SUMMARY OF REQUEST

DATE:	November 29, 2023
FACILITY:	System-Wide
PROGRAM/PRODUCT LINE:	Medical Staff Bylaws and Rules and Regulations
REQUEST:	Request to Approve: (1) The Amendment to the Consulting Medical Staff Category of the Medical Staff Bylaws; and (2) The Newly Revised Rules and Regulations of the Medical Staff of Broward Health.
PURPOSE:	Federal and state law and The Joint Commission require that documents governing the medical staff be approved by the organized medical staff and the governing body. Unilateral changes by either the medical staff or the governing body are not legally permitted.
FISCAL IMPACT:	N/A
BUDGET STATUS:	N/A
LEGAL REVIEW:	The amendment to the Medical Staff Bylaws and the proposed revised Rules and Regulations obtained extensive legal review to ensure that they are consistent with federal and state laws and regulations and accreditation body standards.

APPROVED:  Shane Strum
11/22/2023 08:42 EST DATE: _____

Shane Strum, President/CEO

M E M O R A N D U M

TO: Board of Commissioners

FROM: Shane Strum, President/Chief Executive Officer

DATE: November 29, 2023

SUBJECT: Approval of the Amendment to the Consulting Medical Staff category of the Medical Staff Bylaws; and Approval of the Newly Revised Rules and Regulations of the Medical Staff of Broward Health

BACKGROUND

Medical Staff Bylaws

The current Bylaws of the Medical Staff of Broward Health ("Medical Staff Bylaws") governs all four (4) medical staffs of the North Broward Hospital District (the "District") and was originally adopted in 2013. At that time, several categories of Active Staff membership were created. The Consulting Medical Staff was among these categories, and it is promulgated in Section 3.3.6 of the Medical Staff Bylaws. The Consulting Medical Staff was created to admit licensed psychologists as members under certain circumstances, and to admit physicians and other licensed health care practitioners who practiced in a limited and highly specialized area of medicine or surgery but were unable to obtain board certification. Since 2013, the health care landscape has drastically changed due to community need, physician shortages, modifications to best practices, and different approaches to assessing the competency and quality of care of physicians and other licensed health care practitioners. Due to these changes and the needs of the District's patients, an amendment to the Consulting Medical Staff category in the Medical Staff Bylaws ("Bylaws Amendment") was proposed to the voting members of the Medical Staffs to clarify language, conform to best practice, and to permit additional Consulting Medical Staff members without board certification who can otherwise demonstrate competency and quality of patient care through other means. A side-by-side comparison of the currently written Consulting Medical Staff Category and the proposed Bylaws Amendment for your consideration and vote is attached hereto as Exhibit A.

Medical Staff Rules and Regulations

The current Rules and Regulations of the Medical Staff of Broward Health ("Current Rules and Regs") governs all four (4) medical staffs of the District and was originally adopted in 2006. While there have been significant changes to best practices, clinical quality, and standards governing the delivery of health care, since its enactment the Current Rules and Regs have only been amended once—in 2015. Given the necessity of modernizing the Medical Staffs' written standards, several members of the District's four (4) medical staffs worked with the District's Office of the General Counsel and reviewed current practices, prevailing trends, and industry standards, consulted with subject matter experts and various medical staff members of affected departments throughout the District, and cross-referenced current and suggested practices with federal and state law and accreditation body standards (such as The Joint Commission). The proposed and newly revised Rules and Regulations of the Medical Staff of Broward Health ("Proposed Rules"), which, if adopted, will supersede the Current Rules and Regs, combines this knowledge and expertise and provides clear guidance to currently serving and newly appointed medical staff members regarding the medical staffs' commitment to the quality and safety of patient care. A full copy of the Proposed Rules for your consideration and vote is attached hereto as Exhibit B.

A brief and high-level summary of the Proposed Rules is as follows:

1. Rules for Emergencies, Admissions, and Critical Care: Defines the appropriate categories of "qualified medical personnel" authorized to conduct medical screening examinations on patients, the stabilization and transfer of certain patients (including Baker Act patients), and standards governing the critical care of patients.

2. Rules for Care in the Hospital: Outlines the expectations of patient care, daily contacts, proper communication, appropriate uses of restraints or seclusion, requesting, responding, and documenting consultations, standards governing surgical interventions, joint responsibilities and standards of care for physicians and other health care practitioners (such as dentists, podiatrists, etc.), discharge processes, and procedures when dealing with deceased patients.
3. Medical Records and Health Information: Delineates state and federal law, accreditation standards, and hospital policies concerning proper documentation of medical records to facilitate the continuity of patient care including those pertaining to the use of electronic health records, authentication of signatures, countersignatures, timeliness of completion, consequences for chronic delinquency and habitual delinquency of completing medical records, permitted uses and disclosures consistent with HIPAA, documenting orders, performing histories and physicals and pre- and post-surgical evaluations, and completing discharge summaries.
4. Rules for Advanced Practice Providers: Provides standards and expectations governing advanced practice providers ("APPs") and their care of patients, the supervision and responsibility of APPs, and the procedures regarding concerns and actions taken against APPs.
5. Supervision of Residents, Fellows, Students, and Other Learners: Describes the oversight responsibilities of residents, fellows, and other student health care providers, including the roles of the Graduate Medical Education Committee (GMEC) and the educational expectations of all rotating learners and faculty members.

ACTION/PROJECT DESCRIPTION

Requesting Board approval of: (1) The Amendment to the Consulting Medical Staff category of the Medical Staff Bylaws; and (2) The adoption of the newly revised Rules and Regulations of the Medical Staff of Broward Health.

FINANCIAL/BUDGETARY IMPACT

There is no financial or budgetary impact associated with this request.

JUSTIFICATION

The amendment to the Consulting Medical Staff category of the Medical Staff Bylaws and the adoption of the Proposed Rules was approved by a majority of the voting members of the organized medical staff via a ballot vote on November 2, 2023. Final approval of the Board of Commissioners is required pursuant to federal and state law and The Joint Commission. The relevant provisions of such requirements are as follows:

- 42 C.F.R. § 482.12(a)(1) requires that the categories of practitioners eligible for appointment to the medical staff be determined and approved by the governing body of the hospital.
- 42 C.F.R. § 482.12(a)(4) requires that the governing body of a hospital approve the medical staff's bylaws and rules and regulations.
- 42 C.F.R. § 482.22(b)(1) requires that the medical staff, organized in a manner approved by the governing body of a hospital, be accountable to the governing body for the quality of patient care.
- 42 C.F.R. § 482.22(c)(1) requires that the medical staff bylaws be adopted by the medical staff and approved by the governing body of a hospital.
- Fla. Admin. Code R. 59A-3.272(4) requires that the governing board approve the bylaws and rules and regulations of the medical staff.
- Fla. Admin. Code R. 59A-3.275(1) requires that the medical staff be organized under a set of written bylaws approved by the governing body.

- The Joint Commission Standard MS.01.01.01 EP8 provides that the medical staff bylaws and rules and regulations are adopted by the medical staff and then subsequently approved by the governing body of the hospital.
- The Joint Commission Standard MS.01.01.03 provides that neither the medical staff nor the governing body may unilaterally amend the medical staff bylaws or rules and regulations.

STAFF RECOMMENDATIONS

***Staff Recommendation #1*:**

Therefore, it is requested that the Board of Commissioners of the North Broward Hospital District adopt the amendment to the Consulting Medical Staff category of the Bylaws of the Medical Staff of Broward Health as attached hereto in Exhibit A and incorporated herein by reference.

***Staff Recommendation #2*:**

Therefore, it is requested that the Board of Commissioners of the North Broward Hospital District supersede the current Rules and Regulations of the Medical Staff of Broward Health and adopt the newly revised Rules and Regulations of the Medical Staff of Broward Health to as attached hereto in Exhibit B and incorporated herein by reference.

EXHIBIT A

Amendment to the Consulting Medical Staff Category of the Medical Staff Bylaws

Consulting Medical Staff Category as Currently Written:

3.3.6. CONSULTING MEDICAL STAFF. The Consulting staff category shall consist of members who meet the following criteria:

3.3.6.1 Members who are trained and practice in a limited, but highly subspecialized area of medicine or surgery;

3.3.6.2. Licensed psychologists who are consulted to provide health care to patients and family members in the hospital within the scope of their practice in the form of consultative evaluations and therapy, per their Delineation of Privileges;

3.3.6.3. Because of their very limited, specialized activity in the Hospital, members of the Consulting staff do not have admitting privileges and do not vote.

The requirements of Section 2.1.7.2 regarding Board Certification may be met for an applicant to the Consulting Category who meets the following criteria: (i) completion of an ASTS (American Society of Transplant Surgeons) approved fellowship program; (ii) certification by the Board of Surgery in the country of surgical training; (iii) minimum of two years experience in transplant surgery for which privileges are being requested; (iv) recognized as a Fellow by the American College of Surgeons; and (v) cannot meet the Board Certification requirements due to circumstances regarding his or her training and has not otherwise been denied or failed to achieve Board Certification for any reason. Such waiver must be recommended by the Medical Executive Committee, upon consideration of the recommendation of its Credentials & Qualifications Committee.

Amendment to Consulting Medical Staff Category Proposed for Adoption:

3.3.6. CONSULTING MEDICAL STAFF. The Consulting Medical Staff category shall consist of members who meet the following criteria:

3.3.6.1 Members who are trained and practice in a limited, but highly subspecialized area of medicine or surgery;

3.3.6.2. Members who practice in a specialty or subspecialty of medicine or surgery needed to meet the Hospital's demand for services and there is a shortage of qualified members practicing in such specialties or subspecialties in the Hospital's service area; or

3.3.6.3. Licensed psychologists who are consulted to provide health care to patients and family members in the hospital within the scope of their practice in the form of consultative evaluations and therapy, per their Delineation of Privileges.

The requirements of Board Certification at appointment and reappointment as provided in Section 2.1.7.2 of these Medical Staff Bylaws may be waived for appropriately licensed Consulting Medical Staff members on a case-by-case basis following a recommendation from the Credentials and Qualifications Committee and approval of the Medical Executive Committee based upon a candidate's demonstrated Equivalent Competency (as defined below). Members of the Consulting Medical Staff do not have admitting privileges and do not vote.

For purposes of this Section 3.3.6, "Equivalent Competency" means any of the following: (i) board certification from another comparable and recognized certification board such as, without limitation, the American Board of Physician Specialties; (ii) board certification or the equivalency

of board certification granted in another country that is determined to be equivalent to U.S. certification; or (iii) a demonstrated ability of clinical competence and patient care, as determined in the sole discretion of both the Credentials and Qualifications Committee and the Medical Executive Committee, based on the individual's medical education, training, experience, and reputation as supported by reliable documentation concerning the individual's quality of care, relevant education and training, years of practice, continued medical education, academic affiliations, professional peer recommendations and references, and other relevant documentation supporting the individual's clinical competency.

EXHIBIT B

Newly Revised Medical Staff Rules and Regulations

RULES AND REGULATIONS

OF THE MEDICAL STAFF

OF BROWARD HEALTH

RULES AND REGULATIONS OF THE MEDICAL STAFF
OF BROWARD HEALTH

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RULES AND REGULATIONS OF THE MEDICAL STAFF
OF BROWARD HEALTH

I. PREAMBLE

These Rules and Regulations of the Medical Staff of Broward Health governs all four (4) medical staffs at Broward Health's four (4) regions' Hospitals and any future medical staffs who may be subject to the Bylaws of the Medical Staff of Broward Health (collectively, the "Medical Staff"), and is intended to incorporate current best practices in compliance with all applicable legal, accreditation, and regulatory requirements. Failure of any member of the Medical Staff to adhere to these Rules and Regulations may result in disciplinary action as delineated in the Bylaws of the Medical Staff of Broward Health ("Medical Staff Bylaws"). Except if explicitly limited by a particular section or context of a section, these Rules and Regulations shall be applicable to all members of the Medical Staff. Such Rules and Regulations shall be supplemental to the Bylaws, and to the extent these Rules and Regulations, or any portion hereof, conflicts or is inconsistent with the Bylaws, the Bylaws shall control. To the extent that these Rules and Regulations and/or the Bylaws conflicts or is inconsistent with Broward Health's enabling legislation, any applicable state or federal laws, rules and regulations, or any standards of accreditation applicable to any of Broward Health's regions (collectively, "Health Care Laws"), the Health Care Laws shall control as if fully set forth herein.

II. DEFINITIONS

The words and acronyms not defined in these Rules and Regulations shall have the meanings set forth in the Bylaws regardless of whether they are capitalized unless the context in which they are used clearly requires a different meaning or a different definition is prescribed for a particular section of these Rules and Regulations.

Words not defined shall be given their common and ordinary meaning unless the context in which they are used requires otherwise.

For purposes of these Rules and Regulations, the below terms shall have the following meanings associated with them:

1. **"Accreditation Bodies"** shall have the meaning ascribed to such term in Section VII.A. of these Rules and Regulations.

2. **"Admitting Physician/Practitioner"** means the Physician or other Practitioner with appropriate admitting privileges who admitted a Patient to an inpatient unit (or another Physician or Practitioner who has been delegated and accepts responsibility of the Patient), regardless of the Patient's admission status (i.e., observation or inpatient status), and who, within the Physician or Practitioner's scope of practice, is primarily responsible for a Patient's medical or psychiatric care at the Hospital.

3. **"Advanced Practice Provider"** or **"APP"** means an individual who is not a Physician or Practitioner, but who is duly licensed to practice in the State of Florida by their respective Florida licensing boards, who is qualified by academic and clinical training to perform acts requiring substantial specialized knowledge, judgment, and skill based upon applied principles of psychological, biological, physical, and social sciences, and who may otherwise function in a medical support role and provide direct patient care services under the direction and supervision of a Physician or other Practitioner. Such individuals include, without limitation, physician assistants,

anesthesiology assistants, and advanced practice registered nurses (advanced registered nurse practitioners, certified registered nurse anesthetists, certified nurse midwives).

4. **"Ambulatory Care"** means medical services performed on an outpatient basis, without admission to the Hospital or other facility.

5. **"Anesthesia Services"** has the meaning ascribed to such term in Section IV.D.5.a.i.

6. **"Authenticate"** means a unique and legible handwritten or electronic identifier/signature that is executed or adopted by the person providing health care services to the Patient and authoring the medical record's entry or note, and such person had the intent to sign such entry or note.

7. **"Authorized Consultant Designee"** means an Authorized Designee of a Consulting Physician/Practitioner who has been delegated authority by the Consulting Physician/Practitioner to provide follow-up care and/or Consultations to Patients.

8. **"Authorized Designee"** means a non-Physician and non-Practitioner who is qualified under state and federal law, who is under the supervision of a Physician or other Practitioner, and who has been delegated authority and responsibilities by the Physician or Practitioner to care for Patients on behalf of the Physician or Practitioner.

9. **"Authorized Receiving Individual"** shall have the meaning ascribed to such term in Section V.C.3.b.i.(b).

10. **"Baker Act"** means the Florida Mental Health Act, Part I of ch. 394, Fla. Stat. and its implementing regulations promulgated at Fla. Admin. Code R. 65E-5.

11. **"Broward Health"** means the fictitious name of the North Broward Hospital District.

12. **"Bylaws"** or **"Medical Staff Bylaws"** means the Bylaws of the Medical Staff of Broward Health, as amended from time to time and then in effect.

13. **"Call Coverage Policy"** means Broward Health Policy, GA-004-500: Call Coverage Policy, governing call coverage of the Emergency Departments at the Hospitals.

14. **"Chronically Delinquent"** shall have the meaning ascribed to such term in Section 5.6 of the Medical Staff Bylaws.

15. **"Computerized Provider Order Entries"** or **"CPOE"** means the process of entering and sending treatment instructions – including medication, laboratory, and radiology orders – via a computer application rather than paper, fax, or telephone.

16. **"Concurrent or Simultaneous Surgeries or Procedures"** means surgical procedures when the Critical or Key Components of the procedures for which the Primary Attending Surgeon is responsible are occurring all or in part at the same time.

17. **"Consult"** means the process when a Patient is receiving a Consultation by a Consulting Physician/Practitioner.

18. **"Consultation"** means an evaluation and management service provided on a limited basis at the request of another Physician, Practitioner, or other appropriate individual to either recommend care for a specific condition or problem, or to determine whether to accept responsibility for ongoing management of a Patient's entire care or for the care and treatment of a specific condition or problem.

19. **"Consultation Order"** means the request and order for a Consultation by the Requesting Physician/Practitioner, as further provided in Section IV.C.1.b.

20. **"Consulting Physician/Practitioner"** means a Practitioner performing a Consultation in an advisory capacity, deliberating with, and counseling the Requesting Practitioner, as further provided in Section IV.C.1.b.

21. **"Critical or Key Components"** means those stages of a surgical procedure, as determined by the Primary Attending Surgeon when essential technical expertise and surgical judgment are necessary to achieve an optimal Patient outcome.

22. **"Decedent"** means a Patient who expired while under the care of the Hospital.

23. **"Deep Sedation/Analgesia"** means a drug-induced depression of consciousness during which Patients cannot be easily aroused but respond purposefully following repeated or painful stimulation; cardiovascular function is usually maintained; the ability to independently maintain ventilatory function may be impaired; Patients may require assistance in maintaining a patent airway; and spontaneous ventilation may be inadequate.

24. **"DIO"** means the Designated Institutional Official of the GME Program as further outlined in Section VII.C.2.a. of these Rules and Regulations.

25. **"EHR"** means an electronic health record.

26. **"Emergency Department" or "ED"** means (1) the area of the Hospital licensed by the State of Florida as an emergency room or emergency department; (2) anywhere on the Hospital campus outside of the licensed emergency room or emergency department where a Patient presents themselves and requests examination or treatment (or such a request made on the Patient's behalf) for what may be an Emergency Medical Condition; or (3) anywhere on the Hospital campus outside of the licensed emergency room or emergency department where a Patient presents themselves and a prudent layperson observer would believe, based on the Patient's appearance or behavior, that the Patient needs emergency examination or treatment.

