NCH HEALTHCARE SYSTEM

MEDICAL STAFF
RULES AND REGULATIONS

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ARTICLE I

ADMISSION

Section 1. Who May Admit Patients:

A patient may be admitted to the hospital only by physicians, dentists, and podiatrists who have been appointed to the medical staff and who have been granted privileges to admit patients. Except in an emergency, no patient shall be admitted to the hospital unless a provisional diagnosis has been stated in the patient's medical record. In emergency cases, the provisional diagnosis shall be stated as soon after admission as possible.

Section 2. Transfer of Patients:

Patients shall be admitted for the treatment of any and all conditions and diseases for which the hospital has facilities and personnel. When the hospital does not provide the services required by a patient or for any reason the hospital cannot admit a particular patient who requires inpatient care, the hospital or the attending medical staff Member, or both, shall assist the patient in making arrangements for care in an alternate facility so as not to jeopardize the health and safety of the patient. If the patient is to be transferred to another health care facility, the attending medical staff Member shall enter all the appropriate information on the patient's medical record prior to the transfer. A patient shall not be transferred to another health care facility until the receiving facility has consented to accept the patient and the patient is considered sufficiently stabilized for transport. Clinical records of sufficient content to insure continuity of care shall accompany the patient. All transfers shall be carried out in conformity with hospital policy.

Section 3. Admitting Member's Responsibilities:

Each patient shall be the responsibility of a designated medical staff member (Allied Health Practitioners do NOT have admitting privileges). Attending physicians must come to the Hospital and personally evaluate all new patients before ordering a consultation. In an emergent situation, a request for a consultation may be simultaneous with the attending physician's evaluation. This must include direct communication from the ED physician to the attending physician (rather than through a designated Allied Health Practitioner).

Patients being admitted or transferred to a higher level of care (i.e., PCU to ICU) must be seen by a physician within two to four hours. A critical care consultation may only be

ordered after the patient is evaluated by the admitting physician and with physician-to-physician communication.

In the case of a group practice, the member who admits the patient shall be considered the responsible, designated medical staff member. Such member shall be responsible for: the medical care and treatment; the prompt completeness and accuracy of the medical record; necessary special instructions; and transmitting reports of the condition of the patient to the referring physician and to relatives of the patient. Whenever these responsibilities are transferred to another medical staff member, a note covering the transfer of responsibility shall be entered on the order sheet of the patient's medical record. The practitioner who is responsible for the care of the patient shall provide the hospital with such information concerning the patient as may be necessary to protect the patient, other patients, or hospital personnel from infection, disease or other harm, and to protect the patient from self-harm.

Section 4. Care of Unassigned Patients:

Any patient who presents at the hospital who is not the patient of or has not been referred to a specific medical staff member and who does not express a desire for the medical services of a particular member shall be assigned by the chairperson of the appropriate department. The chairperson shall assign the patient to a member in the department based upon a published roster. Nothing in this provision shall interfere with the patient's right to choose his or her own physician if such a choice is expressed.

The rosters for any emergency room call or other call schedule shall be the responsibility of the chairperson of the appropriate department. If there is a gap in the call schedule, it shall be forwarded to the Medical Executive Committee for approval. If the recommendation of the Medical Executive Committee would result in any gap in coverage, such recommendation will be subject to review by the Board.

Section 5. Dental Patients:

A patient admitted for dental surgery shall be the dual responsibility of the attending dentist or oral surgeon and physician members.

(a) Responsibilities of Dentist or Oral Surgeons:

(1) a detailed dental history justifying hospital admission;

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

(3) a complete operative report, describing the findings and technique used. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments, shall be sent to the pathologist for examination;

(4) progress notes pertinent to the oral condition;

(5) clinical summary or statement; and

(6) discharge order.

(b) Responsibilities of Physician:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to and suitability for anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

(c) Responsibilities of oral surgeons who have been granted appropriate clinical privileges:

(1) perform complete admission history and physical examination;

(2) assess medical risks of the procedure; and

(3) perform other responsibilities listed in (a) above.

Section 6. Podiatric Patients:

A Podiatrist may perform inpatient and outpatient history and physical examinations for ASA Class 1 and 2 patients. For higher risk patients, defined as ASA Class 3, 4 and 5, an M.D. or D.O., history and physical is required for podiatric patients.

Class 1: Normal, healthy patient, without organic physiologic or psychiatric disturbance.

Class 2: Patient with controlled medical conditions without significant systemic effects.

Class 3: A patient having medical conditions with significant systemic effects intermittently associated with significant functional compromise.

Class 4: A patient with a medical condition that is poorly controlled, associated with significant dysfunction and is a potential threat to life.

Class 5: A patient with a critical medical condition that is associated with little chance of survival with or without the surgical procedures.

A Class 3, 4 or 5 patient admitted for podiatric surgery shall be the dual responsibility of the attending podiatrist and physician members.

(a) Responsibilities of Podiatrist:

(1) a history justifying hospital admission;

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

(3) a complete operative report;

(4) pertinent progress notes;

(5) clinical summary or statement; and

(6) discharge order.

(b) Responsibilities of Physician:

(1) medical history pertinent to the patient's general health;

(2) a physical examination to determine the patient's condition prior to anesthesia and surgery; and

(3) supervision of the patient's general health status while hospitalized.

Section 7. Alternate Coverage:

Each medical staff member must ensure that continuous and timely professional care is provided to his/her patients in the Hospital by being available or, during periods of absence from the facility, making arrangements with an alternate Medical Staff member who has appropriate clinical privileges at the Hospital to care for the patient. All staff members are required to notify the hospital administration if they are unavailable and provide the switchboard with the name of the staff member who will cover their practice, both inpatient and outpatient, during their absence. A member who will be unavailable 24 hours or more shall, on the order sheet of the medical record of each of his/her patients, indicate in writing the name of the member who will be assuming responsibility for care of the patient during his/her absence. Violation of this rule should be reported to the President of the Staff or the Medical Executive Committee who shall take steps to verify the violation. A report shall be placed in the member's personal file and the offending staff member shall be given a written warning concerning this violation.

Section 8. Emergency Admissions:

(a) In an emergent situation, an order for a consultation may be simultaneous with the personal evaluation of the patient by the attending physician; this must include

direct communication from the ED physician to the attending physician (rather than through a designated Allied Health Practitioner).

(b) ED physicians must communicate directly with admitting physicians for all unstable patients being admitted to the Hospital from the ED. If an ED patient meets criteria for ICU level care, the ED physician must personally evaluate the patient and directly communicate with the intensivist on call.

(c) The history and physical examination must clearly justify an emergency admission and must be recorded on the patient's chart within twenty-four (24) hours after admission. In the case of a psychiatric admission, the initial work-up shall also include a mental status examination and proposed treatment plan.

(d) Emergency admission patients who do not have a personal physician with admitting privileges shall be assigned to a medical staff Member with appropriate clinical privileges. When an unassigned patient has been seen in the ED and discharged home, the patient has one week to make contact with the physician's office to which he/she has been referred based on the call list. When the patient makes contact, physicians are required to see patients in a timely manner (generally within one week of ED visit, based on medical need). Physicians may not condition the outpatient follow up visit on payment prior to evaluation.

(e) Readmission within thirty (30) days for unassigned patients will be assigned to the on-call physician.

(f) The chairperson of each clinical department shall provide a schedule for the care of unassigned patients. If a medical staff member is unable to assume responsibility for unassigned patients when so scheduled, it shall be that member's responsibility to arrange for a qualified substitute.

