Tampa
General
Hospital

MEDICAL STAFF
RULES & REGULATIONS

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Medical Staff Services - (813) 844-7229

TABLE OF CONTENTS RULES/REGULATIONS OF THE MEDICAL STAFF

DEFINITIONS

The terms found in these Medical Staff Rules and Regulations are identified below:

ADMINISTRATOR means the member of Senior Management on call.

ATTENDING means the Member of the Medical Staff responsible for the care of a Hospitalized patient as opposed to other ancillary practitioners assisting as consultants. Attending Members may supervise the care of patients by interns, residents, advanced practice professionals and/or medical students.

ATTENDING OF RECORD means the practitioner who admits the patient, is responsible at admission for the care of the patient, and is responsible for the discharge summary unless that responsibility is transferred by order.

BOARD means the Board of Directors of the Florida Health Sciences Center, Inc. or its lawful successor.

CHIEF EXECUTIVE OFFICER or CEO means the individual appointed by the Board to act in its behalf in the overall management of the hospital. For the purpose of these rules/regulations, the term "Chief Executive Officer" includes a duly appointed Senior Administrator who has been delegated by the CEO and is serving when the CEO is away from the Hospital. The Medical Staff may rely on all actions of the CEO as being the actions of the Board taken pursuant to a proper delegation of authority of the Board.

CHIEF MEDICAL OFFICER is a physician appointed by the Board to oversee Medical Staff relations.

CHIEF OF STAFF means a Member of the Active Medical Staff who is elected in accordance with the Medical Staff Bylaws to serve as chief officer of the Medical Staff of this h o s p i t a l .

COLLEGE OF MEDICINE means the University of South Florida College of Medicine.

DENTIST means a person who is licensed to practice dentistry pursuant to Chapter 461 of the Florida Statutes and holds a current unrestricted license or as required by these Bylaws.

DEPARTMENT means a separate major clinical division of the Medical Staff organization.

EXECUTIVE COMMITTEE means the Executive Committee (MEC) of the Medical Staff unless specific reference is made to the Executive Committee of the Board.

HOSPITAL means Tampa General Hospital.

MEDICAL STAFF means a formal organization of doctors of medicine, doctors of osteopathic medicine, dentists, podiatrists, and psychologists who have been granted appointment and privileges to attend and provide for a uniform quality of patient care, treatment, and services at the Hospital, within the scope of his/her licensure and approved clinical privileges, based on

training, education and demonstrated competency.

MEDICAL STAFF YEAR means the period from October 1 to September 30 of each year. MEMBER means any professional appointed to and maintaining membership who is in good standing in any category of the Medical Staff in accordance with the Medical Staff Bylaws.

PHYSICIAN means a person who is licensed to practice medicine pursuant to chapter 458 of the Florida Statutes or osteopathic medicine pursuant to chapter 459 of the Florida Statutes and who holds a current, unrestricted license in this State or as required by these Bylaws and or who meets exceptions outlined under 455.02.

PODIATRIST means an individual who is licensed to practice podiatry pursuant to chapter 466 of the Florida Statutes and holds a current unrestricted license or as required by these Bylaws.

PRACTITIONERS include healthcare providers as credentialed by the Medical Staff.

PRIVILEGES means only those specified privileges applied for and granted by the Board to Practitioners to attend patients in the Hospital within the scope of his/her licensure, based on training, education and demonstrated competency.

PSYCHOLOGIST means an individual who is licensed to practice psychology pursuant to Chapter 490 of the Florida Statutes and holds a current unrestricted license or as required by these Bylaws.

SECTION means a subdivision of a Department organized to represent a medical specialty or subspecialty.

STATE means Florida.

NOTE: All pronouns and any variations thereof shall be deemed to refer to persons of either gender.

SECTION I

I. Department and Sections

The Medical Staff shall be organized into the following departments and sections.

A. Department of Anesthesiology;
B. Department of Emergency Medicine;
C. Department of Family Medicine;
D. Department of Internal Medicine, including Sections of:
    1. Allergy
    2. Dermatology
    3. Endocrinology
    4. Cardiovascular Disease
    5. Gastroenterology
    6. Hematology-Oncology
    7. Hospital Medicine
    8. Infectious Diseases
    9. Nephrology
    10. Pulmonary Disease, Critical Care Medicine and Sleep Medicine
    11. Radiation Oncology
E. Department of Neurological Surgery
F. Department of Neurology
G. Department of Obstetrics and Gynecology;
H. Department of Orthopaedic Surgery; including Section of:
    1. Podiatry
I. Department of Otolaryngology Head and Neck Surgery;
J. Department of Pathology
K. Department of Pediatrics
L. Department of Physical Medicine and Rehabilitation
M. Department of Plastic Surgery, including Section of:
    1. Dentistry and Maxillofacial Surgery
N. Department of Psychiatry, including Section of:
    1. Psychology
O. Department of Radiological Services
P. Department of Surgery, including Sections of:
    1. General Surgery
    2. Ophthalmology
    3. Thoracic and Cardiovascular Surgery
    4. Urology
Q. Department of Vascular Surgery

SECTION II

II. ENGLISH LANGUAGE PROFICIENCY

Applicants for the Medical Staff must have demonstrated proficiency in the use of the English language sufficient to assure that there is no risk of impairment of patient care because of difficulty in verbal communication. If an applicant's proficiency in the English language is questioned, the Chief of the Department shall initiate a focused review to determine whether the applicant satisfies the threshold requirement of proficiency in the English language.