27. **"Emergency Care Statutes"** shall have the same meaning ascribed to such term in Section III.D.2.a.ii. of these Rules and Regulations.

28. **"Emergency Medical Condition"** shall have the same meaning ascribed to it at 42 C.F.R. § 489.24, as amended.

29. **"EMTALA"** means the Emergency Medical Treatment and Active Labor Act, codified in 42 U.S.C. § 1395dd, and the regulations promulgated thereunder.

30. **"Fellow"** means a person in fellowship training at Broward Health to obtain subspecialty board certification recognized by a specialty board of the American

Board of Medical Specialties or the American Osteopathic Association.

31. **"FIPA"** means the Florida Information Protection Act of 2014, § 501.171, Fla. Stat.

32. **"General Anesthesia"** means a drug-induced loss of consciousness during which Patients are not arousable, even by painful stimulation; cardiovascular function may be impaired; the ability to independently maintain ventilatory support is often impaired; and Patients often require assistance in maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function.

33. **"GME Advisory Committee"** means the Advisory Committee for Graduate Medical Education established under Section VII.C.3. of these Rules and Regulations.

34. **"GMEC"** means the Graduate Medical Education Committee described in Section VII.C.2. of these Rules and Regulations.

35. **"GME Learners"** shall have the meaning ascribed to such term in Section VII.C.1. of these Rules and Regulations.

36. **"GME Program"** shall have the meaning ascribed to such term in Section VII.C.1. of these Rules and Regulations.

37. **"H&P"** means a medical history and physical examination.

38. **"Habitually Delinquent"** shall have the meaning ascribed to such term in Section V.D.2.a.

39. **"Health Care Laws"** means any state or federal laws, rules, and regulations, including Broward Health's enabling legislation, ch. 2006-347, Laws of Florida, as amended, and any standards of accreditation applicable to any of Broward Health's Hospitals and/or governing the practice of medicine, all as amended from time to time and any subsequent legislation thereof.

40. **"HIM Department"** means the Health Information Management Department of the relevant Hospital responsible for maintaining a Patient's medical record and other protected health information and processing requests for medical information.

41. **"HIPAA"** collectively means the Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (codified at 42 U.S.C. § 1320(d), *et seq.* and 45 C.F.R. Parts 160 and 164), the Health Information Technology for Economic and Clinical Health Act (the HITECH Act) enacted under Title XIII of the American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, the 21st Century Cures Act, Pub. L. No. 114-255 (codified at 45 C.F.R. Parts 170 and 171), and all of the foregoing legislation's implementing statutes and regulations, all as amended from time to time and any successor legislation thereof.

42. **"HIPAA Privacy Rule"** shall mean the privacy regulations promulgated pursuant to HIPAA (Standards for Privacy of Individually Identifiable Health Information) found at 45 C.F.R. Part 160 and Subparts A and E of 45 C.F.R. Part 164.

43. **"HIPAA Security Rule"** shall mean the safeguards, standards, procedures, and security regulations promulgated pursuant to HIPAA (Security Standards for the

Protection of Electronic Protected Health Information) found at 45 C.F.R. Part 160 and Subparts A and C of 45 C.F.R. Part 164.

44. **"Hospital(s)"** means all the acute care hospitals with a medical staff that currently are, or in the future may be, owned and operated by Broward Health and that are governed under, without limitation, ch. 395, Fla. Stat. and regulations promulgated by the Florida Agency for Health Care Administration and Florida Department of Health.

45. **"Hospital Policy"** means any relevant policy and procedure of Broward Health and, to the extent applicable, any policy and procedure of the Hospital where the Physician or other Practitioner is providing Patient care.

46. **"ICU"** means the critical care unit, intensive care ward, or other area or department of the Hospital organized for the provision of care to critically ill patients that provides intensive and specialized medical and nursing care, an enhanced capacity for monitoring, and multiple modalities of physiologic organ support to sustain life during a period of life-threatening organ system insufficiency.

47. **"Immediately Available"** shall have the meaning ascribed to such term in Section IV.D.1. of these Rules and Regulations.

48. **"Informed Consent"** shall have the meaning ascribed to such term in § 766.103, Fla. Stat., the Florida Medical Consent Law.

49. **"Intern"** means a person with a medical degree or its equivalent who is continuing his or her medical training and is in the first year of residency and/or is in their first post-graduate year.

50. **"Involuntary Examination"** has the same meaning prescribed under the Baker Act.

51. **"Learners"** collectively means, and as described in more particularity in Section VII.A.1. of these Rules and Regulations, all allopathic, osteopathic, dental, podiatric, and pharmacy Students, Interns, Residents, Fellows, and other medical professionals rotating and/or being taught at one of Broward Health's Hospitals.

52. **"Medical Screening Examination"** means the initial screening exam and process performed by Qualified Medical Personnel, as delineated in Section III.D.1 of these Rules and Regulations, to determine, with reasonable clinical confidence, whether an Emergency Medical Condition exists when Patients present themselves to the Hospital's Emergency Department and request care.

53. **"Medical Staff"** means the four (4) medical staffs of Broward Health's four (4) Hospitals and any future established medical staffs who may be subject to the Medical Staff Bylaws.

54. **"Medical Staff Bylaws"** means the Medical Staff Bylaws of Broward Health governing and outlining the structure of the medical staffs at Broward Health's Hospitals.

55. **"Moderate Sedation/Analgesia"** means a drug-induced depression of consciousness during which Patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation; cardiovascular function is

usually maintained; no interventions are required to maintain a patent airway; and spontaneous ventilation is adequate.

56. **"Multidisciplinary Surgeries or Procedures"** means a surgery or procedure in which a surgeon of one specialty provides the exposure required by a second surgeon who performs the main surgical intervention (such as a general or thoracic surgeon providing exposure for a neurosurgeon or orthopedist to operate on the spine), or a surgery or procedure that requires the involvement of two or more surgeons of different specialties (such as chest wall or head and neck resection followed by plastic surgical reconstruction, face or hand transplantation, and repair of complex craniofacial defects).

57. **"Overlapping Surgeries or Procedures"** means the practice of the Primary Attending Surgeon initiating and participating in another surgical operation when such Primary Attending Surgeon has completed the Critical or Key Components of the first surgical procedure and is no longer an essential participant in the final phase of the first surgical procedure.

58. **"Patient(s)"** means the individual(s) who present to the Hospital needing or requesting medical care and treatment.

59. **"Permitted Uses and Disclosures"** shall have the meaning ascribed to such term in Section V.B.1.

60. **"Physically Present"** shall have the meaning ascribed to such term in Section IV.D.1. of these Rules and Regulations.

61. **"Physician"** means a doctor of medicine licensed under ch. 458, Fla. Stat. or a doctor of osteopathy licensed under ch. 459, Fla. Stat. and who is a member of the Medical Staff.

62. **"Practitioner"** means, as applicable, properly licensed dentists, oral and maxillofacial surgeons, podiatrists, and psychologists who are current members of the Medical Staff.

63. **"Primary Attending Surgeon"** means the surgical primary Physician or other Practitioner of record or the principal surgeon involved in a specific operation who, in addition to technical and clinical responsibilities, is responsible for the orchestration and progress of a procedure.

64. **"Qualified Anesthetists"** has the meaning ascribed to such term in Section IV.D.5.a.i.

65. **"Qualified Medical Personnel"** means those categories of individuals set forth in Section III.D.1.a.ii. of these Rules and Regulations.

66. **"Read-Back Process"** shall have the meaning ascribed to such term in Section V.C.3.b.i.(c).

67. **"Regional Anesthesia"** means the delivery of anesthetic medication at a specific level of the spinal cord and/or to peripheral nerves, including epidurals and spinals and other central neuraxial nerve blocks.

68. **"Regional Medical Staff Office"** means the administrative department of each Hospital that oversees the administrative affairs of the Medical Staff, and that assists Physicians and other Practitioners, Broward Health's administration, and other personnel by providing resources and information concerning, without limitation, Medical Staff membership, the exercise of clinical privileges, Emergency Department call coverage schedules, and Medical Staff committees and meetings.

69. **"Requested Physician/Practitioner"** means the Physician or other Practitioner who is contacted and requested to provide a Consultation pursuant to a Consultation Order, as further provided in Section IV.C.1.b.

70. **"Requesting Physician/Practitioner"** means the Physician or other Practitioner who requests a Consultation and is authorized pursuant to Section IV.C.1.b. of these Rules and Regulations to request such a Consultation.

71. **"Resident"** means a person who has completed an internship and is engaged in a program of training at Broward Health designed to increase such individual's knowledge of the clinical disciplines of medicine, surgery, pharmacy, dentistry, or any of the other special fields which provide advanced training in preparation for the practice of a specialty.

72. **"Routine Consultation"** means any Consultation being requested or performed that is not in the nature of or otherwise designated as a STAT Consultation.

73. **"Rules and Regulations"** means these Rules and Regulations of the Medical Staff of Broward Health.

74. **"Specialty-Specific Training Program"** shall have the meaning ascribed to such term in Section VII.C.1. of these Rules and Regulations.

75. **"Sponsorship Agreement"** shall have the meaning ascribed to such term in Section VI.B.1. of these Rules and Regulations.

76. **"Sponsoring Physician/Practitioner"** shall have the meaning ascribed to such term in Section VI.B.1. of these Rules and Regulations.

77. **"STAT Consultation"** means a Consultation being requested or performed on an emergent, immediate, or priority basis.

78. **"Student"** means those students currently attending medical, dental, and other health care professional educational institutions who wish to rotate at the Hospital or another Broward Health facility.

III. RULES FOR EMERGENCIES, ADMISSIONS, AND CRITICAL CARE

A. Types of Patients

All Patients, without regard to race, color, creed, religion, sex, gender, sexual orientation or status, national origin, domicile or place of residence, handicap, age, financial status, or ability to pay, shall be accepted whose requirements for care are available and within the Hospital's service capability. Patients whose illness cannot be treated within the capability of the Hospital shall not be admitted to the Hospital and shall be transferred accordingly.

B. Admitting Privileges of Physicians and Practitioners

Only Physicians or other Practitioners with appropriate clinical admitting privileges as provided in their delineation of privileges may admit Patients to the Hospital.

C. Admitting and Provisional Diagnoses

All Patients admitted to the Hospital shall have an admission diagnosis. A provisional diagnosis for emergency admissions shall be provided as promptly as possible.

D. Special Rules for Emergency Patients

1. *Medical Screening Examinations*

a. Medical Screening Examinations Generally

i. Medical Screening Examinations.

Patients presenting to the Hospital's Emergency Department shall receive an appropriate Medical Screening Examination by a Qualified Medical Personnel within the capability of the Hospital's ED, including ancillary services routinely available to the ED, to determine whether an Emergency Medical Condition exists. A Medical Screening Examination is to be provided to all individuals regardless of diagnosis, financial status, ability to pay, race, color, creed, religion, sex, gender, sexual preference or status, national origin, domicile or place of residence, handicap, or age.

ii. Qualified Medical Personnel.

Medical Screening Examinations may only be done by Qualified Medical Personnel. "Qualified Medical Personnel" includes the following individuals:

(a) ED Physicians;

(b) Residents and/or Fellows rotating through the Hospital and under the supervision of an ED Physician;

(c) Physician assistants and advanced practice registered nurses under the supervision of an ED Physician;

(d) In cases of obstetric Patients, registered nurses with appropriate competencies, certified nurse midwives, other advanced practice registered nurses, ED Physicians, and other Physicians who are otherwise trained in obstetrics; and/or

(e) Non-ED Physicians who are active and good-standing members of the Medical Staff, provided the Medical Screening Examination is not significantly delayed as a result.

b. Medical Screening Examinations on Pregnant Patients, Patients in Labor, and Infants

i. Screening of Pregnant Patients. When a pregnant Patient presents to the Hospital, a Qualified Medical Personnel shall examine and determine whether the Patient's presenting complaint is solely related to labor.

ii. Patients in Labor. Patients reporting the onset of labor without other medical complications and a gestational age greater than twenty (20) weeks shall be transported, to the extent practicable, to the Labor and Delivery Unit (to the extent the Hospital has a Labor and Delivery Unit) where they shall receive a complete Medical Screening Examination by a Qualified Medical Personnel.

iii. Patients not in Labor. All other pregnant Patients presenting to the Hospital shall receive a Medical Screening Examination in the same manner in the Emergency Department without being transferred to the Labor and Delivery Unit.

iv. Treatment Plans. Unless an Emergency Medical Condition exists, and only to the extent practicable, if the Medical Screening Examination determines a pregnant Patient is not in active labor, the Patient's treatment plan shall be determined by the obstetric Physician or Advanced Practice Provider that is providing the Patient's prenatal care.

v. Unassigned Patients. In the case of an unassigned Patient who has had either no prenatal care or care by a Physician or Advanced Practice Provider who is not available or not a member of the Medical Staff, a Consultation with the on-call obstetric Physician shall be generated and the on-call obstetric Physician shall determine the Patient's treatment plan.

vi. Infant Examinations. If an infant was born alive in the ED or elsewhere on the Hospital's campus and a request was made on that infant's behalf for Medical Screening Examination, or if a prudent layperson would conclude, based on the infant's appearance or behavior, that the infant needed examination, treatment for a medical condition, or otherwise was suffering from an Emergency Medical Condition, then a Qualified Medical Personnel shall perform a proper Medical Screening Examination on the born-alive infant.

c. Medical Screening Examinations of Psychiatric Patients

A Qualified Medical Personnel may conduct the Medical Screening Examination of psychiatric Patients presenting to the Hospital. To the extent that the Hospital is a Baker Act receiving facility and the Patient is deemed a Baker Act Patient or an Involuntary Examination under the Baker Act has been initiated, such Patient shall be transported, to the extent practicable, to the Hospital's Psychiatric Unit to complete the Involuntary Examination.

2. *Stabilization and Transfer of Patients with Emergency Medical Conditions*

   a. General Rules Regarding Stabilization and Transfer of Patients

      i. Stabilizing Treatment. After a Medical Screening Examination has been performed on the Patient and prior to the transfer of such Patient, such Patient shall be provided stabilizing treatment within the Hospital's and Qualified Medical Personnel's capability and capacity if the Medical Screening Examination determines that the Patient has an Emergency Medical Condition.

      ii. Compliance with EMTALA. The stabilization and transfer of Patients presenting to the ED shall always be consistent with Hospital Policy and the Hospitals' obligations under EMTALA as well as the Medicare Conditions of Participation and § 395.1041, Fla. Stat., all as amended from time to time and then in effect. To the extent that these Rules and Regulations and/or Hospital Policy conflict with EMTALA, the Medicare Conditions of Participation, and § 395.1041, Fla. Stat. (collectively, the "Emergency Care Statutes"), the Emergency Care Statutes shall control as if fully set forth herein.

      iii. Insufficient Capability or Capacity. If the Patient's condition requires immediate medical stabilizing treatment and the Hospital is not able to attend to that Patient because the Emergency Department is operating beyond its capacity, then the Hospital shall transfer the Patient to a hospital that has the capability and capacity to treat the individual's Emergency Medical Condition.

      iv. Transfers of Patients. Once it is determined that a Patient has an Emergency Medical Condition, the Patient may not be transferred prior to being stabilized unless:

         (a) The Patient (or a person acting on the Patient's behalf) requests a transfer in writing after being informed of the Hospital's obligations under EMTALA and the risks of the transfer;

         (b) A Physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from treatment at another facility outweigh the increased risks to the Patient and, in the case of labor, to the unborn child; or

         (c) If a Physician is not present in the ED, a Qualified Medical Personnel has signed the certification after consultation with a Physician, the Physician determines the benefits of the transfer outweigh the increased risks, and the Physician subsequently countersigns the certification.

      Notwithstanding the foregoing, prior to the transfer, the Patient shall be treated within the Hospital's capacity to minimize the risks to the Patient's health and, in the case of a woman in labor, the health of the unborn child; the Hospital shall ensure the receiving facility has

available space and qualified personnel for the treatment of the individual; and the Hospital shall ensure the receiving facility has accepted the transfer.

b. Stabilization and Transfer of Patients in Labor

i. If a Patient is in labor, the Hospital shall deliver the baby and the placenta or transfer appropriately; provided, however, the Patient in labor may not be transferred unless the Patient, or a legally responsible person acting on the Patient's behalf, requests a transfer and a Physician or other Qualified Medical Personnel, in consultation with a Physician, certifies that the benefits to the Patient and/or the unborn child outweigh the risks associated with the transfer.

c. Stabilization and Transfer of Patients with Psychiatric Emergency Medical Conditions

i. Stabilization of Patients with Psychiatric Emergency Medical Conditions

(a) Stabilization of Psychiatric Conditions. If the Patient's Emergency Medical Condition is related to a psychiatric issue, stabilizing treatment may include the administration of chemical or physical restraints in accordance with Section IV.B. of these Rules and Regulations, Hospital Policy, standards imposed by The Joint Commission, and state and federal law.

(b) Documentation and Communication. For Patients requiring psychiatric stabilization and who are admitted to the Hospital, in addition to the applicable documentation and assessments required in Section V.C. of these Rules and Regulations and other documentation required in the medical record by state and federal law, the Admitting Physician/Practitioner shall also be responsible for verbally communicating to all appropriate parties any applicable information, as may be necessary, to protect the Patient from self-harm and/or to protect others.

ii. Transfers and Involuntary Examinations of Patients with Psychiatric Emergency Medical Conditions

(a) Non-Baker Act Transfers

To the extent a Patient is not a Baker Act Patient and/or no Involuntary Examination under the Baker Act has been initiated, the Patient may be transferred or discharged in the same manner as other Patients once stabilized.

(b) Baker Act Transfers and Involuntary Examinations

The following procedures shall be applicable to Baker Act Patients and Patients for whom an Involuntary Examination under the Baker Act has been initiated:

(i) Compliance with Baker Act and Policy. Involuntary Examinations to determine whether a Patient meets criteria for involuntary inpatient or outpatient placement under the Baker Act shall be completed in accordance with Hospital Policy and the Baker Act and may only be performed by a Physician, clinical psychologist, or a psychiatric nurse performing within the framework of an established protocol with a psychiatrist.