(g) Changes to the ED on-call schedule shall be provided, in writing, to the Medical Staff Office seventy-two (72) hours prior to the scheduled on call date.

(h) When assigned to the ED on-call schedule, the on-call physician must respond to requests for consult and assist in the management, care, and treatment of inpatients.

(i) Failure of a member to respond to an emergency call may result in disciplinary action, unless the member presents, in writing, an acceptable reason for not attending the patient to the President of the Medical Staff and the Chief Executive Officer. An unexcused failure to respond to an emergency call shall be reported immediately to the Medical Executive Committee.

(j) All Active Staff and Associate Staff Members may be required to serve on the emergency call rotation schedule. However, those who have served on the

medical staff of this healthcare system for twenty consecutive years may be exempt from this requirement upon petition to the appropriate department.

(k) If a patient is seen by the on-call resident/fellow, the on-call resident reports to an appropriate member of the medical staff with diagnostic and treatment recommendations. The ultimate responsibility is with the Attending member of the medical staff. Residents have the cooperation and advice of the full-time emergency room physicians, as well as the Attending staff and physicians-on call for each specialty.

Section 9. Continued Hospitalization:

(a) The attending medical staff member shall be required to routinely document the need for continued hospitalization after specific periods of stay as defined by the Medical Executive Committee. The documentation must contain:

(1) an adequate written record of the reason for continued hospitalization (a simple reconfirmation of the patient's diagnosis is not sufficient); and

(2) plans for post-hospital care.

(b) If the attending physician materially fails to comply with the requirements in (a) above, then the Medical Executive Committee may request that the attending physician provide written justification of the necessity for continued hospitalization of the patient, including an estimate of the number of additional days of stay and the reason therefor. This report should be submitted within twenty-four (24) hours of receipt of such request. Failure to comply with this policy will be brought to the attention of the Medical Executive Committee.

ARTICLE II

MEDICAL ORDERS

Section 1. General Requirements:

(a) Orders must be clear and complete and entered in the computerized provider order entry ("CPOE") system.* Orders which are improperly written shall not be carried out until they are clarified by the attending medical staff member and are understood by the nurse.

(b) The use of the terms "renew," "repeat," and "continue" and "hold" standing alone are not acceptable as medical orders. In addition, "meds as at home" is not an acceptable order. The physician is responsible for review and ordering of specific medications, dosages and dosing schedules on admission.

(c) All previous orders shall be canceled when a patient goes to surgery. Exceptions to this policy will be short, uncomplicated procedures such as tracheotomy, implantable vascular devices, central line placement, dialysis catheter insertion, and chest tube placement. Additions to the list of these procedures may be petitioned through the Pharmacy & Therapeutics Committee to the Medical Executive Committee from specialty department chairman. The policy may be over-ridden for the above procedures by entering in the CPOE system "Resume Pre-Operative Orders" and naming the procedure. Example: (1) Resume pre-operative orders; (2) Status/Post Groshong catheter placement.

(d) Orders for tests or procedures stated as "daily" shall be reviewed by the attending medical staff Member after three (3) days. At the end of the stated time, any order that would be automatically discontinued must be reentered in the CPOE system if it is to be continued.

(e) All orders must be reviewed when a patient is transferred from one service within the hospital to another. The review of the orders must be documented in the patient's record and on the CPOE system. All existing orders (including medications) are automatically discontinued when a patient is transferred into or out of an intensive care unit or between North Naples Hospital and Downtown Naples Hospital or when discharging a patient from the acute care setting with admission to the Comprehensive Rehabilitation Center and shall be reentered in the CPOE system to reflect the change in the patient's level of care and services.

* The computerized provider order entry ("CPOE") system will be used when available. Prior to the full implementation of CPOE, all reference, in the Rules and Regulations, to CPOE will be interpreted to apply to written orders.

(f) Patients transferred between North Naples Hospital and Downtown Naples Hospital must have new orders entered in the CPOE system.

(g) When medication or treatment is to be resumed after an automatic stop order has been employed, the order that was stopped must be reentered in the CPOE system.

(h) No order shall be discontinued without the knowledge of the attending Member, unless the circumstances causing the discontinuation constitute an emergency.

(i) Patients transferred within either hospital to different levels of care (i.e., ICU to Med/Surg) must have orders reviewed and evaluated in the CPOE system.

Section 2. Who May Enter and Write Orders:

(a) Medical staff members and Allied Health Practitioners (AHP) who have been granted appropriate privileges shall have the authority to enter orders in the CPOE system only as permitted by their clinical privileges or scope of practice. Patient Care orders may be entered by a resident/fellow with approved clinical duties/responsibilities.

(b) All orders must be entered in the patient's record and must be dated, timed and signed by the responsible practitioner and authenticated in the CPOE system.

Section 3. Verbal Orders:

(a) A verbal order may be given by a member of the medical staff or by a member of the Allied Health Practitioner (AHP) staff who has been granted the specific privilege (either in person or via telephone) for medication or treatment and shall be accepted only in an emergency or when the physician and/or AHP cannot physically enter the order in the CPOE system.

(b) A verbal order shall be given only to authorized qualified personnel who shall transcribe the verbal order and enter the order in the CPOE system. The individual accepting the verbal order shall read the complete order back to the ordering practitioner for verification.

(c) The order shall include the date, time, and full signature and title of the person to whom the verbal order has been given. The ordering medical staff member or other individual responsible for the patient must verify, sign, date and time the verbal order within thirty (30) days. Verbal orders given for the following high-risk orders shall be authenticated by the ordering physician within twenty-four (24) hours: restraints and Do Not Resuscitate ("DNR").

(d) Only the following categories of individuals shall be permitted to accept verbal orders, with noted restrictions:

(1) physicians, dentists, podiatrists, psychologists or Allied Health Practitioners with clinical privileges at this hospital, residents/fellows with approved clinical duties/responsibilities at this hospital;

(2) registered nurses and licensed practical nurses;

(3) pharmacists, who may transcribe verbal orders pertaining to drugs;

(4) respiratory therapists, who may transcribe verbal orders pertaining to respiratory therapy treatments;

(5) Speech-Language Pathologists may transcribe verbal orders pertaining to speech-language pathology, swallow evaluations, diet orders, and modified barium swallow evaluations. Speech Language Pathologists may also write and/or enter diet consistency orders in the CPOE for patients following swallowing evaluations;

(6) Licensed Physical Therapists and Occupational Therapists who may transcribe orders pertaining to physical therapy and occupational therapy, respectively;

(7) Sonographers and Nuclear Medicine Technicians who may transcribe orders pertaining to their specialty;

(8) Medical Technologists who may transcribe orders for laboratory tests and Blood Bank services;

(9) Dieticians may implement orders pertaining to diet; and

(10) Social workers and/or Case Managers who may transcribe verbal orders pertaining to the patient's discharge.

Section 4. Orders for Specific Procedures:

(a) Orders for medications and biologicals may only be ordered by medical staff members and other authorized individuals with clinical privileges at the hospital.

(b) All orders for medications and biologicals will be in writing, dated, timed, and authenticated by the practitioner responsible for the care of the patient, with the exception of influenza and pneumococcal vaccines, which may be administered per hospital policy after an assessment for contraindications. Orders for medications should include dose, strength, units, route, frequency, and rate. If not

specifically prescribed as to time or number of doses, the medications will be controlled by automatic stop orders or by protocols.