SECTION III

III. MEDICAL STAFF CONFIDENTIALITY

A. Confidentiality of Patient Medical Records

A patient's medical record is the property of the Hospital. If requested, the record will be made available to any member of the Medical Staff involved in the care of the patient and to members of medical staffs of other hospitals upon written consent of the patient or by the appropriate Hospital authority in an emergency situation. Medical records will otherwise be disclosed only pursuant to patient authorization, court order, subpoena, or statute. Records will not be removed from the Hospital's jurisdiction or safekeeping except in compliance with a court order, subpoena, or statute.

B. Confidentiality of Medical Staff Records, Practitioner Files, Credentialing and Peer Review Information

To the fullest extent permitted by law, the following shall be kept confidential:

- Information submitted, collected, or prepared by any representative of this or any other healthcare facility or organization or medical staff for the purposes of assessing, reviewing, evaluating, monitoring, or improving the quality and efficiency of healthcare provided;
- Evaluations of current clinical competence
- Qualifications for staff appointment/affiliation and/or clinical privileges or specified services;
- The proceedings, investigations, discussions and records of medical review committees or peer review panels or committees;
- Contributions to teaching or clinical research; or

- Determinations that healthcare services were indicated or performed in compliance with an applicable standard of care.

Unless required by law, this information will not be disseminated to anyone other than a representative of the hospital or to other healthcare facilities or organizations of health professionals engaged in official, authorized activities for which the information is needed. Such confidentiality shall also extend to information provided by third parties. Each practitioner expressly acknowledges that violations of confidentiality provided here are grounds for immediate and permanent revocation of staff appointment/affiliation and/or clinical privileges.

All peer review information is privileged and confidential in accordance with medical staff and hospital bylaws, state and federal laws, and regulations pertaining to confidentiality and non-discoverability.

SECTION IV

IV. GENERAL PATIENT MANAGEMENT

A. Admission of Patients:

Tampa General Hospital is a general hospital, which includes acute care and Rehabilitation Center.

1. Who May Admit

   Admission of any patient is contingent on adequate facilities, resources, and personnel being available to care for the patient as determined by the Administrator on Call in conjunction with the Practitioner with admitting privileges. Patients shall be admitted without regard to race, creed, color, sex, national origin, or source of payment.

   A patient may be admitted to the hospital by a Physician, Dentist, Podiatrist, or Oral Surgeon, on the Tampa General Hospital Medical Staff or Certified Nurse Midwife who is in good standing, and has been granted admitting privileges, subject to the conditions provided below and to all other official admitting policies of the Hospital as may be in effect or modified from time to time.

   Admitting privileges will be requested by Practitioners based upon criteria developed by Sections/Departments and approved by the Credentials Committee, Executive Committee and the Hospital Board.

2. Medical Staff Responsibility to Manage and Coordinate Patients' care, treatment, and services

   a) Each patient shall be the responsibility of an attending Practitioner who

is the Attending of Record. The Attending of Record shall be responsible to manage and coordinate the patient's care, treatment, and services, for the prompt completion and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to a referring Practitioner if applicable and to the appropriate relatives and designees of the patient. In the event the Attending of Record will be unavailable, it is the Attending's responsibility to designate an appropriate Practitioner with similar credentials and privileges to render routine and/or emergency care in the event of any absence.

b) The Attending of Record may transfer the responsibility for a given patient to another qualified Practitioner who agrees to accept the transfer following direct communication by the referring physician. In the event that the patient or the physician terminates the patient/physician relationship, the terminated Practitioner remains responsible for the patient care until appropriately transferred to another Practitioner. If transferred, an order covering the transfer of responsibility shall be entered in the medical record and the transfer shall be noted in the progress notes. The Attending of Record remains the person responsible for the patient's care until the transfer has taken place.

c) In an emergency when neither the Attending of Record nor his designee is available, or when a patient/physician relationship has been terminated and the terminated Practitioner is unable to transfer the patient to another qualified Practitioner, the Chief of the Department or Section concerned shall have the authority to assume care of such patient or, in his sole judgment, to call upon any Member of the Department to treat such emergency. The Chief of Staff or his designee shall exercise this authority in the absence I unavailability of the Chief of the Department or Section. In case of failure to reach any of the above, the Administrator shall have the authority to call an appropriate Practitioner.

d) For those services designated as teaching services, patient care responsibility shall be the responsibility of the designated Attending Physician including review and evaluation on a timely basis as designated by these Rules and Regulations (para 4 b(3)) as well as consistent with pre-filed schedules of rotations as approved by the Department or Section.

e) The Medical Staff shall define the categories of medical conditions for reporting of patient conditions and status. These are approved by the Executive Committee and are as follows:

1) **GOOD**
Vital signs are stable and within normal limits. Patient is conscious and comfortable. Prognosis is good to excellent.