(ii) Baker Act Receiving Facilities. Hospitals designated Baker Act receiving facilities shall transfer Patients for whom an Involuntary Examination under the Baker Act has been initiated to the Hospital's Psychiatric Unit, as soon as practicable, for such Patient's Involuntary Examination. The Involuntary Examination period at the Hospital that is a Baker Act receiving facility may not exceed seventy-two (72) hours. If such Hospital determines that the Patient does meet the criteria for involuntary outpatient services or involuntary inpatient placement, the proper procedures under Hospital Policy and the Baker Act shall be adhered to regarding the placement and treatment of the Patient.

(iii) Non-Baker Act Receiving Facilities. To the extent that the Hospital is not a Baker Act receiving facility, such Hospital shall: (i) notify the proper Baker Act receiving facility of the Patient's transfer within two (2) hours after the Patient's condition has been stabilized, and (ii) transfer the Patient to such Baker Act receiving facility within twelve (12) hours of the Patient's stabilization or as soon as otherwise practicable.

(iv) Baker Act Documentation. In all instances, proper protocol, documentation, transfer, notice, discharge, and any other requirements imposed under relevant Hospital Policy and pursuant to Florida law shall be followed for all Baker Act Patients and Patients for whom an Involuntary Examination under the Baker Act was initiated.

(v) Baker Act Discharges. Discharges of any Baker Act Patients or Patients for whom an Involuntary Examination has been initiated shall be consistent with the requirements of Section IV.F.2. and proper notice and documented approval shall be provided in accordance with the Baker Act for the release of any Baker Act Patient or Patient for whom an Involuntary Examination was initiated.

3. *Applicable Definitions*

a. For purposes of this Section III.D. of these Rules and Regulations, a Patient is being "transferred" if there is movement (including the discharge) of Patient outside the Hospital's facilities at the direction of any person employed by (or

affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of an Patient who (i) has been declared dead, or (ii) leaves the Hospital facility without the permission of any such person.

b. For purposes of this Section III.D. of these Rules and Regulations, a Patient is "being stabilized" when (1) necessary medical treatment is provided to ensure that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of a non-labor Patient from the Hospital; (2) with respect to Patient's in labor, that the Patient has delivered the child and the placenta; or (3) when necessary treatment is provided to ensure that the Patient is protected and prevented from injuring or harming the Patient's self or others.

c. For purposes of this Section III.D. of these Rules and Regulations, a Patient is "stabilized" if (1) no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of a non-labor Patient from the Hospital; (2) with respect to Patient's in labor, that the Patient has delivered the child and the placenta; or (3) with respect to a psychiatric Patient, that the Patient is protected and prevented from injuring or harming the Patient's self or others.

E. ICU Admissions

1. Evaluations. Any Patient admitted to the ICU shall be evaluated at the bedside by the Admitting Physician/Practitioner and/or the intensive care Physician ("Intensivist"), or Authorized Designee, as soon as possible, but no later than two (2) hours after the admission order(s) is written.

2. Coordination of Care. The Admitting Physician/Practitioner or transferring Physician or other Practitioner is required to Consult with the Intensivist or Authorized Designee and shall have verbal communication to coordinate such care as is clinically required.

3. Accepting Patients to the ICU. If the ICU follows a closed protocol, acceptance of the Patient is required by the Intensivist.

F. Emergency Department Call Coverage

1. Call Coverage Policy. In order to meet the needs of Patients and to comply with applicable regulatory requirements, all Physicians and other Practitioners providing Emergency Department call coverage are subject to the Call Coverage Policy, as amended, and the Physician's or other Practitioner's call coverage contract with Broward Health.

2. Responding to Calls. The response time of on-call Physicians or Practitioners to respond to requests is delineated in the Call Coverage Policy and the Physician's or other Practitioner's call coverage contract with Broward Health. All Physicians and Practitioners providing Emergency Department call coverage shall respond in the appropriate timeframe required and failure to do so may subject the Physician or other Practitioner to disciplinary action pursuant to the Medical Staff Bylaws, under the Call Coverage Policy, and under state and federal law.

3. Refusing Care. In accordance with the requirements of EMTALA, no Physician or Practitioner providing Emergency Department call coverage may refuse an appropriate transfer accepted by the Hospital.

4. Disputes. The decision regarding the need for the on-call Physician or other Practitioner to physically come to the Hospital and examine the Patient shall be in the sole judgment of, and any dispute over a request to physically come to the Hospital shall always be resolved in favor of, the ED Physician or other Physician or Practitioner who has personally examined and is currently treating the Patient.

5. Unavailability. If the on-call Physician or Practitioner is unable to respond to the Emergency Department due to situations beyond the Physician's or other Practitioner's control (e.g., transportation failure, personal illness, etc.) it is the responsibility of the on-call Physician or Practitioner to notify the ED Physician of the situation and assist in arranging care for the Patient.

IV. RULES FOR CARE IN THE HOSPITAL

A. Inpatient Care Responsibilities Generally

1. Physician Care. In accordance with Section 4.2.11 of the Medical Staff Bylaws, Patients admitted to the Hospital shall be under the care of a Physician member of the Medical Staff with respect to any medical or psychiatric problem that is present on the Patient's admission or develops during the Patient's hospitalization.

2. Patient Responsibility. The Patient's Admitting Physician/Practitioner shall be ultimately responsible for the primary medical care and treatment of each Patient admitted to the Hospital regardless of the Patient's admission status (i.e., observation or inpatient status).

3. Temporary Absences. It is the responsibility of the Admitting Physician/Practitioner to find another Physician or other Practitioner to provide appropriate coverage during the period of the Admitting Physician/Practitioner's temporary absence. For purposes of this Section IV.A.3., "appropriate coverage" means an advance arrangement with another Physician or other appropriate Practitioner to provide care for the Admitting Physician/Practitioner's Patients and to assume the Admitting Physician/Practitioner's responsibilities during the period of the Admitting Physician/Practitioner's temporary absence. The Admitting Physician/Practitioner shall notify the Regional Medical Staff Office of the Physician or other appropriate Practitioner assuming such temporary care and a working phone number to contact such Physician or Practitioner.

4. Leaves of Absence. To the extent the Admitting Physician/Practitioner wishes to take a Leave of Absence, in addition to the foregoing requirements, the Admitting Physician/Practitioner shall follow the standards and provisions of Section 2.12 of the Medical Staff Bylaws.

5. Transfer of Patient Care. Whenever the care of a Patient is transferred to another Physician or Practitioner, a note shall be entered in the Patient's medical record indicating such transfer and a note shall be entered by the Physician or other appropriate Practitioner accepting the transfer and responsibility of the Patient.

If the transfer of care to another Physician or Practitioner is expected or anticipated, the current/outgoing Physician or Practitioner shall notify the Patient and/or the Patient's authorized representative of the new/incoming Physician or Practitioner who shall be assuming primary responsibility for the Patient's care. Alternatively, the new/incoming Physician or Practitioner may make such notification.

6. Daily Evaluation of Patients. The Admitting Physician/Practitioner shall see, evaluate, update the Patient's management plan (as appropriate), and document such encounter of each Patient within twenty-four (24) hours of admission and at least once per calendar day during the Patient's hospitalization. If the Admitting Physician/Practitioner's Authorized Designee rounds on the Patient, the Admitting Physician/Practitioner still maintains ultimate responsibility for the care of the Patient in accordance with any applicable collaborative agreement, teaching responsibilities, policy, procedure, these Rules and Regulations, the Medical Staff Bylaws, and/or applicable state and federal laws.

7. Patient Communication. The Admitting Physician/Practitioner shall keep the Patient and/or the Patient's authorized representative(s) properly informed concerning the Patient's medical condition throughout the Patient's hospitalization. The Admitting Physician/Practitioner shall ensure that the Patient and/or the Patient's authorized representative(s) are provided with sufficient information concerning the Patient's care that includes, but is not limited to, the following:

    a. Conditions that may result in the Patient's transfer to another facility or level of care;

    b. Alternatives to transfer, if any;

    c. The clinical basis for discharge;

    d. The anticipated need for continued care following discharge;

    e. Educational information regarding how to obtain further care, treatment, and/or services needed, as appropriate; and

    f. Disclosure of unexpected outcomes known to the Admitting Physician/Practitioner, in accordance with any relevant and applicable Hospital Policy.

8. Timely and Accurate Documentation. The Admitting Physician/Practitioner shall be responsible for timely and accurate completion of the Patient's medical record, for appropriate documentation justifying the care provided, and for providing the Patient and/or the Patient's authorized representative(s) with pertinent information regarding outcomes of diagnostic tests, medical treatment, and surgical intervention.

B. Seclusion and Use of Restraints on Patients

1. Compliance with Law and Policy. The use of restraints and/or seclusion shall always be in accordance with 42 C.F.R. § 482.13(e), Fla. Admin. Code Rule 59A-3, accreditation standards, and, as applicable, ch. 394, Fla. Stat., Fla. Admin.

Code Rule 65E-5, and any relevant Hospital Policy.

2. Use of Restraints or Seclusion. Restraints or seclusion may only be used on Patients when less restrictive interventions have been determined to be ineffective to protect the Patient, Hospital staff, or others from harm and the type or technique of restraint or seclusion used shall be the least restrictive intervention that will be effective to protect the Patient, Hospital staff, or others from harm.

3. Prohibited Uses of Restraints or Seclusion. Restraints or seclusion may not be used as punishment, retaliation, coercion, or for the convenience of Hospital staff.

4. Individualized Orders and Length of Time. Restraints or seclusion shall only be based on individual orders, and shall be discontinued at the earliest possible time, regardless of the length of time identified in the Physician's or other Practitioner's order.

5. No Standing Orders. Orders for the use of restraints or seclusion shall never be written as a standing order or on an as-needed basis (PRN).

6. Restraints or Seclusion on Baker Act Patients. When restraints or seclusion is used on a Baker Act Patient, such restraints or seclusion shall be properly documented in the Baker Act Patient's medical record and shall contain all documentation required by the Florida Department of Children and Families as well as any applicable requirements of ch. 394, Fla. Stat., Fla. Admin. Code Rule 65E-5, and any relevant Hospital Policy.

7. Restraints or Seclusion on Non-Baker Act Patients. When restraints or seclusion is used on a non-Baker Act Patient, such restraints or seclusion shall be properly documented in the Patient's medical record and shall include all other documentation requirements imposed under state or federal law or any relevant Hospital Policy.

C. Rules Pertaining to Consultations

1. *General Consultation Requirements*

a. Purpose. The purpose of a Consultation is to provide the Patient with prompt specialty evaluation, clinical management, and delivery of comprehensive care and treatment.

b. Responsibility for Requesting Consultations. The Admitting Physician/Practitioner is responsible for requesting Consultations from other Physicians or Practitioners based on the clinical needs or indications of the Patient. Only the Admitting Physician/Practitioner, an Emergency Department Physician (for an emergent Consultation), or a closed-unit Intensivist for Patients in the ICU (each, a "Requesting Physician/Practitioner") may request or order a Consultation ("Consultation Order"). The Physician or Practitioner being requested to provide a Consultation shall be referred to as a "Requested Physician/Practitioner." The Requested Physician/Practitioner (or another Physician or Practitioner

who has been delegated and accepts the responsibility for Consulting the Patient) becomes a "Consulting Physician/Practitioner" after accepting a request for a Consultation.

c. Consultations for Patients in the ICU. If the Patient is admitted to the ICU and the Hospital's ICU follows a closed-unit model, the Intensivist responsible for the Patient's care in the ICU shall endeavor to use the Admitting Physician/Practitioner's preferred Consulting Physician/Practitioners.

d. Prohibited Orders and Consultations. Non-Physicians and non-Practitioners may not independently order Consultations (but may enter an order at the direction of a Physician or other Practitioner), and the Consulting Physician/Practitioner may not Consult other consultants.

e. Additional Consultations. In the event a Consulting Physician/Practitioner determines or believes additional Consultations are indicated beyond the scope of the Consulting Physician/Practitioner's practice, the Consulting Physician/Practitioner shall note such recommendation in the Patient's medical record and verbally communicate such recommendation (in person or by telephone) to the Requesting Physician/Practitioner.

f. Emergencies. Notwithstanding the foregoing, if a Consultation is needed on an emergency basis when the Patient is being seen by the Consulting Physician/Practitioner, the Consulting Physician/Practitioner may order a STAT Consultation. In such an event, the Consulting Physician/Practitioner shall promptly document such request for a Consultation via a Consultation Order in the Patient's medical record and notify the Requesting Physician/Practitioner as soon as practicable.

g. Satisfactory Consultations. A satisfactory Consultation includes an examination of the Patient, a review of all pertinent sections of the Patient's medical record, proper documentation/orders of the Consulting Physician/Practitioner's findings and recommendations (as explained in further detail below), and any verbal communication to applicable parties, as appropriate.

2. *Consulting Priority*

a. Routine Consultations

i. Routine Consultations by On-Call Physicians and Practitioners. When a Routine Consultation is ordered for the applicable Physician or other Practitioner who is on call, the on-call Physician or Practitioner shall evaluate the Patient and respond to the Routine Consultation request in the time and manner requested and required under the Physician's or other Practitioner's call coverage contract with Broward Health and Hospital Policy. Unless the Consultation is accepted by another Physician or Practitioner, on-call Physicians and Practitioners are responsible for Consultations ordered while the Physician or Practitioner was providing call coverage even if the Physician's or Practitioner's call-coverage period ended when the Physician or Practitioner was notified of the Consultation request.

ii. Routine Consultations by Physicians or Practitioners not On-Call. Physicians and other Practitioners who are not otherwise on call when the Routine Consultation is ordered may decline the request for Routine Consultation but shall promptly notify the appropriate nursing unit advising of such declination so the nursing unit may contact another Physician or appropriate Practitioner or the Physician or Practitioner currently providing call coverage.

iii. Time for Completion. A Routine Consultation shall be performed within twenty-four (24) hours of the Consultation order, but the Physician or Practitioner shall endeavor to perform the Routine Consultation, to the extent practicable, on the same day the request was made.

iv. Documentation of Routine Consultations. Upon completion of the Routine Consultation, an opinion or report shall be documented in the Patient's medical record consistent with Section IV.C.4. When a Routine Consultation is made in connection with an operation or procedure, such written opinion or report shall be completed and properly documented in the Patient's medical record prior to the commencement of such operation or procedure except in cases of emergencies.

b. STAT Consultations

i. Notification of STAT Consultation Requests. When a STAT Consultation is requested, it is the responsibility of the Requesting Physician/Practitioner to personally notify the Requested Physician/Practitioner to perform the STAT Consultation that a priority STAT Consultation is being requested and discuss the circumstances giving rise to the STAT Consultation.

ii. Manner of Requesting STAT Consultations. All STAT Consultation requests shall be called to the Requested Physician/Practitioner or the Requested Physician/Practitioner's office or service regardless of the time the request for a STAT Consultation was made.

iii. Designation of STAT Consultations. The Requesting Physician/Practitioner and Requested Physician/Practitioner shall both agree on the STAT nature and designation of the STAT Consultation otherwise the Consultation shall be deemed a Routine Consultation.

iv. STAT Consultations by On-Call Physicians and Practitioners. Physicians and Practitioners providing call coverage are required to accept all STAT Consultations.

v. STAT Consultations by Physicians or Practitioners not On-Call. Requested Physician/Practitioners not providing call coverage shall return the Consultation request call within thirty (30) minutes and advise if the Requested Physician/Practitioner is accepting the STAT Consultation.

vi. Performing STAT Consultations. Once the Requested

Physician/Practitioner becomes the Consulting Physician/Practitioner, either because the Requested Physician/Practitioner accepts the STAT Consultation or because the Physician or other Practitioner is providing call coverage and is required to respond to the STAT Consultation, such STAT Consultation shall be performed within four (4) hours of the Consulting Physician/Practitioner's acceptance unless the Patient's clinical condition requires the Consultation to be performed sooner.

vii. Documentation of STAT Consultations. Upon completion of the STAT Consultation, a written opinion or report shall be documented in the Patient's medical record consistent with Section IV.C.4. When the STAT Consultation is made in connection with an operation or procedure, such written opinion or report shall be completed and properly documented in the Patient's medical record prior to the commencement of such operation or procedure except in cases of emergencies.

viii. Proper Communication. Physician/Practitioner to Physician/Practitioner communication shall always be required for STAT Consultations. All findings, conclusions, orders, and opinions of the Consulting Physician/Practitioner performing a STAT Consultation shall be communicated verbally to the Requesting Physician/Practitioner in addition to properly documenting in the Patient's medical records consistent with Section IV.C.4.

ix. Completion of STAT Consultation. For purposes of this Subsection IV.C.2.b., the STAT Consultation is deemed to have been performed and completed when the Physician or other Practitioner has personally evaluated the Patient; documented their assessment, findings, and recommendation(s) relevant for the management of care of the Patient in the Patient's medical record consistent with Section IV.C.4.; and verbally communicated such recommendations and findings to the Requesting Physician/Practitioner.

3. *Consultations for Trauma Patients*

a. Consultations for trauma Patients shall be consistent with Hospital Policy, Florida's Trauma Center Standards promulgated by the Florida Department of Health, and any applicable certification requirements fashioned by the American College of Surgeons or other relevant accreditation or licensing body.

4. *Documenting Consultations*

a. Consultation Orders Required. All requests for Consultations shall be properly documented in the Patient's medical record via a Consultation Order, and, except in emergency cases, Consultations may not to be performed without a Consultation Order. In emergency situations, a Consultation Order shall be entered electronically into the Patient's medical record as soon as practicable.

b. Contents of Consultation Orders. Consultation Orders by Requesting

Physician/Practitioners shall include:

i. The name of the Requesting Physician/Practitioner;

ii. The name of the Consulting Physician/Practitioner and/or appropriate specialty being Consulted;

iii. The timeframe requested for the Consultation (i.e., STAT or routine); and

iv. The reason, need, and/or clinical indication(s) for the Consultation.

c. Documentation by Consulting Physician/Practitioners. Consulting Physician/Practitioners responding to a request for a Consultation shall properly document:

i. The Consulting Physician/Practitioner's name; and

ii. Written documentation of the Consulting Physician/Practitioner's assessment, evaluation, findings, and recommendation(s) that properly address the specific request for the Consultation.

