital, the deceased will be pronounced dead by the attending physician (who, as applicable, may be an Emergency Department physician), or his or her designee, within a reasonable time frame. Death certificates are the responsibility of the attending physician, and will be completed within 24 hours of when the certificate is available to the attending physician.

(b) The body of a deceased patient can be released only with the consent of the parent, legal guardian, or responsible person, and only after an entry has been made in the deceased
patient’s medical record by the attending physician or other designated member of the
Medical Staff.

(c) It is the responsibility of the attending physician to notify the coroner/medical examiner
of any cases considered by law a coroner/medical examiner’s case.

13.3. Treatment of Family Members:

(a) No member of the Medical Staff will admit, treat or participate in the surgery of a
member of his or her immediate family, including spouse, parent, child, step-child or
sibling, unless otherwise approved by the President of the Medical Staff or the Chief
Executive Officer. This prohibition is not applicable to in-laws or other relatives.

(b) An exception to this prohibition will be made (1) if the patient’s disease is so rare or
exceptional and the physician is considered an expert in the field or (2) in an emergency
where no other Medical Staff member is readily available to care for the family member,
and a transfer is believed to be detrimental to the patient’s health.

13.4. Orientation of New Physicians:

Each new physician will be provided an overview of the Hospital and its operations.

13.5. Birth Certificates:

Birth certificates are the responsibility of the delivering physician and will be completed within
three days of delivery.

13.6 Institutional Review Board

The BHSF Institutional Review Board (“IRB”) shall review and approve all research involving
human subjects, which is conducted at the Hospital or which involves the Hospital’s information
or institutional resources. The IRB shall operate in accordance with all applicable laws and
regulations, including regulations promulgated by the Food and Drug Administration and the
Department of Health and Human Services.

13.7 Influenza Vaccine

Each member of the Medical Staff must obtain the influenza vaccine in accordance with BHSF
680.11: Mandatory Influenza Vaccination.

ARTICLE XIV

AMENDMENTS

These Medical Staff Rules and Regulations may be amended pursuant to Article 8 of the Medical Staff
Bylaws.

ARTICLE XV

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