2) **FAIR**
Vital signs are stable and within normal limits. Patient is conscious. Patient is uncomfortable or may have minor complications. Favorable prognosis.

3) **SERIOUS**
Acutely ill with questionable prognosis. Vital signs may be unstable and not within normal limits. A chance for improved prognosis.

4) **CRITICAL**
Questionable prognosis. Vital signs are unstable and not within normal limits. There are major complications; death may be imminent.

f) Designating any patient care services to an Advanced Practice Professional does not exempt the supervising practitioner from total responsibility of the care of the patient, including timely completion and authentication on all medical record documentation.

3. Categories of Admissions

a) Ambulatory Status. An ambulatory patient receives an outpatient procedure, test or treatment, and it is anticipated that the patient will be able to safely leave the hospital within twenty three (23) hours of admission

b) Inpatient Status. Inpatients require more complex care than can be provided in an outpatient ambulatory setting. The physician should order inpatient services if the physician believes the patient's condition requires acute hospitalization (medical necessity) and that the hospital stay will span two (2) or more midnights. The reason for the hospital admission and the expected length of stay must be documented in the patient's record.

c) Observation Status. Patients should be placed in Observation Status if the physician believes that their hospital stay will span no more than one (1) midnight. Delay in treatment or unavailability of services, resulting in two (2) or more midnights, does not warrant an inpatient admission. Medical necessity must be the principle factor in determining a patient's inpatient status.

d) Medicare inpatients may not be changed to observational status, except in rare circumstances and only in concurrence of the attending and the Utilization Management Committee Chairman (or representative). This status change must occur before the patient is discharged. Patients must

be notified when their admission is downgraded to a bedded outpatient receiving observation services.

Due to the complexity of the CMS ruling regarding patient admission status, physicians are encouraged to contact Case Management when they are unsure which admission category is appropriate for their patient. Case Management may ask physicians to discuss the case with one of the contracted physician consultants with specific expertise in CMS admission rules to help determine the appropriate admission category.

4. Admission Priorities

   The Hospital will admit patients on the basis of the following order of priorities:

   a) Emergency Admission: Emergency admissions are the most seriously ill patients. The condition of this patient is one of immediate and extreme risk. This patient requires immediate attention and is likely to expire without stabilization and treatment. The emergency admission patient will be admitted immediately to the first appropriate bed available.

   b) Urgent Admissions: Urgent admission patients meet the criteria for inpatient admission, however their condition is not life-threatening. Urgent admission patients will be admitted as soon as an appropriate bed is available.

   c) Elective Admissions: Elective admission patients meet the medical necessity criteria for hospitalization but there is no element of urgency for his/her health's sake. These patients may be admitted on a first-come, first-serve basis. A waiting list will be kept and each patient will be admitted as soon as an appropriate bed becomes available.

5. Admission Criteria to Intensive Care, and other Critical Care Units. Patients may be admitted directly or transferred to the Intensive Care Unit by Practitioners under the criteria for admission and according to the following procedure:

   a) In House Transfers
   Patients are admitted from other areas of the hospital through the Admitting Office in consultation with the Nurse Manager on the unit upon the order of a Practitioner. If no bed is available, the Medical Director of the unit or his designee should be contacted in order to facilitate appropriate medical disposition.

   b) Direct Admissions
   The Admitting Office shall follow normal admission procedures and an order must be received for all admissions or transfers.

c) Post Anesthesia Care Unit
Patients may be transferred postoperatively from the post anesthesia room if the Practitioner orders that the patient needs intensive care. If no bed is available in an ICU, the patient may remain in PACU until arrangements can be made for proper bed assignment.

d) Admissions and Transfers to the Intensive Care Unit
Admissions and transfers to the Intensive Care Unit shall be based on need for the facility only. An order must be entered into the electronic medical record.

e) Transfers out of Intensive Care Unit
The unit shall first notify the Admitting Office. An order must be on the chart before transfer. The Admitting Office shall give priority to patients for transfer to the accommodation of their choice over new hospital admissions.

f) Orders Reconciliation
All orders are to be reconciled upon the patient's transfer into, or out of, an ICU.

g) Timely Evaluation
A Member of the Medical Staff or designated Attending Physician must see the patient transferred to any intensive care unit as urgently and as frequently as is consistent with the evolving condition of the patient.

h) Critical Care Unit Policies
In addition to the above, unit specific policies and procedures must be followed as promulgated and amended from time to time.