Notwithstanding the foregoing, the Consultation is not required to be limited in its scope, and the Consulting Physician/Practitioner may determine other issues within the Consulting Physician/Practitioner's field of practice which can and should be addressed by the Consulting Physician/Practitioner and communicated to the Requesting Physician/Practitioner.

d. Orders by Consulting Physician/Practitioners. The Consulting Physician/Practitioner or a non-Physician or non-Practitioner may enter orders for a Patient at the request of the Requesting Physician/Practitioner. However, if performed after usual daytime hours, the Consulting Physician/Practitioner is encouraged to enter orders so as to not delay patient care, unless expressly prohibited from so doing by the Requesting Physician/Practitioner in non-emergency or STAT Consultation cases.

e. Additional Documentation Requirements for Consultations by Residents, Fellows, or APPs. When Consultations are performed by a Resident, Fellow, or APP, in addition to the above-mentioned documentation requirements, the supervising Consulting Physician/Practitioner shall be identified, including a mode of preferred communication, to address comments or questions.

5. *Ongoing Consultation Services*

a. Daily Patient Encounters. Consulting Physician/Practitioners shall see each Patient for the condition or basis which prompted the Consultation request and properly document the assessment, evaluation, findings, and recommendation(s) of each Patient consistent with Section IV.C.4. as clinically indicated until the Consulting Physician/Practitioner has completed the requested care or treatment of the Patient.

b. Temporary Absences. It is the responsibility of the Consulting Physician/Practitioner to find another Physician or appropriate Practitioner to

provide appropriate coverage during the period of the Consulting Physician/Practitioner's temporary absence. For purposes of this Section IV.C.5.b., "appropriate coverage" means an advance arrangement with another Physician or appropriate Practitioner to provide care for the Consulting Physician/Practitioner's Patients and to assume the Consulting Physician/Practitioner's responsibilities during the period of the Consulting Physician/Practitioner's temporary absence. The Consulting Physician/Practitioner shall notify the Regional Medical Staff Office of the Physician or Practitioner assuming such temporary care and a working phone number to contact such Physician or Practitioner.

c. Diagnostic or Therapeutic Procedures. Unless otherwise impracticable, a Consulting Physician/Practitioner shall communicate with the Requesting Physician/Practitioner or such Requesting Physician/Practitioner's Authorized Designee before performing any diagnostic or therapeutic procedure that requires a Patient's Informed Consent.

d. Consulting Physician/Practitioner's Completion of Care. When a Consulting Physician/Practitioner has completed the care or treatment of the Patient, such individual shall make such a notation in the Patient's medical record explicitly indicating the completion of the Patient's care. The Requesting Physician/Practitioner may ask the Consulting Physician/Practitioner to see the Patient again if further Consultation is needed.

D. Rules for Surgery

1. *Applicable Definitions*

For purposes of this Section IV.D. of these Rules and Regulations, "Physically Present" means located in the same room as the Patient, and "Immediately Available" means present elsewhere in the vicinity of the operating room (such as in another operating area, a different operating suite, or the recovery area), reachable through a paging system or other electronic means, and able to return immediately to the operating room.

2. *General Rules for Surgery*

a. Scheduling Surgeries

Emergency procedures shall take priority over all other surgical cases. To reduce wait times for Patients undergoing elective surgeries and to maximize utilization of resources, Physicians and Practitioners shall adhere to relevant Hospital Policy related to scheduling.

b. Intraoperative Responsibility of the Primary Attending Surgeon

i. Personal Responsibility. The Primary Attending Surgeon shall be personally responsible for the Patient's welfare throughout any surgery, procedure, or operation.

ii. Physical Presence. Except in cases where quality Patient care indicates otherwise or there is another valid exception, the Primary

Attending Surgeon shall be Physically Present in the operating suite, or otherwise Immediately Available for the entire surgical procedure.

iii. Unavailability. To the extent the Primary Attending Surgeon is unable to be Physically Present or is unable to be Immediately Available, another attending surgeon shall be assigned to be Immediately Available.

iv. Temporary Departure of the Operating Room. It is permissible for a Primary Attending Surgeon to leave the operating room for a procedure-related task, such as review of pertinent pathology and diagnostic imaging, discussion with the Patient's family, and breaks during long procedures. However, in such instances, the Primary Attending Surgeon shall remain Immediately Available.

c. Concurrent or Simultaneous Surgeries or Procedures

Except in emergency situations or during Multidisciplinary Surgeries or Procedures, no Concurrent or Simultaneous Surgeries or Procedures may be performed by the Primary Attending Surgeon.

d. Overlapping Surgeries or Procedures

i. Overlapping Surgeries or Procedures Permitted. Overlapping Surgeries or Procedures are permitted provided the Primary Attending Surgeon reasonably determines that proceeding to the second operating room would not constitute a Concurrent or Simultaneous Surgery or Procedure.

ii. Appropriate Determination. The Primary Attending Surgeon, in determining when surgeries or procedures constitute Overlapping Surgeries or Procedures rather than Concurrent or Simultaneous Surgeries or Procedures, shall reasonably determine that the Critical or Key Components of the first operation or procedure have been completed, and there is no reasonable expectation that the Primary Attending Surgeon will need to return to the first operation or procedure.

iii. Documentation of Physical Presence. The Primary Attending Surgeon shall document that the Primary Attending Surgeon was Physically Present during the Critical or Key Components of the surgery or procedure.

e. Multidisciplinary Surgeries or Procedures

During surgeries or procedures that are Multidisciplinary Surgeries or Procedures, it is appropriate for surgeons to be present only during the part of the operation that requires their surgical expertise; provided, however, the Primary Attending Surgeon shall be Physically Present or Immediately Available during the entire operation.

f. Delegation to Qualified Physicians, Practitioners, Non-Physicians, and Non-Practitioners

i. Permissible Delegations. In accordance with state and federal law and Hospital Policy, a surgeon may delegate part of the operation to qualified Physicians, Practitioners, Non-Physicians, and Non-Practitioners including but not limited to Residents, Fellows, anesthesiologists, nurses, physician assistants, nurse practitioners, surgical assistants, or another attending under such surgeon's personal direction, provided the surgeon shall be an active participant throughout the Critical or Key Components of the operation.

ii. Prohibited Delegations. Notwithstanding the foregoing, the responsibilities of the Primary Attending Surgeon may not be delegated.

g. Unanticipated or Emergency Circumstances

i. Backup Surgeons. Unanticipated or emergency circumstances may arise during surgeries or procedures that require a surgeon to leave the operating room before completion of the Critical or Key Components of an operation. In these situations, a backup attending surgeon shall be identified and available to promptly come to the operating room.

ii. Simultaneous Emergencies. If more than one emergency occurs simultaneously, the Primary Attending Surgeon may oversee more than one operation until additional attending surgeons are available.

3. *Informed Consent for Operative and Invasive Procedures*

a. Informed Consent Required. Except in emergencies situations, all Patients undergoing operative or other invasive procedures shall have an applicable and properly executed Informed Consent documented in such Patient's medical record.

b. Patient Communication. Before documenting Informed Consent and except in emergency situations, the Physician, Practitioner, or other legally permitted healthcare professional, as provided under § 766.103, Fla. Stat., who performs the operative or invasive procedure shall discuss (either at the Physician's or Practitioner's office, pre-anesthesia area, or other private area) the risks and benefits of the procedure with the Patient and/or authorized representative, and such discussion shall include:

i. A description of the intervention;

ii. The medically acceptable alternative procedures, options, and/or treatments if they exist;

iii. The alternative and/or risks of not having the proposed treatment or procedure performed if applicable;

iv. The need for, risks of, and alternatives to, receiving blood transfusions when needed; and

v. Anesthesia options and risks.

Except in an emergency, if this discussion has not taken place and if a properly completed Informed Consent has not been completed, the Patient may not be sedated, and the Primary Attending Surgeon shall be immediately notified and complete the foregoing tasks before anesthesia is administered.

4. *Preoperative Procedures*

a. Preoperative Documentation Requirements

Prior to any surgery being performed, the Physician or other Practitioner shall ensure that:

i. Pre-Anesthesia Evaluation. A pre-anesthesia evaluation was completed and performed (except in the case of extreme emergency);

ii. Pre-Operative/Procedural Note. There is a properly completed pre-operative/procedural note in the medical record that is documented and Authenticated by the surgeon, which conforms with the requirements of Section V.C.6.a. of these Rules and Regulations, and which contains the formulation of a plan of care (including a plan for anesthesia, nursing care, the operative or invasive procedure, and the level of post-procedure care); and

iii. Regardless of whether surgery is classified as major or minor, and except in emergency situations, that:

(a) History and Physical. There is a complete history and physical workup in the chart of every Patient or, if such history and physical has been transcribed, but not yet recorded in the Patient's chart, that there is a statement to that effect in the Patient's chart; and

(b) Informed Consent. There is evidence of Informed Consent for the operation in the Patient's chart.

b. Universal Protocol

The following Universal Protocol procedures shall occur prior to the performance of any surgeries, and any missing information or discrepancies shall be addressed before starting any procedure.

i. Pre-Procedure Verification Process

The following pre-procedure verification process to verify the correct procedure, for the correct Patient, at the correct site shall be conducted by a surgical team member and such team member shall inform the surgical team that the following has occurred prior to the induction of anesthesia and before the Patient leaves the preprocedural area into the facility for a procedure (except in emergency situations):

(a) Correct Patient. Confirming both verbally with the Patient and by

examining the Patient's Hospital identity bracelet that (a) the Patient's name was correctly identified; and (b) the Patient's date of birth was correctly verified;

(b) Informed Consent. Confirming with the Patient that Informed Consent was obtained and the surgical site and procedure documented in the medical record matches the Patient's understanding; and

(c) Ensuring that all items are available for the procedure which include, but are not limited to:

(i) Complete Documentation. Relevant documentation (e.g., the history and physical, signed Informed Consent form, nursing assessment, and preanesthesia assessment);

(ii) Testing Results. Properly displayed and labeled diagnostic and radiology test results (e.g., radiology images and scans, or pathology and biopsy reports); and

(iii) Appropriate Equipment. Any required blood products, implants, devices, and/or special equipment for the procedure.

ii. Procedural Site Marking

Except when it is technically or anatomically impossible or impractical, prior to the Patient being sedated, the incision or insertion site shall be marked by the surgeon and be clearly visible.

iii. Performing a Time-Out

(a) Initiating Time-Out. Prior to the commencement of the invasive procedure or making the incision, the surgeon shall initiate a "time-out" in the presence and with the participation of the surgical team (i.e., all immediate members performing the procedure).

(b) Verification. During the time-out, the surgical team shall collectively verify and agree that the correct site has been identified to perform the correct procedure on the correct Patient.

(c) Repeat Time-Outs. If the surgeon leaves the operating room and returns, the surgical team shall perform another time-out.

(d) Multiple Procedures. When two or more procedures are being performed on the same Patient, and the surgeon performing the procedure changes, a new time-out shall be taken prior to each procedure being initiated.

(e) Time-Out Documentation. All time-outs shall be properly documented in the Patient's medical record consistent with Hospital Policy.

5. *Anesthesia Services*

   a. General Rules for Anesthesia Services

      i. Qualified Anesthetists. Only properly qualified and privileged Physicians, oral and maxillofacial surgeons, and APPs certified as registered nurse anesthetists and who are under the onsite medical direction of a Physician or oral and maxillofacial surgeon (collectively, a "Qualified Anesthetist") may provide General Anesthesia, Regional Anesthesia, Deep Sedation/Analgesia, or Moderate Sedation/Analgesia (collectively, "Anesthesia Services").

      ii. Review of Conditions and Patient Monitoring. Immediately prior to the administration and induction of Anesthesia Services, a review of the Patient's condition shall be conducted by a Qualified Anesthetist and Patients receiving Anesthesia Services shall be monitored and evaluated before, during, and after the procedure by a Qualified Anesthetist.

      iii. Advanced Directives. A Qualified Anesthetist shall ensure that advance directives and do-not-resuscitate (DNR) orders are discussed with Patients prior to any surgical procedure. Any changes to the Patient's wishes shall be documented and signed by the Patient, Qualified Anesthetist, and shall be obtained and witnessed in accordance with Florida law.

   b. Pre-Anesthesia Evaluations

      i. Pre-Anesthesia Evaluations Generally. Except in extreme emergency cases, a Qualified Anesthetist shall perform a pre-anesthesia evaluation on the Patient prior to any inpatient or outpatient surgery or procedure requiring the administration of any Anesthesia Services.

      ii. Time for Completion of Pre-Anesthesia Evaluation. The pre-anesthesia evaluation shall be completed and documented within forty-eight (48) hours immediately prior to such surgery or procedure requiring Anesthesia Services. The delivery of the first dose of medication(s) for the purpose of inducing anesthesia marks the end of the forty-eight (48) hour time frame. While some of the individual elements contributing to the pre-anesthesia evaluation may be performed prior to the forty-eight (48) hour timeframe, under no circumstances may any of the pre-anesthesia elements be performed more than thirty (30) days prior to surgery or a procedure requiring Anesthesia Services. A review of these pre-anesthesia elements shall be conducted, and any appropriate updates documented, within the forty-eight (48) hour timeframe.

      iii. Contents of Pre-Anesthesia Evaluation. The pre-anesthesia evaluation of the Patient shall include, but not be limited to, the following:

         (a) A review of the Patient's current and past medical history, including anesthesia, drug, and allergy history;

(b) An interview and examination of the Patient;

(c) Notation of anesthesia risk according to established standards of practice (i.e., American Society of Anesthesiologists (ASA) classification of risk);

(d) Identification of potential anesthesia problems, particularly those that may suggest potential complications or contraindications to the planned procedure (e.g., difficult airway, ongoing infection, limited intravascular access); and

(e) Development of the plan for the Patient's anesthesia care, including the type of medications for induction, maintenance and post-operative care and discussion with the Patient (or Patient's representative) of the risks and benefits of the delivery of anesthesia.

c. Intraoperative Anesthesia Records

i. Continuous Monitoring. All Patients shall be monitored during the administration of Anesthesia Services at a level consistent with the potential effect of the anesthesia and appropriate methods shall be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the Patient's physiological status.

ii. Documentation of Intraoperative Events. All events taking place during the induction of, maintenance of, and the emergence from anesthesia shall be documented legibly in an intraoperative anesthesia record.

iii. Contents of Intraoperative Anesthesia Record. The intraoperative anesthesia record shall include, but not be limited to, the following elements:

(a) The name and hospital identification number of the Patient;

(b) The name(s) of the Qualified Anesthetist(s) who administered the Anesthesia Services and, as applicable, the name and profession of the supervising anesthesiologist or operating Physician or Practitioner;

(c) Name, dosage, route, and time of administration of drugs and anesthesia agents;

(d) Techniques(s) used and Patient position(s), including the insertion/use of any intravascular or airway devices;

(e) Name and amounts of IV fluids, including blood or blood products if applicable;

(f) Time-based documentation of vital signs as well as oxygenation and ventilation parameters;

(g) All pertinent events taking place during the induction of, maintenance of, and emergence from anesthesia; and

(h) Any complications, adverse reactions, or problems occurring during the Anesthesia Services, including the time and description of symptoms, vital signs, treatments rendered, and the Patient's response to treatment.

d. Post-Anesthesia Evaluations

i. Post-Anesthesia Documentation. A Qualified Anesthetist shall complete and document in the medical record a post-anesthesia evaluation for all Patients receiving Anesthesia Services.

ii. Time for Completion of Post-Anesthesia Documentation. The post-anesthesia evaluation shall be completed no later than forty-eight (48) hours after surgery or a procedure requiring Anesthesia Services. The calculation of the forty-eight (48) hour timeframe begins at the point the Patient is moved into the designated recovery area.

iii. Participation of Patient. The evaluation shall not begin until the Patient is sufficiently recovered from the acute administration of the Anesthesia Services so the Patient may actively participate in such evaluation.

iv. Elements of Post-Anesthesia Documentation. The elements of a post-anesthesia evaluation shall include the Patient's condition, be clearly documented in conformance with current standards of anesthesia care, and, at a minimum, include the following:

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

(b) Cardiovascular function, including pulse rate and blood pressure; and

(c) Mental status.

e. Release of Patients from Post-Anesthesia Care

i. Discharge Criteria. Patients may only be discharged from the recovery area by a qualified Physician or Practitioner according to criteria approved by the American Society of Anesthesiologists, using a modified Aldrete Recovery Score or similar post-anesthesia recovery scoring system.

ii. Documenting the Discharge. Post-operative documentation shall record the Patient's discharge from the post-anesthesia care area and record the name of the Physician or other Practitioner responsible for discharge.

iii. Release to Responsible Parties. Patients who have received anesthesia in an outpatient setting may only be discharged to the company of a responsible, designated adult.

iv. Follow-Up Care Instructions. When Anesthesia Services are performed on an outpatient basis, the Patient shall be provided with written

instructions for follow-up care that includes information about how to obtain assistance in the event of post-operative problems. The instructions shall be reviewed with the Patient or the individual responsible for the Patient.

6. *Tissue Specimens*

   a. Excepted Specimens. The Medical Executive Committee may approve a written policy excepting certain categories of specimens from examination following its determination that such excepted categories of specimens will not compromise quality of Patient care or that examination of such categories of specimens will yield no useful information.

   b. Pathologist Examination. With the exception of those categories of specimens excepted by the Medical Executive Committee in a written policy, all tissue specimens removed during a surgical procedure shall be properly labeled and sent to the laboratory for examination by the pathologist, who shall determine the extent of examination necessary for diagnosis. The specimen shall be accompanied by pertinent clinical information, including its source and the preoperative and postoperative surgical diagnosis, and be accompanied by a completed requisition form. The pathologist shall sign and Authenticate the pathologist's report which shall become part of the Patient's medical record.