(c) Radiological and diagnostic imaging services may be ordered by an individual who has been granted privileges and other individuals as allowed by state law.

(d) Respiratory care services may be provided on the order of a physician.

(e) All requests for radiological and other special examinations and services shall contain a statement of the reason for the examination. An order for a serial electrocardiogram must specify both the desired frequency and the duration of the series. This rule does not apply to orders that are entered in the CPOE system for patients in ICU.

(f) All orders for therapy shall be entered in the patient's record via the CPOE system and signed or countersigned by the ordering practitioner.

(g) Therapeutic diets shall be prescribed by the attending member on the patient's chart by entering the order into the CPOE system. Orders for diets must be specific as in the case of limited sodium diets where the desired sodium content must be stated in either milligrams or grams.

(h) Physical restraints shall be used only when other methods to control behavior fail and they are necessary to prevent injury to the patient or others. Orders for patient restraint must comply with nursing and risk management policy as available through the Hospital's policy documents.

(i) Advance Directives, including, but not limited to, Living Will, Durable Power of Attorney for Health Care, Designation of Health Care Surrogate shall be considered in the orders for the patient.

ARTICLE III

MEDICAL RECORDS

Note: all reference to required documentation in the medical record may be written or electronic (reference: written, documented, recorded, entered, etc.).

Section 1. General Rules:

(a) A medical record shall be maintained for every inpatient, outpatient and emergency patient at the hospital. The attending medical staff member shall be responsible for the preparation of a complete and legible medical record for each patient under his or her care. This responsibility cannot be delegated.

(b) The contents of the record shall be pertinent and current. A single medical staff member shall be identified in the medical record as being responsible for the patient at any given time. A member's routine orders, when applicable to a given patient, shall be (i) reproduced in detail on the order sheet of the patient's record; (ii) dated, timed and authenticated by the attending practitioner; and (iii) entered in the CPOE system. Medical record contents for rehabilitation patients admitted to the Comprehensive Rehabilitation center must include all regulatory documentation requirements specific to physician documentation.

(c) Abbreviations on the unapproved abbreviations and/or symbols list may not be used. No abbreviations, signs or symbols shall be used to record a patient's final diagnosis or any unusual complications.

(d) The following requirements shall be enforced by all department chairpersons:

(1) Histories and physicals shall be recorded on the patient's chart within twenty-four (24) hours following admission of the patient and prior to surgery.

(2) All consultations shall contain the date of the consultation and shall be documented on the patient's chart within twenty-four (24) hours of the consultation.

(3) Progress notes for all patients must be documented by the attending physician or his/her designee as frequently as indicated by the patient's clinical condition, but at least daily, with the exception of rehab patients. Progress notes shall be written at least three (3) times a week for rehab patients.

(4) All operations performed shall be fully described by the operating surgeon who shall record information after the procedure consistent with that required in Section 7(c) of this Article.

(5) When an autopsy is performed, provisional anatomic diagnoses shall be recorded in the medical record within seventy-two (72) hours and the complete protocol shall be made part of the record within sixty (60) days, unless exceptions for special studies are authorized by the Medical Executive Committee.

Section 2. Authentication:

All entries in the record shall be dated, timed and authenticated by the person making the entry. Each entry must be individually authenticated by the signature or the electronic signature of the individual making the entry. Indications of authentication can include written signature or initials, computer signature, electronic signature (sequence of keys). Documentation by allied health professionals, residents, fellows, and students show evidence of supervision through the authentication of the responsible supervising physician where applicable.

Section 3. Contents:

(a) A complete medical record shall include:

(1) identification data, including the patient's name, address, date of birth, and next of kin, as well as a single unit number that identifies the patient and the patient's medical record;

(2) date of admission and discharge;

(3) medical history, including:

(i) chief complaint;

(ii) conditions present on admission;

(iii) details of the present illness, including, when appropriate, assessment of the patient's emotional, behavioral and social status;

(iv) relevant past, social, and family histories;

(v) menstrual and obstetrical history in females;

(vi) an inventory by body systems; and

(vii) relevant drug reactions including allergies;

(4) provisional admitting diagnosis;

(5) report of a physical examination, including but not limited to vital signs, head, chest, abdomen, and extremities, or a note as to the contraindications for such an examination or valid reasons why the examination was not performed;

(6) a statement of the conclusions or impressions drawn from the admission history and physical examination;

(7) a statement of the course of action planned for the patient while in the hospital;

(8) diagnostic and therapeutic orders;

(9) evidence of appropriate informed consent;

(10) evidence of medication and dosage administered;

(11) clinical observations, progress notes, nursing notes, consultation reports;

(12) reports of procedures, tests, and the results, including medical and surgical notes and reports;

(13) reports of pathology and clinical laboratory examinations, radiology, and nuclear medicine examinations or treatment, anesthesia records, and any other diagnostic or therapeutic procedures;

(14) copy of ambulance run report given to hospital if patient was delivered to hospital by ambulance;

(15) appropriate social work services, if provided; and

(16) conclusions at termination of hospitalization, including provisional diagnosis or reason(s) for admission, principal and additional or associated diagnoses, clinical resume, final progress note, or discharge plan, and, when appropriate, autopsy report.

(b) All medical record forms shall be standardized, and no revision, deletion, or discontinuance of these forms shall be made without the approval of the applicable committee(s) and the Medical Executive Committee. All new forms proposed for use in the medical record shall be submitted to the applicable committee(s) and, where appropriate, to the Medical Executive Committee for review. The applicable committee(s) shall approve (or reject) all forms recommended for inclusion in the medical record and shall notify the Medical

Executive Committee concerning such action. Approved changes will not be made until the mechanics of standardization have been accomplished.

Section 4. History and Physical:

(a) A complete medical history and physical examination shall be recorded on the patient's chart within twenty-four (24) hours after registration or inpatient admission but prior to surgery or a procedure requiring anesthesia services, by a medical staff member. The documentation can be in the form of a history and physical or a progress/office note. This report shall reflect a comprehensive current physical assessment by the medical staff Member. Allied Health Practitioners (AHP) may also be granted privileges by the hospital to perform histories or physicals. Residents and fellows may perform histories and physicals. Students may perform histories and physicals pursuant to section XII.

(b) When a history and physical (or update to a history and physical) has been completed by an AHP who is required by state scope of practice laws to have medical record documentation countersigned, the history and physical should be countersigned by the supervising physician within twenty-four (24) hours of registration or inpatient admission or prior to surgery or a procedure requiring anesthesia services.

(c) When a history and physical has been documented by a resident/fellow, the history and physical shall be countersigned by the supervising physician within twenty-four (24) hours of registration or inpatient admission or prior to surgery or a procedure requiring anesthesia services.

(d) If a history and physical has been performed within thirty (30) days prior to admission, a durable, legible copy of the history and physical may be used in the hospital medical record. A documented plan of treatment should be included in the history and physical or the progress notes. If the history and physical has been completed prior to admission or readmission, an updated examination of the patient, including any changes in the patient's condition must be completed and documented within twenty-four (24) hours after registration or inpatient admission or readmission and prior to surgery or a procedure requiring anesthesia services to reflect any changes in the patient's condition since the date of the original history and physical or to state that there have been no changes in the patient's condition. All updates must be timed, dated and signed.