B. Consents

1. The patient's right of self-decision can be effectively exercised only if the patient possesses enough information to enable an informed choice. The patient should make his or her own determination regarding medical treatment. The practitioner's obligation is to present the medical facts accurately to the patient, or the patient's surrogate decision-maker, and to make recommendations for management in accordance with good medical practice. The practitioner has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a process of communication between a patient and the practitioner that results in the patient's authorization or agreement to undergo a specific medical intervention. Informed consent should follow Hospital policy.

2. Verification of Proper Site and Procedure
Immediately prior to the initiation of any surgery/procedure (whether in the OR, unit, or other location), the surgery/procedure team will pause to confirm the

side, site, presence of any specifically required equipment, patient and procedure. (Surgery may not proceed without this verification of patient, procedure, position, site, and specific equipment.)

See Administrative Policy TX-179--Universal Protocol: “Identification and Verification of Patient, Procedure, and Surgical Site” for the specific steps in the pre-procedure verification process, marking the operative/procedure site, exemptions to site marking, and "timeout" or "pause for the cause" immediately before starting the procedure.

3. Timeframe
   A signed consent is valid as long as the patient remains in the hospital, there is no significant change in the patient's condition which would increase the risks and complications of the procedure to be performed and unless revoked by the patient.

C. Transfer of Patients

1. Inter-hospital Transfers
   All requests for the acceptance of inter-hospital transfers must be directed to the Transfer Center, 844-7979.

   The referring source will have two (2) options:

   a) The referring physician may initiate the transfer request directly through the Transfer Center if he/she does not know the appropriate Member of the TGH Medical Staff with admitting privileges. The Center will select the appropriate Attending from the on-call schedule if no specific Member is noted or requested.

   b) Direct Referral to a Specific Attending

      The Attending requesting transfer of the patient must contact the Transfer Center. The Transfer Center will be responsible for coordinating and verifying all information relevant to the transfer.

      Lack of funding is not a reason for transfer. The Transfer Center will process a financial clearance, obtain administrative approval, and notify the receiving Member when a determination of acceptance has been made. A reasonable record of the immediate medical problem must accompany the patient.

2. Emergency Transfers

   The Emergency Medical Treatment & Labor Act and Florida Access to Emergency Services and Care laws require acceptance of patients referred for transfer from an outside ED when the referring facility cannot provide needed

care. EMTALA & FAESC allow TGH to refuse the transfer when TGH lacks the capacity and capability to treat the patient. Refer to hospital policy for further clarification.

3. Transfer from One Room to Another

In-house patient transfers will customarily follow this Priority:

a) Isolation-Policies of the Infection Control Committee regarding isolation requirements for infectious patients.

b) Regular room assignment to a Critical Care bed assignment.

c) Critical Care to regular room.

d) Improper Bed Placement-Transferring a patient onto a floor to which they would normally be assigned.

e) Hospital convenience-Transferring a patient to make a bed available for additional admissions.

f) Physician's order.

g) Patient request-Transferring a patient into an accommodation that they have requested.

4. Transfer from Tampa General Hospital

a) a. General Requirements

A patient may be transferred to another medical care facility only upon the order of the Attending, only after arrangements have been made for admission with the other facility, including its consent to receive the patient, and only after the patient is considered sufficiently stabilized for transport. All pertinent medical information necessary to insure continuity of care must accompany the patient, along with appropriate patient authorization.

b) Transfer Requested by Emergency or Critically Ill Patients

A transfer requested by an emergency or critically ill patient or his family is not permitted until a Member has explained to the patient or his family the seriousness of his condition and generally not until a Member has determined that his condition is sufficiently stabilized for safe transport. In each case, the appropriate release form, including a summary of the explanation given to the patient and the findings that indicates the patient was sufficiently stabilized, is to be executed, signed by the patient or on

behalf of him by a duly authorized agent, witnessed by a third party, and signed by the Member. If the patient or his agent refuses to sign the release, a completed form without the patient's signature and a note indicating his refusal must be included in the patient's medical record. The form and note must be signed by those involved with the patient's care at the time the transfer is affected.

D. Discharge of Patients

1. Discharge Order
   A patient may be discharged only by an order from the Attending/Resident/Midlevel.

2. Discharge Diagnosis
   Final diagnoses shall be recorded in full, dated, timed and signed by the responsible practitioner at or before the time of the discharge of the patient in the patient's medical record.

3. Discharge Time
   To facilitate scheduling of patient discharges, the Attending should write an order of pending discharge the evening before. The Attending is encouraged to discharge his patients by 11:00 a.m. on the day of discharge.

4. Discharge against Medical Advice
   A patient who demands discharge against the advice of the Attending shall be asked to sign a release form, attested by the patient or his legal representative and witnessed by a competent third party. If a patient leaves the Hospital against the advice of the attending practitioner, or without proper discharge, both the Attending and the applicable charge nurse shall make a notation of the incident in the patient's medical record.