7. *Post-Procedure Examination and Documentation*

   a. Post-Procedure Assessment. The post-procedure status of the Patient shall be assessed on admission to the recovery area and prior to discharge from the recovery area. Only a member of the Medical Staff may discharge the Patient from the recovery area in accordance with Section IV.D.5.e.i. of these Rules and Regulations.

   b. Post-Procedure Documentation and Follow-Up. Immediately following the surgery, the surgeon who performed the procedure shall complete, document, and sign a post-operative/procedural report describing the surgeon's techniques and findings consistent with Section V.C.6.b. of these Rules and Regulations. Such surgeon shall visit and see the Patient daily and a daily progress note shall be properly documented until the surgeon reasonably determines and documents that visiting the Patient is no longer clinically necessary.

E. Rules for Dentists, Oral and Maxillofacial Surgeons, Podiatrists, and Psychologists

1. *General Rules*

   a. Dual Roles and Joint Care. Patients admitted to the Hospital for dental care, dental surgery, podiatric care, or mental health treatment shall be under the joint care of a Physician and the applicable dentist, oral and maxillofacial surgeon, podiatrist, or psychologist.

   b. Physician Care. In all circumstances, a Physician shall be responsible for the care of Patients who (i) possess medical or psychiatric problems that are

present upon admission or develop during hospitalization; and (ii) such medical and psychiatric problems are not specifically in the dentist's, oral and maxillofacial surgeon's, podiatrist's, or clinical psychologist's scope of practice.

2. *Joint Care and Responsibilities*

The following responsibilities, without limitation, shall apply when Patients are admitted to the Hospital and are under the joint care of a Physician and a dentist, oral and maxillofacial surgeon, podiatrist, or psychologist:

a. Responsibilities of Physicians

In addition to being responsible for the care of Patients as provided above, in all circumstances Physicians shall also be responsible for the following, as applicable, prior to the induction of Anesthesia Services and the start of an operation or procedure of a Patient undergoing an operation or procedure:

i. Medical History. Providing a medical and/or psychiatric history pertinent to the Patient; and

ii. Physical. Completing a non-dental physical examination to determine the Patient's condition.

b. Responsibilities of Dentists and Oral and Maxillofacial Surgeons

To the extent a Patient is admitted or requires care for a dental problem or for dental surgery, the relevant oral and maxillofacial surgeon or dentist shall be responsible for the following, as applicable:

i. Dental History. Providing a detailed dental history justifying Hospital admission for the Patient;

ii. Progress Notes. Completing daily progress notes pertinent to the Patient's oral condition(s);

iii. Operation and Procedure Requirements. In situations when the Patient will be undergoing an operation or procedure:

(a) Pre-Operative/Procedural Notes. Properly completing a pre-operative/procedural note consistent with Section V.C.6.a. of these Rules and Regulations with a detailed description of the examination of the oral cavity and a pre-operative diagnosis;

(b) Post-Operative/Procedural Reports. Properly completing a detailed post-operative/procedural report in accordance with Section V.C.6.b. of these Rules and Regulations describing the techniques used, the findings made, and, if applicable, the number of teeth and fragments removed from the Patient;

(c) Specimens. With the exception of those categories of specimens excepted by the Medical Executive Committee in a written policy, sending all tissue, including teeth and fragments, to the laboratory

for examination by the pathologist consistent with Section IV.D.6. of these Rules and Regulations; and

iv. Discharge Summaries. Properly completing a discharge summary in accordance with Section V.C.7. of these Rules and Regulations.

The Physician and respective oral and maxillofacial surgeon or dentist shall collectively possess the responsibility of the Patient's discharge.

c. Responsibilities of Podiatrists

To the extent a Patient is admitted or requires care for a podiatric issue, the podiatrist shall be responsible for the following, as applicable:

i. Podiatric History. Providing a detailed podiatric history justifying Hospital admission for the Patient;

ii. Progress Notes. Completing daily progress notes pertinent to the Patient's podiatric condition(s);

iii. Operation and Procedure Requirements. In situations when the Patient will be undergoing an operation or procedure:

(a) Pre-Operative/Procedural Notes. Properly completing a pre-operative/procedural note consistent with Section V.C.6.a. of these Rules and Regulations with a detailed description of the podiatric findings and a pre-operative diagnosis;

(b) Post-Operative/Procedural Reports. Properly completing a detailed post-operative/procedural report in accordance with Section V.C.6.b. of these Rules and Regulations describing the techniques used and the findings made;

(c) Specimens. With the exception of those categories of specimens excepted by the Medical Executive Committee in a written policy, sending all tissue to the laboratory for examination by the pathologist consistent with Section IV.D.6. of these Rules and Regulations; and

iv. Discharge Summaries. Properly completing a discharge summary in accordance with Section V.C.7. of these Rules and Regulations.

The Physician and podiatrist shall collectively possess the responsibility of the Patient's discharge.

d. Responsibilities of Psychologists

i. Psychologist Privileges. Psychologists shall not have admitting privileges or privileges to order medications, laboratory testing, radiology testing, or EEG or EKG testing.

ii. Psychologist Responsibilities. To the extent a Patient is admitted or requires care for a mental health or psychological issue, the psychologist shall be responsible for the following, as applicable:

(a) Progress Notes. Completing progress notes and writing orders for treatment (provided that such orders are within the scope of the psychologist's license, certificate, or other legal credentials);

(b) Testing. Selecting, administering, and interpreting psychological tests, including personality, projective, neuropsychological, cognitive, educational, and vocational tests;

(c) Treatment and Evaluations. Engaging in crisis intervention, participating in treatment planning, and performing psychological consultations, mental status exams, and psychological and/or psychosocial histories;

(d) Therapy and Discharge Planning. Conducting individual, family, and group therapy, biofeedback sessions, and participating in discharge planning; and

(e) Baker Act Examinations. Initiating and rescinding 72-hour Involuntary Examinations and evaluations of Patients under the Baker Act.

F. Discharge Process

1. *Discharge Process of Non-Baker Act Patients*

For non-Baker Act Patients, the discharge process is as follows:

a. Discharge Requirements Generally. Patients may only be discharged from the Hospital when, within reasonable clinical confidence, it is determined that the Patient has reached the point at which the Patient's continued care, including diagnostic work-up and/or treatment, could reasonably be performed as an outpatient; or the Patient requires no further treatment, and the Admitting Physician/Practitioner has provided written documentation of such findings.

b. Discharge Orders. Patients may be discharged only by an order from the Admitting Physician/Practitioner or the Admitting Physician/Practitioner's Authorized Designee.

c. Continuing Care. The discharge order, process, and corresponding documentation shall provide for continuing care based on the Patient's assessed needs at the time of discharge.

d. Prohibition of Conditional Discharge Orders. "Conditional" discharge orders (e.g., "discharge patient when ok with consultant," or "discharge patient if MRI ok," etc.) are strictly prohibited.

e. Notifications and Documentation Requirements of AMA Discharges. Should a Patient leave the Hospital without a proper discharge (absent without leave or AWOL), or should a Patient express a desire to leave the Hospital before the completion of the Patient's treatment course/management plan (against medical advice or AMA), the Admitting Physician/Practitioner responsible for the care of the Patient shall be notified. The circumstances of the Patient's

departure from the Hospital shall be properly documented in the Patient's medical record.

f. Discharge Instructions for AMA Patients. Any Patient leaving the Hospital against medical advice or without the consent of the Admitting Physician/Practitioner or the Admitting Physician/Practitioner's Authorized Designee shall sign the discharge instructions and Patient Refusal Form according to Hospital Policy. If a Patient who leaves the Hospital against medical advice refuses to sign the foregoing documents, the Admitting Physician/Practitioner shall document the circumstances of refusal in the Patient's medical record.

2. *Discharge Process of Baker Act Patients*

To the extent that a Patient is a Baker Act Patient or a Patient for whom an Involuntary Examination has been initiated pursuant to the Baker Act, Hospital Policy, applicable provisions of the Baker Act, and the following requirements apply:

a. Discharges of Patients not Meeting Baker Act Criteria Following an Involuntary Examination

i. Release of Patients not Meeting Baker Act Criteria. To the extent the Hospital performs an Involuntary Examination on a Baker Act Patient or a Patient for whom an Involuntary Examination has been initiated and finds that the Patient does not to meet the criteria for involuntary outpatient services or involuntary inpatient placement, the Patient may be offered voluntary services or placement, if appropriate, or released directly from the Hospital consistent with Hospital Policy and the Baker Act.

ii. Prohibited Psychiatric Nurse Discharges. Under no circumstances may a psychiatric nurse approve the release of such a Patient if the Involuntary Examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.

b. Discharges of Patients Meeting Baker Act Criteria

i. Release of Patients Meeting Baker Act Criteria. Baker Act Patients and Patients for whom an Involuntary Examination under the Baker Act was initiated may only be released by the following individuals: Psychiatrists, clinical psychologists, a psychiatric nurse performing within the framework of an established protocol with a psychiatrist, or an attending ED Physician with experience in the diagnosis and treatment of mental illness.

ii. Prohibited Psychiatric Nurse Discharges. Under no circumstances may a psychiatric nurse approve the release of such a Patient if the Involuntary Examination was initiated by a psychiatrist unless the release is approved by the initiating psychiatrist.

In all circumstances, proper protocol, documentation, transfer, notice, discharge, and documented approval shall be provided in accordance with the Baker Act and Hospital Policy for the release of any Baker Act Patient or Patient for whom an Involuntary Examination was initiated.

G. Pronouncing Death

1. *General Rules*

a. Withdrawal of Life Support. Withdrawal of life support may only be implemented by an order from the Physician or other Practitioner primarily responsible for the Patient's care and in accordance with Hospital Policy.

b. Time for Death Pronouncement. With the exception of declaring a Patient's death in cases where there is the irreversible cessation of the functioning of the Patient's entire brain including the brain stem (which is governed under § 382.009, Fla. Stat.), the deceased Patient ("Decedent") shall be pronounced dead within one (1) hour by the Physician or other Practitioner primarily responsible for the Patient's care, another member of the Medical Staff, or the Registered Charge/Senior Resource Nurse.

c. Death Notification and Documentation Requirements. The individual who made the pronouncement of death shall notify the Admitting Physician/Practitioner if the Patient was admitted to the Hospital (unless the pronouncement was made by the Admitting Physician/Practitioner) and note the declaration of death in the Decedent's medical record before the Decedent's body is released to the funeral home.

d. Familial and Caretaker Notifications. The Physician or other Practitioner primarily responsible for the Patient's care, or such Physician's or Practitioner's Authorized Designee, shall notify the Decedent's next of kin and/or authorized representative.

2. *Recognition of Brain Death*

The determination of death by neurologic criteria shall always be made, and notice shall be given and recorded in the Patient's medical record, in accordance with § 382.009, Fla. Stat., and Hospital Policy.

3. *Death Certifications*

a. Time for Completion of Death Certifications. Following a Patient's death, the Admitting Physician/Practitioner for admitted Patients, or the Primary Physician/Practitioner or other attending Physician or Practitioner for Patients not admitted, shall complete the Decedent's death certificate within seventy-two (72) hours after receipt of the death certificate in accordance with § 382.008(3), Fla. Stat.

b. Death Certification Requirements. The individual signing the death certification shall also certify over his or her signature the cause of death to the best of his or her knowledge and belief.

c. Primary Physician/Practitioners. For purposes of this Section IV.G.3., the

"Primary Physician/Practitioner" means a Physician, physician assistant, or advanced practice registered nurse who treated the Decedent through examination, medical advice, or medication during the twelve (12) months preceding the date of death.

4. *Autopsies*

In deaths not accepted or requested by the Medical Examiner, and after appropriate notification and with appropriate consent, qualified Physicians and Practitioners shall attempt to secure autopsies for all deaths in which the cause of death or a significant major diagnosis cannot be determined within reasonable certainty on clinical grounds. The procedures for autopsies shall be in accordance with Hospital Policy.

5. *Anatomical Gifts*

a. Compliance with Law and Policy. In accordance with Florida law, in instances when a Patient or other individual authorized under § 765.512(3), Fla. Stat., makes an anatomical gift of a Patient's body, the donation of such anatomical gift(s), including organ and tissue donations, shall adhere to the requirements of pt. V of ch. 765, Fla. Stat. and Hospital Policy.

b. Prohibited Participation. In accordance with § 765.517(2), Fla. Stat., in no event may the Patient's primary care Physician, any Physician or other Practitioner attending to the Patient at the Patient's death, or the Physician who certifies the Patient's death, participate in the procedures for removing or transplanting any part of the Patient.

V. MEDICAL RECORDS AND HEALTH INFORMATION

A. General Guidelines Regarding Medical Records

1. Creating Medical Records. A properly documented medical record shall be developed for each Patient admitted to the Hospital and, as applicable, for Patients examined in the Emergency Department or receiving Ambulatory Care services.

2. Purposes of Medical Records. Medical records contain pertinent and current medical information regulated under state and federal law, Hospital Policy, the Medical Staff Bylaws, and these Rules and Regulations. Such medical information comprises all data and information gathered about a Patient from the moment they enter the Hospital or Ambulatory Care setting (and additional information derived from other sources at times prior to entering the Hospital or Ambulatory Care setting) to the moment of discharge, departure, or transfer. As such, the medical record functions not only as a historical record of a Patient's episode(s) of care, but also as a method of communication between Physicians, Practitioners, Medical Staff members, and staff that can facilitate the continuity of care and aid in clinical decision making.

3. Compliance with Laws and Standards. A Patient's medical record, health information, and the contents therein, as well as the completion, safekeeping, and confidentiality of a Patient's medical record, shall be compliant with the

Medical Staff Bylaws, these Rules and Regulations, applicable regulatory or accreditation guidelines, standards, or rules, state and federal law, and Hospital Policy.

4. Hospital Property. Medical records are the property of the Hospital. Medical records may only be removed from the Hospital if permitted and in accordance with Hospital Policy.

5. Release of Information. Medical information, written and/or verbal, may only be released in accordance with HIPAA, FIPA, other applicable state and federal law, and Hospital Policy as described in more particularity in Section V.B.

6. Timeliness of Completion. All medical records shall be completed timely and contain complete and sufficient information that:

   a. Identifies the Patient;

   b. Supports the diagnosis/condition of the Patient;

   c. Justifies the care, treatment, and services provided to the Patient;

   d. Documents the course and results of care, treatment, and services; and

   e. Promotes continuity of care among providers.

   For purposes of this Section V.A.6., "timely" means completed at or before thirty (30) days following the Patient's discharge unless a sooner time is prescribed under these Rules and Regulations.

7. Responsibility for Entries. Medical Staff members are responsible for entries, notes, or portions of the Patient's medical record applicable to the care such Medical Staff member provided to the Patient, but are not responsible for entries, notes, or portions of a medical record that another Medical Staff member providing the Patient's care is otherwise responsible for.

8. Electronic Record Required. To the extent practicable, all clinical entries in the Patient's medical record shall be done or transmitted electronically in the Patient's medical record. Such clinical entries, including transcribed verbal orders, shall be conducted consistent with Hospital Policy, and shall be complete, accurately dated, timed, Authenticated, and legible by the Physician or other Practitioner evaluating or providing the service to the Patient.

9. Electronic Signatures. The use of electronic signatures shall be consistent with Hospital Policy. No Medical Staff member shall use an identifier that can be readily used by someone who did not render medical care to the Patient or who did not author the medical record's entry or note (e.g., the use of a rubber stamp signature). Nor shall any Medical Staff member provide another person access to such Medical Staff member's unique identifier (e.g., giving out the password used for the Medical Staff member's profile).

10. Authorized Entries. Only authorized individuals as defined under Hospital Policy may make entries in medical records, and only those Medical Staff members who provided care to the Patient make entries in the Patient's medical record, or

parts thereof.

11. Countersignatures. To the extent that documentation, information, or data in a Patient's medical record is initially completed by a non-Physician, non-Practitioner, or Learner (as permitted under state or federal law) but applicable Healthcare Laws, Hospital Policy, the Bylaws, or these Rules and Regulations require a Physician or other Practitioner to transmit or record such documentation, information, or data, such documentation, information, or data that is initially completed by the non-Physician, non-Practitioner, or Learner shall be countersigned by the responsible Physician or Practitioner within twenty-four (24) hours. Examples of such records and documentation that require the Physician or Practitioner's countersignature include, without limitation: history and physical examinations; Consultation reports; operative reports; labor and delivery records; the discharge summary or final progress note; the final diagnosis on the Face Sheet; and Do Not Resuscitate (DNR) Orders.

12. Professionalism. Professionalism is expected by all healthcare professionals responsible for maintaining the medical record, including Medical Staff members. Personal or editorial comments by or between healthcare professionals accessing or entering information in the medical record is unprofessional, unwarranted, and strictly prohibited.

B. Access to Medical Records

1. Permitted Uses and Disclosures. No member of the Medical Staff may disclose any Patient's medical record or the contents thereof to anyone other than to individuals or entities involved in payment reimbursement for health care services rendered to the Patient, individuals or entities involved in the Patient's treatment, or for purposes of health care operations ("Permitted Uses and Disclosures"), all as defined in the HIPAA Privacy Rule, and all in accordance with the procedures delineated in Hospital Policy, FIPA, and the HIPAA Security Rule. Examples of such individuals or entities that may fall within the foregoing categories of Permitted Uses and Disclosures include, but are not limited to, (a) staff employed at the Hospital involved in the Patient's care; (b) Physicians, Practitioners, and APPs involved in the Patient's care; (c) health care and non-health care professional trainees, Students, Learners, Residents, and Fellows receiving educational training; (d) individuals involved in quality oversight, assessment, and improvement activities; (e) individuals involved in the review of the competence or qualifications of Physicians, Practitioners, or other health care professionals; (f) individuals for the purposes of bona fide study and research in accordance with current Institutional Review Board guidelines and regulations; and (g) third-party payers for the purposes of reimbursement for health care services rendered to the Patient. The HIPAA Privacy Rule, the HIPAA Security Rule, Hospital Policy, and FIPA shall always govern the Permitted Uses and Disclosures and the method for transmitting the Permitted Uses and Disclosures.