(e) The medical record shall document a current, thorough physical examination prior to the performance of an operative/invasive procedure. When the history and physical examination are not recorded before an operative/invasive procedure or any potentially hazardous diagnostic procedure, the procedure shall be cancelled unless the attending medical staff member states in writing that an emergency situation exists, or that any such delay would be detrimental to the patient.

(f) For outpatient surgery, the history shall include documentation of the indications and symptoms warranting the procedure, listing of the patient's current medications, any existing co-morbid conditions, and previous surgeries.

(g) In the case of readmission of a patient, all previous records shall be available for use by the attending Medical Staff Member.

(h) In the case of emergency surgery, where the patient is received directly from the emergency department, the ED physician's dictated ER note may be used as the history and physical in order to perform the surgery. However, the attending physician must dictate his/her own history and physical within twenty-four (24) hours of patient admission.

Section 5. Progress Notes:

Progress notes should provide a pertinent chronological report of the patient's course of care in the hospital. Progress notes may be written by members of the Medical Staff and by Allied Health Practitioners as permitted by their clinical privileges or scope of practice. Progress notes may be written by residents/fellows based on their clinical duties/responsibilities. Progress notes shall be legible, shall document the date of observation, and shall contain sufficient information to insure continuity of care at this hospital or other health care facility to which the patient might later be transferred. Where possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

Section 6. Surgical Records:

(a) Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery:

(1) verification of patient identity;

(2) medical history and supplemental information regarding drug sensitivities and other pertinent facts;

(3) general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand anesthesia and surgery;

(4) provisional diagnosis;

(5) laboratory test results;

(6) consultation reports;

(7) surgical consent form signed by the patient or the patient's legal representative;

(8) x-ray reports, if applicable; and

(9) other ancillary reports, if applicable.

Except in an emergency, failure to include the above data in the patient's record shall result in an automatic cancellation of the surgery.

(b) The patient should not leave for the operating room until the chart is complete or the operating room has received a telephone message that the tests are done but no report received.

(c) In an emergency situation, the attending surgeon shall write a note on the patient's condition, stating that a delay would constitute a danger to the health or safety of the patient. If the history and physical have been transcribed but not yet entered in the chart, or dictated but not transcribed, an admission note and statement to that effect may be entered in the chart by the attending practitioner.

Section 7. Operative Reports:

(a) A provisional (pre-operative) diagnosis is recorded before the operative procedure by the attending surgeon responsible for the patient.

(b) An operative report shall be recorded in the medical record immediately after surgery and shall contain the following information:

(1) the patient's name and hospital identification number;

(2) date and time of the procedure;

(3) a description of the surgery and related findings;

(4) identification of the technical procedures used;

(5) a description of the specimens removed;

(6) a description of the estimated blood loss;

(7) the pre-operative and post-operative diagnosis;

(8) identification of the complications encountered;

(9) the names of the primary surgeon and assistants, including a description of surgical tasks performed;

(10) the type of anesthesia used; and

(11) prosthetic devices, grafts, tissues, transplants, or devices implanted (if any).

(c) The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery.

(d) An operative progress note should also be entered in the medical record immediately after surgery in order to provide pertinent information for use by any practitioner who is required to attend the patient. This progress note should include the names of the physician(s) and physician assistants, procedure performed, findings, estimated blood loss, specimens removed, and post-operative diagnosis. If the operative report is completed by a resident/fellow, the surgeon must review and authenticate the operative report prior to the patient going to the next level of care.

Section 8. Anesthesia Note:

(a) A pre-anesthesia evaluation shall be documented in the medical record of all patients undergoing surgery, anesthesia, or moderate or deep sedation. The pre-anesthesia evaluation will be performed by an individual qualified to administer anesthesia. The pre-anesthesia evaluation shall be recorded in the medical record within forty-eight (48) hours and updated within twenty-four (24) hours prior to the surgery or the administration of anesthesia or sedation.

(b) The pre-anesthesia evaluation will include:

(1) a review of the medical history, including anesthesia, drug and allergy history;

(2) an interview and examination of the patient;

(3) notation of any anesthesia risks;

(4) identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway);

(5) development of a plan for the patient's anesthesia care (i.e., discussion of risks and benefits); and

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

(c) 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) the name and hospital identification number of the patient;

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

(3) the name, dosage, route time, and duration of all anesthetic agents;

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

(5) the name and amounts of IV fluids, including blood or blood products, if applicable;

(6) time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

(7) any complications, adverse reactions or problems occurring during anesthesia and the patient's status upon leaving the operating room.

(d) A post-anesthesia evaluation shall be documented in the medical record of all patients who have undergone surgery, anesthesia, or moderate or deep sedation. The post-anesthesia evaluation shall be recorded in the medical record by an individual qualified to administer anesthesia, no more than forty-eight (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 post-anesthesia 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.

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

(1) respiratory function;

(2) cardiovascular function;

(3) mental status;

(4) temperature;

(5) nausea and vomiting; and

(6) post-operative hydrations.

(f) The documentation records the patient's discharge from the post-anesthesia care area by the responsible licensed independent practitioner or according to approved discharge criteria.

Section 9. Pathology Report:

(a) All specimens removed during a surgical procedure shall be properly labeled, packaged in preservative as designated, identified as to patient, and sent to the laboratory for examination by the pathologist. The specimen must be accompanied by pertinent clinical information, including its source and the pre-operative and post-operative surgical diagnosis. The pathologist shall document the receipt of all surgically removed specimens, determine the extent of examination necessary for diagnosis, and sign the pathology report which shall become part of the patient's medical record. The pathology report should be filed in the record within twenty-four (24) hours of completion, if possible.

(b) The procedure for handling foreign bodies and objects will conform with Joint Commission Standards.

Section 10. Radiology:

All x-ray electronic images shall remain the property of the Hospital and shall be maintained as a part of the records for seven (7) years as required by Florida law.

Section 11. Medical Information from Other Hospitals or Health Care Facilities:

The Health Information Management Department shall transmit a written request, by any method, with the patient's written authorization, to other hospitals or health care facilities requesting data concerning the patient's previous admissions, record name, birthdate, and dates of previous hospitalization. Information received in response to said request shall not become part of the patient's medical record at this hospital unless authenticated by the attending medical staff member as part of the current medical record. Information received from other institutions for rehabilitation admissions shall become part of the patient's medical record at this hospital unless otherwise directed by the attending medical staff member.

Section 12. Discharge Summaries:

(a) A clinical discharge summary, prepared by the practitioner discharging the patient, shall be included in the medical records of all patients except, those with procedures/conditions who require less than a forty-eight (48) hour period of hospitalization, normal newborn infants, and uncomplicated obstetrical deliveries.

A final progress note, which should include any instructions given to the patient or the patient's representative, may be substituted for the discharge summary of these patients.

(b) The discharge summary shall include:

(1) reason for hospitalization;

(2) significant findings;

(3) complications;

(4) procedures performed and treatment rendered;

(5) condition of the patient on discharge;

(6) specific, pertinent instructions given to the patient or the patient's representative; and

(7) provisions for follow-up care.

(c) The condition of the patient at discharge should be stated in terms that permit a specific measurable comparison with the patient's condition at admission. When preprinted instructions are given to the patient or the patient's representative, the record shall so indicate and a copy of the preprinted instruction sheet used should be on file in the medical record department. All discharge summaries shall be authenticated by the attending medical staff member.