5. Discharge of Minor Patient
   Any individual who cannot legally consent to his own care shall be discharged only to the custody of parents, legal guardian, person standing in loco parentis, or another responsible party, unless otherwise directed by the parent or guardian or court of competent jurisdiction. If the parent or guardian directs that discharge be made otherwise, he shall so state in writing and the statement must be made a part of the patient's medical record.

6. Administrative Discharge
   A patient may be administratively discharged when his/her behavior has made it impossible to treat the patient and still maintain optimum levels of care and safety to the health care team and other patients. The attending physician has specific responsibilities in these cases as specified in hospital policy.

E. General Conduct of Care

1. Utilization of Hospital Resources
   Recognizing that health care resources are limited, all Practitioners will be expected to make appropriate use of these resources. Members of the Medical Staff whose pattern of usage exceeds that of others treating similar problems will be required to justify their utilization rate.

   In order to utilize health care resources efficiently and to aid the hospital in maintaining compliance and to insure proper coding, members of the medical staff are required to:

   a) Respond to all "doc queries" within 72 hours unless otherwise excused by a Medical Staff Officer.

   b) Assist Case Management with delineating the proper admission status of a patient. This includes engaging with physician consultants when necessary.

   c) Attend mandatory documentation training. The length and type of training to be determined by the Medical Executive Committee.

   d) The Attending is required to document the need for continued hospitalization after specific periods of stay as specified by the Utilization Review Committee of this hospital and approved by the clinical department and the Executive Committee of the medical staff. This statement must contain:

      (i) Adequate documentation of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

      (ii) The estimated period of time the patient will need to remain in the hospital;

      (iii)Plans for post-hospital care.

2. Practitioner's Visits

   All hospitalized patients must be seen by the attending physician, a member of the house staff, appropriate covering physician or credentialed practitioner at least daily or more frequently as required by the patient's condition or circumstances.

   A progress note must be documented on each patient daily in sufficient detail to allow formulation of a reasonable assessment of the patient’s clinical status at the time of observation. A progress note may be written by any credentialed practitioner or by a resident or fellow.

3. Consultations

Consultations are categorized by recommended cases, and mandatory types of patients:

a) Recommended Consultations

Consultation with a qualified practitioner is recommended in the following cases:

(i) Problems of critical illness in which any significant questions exist of appropriate procedure or therapy.

(ii) Cases of difficult or equivocal diagnosis or therapy.

(iii)Cases where the patient is not a good risk for operation or treatment.

(iv)When the patient is found on admission to have, or develops subsequent to admission, a condition that is beyond the approved, delineated privileges of the Attending, or unusually complicated situations where specific skills of other Practitioners may be needed.

(v) When requested by the patient or his family.

(vi)In accordance with specific critical care unit policy.

(vii) An admission by a member of the Department of Family Practice to the Coronary Care Unit, by a Cardiologist.

(viii) Palliative care consultation is recommended in patients with far advanced, life-limiting or terminal conditions to assist in management of symptom distress and discussions of care goals.

b) Mandatory Consultation

(i) When & pregnant woman is admitted to a Critical Care Unit for a diagnosis unrelated to the pregnancy, consultation by an obstetrician is required.

(ii) When a pediatric patient under the age of 18 is admitted to a Critical Care Unit, consultation by a Pediatrician or a Pediatric Surgeon is required.

(iii)Overdose patients or suicidal patients require a psychiatry consult

within 24 hours

c) STAT consults must be practitioner to practitioner.

d) Responsibility for Request

(i) The Attending is primarily responsible for requesting consultation with a qualified consultant when indicated. Except in an emergency, he/she shall provide authorization for consultation. Consults shall take place without regard to race, creed, color, sex, national origin, or source of payment.

(ii) Where circumstances are such as to require consultation, the Chief of the Department or the Chief of Staff or the Chief Medical Officer may request a consultation.

(iii)If for any reason, the Practitioner asked to consult is unable to accept the referral or otherwise refuses the referral to consult, the consultant shall notify the Attending within twenty four (24) hours of that refusal.

e) Timeliness of Consultation

Consultations shall be completed within twenty-four (24) hours of the request. Completed consultations shall include a review of the patient's record, examination of the patient, with an assessment and plan developed and signed by the attending. If a resident, fellow, or Advanced Practice Professional has seen the patient, the case should be discussed with the attending and so noted in the chart. The request for consultation should include a specific question for the consultant.

f) All consultations will be for the consultant to consult and treat the patient, unless designated otherwise in the consultation request.

g) Use of ED on Call Roster

In cases where a practitioner cannot obtain voluntary consultation on an inpatient, the ED call list will be used to determine the practitioner who must consult on the patient.

4. Orders

a) Standard

The Practitioner's orders must be in electronic form. PRN or "as needed" orders will include an indication for administration of medication or treatment.

b) Authorization

Authorized orders shall include those written by Practitioners within the authority of their clinical privileges.

c) STAT Orders

Should only be requested for a medical emergency.