2. Access to Former Medical Staff Members and Others. When permitted under Hospital Policy, former Medical Staff members may be permitted access to information included in the medical records of their Patients for those periods of time during which they attended such Patients in the Hospital, and when permitted under Hospital Policy and state and federal law, other individuals

responsible for a Patient's care may be permitted access to information included in such Patient's medical records.

3. Readmissions. Upon readmission of a Patient, any previous medical records maintained by the Hospital shall be available for use to facilitate the provision of Patient care.

4. Requests for Medical Records. Unless otherwise permitted under Hospital Policy, all requests for medical records or medical information pertaining to current or former Patients, whether by a Patient or another individual, shall be directed to the relevant Hospital's Health Information Management Department for processing and only the Hospital's Health Information Management Department may process and release medical records pursuant to such a request.

C. Content of Medical Records

1. *Content Generally*

a. Hospital Records

As applicable and appropriate, the following data and information, without limitation, shall be included in a Patient's medical record:

i. Identification Data, Consents, and Directives: Patient identification data including the Patient's race and ethnicity, and all information required for completion of birth, death, and stillbirth certificates; evidence of known advanced directives; documentation of Informed Consent; a record and Routine Inquiry Form indicating the Patient's wishes to donate organs or tissue in the event of the Patient's death;

ii. Personal, Family, Medical, and Treatment History and Physical: The Patient's medical, personal family, and treatment history; Patient complaint(s); the Patient's history of present illnesses; the Patient's initial diagnosis, diagnostic impression(s), or condition(s), and any applicable secondary diagnoses and procedures when applicable; a physical examination of the Patient; any findings of assessments and reassessments; any conclusions or impressions drawn from the Patient's medical history and physical examination; the reason(s) for admission for care, treatment, and services at the Hospital; documentation that justifies the care, treatment, and services provided to the Patient at the Hospital; documentation that supports the diagnosis/condition of the Patient;

iii. Medical, Clinical and Treatment Reports, Orders, and Records: Reports of any current, previous, and/or external emergency care, treatment, and services provided to the Patient including social work services reports if provided; a copy of the patient care record in accordance with Fla. Admin. Code. R. 64J-1.001(18) if the Patient was delivered to the Hospital by ambulance; the Patient's receipt and other records of transplant or implants of organs or tissues; any diagnoses, including provisional and pre-operative diagnoses and conditions

established during the Patient's course of care, treatment, and services at the Hospital; a copy of the Hospital Outpatient Observation Notice or Medicare Outpatient Observation Notice if the Patient was placed on observation status as required by § 395.301(3), Fla. Stat.; documentation regarding complications, hospital-acquired infections, and unfavorable reactions to drugs and anesthesia; any observations relevant to the Patient's care, treatment, and services; the Patient's response to care, treatment, and services; any intercurrent diseases and psychiatric diagnoses if the Patient is committed for psychiatric care; Consultation reports and other special reports along with appropriate findings by clinical and other staff involved in the care of the Patient; clinical and laboratory reports; radiology services reports and other ancillary diagnostic and therapeutic testing results and reports; medical or surgical treatment notes, operative reports, and other required documentation for Patients undergoing operative or other invasive procedures as noted in greater detail in Section V.C.6. of these Rules and Regulations; pathological findings; progress notes; any medications ordered, prescribed, or administered, including the strength, dose, route, date, and time of administration; and

iv. Plan of Care and Discharge: An individualized written plan of care, treatment goals, and services appropriate to the Patient's needs, which shall be discussed with the Patient and revised as clinically necessary; final diagnoses; condition(s) on discharge; a discharge summary, plan, and evaluation; any transition of care needs and plans; any medications dispensed or prescribed on discharge; certifications of transfer of the Patient between hospitals as specified by Fla. Admin. Code R. 59A-3.255; and autopsy reports and findings when performed and applicable.

b. Ambulatory Care Records

At a minimum, and as applicable and appropriate, medical records for Patients receiving ambulatory services shall include the following information, and such information shall be updated as necessary:

i. Patient identification data;

ii. Chief Complaint(s);

iii. Present illness and relevant history of the illness or injury and of physical findings;

iv. Past personal history, family medical history, and physical examination report;

v. An appropriate Informed Consent signed by the Patient;

vi. Diagnostic and therapeutic orders;

vii. Clinical observations, including the results of treatment;

viii. Medical and surgical treatment notes and reports including

Consultation reports;

ix. Reports of procedures and tests, and their results including, without limitation, tissue reports, clinical laboratory reports, and radiology, diagnostic imaging, and ancillary testing reports;

x. Provisional and pre-operative diagnosis or impression;

xi. Allergies;

xii. Record of medications and dosages administered;

xiii. Physician orders and Physician and nurse progress notes;

xiv. Final diagnosis and discharge summary;

xv. Autopsy report, if applicable;

xvi. Referrals to physicians, practitioners, or providers of services internal or external to the Hospital;

xvii. Communications to and from physicians, practitioners, or providers of service external to the Hospital;

xviii. Growth charts for children and adolescents as needed when the service is the source of primary care; and

xix. Immunization status of children and adolescents and others as determined by state and federal law and/or Hospital Policy.

2. *Symbols and Abbreviations*

Only Medical Staff approved symbols and abbreviations, which may be requested from the HIM Department, may be used for entries in medical records, orders, or other medication-related documentation. Physicians and other Practitioners may not use any abbreviations on The Joint Commission's Official "Do Not Use" List. Notwithstanding the foregoing, in no event may any abbreviations (even Medical Staff approved abbreviations) be used on the face sheet in a Patient's medical record.

3. *Orders for Treatment*

a. General Rules for all Orders

i. Physicians and Practitioners with Privileges. Orders for treatment may only be written by a Physician or other Practitioner granted clinical privileges to write orders or, as prescribed in these Rules and Regulations, a non-Physician or non-Practitioner directed by a Physician or Practitioner to write such an order.

ii. Consistent with Hospital Policy. Only those medication orders deemed acceptable for use under Hospital Policy may be used.

iii. Contents of Orders. Orders for medication shall be entered or written in accordance with Hospital Policy and include the medication name,

medication dose, medication route, and medication frequency.

iv. Contents of Medication Titration Orders. Medication titration orders shall be entered or written in accordance with Hospital Policy and include the medication name, medication route, initial rate of infusion (dose/unit of time), incremental units to which the rate or dose can be increased or decreased, how often the rate or dose can be changed, the maximum rate or dose of infusion, and the objective clinical measure to be used to guide changes.

v. Authentication of Orders. All orders, including verbal orders, shall be dated, timed, and Authenticated promptly by the ordering Physician or other Practitioner. In the extraordinary circumstances where a handwritten and paper-based order is used, such order shall be legible.

vi. Computerized Provider Order Entries. Computerized provider order entries ("CPOE") shall be used by Physicians and Practitioners to enter Patient orders, and such orders, to the extent practicable, shall be entered directly into the Patient's electronic health record ("EHR") as noted in Section V.A.8. of these Rules and Regulations.

vii. Paper Orders. In the limited circumstances where paper orders are authorized and used, such paper orders shall be Authenticated and signed within thirty (30) days of discharge.

viii. Documentation of Diagnosis and Conditions. A diagnosis, condition, or indication for use shall be documented somewhere in the Patient's medical record for each medication ordered.

ix. Orders for Outpatient Tests. Orders for outpatient tests shall properly document the diagnosis for which the ordering of the test is necessary.

x. Summary Orders Prohibited. The use of the summary (blanket) orders (e.g., "renew," "repeat," "resume," and "continue") to resume previous medications is not permitted and may not be used.

xi. Responsibility for Evaluation and Modification of Orders. It is the responsibility of the Patient's clinical team to reconcile all orders, including medications, and to decide what to continue, modify, or discontinue in the best interests of the Patient under the circumstances present.

b. Verbal and Telephonic Orders

i. General Rules Regarding Verbal and Telephonic Orders

(a) Authenticating Verbal and Telephone Orders. Verbal orders shall be Authenticated and signed before the ordering Physician or other Practitioner leaves the immediate area, and telephone orders shall be Authenticated and signed by the ordering Physician or other Practitioner within seven (7) days of the order.

(b) Receiving Verbal and Telephone Orders. Only those duly

authorized personnel, as defined in Hospital Policy and functioning within their scope of practice, may accept verbal and/or telephone orders (an "Authorized Receiving Individual"). Such Authorized Receiving Individual may include, but are not limited to, APPs, registered nurses, licensed practical nurses, respiratory therapists, physical/occupational/speech therapists, dieticians, and pharmacists.

(c) Performing Read-Backs. Before acting on a verbal or telephone order, the Authorized Receiving Individual shall use a "read-back" process to verify the information (the "Read-Back Process"). The Read-Back Process shall include the order being read back to the ordering Physician or other Practitioner, and the ordering Physician or other Practitioner verbally confirming that the order is correct.

(d) Prohibited Verbal and Telephone Orders. Verbal or telephone orders may not be accepted for investigational drug, device or procedure protocols, chemotherapy drug orders, or for orders to withhold or withdraw life support.

ii. Verbal Orders

(a) Permissible Verbal Orders. The use of verbal orders shall be limited to situations where entry of the order is not possible either because the EHR is not able to accommodate the orders, the Physician or other Practitioner is physically unable to perform CPOE, or when an emergency exists preventing the Physician or Practitioner from performing CPOE.

(b) Presence of Ordering Physician or Practitioner. When a verbal order is used, the ordering Physician or other Practitioner shall be present on the unit, floor, or in the immediate Patient care area.

(c) Receipt of Verbal Orders. Verbal orders shall be received and entered by an Authorized Receiving Individual and concurrently with the ordering Physician or other Practitioner present.

(d) Read-Backs. The Read-Back Process shall be followed for all verbal orders before being carried out.

(e) Cosign Verbal. The Authorized Receiving Individual shall note "cosign verbal" in the EHR.

(f) Documenting Verbal Orders. Verbal orders shall properly document the date, the time the verbal order was received, and the names of individuals who gave, received, recorded, and implemented the orders.

(g) Authenticating Verbal Orders. Verbal orders shall be electronically signed and Authenticated by the ordering Physician or other Practitioner prior to the ordering Physician or Practitioner

leaving the Patient care area.

iii. Telephonic orders

(a) Permissible Telephone Orders. Telephone orders are acceptable only when clinical circumstances dictate the need for such an order to expedite a Patient care need, when the ordering Physician or other Practitioner is physically distant from the Hospital, and when the ordering Physician or other Practitioner does not have access to the EHR.

(b) Receiving Telephone Orders. Telephone orders shall be concurrently received and entered by an Authorized Receiving Individual while the ordering Physician or other Practitioner is on the phone giving the order.

(c) Read-Backs. The Read-Back Process shall be followed for all telephone orders before being carried out.

(d) Cosign Phone. The Authorized Receiving Individual shall note "cosign phone" in the EHR.

(e) Authenticating Telephone Orders. The transcribed telephone order shall be forwarded to the message center and the ordering Physician or other Practitioner shall electronically sign and Authenticate such order within seven (7) days.

c. Pre-Printed and Electronic Standing Orders, Order Sets, and Protocols

Pre-printed and electronic standing orders, order sets, and protocols for Patient orders may only be used under the following circumstances:

i. Approval Process. Such orders and protocols have been reviewed and approved by the Medical Staff and the Hospital's nursing and pharmacy leadership;

ii. Consistency with Evidence-Based Guidelines. Such orders and protocols are consistent with nationally recognized and evidence-based guidelines;

iii. Periodic Reviews. Periodic and regular review of such orders and protocols is conducted by the Medical Staff and the Hospital's nursing and pharmacy leadership to determine the continuing usefulness and safety of the orders and protocols; and

iv. Documenting Standing Orders and Protocols. Such orders and protocols are dated, timed, and Authenticated promptly in the Patient's medical record by the ordering Physician or Practitioner or by another Physician or Practitioner responsible for the care of the Patient if permitted under Florida law (including Florida scope-of-practice law governing such Physician or Practitioner), Hospital Policy, the Medical Staff Bylaws, and these Rules and Regulations.

4. *Histories and Physicals*

Regardless of a Patient's admission status (i.e., observation or inpatient status) or Hospital encounter (inpatient or outpatient) the following standards apply for medical histories and physical examinations:

a. Hospital Admissions

i. Completion of H&Ps. All Patients presenting to the ED or admitted to the Hospital for care, regardless of admission status (i.e., observation or inpatient status), shall receive a complete medical history and physical examination ("H&P") within twenty-four (24) hours.

ii. Updates of H&Ps Already Completed. If the H&P was completed within thirty (30) days prior to inpatient admission or registration of the Patient, only an update is required, and such update shall be completed, to the extent practicable, within twenty-four (24) hours after the Patient physically arrives for admission or registration but prior to surgery or a procedure requiring Anesthesia Services.

iii. Time for Completion of New H&Ps. To the extent practicable, if the H&P has not been completed within thirty (30) days prior to inpatient admission or registration of the Patient, such H&P shall be completed and properly documented in the Patient's medical record within twenty-four (24) hours of the Patient's arrival for admission or registration, including weekends and holidays, but prior to any surgery or procedure requiring Anesthesia Services.

iv. Performing the H&Ps. For Patients presenting to the ED, the ED Physician or an Advanced Practice Provider shall perform the H&P. To the extent an APP completes an ED Patient's H&P, such H&P shall be reviewed and countersigned by the ED Physician supervising the APP. For Patients admitted to the Hospital for care (regardless of status), the Admitting Physician/Practitioner or an Advanced Practice Provider shall perform the H&P. To the extent an APP completes a Patient's H&P, such H&P shall be reviewed and countersigned within twenty-four (24) hours by the Physician or other Practitioner supervising the APP.

b. Ambulatory Care and Outpatient Surgical and Operative Encounters

i. Completion of H&Ps Prior to Surgery. Regardless of whether surgery is classified as major or minor, the Physician or other Practitioner primarily responsible for the Patient's care shall ensure, prior to any surgery being performed, except in emergency situations, that there is a complete history and physical workup in the medical record of every Patient or, if such has been transcribed, but not yet recorded in the Patient's chart, that there is a statement to that effect in the medical record.

ii. Time for Completion of H&Ps for Ambulatory Care. When an H&P of the Patient is completed within thirty (30) days prior to ambulatory,

outpatient surgical and outpatient operative encounters, an update is required within twenty-four (24) hours following the Patient's physical arrival for admission or registration but prior to any surgery or procedure requiring Anesthesia Services. Any H&P completed more than thirty (30) days prior to the Patient's admission or registration may not be updated and a new H&P shall be completed consistent with Section V.C.4.a. above.

c. Content of Histories & Physicals

At a minimum, all Patient H&Ps shall contain the following elements, as applicable:

i. History

(a) Chief complaint(s);

(b) History of present illness;

(c) Allergies;

(d) Medications, including over-the-counter medications or herbs;

(e) Review of systems;

(f) Past medical/surgical history; and

(g) Family history and social history.

ii. Physical

(a) Vital signs;

(b) Physical examination; and

(c) Any pertinent diagnostic tests and the results thereof.

iii. Assessment and Plan of Care

(a) All conclusions and impressions drawn from the Patient's H&P inclusive of the Patient's admitting diagnosis and identification of potential problems needing further assessment; and

(b) Recommendation for a plan of care.

d. Validity of Histories and Physicals

i. Continued Validity of H&Ps. A properly executed H&P is valid for the Patient's entire length of stay in the Hospital. A new H&P or update to the H&P is not required when a Patient remains continuously Hospitalized. Any changes to the Patient's condition shall be documented in the Patient's daily progress notes. If the Patient has been discharged, then readmitted, there shall be a valid H&P (no greater than 30 days) and it shall be updated within twenty-four (24) hours after re-admission or registration but prior to a surgical procedure

or other procedure requiring anesthesia.

ii. Prenatal Records as Valid H&Ps. The prenatal record may be utilized as a valid history and physical for purposes of any Hospital admission, including for surgery and other procedures related to obstetrical Patients, provided it is updated to reflect the Patient's condition upon admission.

5. *Progress Notes*

The Admitting Physician/Practitioner, as well as any applicable Consulting Physician/Practitioner who is Consulting a Patient, is responsible for ensuring that the Patient's medical record contains accurate and complete descriptions of the Patient's progress in the Hospital through the documentation of progress notes.

a. Content and Requirements of Progress Notes. Progress notes shall, at a minimum, conform with the following:

i. Entries on Dates of Service. Be entered on the day that services are rendered;

ii. Reports and Observations. Provide a pertinent chronological report of the Patient's course in the Hospital and any observations relevant to the Patient's care, treatment, and services while in the Hospital;

iii. Legibility and Authenticated. Be legible, recorded, dated, timed, and Authenticated at the time of observation or delivery of care;

iv. Sufficient Content. Contain sufficient content to ensure continuity of care if the Patient is transferred;

v. Document Problems, Orders, and Results. List each of the Patient's clinical problems, correlated with specific orders and results;

vi. Reflect Changes. Reflect any change(s) in the Patient's clinical condition, and any necessary changes to the Patient's plan of care;

vii. Documentation for Consultants. For Consulting Physician/Practitioners, the Consulting Physician/Practitioner's involvement and participation in the care of the Patient, and a list of each of the clinical problems, diagnoses, and observations pertaining to the Patient's care for which the Consulting Physician/Practitioner was Consulted; and

viii. Teaching Attestations. As appropriate and applicable, contain a teaching attestation in accordance with applicable Health Care Laws for the Physician's or other Practitioner's teaching and supervising of Learners.

b. Daily Documentation and Compliance with Requirements. At a minimum, the Admitting Physician/Practitioner shall complete and document progress notes in the Patient's medical record daily in accordance with the

requirements above. If the Patient is admitted to the ICU, the Intensivist attending to the Patient shall also complete and document progress notes in the Patient's medical record daily in accordance with the requirements above.