Section 13. Delinquent Medical Records:

(a) All History and Physicals must be documented on the chart within twenty-four (24) hours following admission. Operative reports shall be dictated immediately after surgery with an operative note written in the chart immediately after surgery. An individual who has not completed his or her H & P dictation within 24 hours of admission shall be considered delinquent and shall be notified of such delinquency by the Health Information Management Department unless the individual is without fault. The following penalty shall be invoked for each delinquent H & P:

(1) A fine of $100 per delinquent H & P.

(b) All other medical record dictations shall be completed within thirty (30) days following discharge. An individual who has not completed his or her medical record dictation within thirty (30) days after discharge shall be considered delinquent and shall be notified of such delinquency by the Health Information

Management Department unless the individual is without fault. Signatures must be completed within thirty (30) days.

(c) After thirty (30) days from the receipt of notice from the Health Information Management Department that the member has failed to complete a medical record or records, the member's department chairperson shall be notified. The department chairperson will contact and inform the member that he/she has forty-eight (48) hours to complete the medical record or records. If the medical records remain incomplete at that time, all clinical privileges of the member shall be voluntarily relinquished unless the member is without fault.

(d) Failure to complete the medical records that caused voluntary relinquishment of all clinical privileges three (3) months subsequent to the relinquishment of such privileges may result in disciplinary action as outlined in applicable Medical Staff Bylaws and Policies.

(e) No medical staff member or other individual shall be permitted to complete a medical record on an unfamiliar patient in order to retire that record.

Section 14. Possession, Access and Release:

(a) All medical records (paper and electronic) are the physical property of the hospital and may be removed from the hospital's jurisdiction and safekeeping only for purposes of medical care and treatment of a patient, medical care evaluation studies, teaching conferences, chart completion, as needed by the Chief Executive Officer, or in accordance with a court order, subpoena, or statute. When such a removal is mandated, every reasonable attempt shall be made to notify the attending medical staff Member. Unauthorized removal of a medical record (paper or electronic) from the hospital by a Member shall constitute grounds for suspension from the Medical Staff.

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

(c) Upon written approval of the Chief Executive Officer, access to the paper or electronic medical records of all patients shall be afforded to medical staff Members in good standing for bonafide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the Chief Executive Officer, former medical staff Members shall be permitted access to information from the paper or electronic medical records of their patients covering all periods during which they attended such patients in the hospital. Any publication of compiled data from the hospital's patient medical records is forbidden without written approval of the Chief Executive Officer.

(d) Written consent of the patient is required for release of medical information to those not otherwise authorized to receive information.

Section 15. Filing of Medical Record:

A paper or electronic medical record shall not be permanently filed until it is completed by the attending medical staff Member or is ordered filed by the Medical Record Committee. When reports, e.g., laboratory, radiology, etc., are received in the Health Information Management Department after discharge of the patient, the paper or electronic medical record, with the recently received reports flagged, will be available for the member to review before the record is permanently filed.

ARTICLE IV

CONSULTATIONS

Section 1. General:

(a) For the purpose of this Article "consultation" and "second opinion" shall be interchangeable.

(b) The attending medical staff member shall be responsible for requesting consultation when indicated and for calling in a qualified consultant. A request for a consult placed during the night should be called "real time" rather than held for 7:00 a.m. call.

(c) Requests for a consultation shall be entered on an appropriate form in the patient's medical record and shall include the reason for requested consultation. All requests for consultations shall have a corresponding entry in the CPOE system documenting the reason for the consult. If the history and physical are not part of the patient's medical record and the consultation form has not been completed, it shall be the responsibility of the attending medical staff member requesting the consultation to provide this information to the consultant. STAT Consult requests require physician to physician communication.

(d) Before placing a new order for a consultation, an attending physician must personally evaluate any new patient and any unstable patient. Requests for consultations must be communicated physician-to-physician.

(e) If a nurse employed by the hospital has reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, that nurse shall notify the Director of Nursing who, in turn, may refer the matter to the Chief Medical Officer. The Chief Medical Officer may bring the matter to the attention of the chairperson of the department in which the Member in question has clinical privileges. Thereafter, the chairperson of the department may request a consultation after discussion with the attending member of the medical staff.

(f) It is the duty of the Credentials Committee, the department chairpersons, and the Medical Executive Committee to make certain that members of the medical staff request consultations when needed.

Section 2. Who May Give Consultations:

Any member of the medical staff with clinical privileges at this hospital can be asked for consultation within his or her area of expertise. In circumstances of grave urgency, or where consultation is required by these rules and regulations or imposed by the

Credentials Committee, the Board, the Chief Executive Officer, the President of the Medical Staff or the appropriate department chairperson shall at all times have the right to call in a consultant or consultants.

Section 3. Required Consultations:

Consultations shall be required in all non-emergency cases whenever requested by the patient or the patient's personal representative if the patient is incompetent. Consultations are also required in all cases in which, in the judgment of the attending medical staff member:

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

(b) there is doubt as to the best therapeutic measures to be used;

(c) unusually complicated situations are present that may require specific skills of other practitioners;

(d) the patient is not a good medical or surgical risk.

Additional requirements for consultation may be established by the hospital as required.

Section 4. Psychiatric Consultations:

Psychiatric consultation and treatment shall be requested for and offered to all patients who present self-destructive behavior, i.e., attempted suicide, chemical overdose, etc. If psychiatric care is recommended, evidence that such care has at least been offered and/or an appropriate referral made must be documented in the patient's medical record.

Section 5. Surgical Consultations:

Whenever a consultation is requested prior to surgery, the Director of Surgical Services shall ascertain that an adequate notation of the consultation appears in the patient's medical record. If it does not so appear, surgery and anesthesia shall not proceed.

Section 6. Mandatory Consultations:

When a consultation requirement is imposed by the Credentials Committee or the Medical Executive Committee, pursuant to the Credentialing Policy, or by the Board, the required consultation shall be rendered by a member of the medical staff with the same credentials. Failure to obtain required consultations shall constitute grounds for precautionary suspension pursuant to the Credentialing Policy.

Section 7. Routine Consults:

Must be completed within 24 hours of the request or within a time frame agreed upon by the requesting and consulting physician;

Section 8. Critical Care Unit Consults:

Must be completed within 12 hours of the request, unless the patient's condition requires that the physician complete the consultation sooner; and

Section 9. STAT/Emergent Consults:

Must be completed as soon as possible. Consistent with the Emergency Medical Screening Policy, if a physician is on call for the ED, then the physician is expected to respond within 30 minutes, or within a time frame agreed upon by the requesting and consulting physician. If the physician who is being requested to perform a STAT/emergent consult is not on call, the physician should respond within 30 minutes (or within a time frame agreed upon by the requesting and consulting physician) or, alternatively, must contact the requesting physician and communicate when the consult will be performed.

Section 10. Contents of Consultation Report:

Each consultation report shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, an actual examination of the patient and the patient's medical record. This report shall be made a part of the patient's medical record. A statement, such as "I concur," shall not constitute an acceptable consultation report. Where non-emergency operative procedures are involved, the consultant's report must be recorded in the patient's medical record prior to the operation. The consultation report shall contain the date of the consultation, an opinion, and the signature of the consultant.

ARTICLE V

INFORMED CONSENT

Section 1. Responsibility for Obtaining Informed Consent:

(a) The hospital's admission consent form must be signed by the patient or the patient's representative at the time of admission. The admitting office shall notify the attending medical staff member whenever such consent has not been obtained.