Imaging STAT Orders

Practitioners ordering STAT imaging (formerly referred to as "Wet Reads") must leave a contact number with the Order. This will enable the radiologists to call the ordering practitioner directly once the reading is complete.

d) Verbal/Telephone Orders

(i) Verbal Orders

Are discouraged and should be used judiciously

(ii) Telephone Orders

Are discouraged and should be given only when the practitioner does not have access to Epic

(iii) A verbal/telephone order shall be dictated to a licensed nurse by a Practitioner within the authority of their clinical privileges. Other health care practitioners such as respiratory therapists or technicians (restricted to respiratory therapy or ventilator orders), registered pharmacists or pharmacy interns under the direct supervision of a registered pharmacist (restricted to medications or laboratory tests used to monitor medications), orthopedic technicians, social workers, dieticians, audiologists, speech therapists, radiologic technologists, ultrasound technologists, and nuclear medicine technologists, may accept verbal/telephone orders related to their area of responsibility dictated by a Practitioner within the authority of their clinical privileges. . All verbal/telephone orders shall be authenticated by the licensed nurse or other health care professional who has taken the order. The Practitioner can expect the individual receiving the verbal/telephone order to read back the order for confirmation.

(iv) All verbal/telephone orders must be dated, timed, and authenticated by the ordering Practitioner or another Practitioner

who is responsible for the care of the patient. A responsible Practitioner shall authenticate orders for restraints and DNR orders within 24 hours and all other orders shall be authenticated promptly and in no event more than thirty (30) days following discharge.

e) Medication Orders Reconciliation

Orders Reconciliation will automatically occur upon admission (reconcile ALL prior to Admission Medications), post procedure including all operative and all invasive procedures done in the Cardiovascular Center, transfer between levels of care and at discharge.

f) Discharge Orders

The patient shall be discharged only upon documented orders from the Attending or their designee. Dentists, oral surgeons and podiatrists may write discharge orders on their patients without medical problems. Dental, oral surgery and podiatry patients with medical problems for which care is being rendered during the hospital stay must receive medical clearance for discharge from the Physician Member providing care and treatment for the medical condition.

5. Routine Lab Tests Performed Outside of Hospital

Routine lab test results performed outside the hospital premises will be accepted provided the work is performed at a College of American Pathologists approved, state-certified laboratory within the previous 48 hours. Test results performed by out- of-state College of American Pathologists approved reference laboratories will also be accepted provided they meet federal and/or state requirements for licensure within their respective jurisdiction and have been performed within the previous 48 hours.

6. Hospital Pharmaceutical Formulary

A hospital formulary will be prepared and kept up to date by the Director of Pharmaceutical Services with the approval and the direction of the Pharmacy and Therapeutics Committee of the Medical Staff. All formulary information is quickly and easily available to all health professionals when needed. The Hospital Pharmacy is authorized to dispense, and the nurses to administer, drugs under their generic name, and in certain cases therapeutic equivalent drugs may be substituted for those ordered by the Practitioner, when such therapeutic equivalent formulary has been approved by the Pharmacy and Therapeutics Committee. If a Practitioner wishes to have an original order for a non-formulary" drug filled with no substitution, he must comply with non-formulary

request procedures.

7. Clinical Research

    a) a. Investigational Drugs
    All drugs and medications to the patient shall be approved by the Federal Drug Administration (FDA) or, in the case of investigational drugs, be approved for use by the responsible Institutional Review Board and dispensed by the Pharmacy.

    b) Study Consents and HIPAA Forms
    Copies of consents and TGH HIPAA forms must be added to the patient's medical chart shortly after obtaining consent and must be placed in the designated tab section.

8. Patient's Own Medications

    To avoid potential risks involved in duplication of drugs, synergistic actions, possible interaction(s) and dispensing errors, the administration of medication(s) to a patient other than those distributed directly from the Pharmacy inventory is prohibited except as described below.

    Exceptions: if a patient's own medications, brought into the Hospital by a patient, are identified by a hospital pharmacist, the patient's own medication may be administered under the following circumstances:

    a) when the Pharmacy neither stocks nor can obtain a critical drug prior to the next scheduled dose; and

    b) when there is an order from the Practitioner responsible for the patient to administer the drugs.

    c) Self-administration of medications by patients is permitted on a specific order by the authorized prescribing Practitioner listing each medication, dosage and schedule.

    If the drugs brought into the Hospital by a patient are not to be used during the patient's hospitalization, they are packaged and sealed and either given to the patient's family or stored in the pharmacy and returned to the patient at the time of discharge, provided such action is approved by the Practitioner responsible for the patient.

9. Code Blue

    Any patient who is found in a non-breathing and/or pulseless condition shall receive treatment according to the Policy for cardiopulmonary resuscitation with the exception of a patient who has a "DNR/LIMITED

CODE BLUE or NO CODE" order documented on his chart by his/her Practitioner.

10. Response Times

Practitioners should respond to calls and pages within thirty (30) minutes, if possible. Documented failures will be reviewed and policy will be followed. Physical response times will be determined by the acuity of the patient.