6. *Operative/Procedural Reports and Notes*

All Patients who undergo any operation or procedure shall have a pre-operative/procedural note documented prior to the operation or procedure, and a complete post-operative/procedural report shall be entered and Authenticated in the Patient's medical record after such intervention to facilitate ongoing clinical care.

a. Pre-Operative/Procedural Notes

i. Contents of Pre-Operative/Procedural Notes. Prior to the initiation of any operation or procedure, a pre-operative/procedural note shall be documented in the Patient's medical record and, at a minimum, shall include the indications for the operation/procedure; and the plan of care inclusive of a plan for anesthesia, nursing care, the operative or invasive procedure, and the level of post-procedure care.

ii. Responsibility of Operating Physician or Practitioner. The pre-operative/procedural note shall be signed and Authenticated by the Physician or other appropriately qualified Practitioner primarily responsible for performing the operation or procedure. This requirement applies to outpatients as well as inpatients, including donors and recipients of organs and tissues.

iii. Pre-Operative/Procedural Notes and H&Ps. The Patient's H&P may be combined with the pre-operative/procedural note or done separately. In the case of emergent procedures, an H&P performed by an ED Physician that satisfactorily addresses the components of Section V.C.4. of these Rules and Regulations, shall be deemed to have met this requirement.

iv. Non-Compliance. The failure by any Physician or Practitioner to follow the above requirements relating to pre-operative/procedural notes may result in a referral to peer review and any and all adverse disciplinary action(s) provided in the Medical Staff Bylaws.

b. Post-Operative/Procedural Reports and Notes

i. Completion of Post-Operative/Procedural Reports. A post-operative/procedural report shall be written or dictated in the Patient's medical record immediately after an operative or other high-risk procedure with sufficient information to manage the Patient throughout the postoperative period.

ii. Content of Post-Operative/Procedural Reports. The following documentation and pertinent information, at a minimum, is required for all post-operative/procedural reports:

(a) The name(s) of the Physician(s) or Practitioner(s) who performed the operation or procedure, their assistants, and the anesthetist;

(b) The pre-operative/procedure diagnosis;

(c) The post-operative/procedure diagnosis;

(d) The name and full description of operation or procedure performed;

(e) The type of anesthetic used;

(f) The findings of the operation or procedure;

(g) Any estimated blood loss;

(h) Any specimens removed;

(i) Any implants and/or devices implanted in the Patient; and

(j) Any perioperative/periprocedural complications and management of those events.

iii. Area of Completion of Post-Operative/Procedural Reports. If the Physician or other Practitioner performing the operation or high-risk procedure accompanies the Patient from the operating room to the next unit or area of care, the operative/procedural report, or operative/procedural note, as applicable, may be written or dictated in the new unit or area of care. The pre-operative area, operating room, and post-anesthesia care unit are considered the same level of care for purposes of this requirement.

iv. Applicable Definitions. For purposes of this Section V.C.6.b., "immediately after an operative or other high-risk procedure" shall be defined as upon completion of procedure, before the Patient is transferred to the next level of care.

v. Delays of Post-Operative/Procedural Reports. If the operative/procedural report is not placed in the medical record immediately after the operative or other high-risk procedure due to transcription or filing delay, then a post-operative/procedural progress note with the required information described below shall be entered in the Patient's medical record immediately after the operative or other high-risk procedure to provide pertinent information for anyone attending to the Patient. The post-operative/procedural progress note is not in lieu of a full operative/procedural report, and, to the extent that a post-operative/procedural progress note is done due to a delay, a full operative/procedural report shall be completed by the Physician or other Practitioner as soon as practicable.

vi. Content of Post-Operative/Procedural Notes. To the extent an immediate post-operative/procedural note is used because a post-operative/procedural report cannot be immediately entered (as noted

above), the post-operative/procedural note shall contain, at a minimum: (a) the name(s) of the primary operating Physician(s) and/or Practitioner(s) and their assistants; (b) a brief summary of the procedure performed and a description of each procedure finding; (c) estimated blood loss; (d) specimens removed; and (e) postoperative diagnosis.

vii. Non-Compliance. The failure by any Physician or Practitioner to follow the above requirements relating to post-operative/procedural reports and notes may result in a referral to peer review and any and all adverse disciplinary action(s) provided in the Medical Staff Bylaws.

7. *Discharge Summaries*

a. Discharges Generally. Patients may only be discharged from the Hospital in accordance with Section IV.F. of these Rules and Regulations. Patients experiencing an Emergency Medical Condition shall be stabilized (as defined in Section III.D.3.c. of these Rules and Regulations) prior to being transferred or discharged.

b. Responsibility to Complete the Discharge Summary. The Physician or other Practitioner who discharges the Patient is responsible for ensuring the completion of the Patient's discharge summary.

c. Contents and Completion of the Discharge Summary. The electronic or dictated discharge summary shall be completed as soon as possible but no later than thirty (30) days following the Patient's discharge. The discharge summary shall include, but are not limited to, the following components:

i. The reason for hospitalization;

ii. Any significant findings;

iii. The procedures performed;

iv. All Physicians, Practitioners, and services Consulted;

v. The care, treatment, and services provided;

vi. The Patient's condition and disposition at discharge;

vii. Discharge information provided to the Patient, family, and/or other authorized representative(s), such as:

(a) Medications;

(b) Diet;

(c) Physical activity; and

(d) Follow-up care;

viii. Documentation, as applicable, noting that the final laboratory and/or any other essential reports are not available and finalized at the time of discharge; and

ix. Provisions for follow-up care.

d. Tumor-Node-Metastasis. As applicable, the Tumor-Node-Metastasis (TNM) Clinical Stage (CS) of tumor may be assigned before the medical record is completed. If the Pathological Stage (PS) of the tumor is available before discharge, it should also be included in the Patient's discharge summary.

e. Discharge Summaries of Newborns. For newborn Patients with uncomplicated deliveries, or for Patients hospitalized for less than forty-eight (48) hours, a final progress note may substitute for the Discharge Summary. To the extent a final progress note is used, the final progress note shall, at a minimum, include the outcome of the Patient's hospitalization, the Patient's condition and disposition at discharge, and all discharge instructions and provisions for follow-up care.

f. Intra-Hospital Transfers. When a Patient is transferred to a different level of care within the Hospital and caregivers change, a transfer summary or progress note may be substituted for a discharge summary. If the caregivers do not change, a progress note may be used.

D. Completion of Medical Records

All medical records shall be completed, Authenticated, and contain a final diagnosis within thirty (30) days of discharge or outpatient care unless an earlier time is prescribed under these Rules and Regulations.

1. *Chronic Delinquency in Completing Medical Records*

a. Definition of Chronic Delinquency. In accordance with the Medical Staff Bylaws, "Chronically Delinquent" medical records (as defined under Section 5.6 of the Medical Staff Bylaws) may result in a referral to the Hospital's Peer Review Committee or Medical Executive Committee and/or subject the Chronically Delinquent Physician or Practitioner or other Medical Staff member to disciplinary action up to and including temporary suspension. Any disciplinary action taken against Physicians, Practitioners, and other Medical Staff members due to Chronically Delinquent medical records are not subject to hearing rights as further delineated in the Medical Staff Bylaws.

b. Consequences of Chronic Delinquency. To the extent a Physician's or Practitioner's privileges are suspended due to the delinquency of medical records, only emergency surgeries or surgeries scheduled for the same day of the Physician's or Practitioner's suspension may proceed. The Physician or Practitioner shall not be permitted to admit new Patients, schedule new procedures, perform procedures following the date of the Physician's or Practitioner's suspension, perform Consultations, or cover or participate in emergency call coverage during the period when the Physician's or other Practitioner's privileges are suspended due to delinquent medical records. Any exceptions to this requirement shall be approved by the Hospital's Chief Executive Officer or Regional Chief Medical Officer in consultation with the Hospital's Chief of Staff, or, if the Hospital's Chief of Staff is unavailable, the Vice Chief of Staff, the applicable Department Chair, or a designee of the Chief of Staff. Notwithstanding the foregoing, the suspended Physician or

Practitioner shall continue to treat and care for, or otherwise find an appropriate Physician or Practitioner for the treatment and care of, the Physician's or Practitioner's Patients who were admitted to the Hospital prior to the date of the Physician's or Practitioner's suspension (or the date of suspension if a surgery was scheduled and performed on the same date of the Physician's or Practitioner's suspension).

2. *Habitual Delinquency in Completing Medical Records*

   a. Definition of Habitual Delinquency. A Physician or other Practitioner is deemed to be "Habitually Delinquent" when the Physician or Practitioner is referred to the Hospital's Peer Review Committee or Medical Executive Committee three (3) or more times in a twelve (12) month period for failing to timely complete medical records. Physicians and other Practitioners who are Habitually Delinquent but not Chronically Delinquent in the timely completion of medical records, in addition to any other appropriate disciplinary actions under the circumstances, may be subject to the one (1) or more of the following disciplinary actions:

      i. A $100.00 fine for each delinquent medical record existing on or after the Physician's or Practitioner's referral to the Hospital's Peer Review Committee or Medical Executive Committee;

      ii. A letter of reprimand regarding the Physician's or Practitioner's lack of diligence and the potential barriers to continuity of patient care;

      iii. A warning letter regarding potential consequences for future Habitual Delinquency; and

      iv. Placement on Focused Professional Practice Evaluation (FPPE) which may result in further disciplinary action.

   b. Consequences of Habitual Delinquency. Any fines imposed for being Habitually Delinquent shall be invoiced to the applicable Physician or other Practitioner and shall be due and payable within thirty (30) days of the issuance of the invoice by the Medical Staff. Reappointment to the Medical Staff and/or renewal of clinical privileges shall not be approved for Physicians and other Practitioners who have unpaid fines at the time of reappointment.

3. *Habitually Delinquent and Chronically Delinquent Physicians and Practitioners*

   In addition to suspension as provided under Section 5.6 of the Medical Staff Bylaws and Section V.D.1. of these Rules and Regulations, as well as any other disciplinary action appropriate under the circumstances, those Physicians and other Practitioners who meet the definition of being both Chronically Delinquent and Habitually Delinquent shall also be subject to all the disciplinary actions delineated in Section V.D.2. of these Rules and Regulations.

E. Corrections of Medical Record Entries

If a Physician, Practitioner, or other individual makes an error in a medical record, a correction to the error shall be made as soon as practicable. The following rules apply

to corrections of entries in medical records.

1. *Electronic Health Records*

   In electronic health records, an error in a medical record entry may be corrected through creating a comment field or narrative entry in the original record or by creating a new amended record. To the extent an amended record is created, the Physician, Practitioner, or other applicable individual shall note the correction and location of the amended record in the original record with the error. When correcting or making a change to a medical record entry, the original entry shall remain viewable, the current date and time shall be entered, the Physician, Practitioner, or other authorized person making the change shall be identified and properly Authenticate such record, and the reason for the correction shall be noted. In no event may a medical record entry be erased, deleted, or rendered illegible.

2. *Paper Records*

   To the extent a paper record is used, the Physician, Practitioner, or other individual shall cross out the original entry with a single line and initial next to the line, ensure that the error is still legible, enter the correct or amending information, sign, date, and Authenticate the correction, and note the reasoning for making such correction.

VI. RULES FOR ADVANCED PRACTICE PROVIDERS

A. Membership and Privileges of Advanced Practice Providers Generally

The conditions and consideration of Medical Staff membership and clinical privileges of APPs is governed under Section 3.6 of the Medical Staff Bylaws. The following categories of APPs are eligible and are credentialed and considered for Medical Staff membership and clinical privileges in the same manner as Physicians and other Practitioners under the Medical Staff Bylaws: physician assistants, certified anesthesiologist assistants, and advanced practice registered nurses (i.e., certified nurse midwives, certified nurse practitioners, certified registered nurse anesthetists, clinical nurse specialists, and psychiatric nurses). All other categories of APPs have their qualifications and ongoing competence verified by the Hospital.

B. Responsibilities and Limitations of Advanced Practice Providers

The following responsibilities and limitations apply to all APPs granted Medical Staff membership and clinical privileges:

1. Supervision of APPs. All APPs shall be under the supervision and direction of a Physician or other properly qualified Practitioner ("Sponsoring Physician/Practitioner") and the terms of the relationship shall be documented in an approved sponsorship agreement (filed in the Hospital's Medical Staff Office and containing all the required components provided in Section 3.6 of the Medical Staff Bylaws) between the Physician or Practitioner and APP ("Sponsorship Agreement").

2. APP Privileges. An APP may receive privileges for only one (1) specialty at a time.

3. Compliance with Bylaws, Rules, and Policies. APPs are subject to and shall comply with the Medical Staff Bylaws, these Rules and Regulations, and all applicable Hospital Policies.

4. APP Assignment. APPs shall be assigned to the Hospital department that the Sponsoring Physician/Practitioner is assigned to, and such APP shall be subject to all applicable departmental policies and procedures.

5. Office Appointments. APPs are not eligible to hold office or to vote on Medical Staff or department-specific matters.

6. Termination APP Membership and Privileges. An APP's Medical Staff membership and clinical privileges shall automatically terminate upon termination of the APP's Sponsoring Physician/Practitioner's Medical Staff membership unless another Physician or qualified Practitioner assumes the supervision of the APP in accordance with the requirements of Section 3.6 of the Medical Staff Bylaws. The APP shall not be entitled to any Fair Hearing rights for such termination of the APP's Medical staff membership and clinical privileges.

7. APP Admission and Discharge Orders. An APP may only enter admission or discharge orders for a Patient after review by the Sponsoring Physician/Practitioner, and such orders by the APP shall be countersigned by the Sponsoring Physician/Practitioner no later than twenty-four (24) hours after the APP's entry of the order.

8. Medical Record Entries. Properly credentialed and privileged APPs may make appropriate entries and complete clinical records as permitted under applicable Health Care Laws, the Medical Staff Bylaws, and these Rules and Regulations. All entries and clinical records completed by APPs shall be reviewed and countersigned by the Sponsoring Physician/Practitioner.

9. Medical Screening Examinations. Those APPs deemed "Qualified Medical Personnel" pursuant to Section III.D.1.a.ii. of these Rules and Regulations may perform the Medical Screening Examination of Patients presenting to the Emergency Department with an Emergency Medical Condition.

10. Involuntary Examinations. Those APPs permitted under applicable Health Care Laws and Section III.D.2.c.ii.(b)(i) of these Rules and Regulations may perform the Involuntary Examination of Baker Act Patients within the framework of an established protocol with a psychiatrist.

11. Anesthesia. Pursuant to Section IV.D.5.a.i. of these Rules and Regulations and § 395.0191(2)(b), Fla. Stat., APPs certified as registered nurse anesthetists may only administer anesthesia to Patients if such APP is under the onsite medical direction of a Physician or oral and maxillofacial surgeon and in accordance with an established written protocol.

12. Responsibility for APPs. The granting of Medical Staff membership and clinical privileges to an APP alone is not permission to treat illnesses or to make

pathologic findings; rather, such permission may only be extended to an APP through an established written protocol with the APPs Sponsoring Physician/Practitioner. To the extent such permission is extended to an APP by the APP's Sponsoring Physician/Practitioner, the Sponsoring Physician/Practitioner remains ultimately responsible for the care of Sponsoring Physician/Practitioner's Patient.

13. APP Updates. APPs shall update the applicable Medical Staff Office within seven (7) days of any change to the APP's licensure or the APP's Sponsoring Physician/Practitioner.

C. Responsibilities of Sponsoring Physician/Practitioners

Sponsoring Physician/Practitioners shall possess the following responsibilities when supervising and sponsoring APPs:

1. Sponsoring Physician/Practitioner Ultimately Responsible. Sponsoring Physician/Practitioners are ultimately responsible for the Patient's care and treatment, and Sponsoring Physician/Practitioners are responsible for the proper supervision of their APPs.

2. Rounding of Sponsoring Physician/Practitioner. Rounding of a Sponsoring Physician/Practitioner shall occur on the same day of service an APP rounds on a Patient and the Sponsoring Physician/Practitioner shall countersign the APP's note within twenty-four (24) hours.

3. Patient Communication. Sponsoring Physician/Practitioners shall inform their Patients of the role(s) of the APP in the Patient's care and treatment.

4. Accessibility. Sponsoring Physician/Practitioners shall be readily accessible to APPs, and, when warranted and necessary, shall be physically present for the direct oversight of the APP.

5. Sponsoring Physician/Practitioner Temporary Absences. Sponsoring Physician/Practitioners shall, when not immediately available, designate another Physician or appropriately qualified Practitioner to supervise the APP. The Physician or other Practitioner delegated such authority and responsibility shall be designated in and a signatory to the approved Sponsorship Agreement filed in the Hospital's Medical Staff Office.

D. Additional Rules, Responsibilities, and Limitations for Certified Nurse Midwives and their Sponsoring Physician/Practitioners

APPs who are certified nurse midwives and their Sponsoring Physician/Practitioners, in addition to the applicable responsibilities and limitations defined in Sections VI.B. and VI.C. above, shall also be subject to the following rules, responsibilities and limitations:

1. Management of Patients. Certified nurse midwives, with appropriate privileges and in accordance with an established protocol approved by the Medical Staff and Hospital, may independently manage Patients during routine (non-high risk) labor and delivery. Such management may include performing, as well as

obtaining appropriate consents for, amniotomies, episiotomies and repairs, ordering appropriate medications, and performing postpartum examinations. A Sponsoring Physician/Practitioner does not need to see a Patient daily if the Patient is being independently managed by a certified nurse midwife, and medication orders by certified nurse midwives do not need to be countersigned by a Physician or other Practitioner.

2. Sponsoring Physician/Practitioner Privileges. The Sponsoring Physician/Practitioner of a certified nurse midwife shall possess full obstetrical privileges and the certified nurse midwife shall be employed by or professionally affiliated with the Sponsoring Physician/Practitioner or the Sponsoring Physician/Practitioner's group.

3. Patient Communication. Sponsoring Physician/Practitioners shall inform Patients being managed by a certified nurse midwife of the Sponsoring Physician/Practitioner's and certified nurse midwife's respective roles in the care of the Patient in routine care and in the event of a complication during labor and delivery.

4. Admission Orders. Certified nurse midwives may only enter admission orders for Patients after review by the Sponsoring Physician/Practitioner, and such orders by the certified nurse midwives shall be countersigned by the Sponsoring Physician/Practitioner.