(b) After hospital admission, it shall be the responsibility of the attending practitioner to obtain consent from the patient in the following circumstances:

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

(2) the medical staff member performing a non-routine or high-risk medical procedure shall obtain the patient's consent to any such procedure;

(3) the anesthesiologist or anesthetist shall obtain the patient's consent to the administration of anesthesia.

(c) Except in emergencies, a failure to include a completed consent form in the patient's medical record prior to the performance of surgery or diagnostic procedure shall result in the automatic cancellation of the surgery or procedure.

(d) Whenever the patient's condition prevents the obtaining of a consent, every effort shall be made to obtain the consent of the patient's representative prior to the procedure or surgery. All such efforts shall be documented in the patient's medical record. Any emergency involving a minor or otherwise incompetent patient in which consent cannot be immediately obtained from the minor's parents, legal guardian, or appropriate next of kin, should be fully explained on the patient's medical record. Whenever possible, a consultation shall be made before any operative procedure is undertaken where consent has not been obtained.

(e) Should a second operation be required during the patient's stay at the hospital, a second consent shall be obtained. If two (2) or more specific procedures are to be done at the same time and such information is known in advance, both procedures may be described and consented to on the same form.

Section 2. Definitions:

The following definitions shall be applied when obtaining consent to treatment:

(a) Informed Consent – consent obtained from the patient or the patient's representative after being informed by the attending medical staff member of the nature and risks of and the alternatives to the proposed treatment.

(b) Emergency – a situation when, within a reasonable degree of medical certainty, delay in initiation of the proposed surgical or medical treatment or procedure would endanger the health of the patient.

(c) Emancipated Minor – an individual under the age of 18 who is married, has been married or an unwed pregnant or minor mother.

Section 3. Who May Consent:

(a) A competent adult or emancipated minor may authorize any medical or surgical procedure to be performed upon his or her body, or for medical or surgical care or services for her child, and the consent of no other person shall be required or shall be valid. Emancipated minors may consent to procedures on themselves and on their children.

(b) Written consent shall be obtained from the parents or legal guardian of a non-emancipated minor before any surgical or medical procedure is performed on the minor, except in the following cases in which minors may consent for their own care:

(1) pregnant minors seeking care related to their pregnancy; or

(2) treatment for substance or alcohol abuse.

(c) An unwed minor mother may consent to the performance of medical or surgical care for her child.

(d) Written consent shall also be obtained in all non-emergency situations from the legal representative of any incompetent adult before any surgical or medical procedure is performed.

Section 4. Informed Consent Forms:

A properly executed informed consent form contains the following minimum elements:

(a) name of the hospital where the procedure or other type of medical treatment is to take place;

(b) name of the specific procedure or other type of medical treatment for which consent is being given;

(c) name of the responsible practitioner who is performing the procedure or administering the medical treatment;

(d) a statement that the procedure or treatment, including the anticipated benefits, material risks, and alternative therapies, was explained to the patient or the patient's legal representative;

(e) signature of the patient or the patient's legal representative;

(f) the date and time the informed consent form was signed by the patient or the patient's legal representative;

(g) date, time and signature of the person witnessing the patient or the patient's legal representative signing the consent form, if applicable;

(h) indication or listing of the material risks of the procedure or treatment that were discussed with the patient or the patient's representative;

(i) if applicable, a statement that physicians other than the operating practitioner will be performing important tasks related to the surgery, in accordance with the hospital's policies; and

(j) if applicable, a statement that qualified medical practitioners who are not physicians who will perform important parts of the surgery or administration of anesthesia will be performing only tasks that are within their scope of practice, as determined under state law and regulation, and for which they have been granted privileges or a scope of practice by the hospital.

Section 5. Incompetent Patients:

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

Section 6. Unusual Cases:

(a) When questions arise regarding patient consent or when unusual circumstances occur not clearly covered by these rules and regulations, the attending medical staff member shall promptly confer with hospital management concerning such matters. The hospital will make every effort to assist the attending practitioner in obtaining the required consent and to provide information relative to such matters. However, it is the ultimate responsibility of the attending practitioner to comply with the requirements contained in these rules and regulations.

(b) Clinical departments may propose specialized consent forms for specific procedures when deemed desirable or when legally required. Such form shall become effective when approved by the Medical Executive Committee.

Section 7. Sterilization:

Absent a court order, no consent other than from the patient will be accepted for a surgical procedure resulting in sterilization. Before consenting to a sterilization procedure, the patient must be informed and understand that the restoration of fertility is unlikely.

Section 8. Abortion:

Any pregnant woman may authorize an abortion to be performed and the consent of no other person is required. A written consent must be obtained and placed in the medical record before an abortion can be performed.

(a) The decision to perform an abortion must be left to the medical judgment of the pregnant woman's attending medical staff member in consultation with the patient.

(b) Abortions shall be performed only by members of the medical staff qualified to identify and manage complications when they arise from the procedure. No medical staff member shall be required to perform, nor shall any patient be forced to accept an abortion.

Section 9. Refusal to Consent:

A patient or, if incompetent, the patient's representative retains the right to refuse medical treatment, even in an emergency situation. A second medical opinion should be recommended and obtained when a patient refuses treatment. If, a patient continues to refuse such treatment, after an explanation of the potential risks that could result from lack of treatment, a refusal of care and appropriate release of responsibility form should be executed, and, if possible, signed by the patient. Such form(s) should be kept in the patient's medical record.

ARTICLE VI

PHARMACY

Section 1. General Rules:

(a) All drugs and medications administered to patients shall be:

(1) listed in the latest edition of "United States Pharmacopoeia," "National Formulary," "American Hospital Formulary Service," "A.M.A. Drug Evaluations," or "New and Non-official Drugs," with the exception of drugs for bona fide clinical investigations whose use is in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals, and approved by the Pharmacy and Therapeutics Committee;

(2) reviewed by the attending medical staff member at least weekly to assure the discontinuance of all drugs no longer needed;

(3) cancelled automatically when the patient goes to surgery; and

(4) reviewed by the pharmacist before the initial dose of medication is dispensed (except in an emergency when time does not permit). In cases when the medication order is entered in the CPOE system, when the pharmacy is "closed" or the pharmacist is otherwise unavailable, the medication order shall be reviewed by the pharmacist as soon thereafter as possible.

(b) The physician is responsible for review and ordering of specific medication, dosages and dosing schedules on admission, including accurately and completely reconciling medications. Patients transferred within either hospital to different levels of care must have new orders entered in the CPOE system which include accurate and complete medication reconciliation. Patients discharged from the hospital and/or referred or transferred to another setting, service, practitioner or level of care within or outside the organization must have medication orders entered in the CPOE system, which includes accurate and complete medication reconciliation. The complete list of medications is to be provided to the patient on discharge from the facility, as well as to the next provider of service.

(c) A pharmacist may prepare intravenous solutions with additives, dilute, dried or concentrated injectables, or prepare unit dose medications for administration by an appropriately licensed individual as specified in Nursing and Administrative Policy (attached herewith). Each drug dose shall be recorded in the patient's medical record and properly signed after the drugs have been administered.

(d) Self-medication by patients shall not be permitted, unless the attending medical staff member so orders.

(e) The pharmacist may dispense the generic equivalent drug which has been accepted for the Formulary by the Pharmacy and Therapeutics Committee when a trade drug name is prescribed. An Member may object to the use of the generic equivalent for a particular patient and may request the specific product by entering the words "MEDICALLY NECESSARY" on the order. In such an instance, the member of the medical staff must be notified by the hospital pharmacy prior to the substitution of any equivalent generic drug for a specific trade name drug.