F. Hospital Deaths and Autopsies

1. Hospital Deaths

a) Pronouncement

In the event of the death of a patient in the hospital, the deceased shall be pronounced dead by the Attending or his designee within a reasonable period of time. Two RNs may also pronounce patients according to policy.

b) Reportable Deaths

Reporting of deaths to the Office of the Medical Examiner shall be carried out when required by, and in conformance with, local law. (Fla. Stat. §406.11)

c) Death Certificate

The death certificate must be signed by the Attending Physician or his resident physician within 72 hours unless the death is a Medical Examiner's case, in which event the death certificate may be issued only by the Medical Examiner. When a reported case is declared "No Jurisdiction" or "Jurisdiction Terminated" by the Medical Examiner, the Attending Physician signs the death certificate. If an autopsy is performed, the pathologist may sign the death certificate.

d) Release of Body

The body may not be released until an entry has been made and authenticated in the deceased's medical record by a Medical Staff Member or his or her designee. In a Medical Examiner's case, the body may not be released to other than Medical Examiner personnel or to police officers, except upon the receipt of an "Order to Release Body" form issued by the Medical Examiner. All other policies with respect to the release of dead bodies shall conform to local law.

2. Organ Recovery

Patients at the time of death or near the time of death in Tampa General Hospital will be assessed for acceptability of organ/tissue donation in accordance with Florida law. (Fla. Stat. §765.512).

Families or guardians of patients meeting acceptable criteria will be given an opportunity to consider the donation of organs and/or tissue for transplantation and/or research. Consent for donation must be requested by a trained requestor. At TGH, LifeLink Coordinators are the appropriate requestors.

The Medical Examiner's permission is required in all accidents, suicides and homicide cases. This will be obtained by the transplant coordinator.

When a donor organ is removed for purposes of donation, there should be an operative report that includes a description of the technique used to remove and prepare or preserve the donated organ.

3. Autopsies

It is the duty of the attending physician to attempt to secure consent for an autopsy in all cases of unusual deaths, and in cases of medicolegal or educational interest. A provisional anatomic diagnosis will be recorded on the medical record within seventy-two (72) hours, and the complete autopsy report will be made part of the medical record within thirty (30) days unless an explanatory note is written. Autopsies should be done only following hospital policy.

SECTION V

V. MEDICAL RECORDS

A. Abbreviations

1. Certain abbreviations have been shown to cause medical errors. Below is a list of prohibited abbreviations:

a) U, U, IU (write out “units/International Units”)

b) QD or qd (write out “every day or daily”).

c) MS, MSO4 (write out “Morphine Sulfate”)

d) MgSO4 (write out “Magnesium Sulfate”)

e) Trailing zero (use the whole number without a decimal)

f) Lack of leading zero (use a leading zero when using fractioned doses)

g) QOD (write out “every other day”)

2. It is to be expected that this list will be modified from time to time. When modifications are made, the new prohibited abbreviations will be presented to Executive Committee (MEC) and added to these rules and regulations.

3. The Quality Improvement department will do audits for compliance with the use of approved abbreviations, with the results forwarded to the Chief Medical Officer and the Chief of Staff

4. If prohibited abbreviations are found in the medical record, the page will be copied and sent to the Practitioner who wrote the prohibited abbreviation. If five prohibited abbreviations are found in one calendar month, the Practitioner will be considered in violation of the rule and is subject to corrective action pursuant to the Bylaws.

5. To avoid misinterpretation, symbols and abbreviations are used in the medical record only:

    a) When they have been approved by the Medical Staff.

    b) When there is an approved explanatory legend available to those who are authorized to make entries in the medical record and to those who interpret them. (Each abbreviation or symbol may have only one meaning).

    c) In areas of the record OTHER than the final diagnoses which must be recorded or dictated in full.

    d) An official record of abbreviations approved by the Executive Committee shall be kept on file in the Health Information Management Department.

    e) If they are not on the hospital's unauthorized abbreviations list.

B. Authentication

1. All entries in the record must be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided and a method is established to identify the author's entries.

2. Entries by Residents: The Attending shall authenticate (countersign) the History and Physical Examination, Discharge Summary, Operative Report and Consults

3. Entries by Advanced Practice Professionals: The Attending shall authenticate (countersign) the History and Physical examination, Discharge Summary, and Consults.

4. Other specified professional personnel entries will be authenticated (countersigned) as directed by hospital department policies and procedures.

5. The parts of the medical record that are the responsibility of the Practitioner are authenticated by him or her.

6. Every patient admitted to TGH needs an authenticated bed request (admission) order.

   All verbal and telephone orders requesting an inpatient admission must be signed, dated and timed by the attending physician prior to the patient's discharge. Admission orders initially entered by Advanced Practice Professionals or Residents must also be signed by the Attending Physician prior to the patient's discharge.