5. Review, Documentation, and Supervision. The certified nurse midwife's Sponsoring Physician/Practitioner shall review the medical care rendered by the certified nurse midwife and shall document whether the approved protocols and procedures were followed by the certified nurse midwife.

E. Adverse Actions of Advanced Practice Providers

APPs shall not be subject to the Fair Hearing procedures provided in the Medical Staff Bylaws. Instead, any adverse actions affecting an APP's Medical Staff membership or clinical privileges shall be governed under Section 3.6 of the Medical Staff Bylaws. The procedure shall be as follows:

1. Reporting Concerns. All clinical, professional, or behavioral concerns of an APP shall be submitted in writing to the APP's Department Chair. The Department Chair shall determine if further action is warranted and, if appropriate, make a recommendation to the Hospital's Medical Executive Committee.

2. Department Chair Review. During the Department Chair's review, if there are reasonable grounds to believe that the conduct, activities, or inaction of an APP poses a threat or significant impairment to the life, well-being, health, or safety of any Patient, employee, or other person present at the Hospital and that the failure to take prompt action may result in imminent danger to the life, well-being, health, or safety of any such person, the Chair, in consultation with the Chief of Staff and Chief Executive Officer of the Hospital, may summarily suspend the APP during the pendency of the review and such summary suspension shall remain in effect until the final action taken against the APP or until lifted by the Hospital's MEC.

3. Department Chair Recommendations and APP Responses. If the Department Chair makes an adverse recommendation to the MEC, the APP shall be afforded the opportunity, either in writing or in person as determined appropriate by the MEC, to provide additional information and respond to and rebut the issues and allegations raised. The Sponsoring Physician/Practitioner shall have no right to respond to allegations against an APP unless otherwise granted such privilege by the MEC.

4. Appeals. Following the action of the MEC, the APP shall have the right to appeal in accordance with Section 3.6 of the Medical Staff Bylaws.

5. Department Chair Unavailability. To the extent the Department Chair of the APP's Department is unavailable, the Department Vice-Chair shall assume the Department Chair's responsibilities provided in this Section VI.E. To the extent the Department Chair and Vice-Chair are unavailable, the Chief of Staff of the Hospital may assume, or otherwise delegate to another competent Physician or Practitioner, the roles and responsibilities of the Department Chair as provided in this Section VI.E.

VII. SUPERVISION OF RESIDENTS, FELLOWS, STUDENTS, AND OTHER LEARNERS

A. Supervision of all Learners Generally

1. Medical Education and Learners. Broward Health operates teaching Hospitals that serve as a training ground for medical, dental, pharmacy, and other health care related Students attending undergraduate and graduate educational institutions, and Broward Health also operates postdoctoral graduate educational programs that train and educate Interns, Residents, Fellows, and other medical professionals (collectively, "Learners") in the provision of medical care at Hospitals.

2. Compliance and Consistency with Accreditation Standards. Broward Health is accredited to provide such teaching by various accreditation bodies and agencies that govern the training of these Learners including, without limitation, the Accreditation Council for Graduate Medical Education ("ACGME"), the American Osteopathic Association, Commission on Dental Accreditation, the American Society of Health-System Pharmacists, and other educational accrediting agencies (collectively, "Accreditation Bodies"). Because Broward Health is accredited by these Accreditation Bodies, the training and education of Learners shall always be consistent with such applicable and governing Accreditation Bodies, and to the extent that any applicable Accreditation Body standards conflict with the provisions of these Rules and Regulations governing the teaching and training of such Learners, the Accreditation Body's standards shall control as if fully set forth herein.

B. Medical, Dental, and Health Professional Students

1. *Medical, Dental, and Health Professional Students Generally*

a. Broward Health Student Affiliations. Broward Health has several affiliations with educational institutions and hospitals throughout the country where medical, dental, and other health care professional students (collectively,

"Students") matriculate, and Broward Health accepts rotations from such educational institutions and hospitals for Students who wish to gain clinical experience. Students are considered and selected to participate in these rotations through Broward Health's Department of Learning and/or Broward Health's Graduate Medical Education Department in conjunction with the Hospitals.

b. Oversight of Students. These Students are overseen and supervised by Broward Health's Department of Learning and/or Broward Health's Graduate Medical Education Department and are subject to, and required to comply with, all Hospital Policies.

c. Selection of Supervising Physicians and Practitioners. The selection and approval of supervising Physicians and Practitioners is a joint decision by the foregoing departments and the Hospitals.

2. *Supervision of Students*

a. Level of Student Supervision. The appropriate level of supervision of a Student is governed by applicable Health Care Laws, Hospital Policy, and Accreditation Body requirements. All Physicians and other Practitioners providing supervision of Students shall adhere to such requirements. The amount of direct and/or indirect supervision required for each Student varies according to the clinical nature of each Patient, and shall be commensurate with the level of training, education, and experience of the Student that is involved with the Patient's care. In all circumstances, when deciding the appropriate level of supervision, Physicians and Practitioners shall analyze and be guided by clinical practice, safety, and care, and each Patient, Student, and the relevant specific circumstances shall be considered to ensure safe, effective, and high-quality Patient care.

b. Student Performance or Professionalism Concerns. Any performance or professionalism concerns regarding a Student's educational experience or conduct shall be directed to the applicable designated official at the respective Hospital or the applicable supervising department.

3. *Student Documentation*

Medical Students are permitted to make entries in a Patient's medical record, but such Student notes shall not be part of the medical record, are strictly for the purpose of Student training, and may not be used or considered in the care of the Patient.

4. *Performance and Professionalism of Supervising Physicians and Practitioners*

Physicians and other Practitioners providing training and education to Students are subject to, and shall always comply with, Hospital Policy and the applicable Accreditation Body policies. Physicians and Practitioners shall directly observe, evaluate, and frequently provide written and verbal feedback on Student performance during each Student rotation or similar educational assignment consistent with the requirements of the applicable rotation.

C. Graduate Medical Education

1. *Graduate Medical Education Generally*

Broward Health runs an accredited Graduate Medical Education Program ("GME Program") where it supervises, teaches, and trains Interns, Residents, and Fellows (collectively, "GME Learners") through didactic and clinical training in various specialties and subspecialties (individually, a "Specialty-Specific Training Program" and collectively, the "Specialty-Specific Training Programs"). GME Learners are considered and selected to participate in the GME Program each academic year by the respective Program Director overseeing the Specialty-Specific Training Program. Additionally, the GME Program has affiliations with various institutions permitting GME Learners to rotate at various facilities throughout South Florida and permitting GME Learners employed by other institutions to rotate in the Hospitals. With the exception of Fellows who are granted privileges as an attending Physician or other Practitioner, as explained in greater detail in Section VII.C.8. below, such GME Learners are not eligible for membership on the Medical Staff. Physicians and Practitioners providing training for these GME Learners are selected by the Program Director of each Specialty-Specific Training Program and the appointment is reviewed and approved by GMEC (as defined below) after GMEC's review of the qualifications and attributes of each selected Physician and Practitioner.

2. *Graduate Medical Education Committee*

a. Graduate Medical Education Committee's Role and Purpose

The Graduate Medical Education Committee ("GMEC") oversees matters concerning the GME Program, including, but not limited to, the coordination and development of teaching faculty and the educational processes; overseeing the quality of the learning and working environment of each of the Specialty-Specific Training Programs and the GME Programs' participating sites; overseeing the quality of educational experiences in each Specialty-Specific Training Program that lead to measurable achievement of educational outcomes as identified in the ACGME Program Requirements; the approval of new program directors, policies, and major changes in the GME Program; and all the other roles and responsibilities outlined in ACGME's Institutional Requirements. GMEC shall meet a minimum of once every quarter during each academic year. The specific structure, roles, responsibilities, meetings, and GMEC procedural requirements are governed under the applicable GME Program's policies governing GMEC.

Insofar as the Board of Commissioners of North Broward Hospital District is responsible for the oversight of Broward Health's GME Program in accordance with ch. 2006-347, Laws of Florida, as amended, applicable Health Care Laws, and the accreditation standards of ACGME, The Joint Commission, and other Accreditation Bodies, GMEC reports directly to the Board. The Chief of Staff Appointees (as defined below in Section VII.C.2.b.)

and the GME Program's Designated Institutional Official ("DIO"), or designee, shall periodically present informational reports to each Hospital's Medical Executive Committee.

b. Graduate Medical Education Committee's Composition

GMEC's voting members shall be composed of the DIO, who shall be the chair of GMEC; a representative sample of, and in no event less than two (2), Program Directors from the Specialty-Specific Training Programs; a minimum of two (2) peer-selected Residents or Fellows from among the Specialty-Specific Training Programs; a quality improvement or patient safety officer or designee; and two (2) representatives from each Hospital, selected by the Hospital's respective Chief of Staff, who actively participates in educational training in the GME Program and who is affiliated with, and/or has requisite knowledge of, relevant post-graduate training (a "Chief of Staff Appointee"). In order to carry out GMEC's responsibilities, additional members may be appointed from time to time at the discretion of the DIO, and as confirmed and approved by the voting members of GMEC. All members shall be appointed for a term commensurate with their leadership role in the GME Program.

3. *Advisory Committee for Graduate Medical Education*

a. Advisory Committee's Role and Purpose

The Medical Staff is committed to the advancement of graduate medical education and the support of the GME Learners at Broward Health. To that end, the Medical Staff has established the Advisory Committee for Graduate Medical Education ("GME Advisory Committee") to support the GME Program. The GME Advisory Committee's mission is to enhance health care and graduate medical education at Broward Health by collaborating with Broward Health's administration, the DIO, and GMEC to support initiatives, best practices, and advancements that enhance the quality of health care provided to Patients, strengthen communication between the Medical Staff and the GME Program, and improve the well-being and education of the GME Learners.

The GME Advisory Committee's roles include, but are not limited to, encouraging the innovation and service of the GME Program's faculty members; advising and communicating with GMEC on matters and issues of importance of the GME Program's faculty; recommending and advising the GMEC on the establishment of additional Specialty-Specific Training Programs; recommending and advising the GMEC on improvements to current Specialty-Specific Training Programs; recommending to GMEC changes to the GME Program's policies; creating subcommittees of the GME Advisory Committee to further its mission and roles; and any further initiatives the GME Advisory Committee deems appropriate for the advancement of the GME Program at Broward Health.

The GME Advisory Committee shall meet at least one (1) time each year, or more often as determined and called by the GME Advisory Committee's chairperson or at least three (3) voting members of the GME Advisory Committee. The chairperson of the GME Advisory Committee shall present the GME Advisory Committee's issues, concerns, and recommendations to the GMEC. To the extent the GME Advisory Committee's issues and concerns are not resolved by the GMEC or to the extent the GME Advisory Committee's recommendations are not adopted by the GMEC, the chairperson of the GME Advisory Committee may raise such matters at the next meeting of the Joint Conference Subcommittee established under Section 9.16 of the Medical Staff Bylaws. To the extent that such matters cannot be resolved at the Joint Conference Subcommittee, such matters may be raised by the chairperson of the GME Advisory Committee at the next Joint Conference Committee established under Section 9.15 of the Medical Staff Bylaws.

b. Advisory Committee's Composition

The GME Advisory Committee's voting members shall be composed of the currently serving Chiefs of Staff of the Hospitals and the immediate past Chiefs of Staff of the Hospitals. Each year at a GME Advisory Committee meeting, the GME Advisory Committee's voting members shall elect the GME Advisory Committee's chairperson, who shall be a currently serving Chief of Staff at one (1) of the Hospitals, to serve for a one-year term. The DIO, the Chief Executive Officers of the Hospitals, and Broward Health's Chief Medical Officer shall serve as non-voting ex-officio members of the GME Advisory Committee. The chairperson of the GME Advisory Committee may invite individuals to attend the GME Advisory Committee's meetings to assist the GME Advisory Committee in carrying out its roles and responsibilities.

4. *Supervision of GME Learners*

a. Supervision of GME Learners Generally. GME Learners are overseen by qualified and GMEC-approved Physicians and Practitioners who provide these GME Learners with appropriate supervision and conditional independence, allowing them to attain the knowledge, skills, attitudes, and empathy required for autonomous practice.

b. Physician and Practitioner Responsibility for Patient Care. While GME Learners may participate in the care of a Patient, the Physician or other Practitioner is ultimately responsible for the Patient's care. Accordingly, proper supervision of GME Learners is vital to the proper and safe delivery of Patient care.

c. Level of Supervision of GME Learners. The appropriate level of supervision of a GME Learner is based on applicable Health Care Laws, Hospital Policy, and written Specialty-Specific Training Program supervision policies consistent with the Accreditation Bodies' common and Specialty-Specific

Training Program requirements. All Physicians and Practitioners providing clinical and/or didactic instruction to the GME Learners shall adhere to the requirements of applicable Health Care Laws, Hospital Policy, and their respective Specialty-Specific Training Program's policies governing the supervision of the GME Learners. The proper level of supervision of a GME Learner shall be commensurate with such GME Learner's level of autonomy in practice and clinical knowledge, competency, and abilities, and may vary depending on the specific Patient being treated, the procedure involved, Patient safety, complexity, acuity, urgency, risk of serious adverse events, and/or other pertinent variables. In all circumstances, when deciding the appropriate level of supervision, Physicians and Practitioners shall analyze and be guided by clinical practice, safety, and care, and each Patient, GME Learner, and specific circumstances shall be considered to ensure safe, effective, and high-quality Patient care.

d. Performance or Professionalism Concerns. Any performance or professionalism concerns regarding a GME Learner's educational experience or conduct shall be directed to the applicable Program Director, Designated Institutional Officer, and/or Regional Medical Officer.

5. *Patient Communication*

Each Patient shall have an identifiable and appropriately credentialed and privileged Physician or other Practitioner responsible and accountable for such Patient's care. This information shall be made available to the Patients, the GME Learners, other faculty members, and other members of the Patient's health care team. GME Learners and Physicians and Practitioners training GME Learners shall inform each Patient of their respective roles in that Patient's care when providing direct Patient care.

6. *Teaching Faculty Performance and Professionalism*

a. Compliance with Policies. Physicians and Practitioners providing training and education to GME Learners are subject to, and shall always comply with, Hospital Policy and the GME Program's and applicable Specialty-Specific Training Program's policies. Physicians and Practitioners shall directly observe, evaluate, and frequently provide written and verbal feedback on GME Learner performance during each rotation or similar educational assignment consistent with the requirements of each Specialty-Specific Training Program.

b. Program Director Approval. Teaching Physicians and Practitioners may only serve and participate in the GME Program with the continued approval of the applicable Specialty-Specific Training Program's Program Director.

c. Faculty Evaluations. Each Physician and Practitioner who interacts with GME Learners shall be evaluated by the Program Director and other administrative members of the GME Program team based on the teaching Physician's or Practitioner's clinical teaching abilities, engagement with the educational program, participation in faculty development related to their skills as an educator, clinical performance, professionalism, and scholarly activities. This

evaluation shall likewise include written, anonymous, and confidential evaluations by the GME Learners. At least annually, each teaching Physician or teaching Practitioner shall receive feedback on their evaluations.

7. *GME Learner Documentation*

GME Learners' medical record documentation shall be commensurate with their level of training and competence, under the general supervision of an appropriately privileged teaching Physician or Practitioner. All entries in a Patient's medical record related to H&Ps, operative reports, Consultations, discharge summaries, and outpatient notes shall be countersigned and Authenticated by the Physician or other Practitioner directly supervising the GME Learner.

8. *Fellows with Attending Physician or Practitioner Privileges*

Fellows may wish to receive privileges to serve as an attending Physician or other Practitioner at one (1) or more of the Hospitals or other Broward Health facilities. A Fellow shall have prior approval from the Fellow's Program Director and the relevant Department Chair at the Hospital or other facility to receive such attending Physician or Practitioner privileges. Such Fellows shall be subject to the requirements of the Medical Staff Bylaws and these Rules and Regulations and shall be fully credentialed and privileged prior to engaging in such activities. In no event may a Fellow act as an attending Physician or Practitioner at any Hospital or other facility at which such Fellow is or will receive fellowship training.

VIII. CONSTRUCTION

The title of article, section, subsection, and paragraph headings in these Rules and Regulations are for convenience of reference only and shall not govern or affect the interpretation of any of the terms or provisions of these Rules and Regulations. The use in these Rules and Regulations of the term "including" and other words of similar import mean "including, without limitation" and where specific language is used to clarify by example a general statement contained herein, such specific language shall not be deemed to modify, limit, or restrict in any manner the construction of the general statement to which it relates. Unless the context requires otherwise, the word "or" is not exclusive and the words "herein," "hereof," "hereunder," and other words of similar import refer to these Rules and Regulations as a whole, and not to any particular section, subsection, paragraph, subparagraph, or clause contained in these Rules and Regulations. The use of terms importing the singular shall also include the plural, and vice versa. The term "shall" is mandatory and "may" is optional. The reference to an agreement, instrument, or other document means such agreement, instrument, or other document as amended, supplemented, and modified from time to time to the extent permitted by the provisions thereof, and the reference to a statute, regulation, or accreditation standard means such statute, regulation, or accreditation standard as amended from time to time and includes any successor guidelines, standards, or legislation thereto along with any regulations promulgated thereunder. The terms "his," "her," "its," and similar terms shall be interpreted interchangeability unless context requires otherwise.

IX. AMENDMENT OF RULES

Amendments to the Rules and Regulations shall follow the procedure outlined in the Bylaws of the Medical Staff of the North Broward Hospital District.

X. ADOPTION

These Rules and Regulations of the Medical Staff shall be adopted by the Unified Medical Staff Committee in accordance with the Bylaws and shall replace any previous Rules and Regulations of the Medical Staff becoming effective when approved by the Board of Commissioners of the North Broward Hospital District. They shall, when adopted and approved, be equally binding on the Board of Commissioners and the Medical Staff of Broward Health.

_____ _____

Date Chairperson
Unified Medical Staff Committee

Approved by the Governing Body of the North Broward Hospital District.

_____ _____

Date Chairperson
Board of Commissioners of the North Broward Hospital District