Section 2. Patient's Own Drugs:

Patients are not permitted to bring their own medications into the NCH Healthcare System (exception of eye drops). If it is determined there is a compelling reason to do so, the physician's order must specify the name of the drug, the dose and the directions. Pharmacy procedures for identification and storage will be followed.

Section 3. Medication Errors; Adverse Reactions:

(a) Any medication error or apparent drug reaction shall be reported immediately to the member of the medical staff who ordered the drug. An entry of the medication given in error or the apparent drug reaction, or both, shall also be recorded in the patient's medical record.

(b) Any adverse drug reaction shall be immediately noted on the medical record of the patient in the most conspicuous manner possible in order to notify everyone treating the patient, throughout the duration of hospitalization, of this drug sensitivity, and to prevent a recurrence of an adverse reaction. Notification of all drug sensitivities, including any apparent adverse reaction, shall be sent to the appropriate medical staff Member and to the director of pharmaceutical services.

(c) Transfusion reactions shall also be immediately documented in the patient's medical record and reported to the appropriate medical staff member.

Section 4. Stop Orders:

All pre-existing orders are canceled when the patient undergoes surgery. Medications are canceled upon prescriber-issued discontinuation order, or are stopped per physician order for a specific number of doses or days of therapy. Approval for specific medication stop orders must be approved by the Medical Executive Committee. Respiratory therapy treatments shall be assessed every 48 hours for renewal per respiratory therapy. Provision for patients with extended hospital stays: after thirty (30) days in hospital, pharmacy will print a renewal medication administration record and place on the patient's

chart. The attending physician will review and indicate any changes appropriate to the therapeutic regimen.

ARTICLE VII

INFECTION CONTROL

Section 1. General:

(a) All nursing units shall follow the standard procedure for isolation as outlined in the Infection Control Manual which is based on the Center for Disease Control's Guidelines for Isolation Precautions in Hospitals (CDC Guidelines).

(b) Any patient with a known or suspected communicable disease or infection shall be isolated as required by the Infection Control Manual. The attending member of the medical staff will be notified. The Chairperson of the Infection Control Committee shall be empowered to order appropriate isolation procedures or epidemiologic investigations as required.

(c) The charge nurse of a unit may order a culture of a draining wound with Attending Physician approval. Cultures of draining wounds and stool cultures on patients with unexplained diarrhea may be requested by a department chairperson in consultation with the Chairperson of the Infection Control Committee or the Infection Control Registered Nurse.

(d) Medical staff member, employees, and other health care personnel with infections with significant risk shall not be permitted in the surgery suite, delivery room, nursery, or obstetrics department.

(e) When a series of infections, including post-operative infections, occur, the Chairperson of the Infection Control Committee shall initiate procedures necessary to investigate and prevent further spread of infection.

(f) A culture should be taken when an incision and drainage is performed.

Section 2. Policies and Procedures:

The Infection Control Committee, in conjunction with any applicable individual department, shall develop written policies and procedures which outline the hospital's infection control program. These policies and procedures shall be reviewed at least every two years and shall include the following:

(a) a requirement that a record of all reported infections be maintained that includes the identification and location of the patient, the date of admission, onset of infection, the type of infection, the cultures taken, the results when known, any antibiotics administered, and the identity of the practitioners responsible for the care of the patient;

(b) a classification system that groups all reported infections into categories;

(c) a requirement that at least a weekly check for outdated sterile items be performed, whether in all nursing units or by central supply;

(d) specific policies and procedures related to accidental needlesticks;

(e) specific policies related to the handling and disposal of biological waste;

(f) specific policies and procedures related to admixture and drug reconstitution, and to the manufacture of intravenous and irrigating fluids;

(g) specific policies related to protective clothing and drapes, sterilization techniques, routine cleaning techniques, and handling of materials and maintenance of the inanimate environment;

(h) specific policies related to the selection, storage, handling, use and disposition of disposable items;

(i) specific policies related to decontamination and sterilization activities performed in central services and throughout the hospital, including but not limited to a requirement that steam gas (ETO) and hot air sterilizers be tested with live bacterial spores at least weekly;

(j) specific policies regarding the indications for and types of isolation to be used for each infectious disease;

All linen is treated as potentially infectious; segregation is not necessary as the receiving laundry facility uses Universal Precautions; and

(k) a requirement that all cases of communicable diseases be promptly and properly reported in accordance with the applicable statutory procedure.

ARTICLE VIII

DISCHARGE

Section 1. Who May Discharge:

Patients shall be discharged upon a written, verbal or telephone order of the attending medical staff Member. Discharge summaries completed by allied health professionals, residents, fellows, and students must be countersigned by the responsible supervising physician where applicable. Should a patient leave the hospital against the advice of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the hospital's release form prior to departure.

Section 2. Discharge Planning:

(a) Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, including an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. When hospital personnel determine no discharge planning is necessary in a particular case, that conclusion shall be noted on the medical record of the patient.

(b) Discharge planning shall include, but need not be limited to, the following:

(1) appropriate referral and transfer plans;

(2) methods to facilitate the provision of follow-up care; and

(3) information to be given to the patient or the patient's family or other persons involved in caring for the patient on matters such as the patient's condition, health care needs, activity restrictions, and any necessary medical regimens including drugs, diet, or other forms of therapy.

(c) Sources of additional help from other agencies and procedures to follow in case of complications should also be part of the discharge plan. All such information should be provided by the attending member.

Section 3. Discharge of Minors and Incompetent Patients:

Any individual who cannot legally consent to his or her own care shall be discharged only to the custody of a parent, legal guardian, person standing in loco parentis, or other responsible party, unless otherwise directed by a parent, guardian, or order of court. If the parent or guardian directs that discharge be made otherwise, that individual shall so

state in writing, and the statement shall become a part of the permanent medical record of the patient.

ARTICLE IX

AUTOPSIES

Section 1. Autopsies and Disposition of Bodies:

(a) The remains of any deceased patient, including a fetal death or a neonatal death, shall not be subjected to disposition until death has been pronounced. The event of a death shall be adequately documented within a reasonable period of time by the attending member or another designated medical staff member or resident. When the event of death is completed by the resident/fellow, it shall be reviewed and authenticated by the supervising physician. The body of a deceased patient can be subjected to disposition only with the consent of a parent, legal guardian, or responsible person. Death certificates are the responsibility of the attending medical staff member and must be completed within twenty-four (24) hours of death or birth in the case of fetal death.

(b) It shall be the duty of all medical staff members to secure consent to meaningful autopsies whenever possible and in accordance with state and local laws. An autopsy may be performed only with proper consent in accordance with state law and hospital policy. All autopsies shall be performed by the hospital pathologist or a designee. Consent for an autopsy shall be effective only by inclusion of such notation on the appropriate hospital form signed by the appropriate legal representative of the patient. Written consent may be given by telegram. A duly witnessed telephone consent is acceptable in lieu of written consent in those circumstances where obtaining written consent would result in undue delay. A copy of the autopsy report shall be forwarded to the attending medical staff member and included in the patient's medical record.

(c) Provisional anatomic diagnoses shall be recorded on the medical record within seventy-two (72) hours and the complete protocol shall be made a part of the patient's medical record within sixty (60) days.

(d) The Medical Staff is involved in the use of developed criteria for autopsies. Members of the Medical Staff shall make all reasonable efforts to secure meaningful autopsies where possible when the following is evident:

(1) Unusual circumstances where important scientific or medical questions regarding the patient's death can be answered;

(2) Discrepancy between the clinical history and/or management; and

(3) In deaths where the Pathology Staff and Doctors are exposed to potential agents with unacceptability high personal risks, such as unexplained

dementia (e.g., Creutzfeldt Jacobs disease) or AIDS patients, the autopsy will be arranged at a facility equipped to handle such high risk cases.

Section 2. Medical Examiner's Cases:

It is the responsibility of the attending medical staff member or designee to notify the District Medical Examiner of any deaths that occur under the following circumstances:

When any person dies in the State:

(a) of criminal violence;

(b) by accident;

(c) by suicide;

(d) suddenly, when in apparent good health;

(e) unattended by a practicing physician or recognized practitioner;

(f) in any prison or penal institution;

(g) in police custody;

(h) in any suspicious or unusual circumstance;

(i) by criminal abortion;

(j) by poison;

(k) by disease constituting a threat to public health;

(l) by disease, injury, or toxic agent resulting from employment;

(m) when a dead body is brought into the State without proper medical certification; and

(n) when a body is to be cremated, dissected or buried at sea.

The District Medical Examiner shall be the authority in any case coming under any of the above-referenced categories to perform, or have performed, whatever Autopsies or Laboratory examinations he or she deems necessary in the public interest.

ARTICLE X

MISCELLANEOUS

Section 1. Disaster Plan:

(a) The Medical Staff of the NCH Healthcare System plays an integral role in hospital emergency response plans. Specific plans and policies for responding during an actual event are outlined in the NCH Emergency Operations Plan (EOP). NCH Medical Staff are required to participate in emergency response activities that apply to any medical surge, mass casualty, patient evacuation, or severe weather event. In addition, NCH medical Staff may be requested to participate in emergency response policy review, emergency plan exercises, drills, and training activities.

(b) During a severe weather event the following Medical Specialties will be required to board on-site.

(1) Emergency Department

(2) Hospitalist

(3) Critical Care / Intensivist (Downtown Hospital & North Naples Campus)

(4) Interventional Cardiology

(5) Orthopedic Surgery

(6) Pathology

(7) General Surgery

(8) Anesthesia

(9) Radiology: Interventional Neuroradiology, Interventional, Diagnostic

(10) Neonatology (North Naples Campus only)

(11) Pediatric Intensivist (North Naples Campus only)

(12) OB/GYN (North Naples Campus only)

Notification and ongoing communications during these events will be coordinated through the NCH Medical Staff Office or the NCH Incident Command Center.

Additional Medical Specialties may also be required to board on-site as determined by the Leadership Council.

(c) During an actual emergency event that requires a full-scale response by the NCH Healthcare System, the Medical Staff will be activated as needed by using the "on-call" system. Those Physicians/Practitioners who are on-call for their respective medical section, as designated in the AMION call system will be responsible for reporting to the Hospital for assignment.

(d) In the extreme case that patients must be evacuated externally to other hospital facilities, the primary Physician assigned to the patient or the On-call Physician as designated in section C above will be required to obtain medical coverage for the patient and to assist in the transfer process as requested by the NCH Medical Staff Office, NCH Incident Command Center and/or NCH Nursing Services.

Section 2. Reports:

It shall be the responsibility of each medical staff member to report, in writing, to the President of the Medical Staff or the Chief Executive Officer any conduct, acts or omissions by medical staff members, which are believed to be detrimental to the health or safety of patients or to the proper functioning of the hospital, or which violates professional ethics.

Section 3. General Rules Regarding Medical Staff Affairs:

(a) Medical staff members shall not create an audio or video recording of such meetings without the unanimous consent of all those in attendance.

(b) Written attendance records shall be maintained for all meetings of the medical staff, departments, and committees. This responsibility shall be discharged by the presiding officer of the meeting or a designee. Minutes of meetings shall reflect the educational program and clinical review conducted at each meeting and other issues and topics discussed and/or addressed. Unless confidential, members may request and will be provided with a copy of handouts and slides presentations.

Section 4. Research Activities:

(a) Participation in research projects by medical staff members is encouraged. To ensure adequate compliance with any applicable laws, regulations, or guidelines, medical staff members shall consult with and obtain the approval of the Investigational Review Board (IRB), a committee of the Board of Trustees, regarding any research projects in which they propose to participate.

(b) Policy considerations pertaining to medical and/or scientific research projects of the medical staff shall be reviewed by the Medical Executive Committee and by the Investigational Review Board (IRB), a committee of the Board of Trustees.

(c) The results of all research projects (clinical, statistical, or otherwise), and all publications written or provided by medical staff members using the name of this hospital, must be submitted to the Investigational Review Board (IRB), a committee of the Board of Trustees, for approval prior to publication.

(d) Specific protocols shall be followed in the case of any pharmaceuticals to be used. Such protocols shall be submitted to the Pharmacy and Therapeutics Committee for review and approval.

(e) Physicians shall not access patient records in PowerChart and perform research activities without formal approval from the IRB which must include patient consent and authorization for the defined research study.

Section 5. Orientation of New Medical Staff Members:

(a) Medical Staff Services, the hospital Health Information Management Department and nursing service shall orient each new medical staff member as to their respective areas, detailing those activities and/or procedures that will help new staff members in the performance of their duties.

(b) In addition, each new medical staff member shall be introduced to the various hospital departments by the Chief Executive Officer or a designee.

Section 6. Definitions:

The definitions contained in Article I of the Medical Staff Bylaws and the Credentialing Policy are hereby incorporated by reference and shall apply to these rules and regulations as well.

ARTICLE XI

AMENDMENTS OF THESE RULES AND REGULATIONS

(a) Rules and Regulations shall set standards of practice that are to be required of each individual exercising clinical privileges in the hospital, and shall act as an aid to evaluating performance under, and compliance with, these standards. These Rules and Regulations shall have the same force and effect as the Medical Staff Bylaws and the Credentialing Policy.

(b) Particular Rules and Regulations may be adopted, amended, repealed or added by vote of the Medical Executive Committee at any regular or special meeting, provided that copies of the proposed amendments, additions, or repeals are posted on the medical staff bulletin board and made available to all members of the Medical Executive Committee fourteen (14) days before being voted on, and further provided that all written comments on the proposed changes by individuals holding current appointments to the medical staff are brought to the attention of the Medical Executive Committee before the change is voted upon. Changes in the rules and regulations shall become effective when approved by the Board.

(c) These Rules and Regulations may also be adopted, amended, repealed, or added by the medical staff at a regular meeting or special meeting called for that purpose provided that the procedure used in amending the medical staff bylaws is followed. All such changes shall become effective when approved by the Board.

Approved by the Medical Executive Committee:	August 9, 2016
Approved by the Professional Capabilities Committee:	August 11, 2016
Approved by the Board of Trustees:	September 28, 2016
Revisions approved by the Medical Executive Committee:	May 11, 2020
Revisions approved by the Board of Trustees:	May 12, 2020
Revisions approved by the Medical Executive Committee:	July 14, 2020
Revisions approved by the Professional Capabilities Committee:	July 16, 2020
Revisions approved by the Medical Staff	July 21, 2020
Revisions approved by the Board of Trustees:	July 22, 2020