C. Discharge Summary

1. The Discharge Summary recapitulates the medically necessary reason for hospitalization, the significant clinical findings, the procedures performed and treatment rendered, the condition of the patient on discharge, and any specific instructions given to the patient and/or family, as pertinent, i.e., physical activity, medication, diet and follow-up care. The condition of the patient on discharge should be stated in terms that permit a specific measurable comparison with the condition on admission.

2. Discharge Summary Content. Discharge summaries shall contain a final diagnosis stated in standard nomenclature with no abbreviations. A final progress note may be substituted for the discharge summary in the case of normal infants, and uncomplicated obstetric deliveries.

3. A death summary is required for all patients who expire.

D. Medical Record Completion

1. Responsibility for Completion: The Attending of Record is responsible for the completion of the medical record.

2. Definition of a Completed Medical Record:

   a) At the minimum, a medical record is considered complete when all entries are authenticated and the following required contents are present:

   - a discharge summary when length of stay is in excess of 48 hours;

   - a discharge or final progress note when length of stay is 48 hours or less;

- a complete history & physical report;
- an operative note and/or procedure report, if indicated;
- all entries authenticated.

b) The following records must be completed and authenticated as stated below to avoid suspension of clinical privileges:

- Admission Orders must be signed prior to discharge.
- The History and Physical must be documented and present within 24 hours of admission, or prior to (1) all surgical procedures, (2) invasive procedures that may require a 23 hour admission/observation, (3) other invasive procedures at the discretion of the physician; and (4) any procedure that requires anesthesia services. The history & physical must be authenticated within thirty (30) days following discharge.
- Operative and Procedure Reports must be documented and present within 48 hours of the procedure date and authenticated within thirty (30) days following discharge. .
- Consultation Reports must be authenticated within thirty (30) days following discharge.
- The Discharge Summary must be documented, present and authenticated within thirty (30) days following discharge.

c) Records not completed by the Attending within thirty (30) days of discharge are classified as delinquent and may result in suspension of certain privileges.

d) Responses to documentation queries are to be provided within 72 hours of receipt.

3. Responsibility for Medical Records

a) Admitting practitioner is the physician or Certified Nurse Midwife identified in the admitting orders and is the practitioner responsible for completion of the history and physical examination.

b) Attending physician is the physician responsible for the care of the patient at that point in time, as identified in the electronic medical record.

c) Discharging physician is the physician who wrote the discharge order (or is supervising the practitioner who wrote the discharge order) and is

responsible for the completion of the discharge summary.

4. Privileges Suspension:

   If a Practitioner has delinquent incomplete records, pursuant to the process set out in the Medical Staff Bylaws, the Chief of Staff shall suspend Practitioner's privileges for elective hospital admissions, elective surgeries/procedures, regardless of venue, and other elective hospital based services until all of Practitioner's available delinquent records have been completed.
   A Practitioner under such medical records privilege suspension may continue to treat those patients currently admitted to the hospital and may admit and treat those patients scheduled for surgery or other procedures prior to the suspension.

   The suspended Practitioner may not admit any patient not previously scheduled for admission and may not schedule any non-emergent surgeries or procedures regardless of venue, until the suspension is lifted.

   Medical record privilege suspensions may be considered by the Professional Credentials Committee and utilized as reappointment criteria.

   When a Practitioner is unavailable due to illness or vacations, the absence must be reported in advance to the Health Information Management Department to prevent a suspension of admission privileges.

5. Privileges Reinstatement:

   The medical records privilege suspension shall be lifted and admission privileges reinstated when the Practitioner has completed all available delinquent records. Reinstatement does not require further administrative action.

6. Delinquent Record Notification Process:

   Resident physicians may be assigned the responsibility of record completion to include history and physicals, clinical resumes, and operative reports. However, counter signature by Attending is required for these entries in the medical record. Residents will receive notification of all incomplete records which they have been assigned via the Epic EMR In-Basket.

   If record completion by both the Resident and Attending has not been secured within the required timeframes as described in Section V.D.2 3, the Attending staff member will be held responsible for record completion and will be subject to admission privilege suspension. The Chief of the respective teaching service shall be notified of resident medical record delinquencies.

   If Advanced Practice Professional record completion has not been secured within

thirty (30) days post discharge, the supervising staff member will be held responsible for record completion and will be subject to admission privilege suspension.

All operative reports or procedures that are not completely documented within twenty-four (24) hours of performance of the procedure will result in loss of surgery/procedure booking privileges after notification to the physician who must dictate the report. Surgery booking privileges are restored when the reports are electronically documented and no other medical record delinquency is present.

No Practitioner is required to complete a medical record on a patient unfamiliar to him or her in. order to retire a record. If a record is incomplete that was the responsibility of a Practitioner who is deceased or unavailable permanently or protractedly for other reasons the Health Information Management Committee may declare any medical record complete for purposes of filing and will document this action in the Health Information Management Committee minutes.

E. Consents for Record Removal

Medical records shall be confidential, secure, current, authenticated, legible and complete. The medical record is the property of the Hospital, and is maintained for the benefit of the patient, the staff and the Hospital. It is the hospital's responsibility to safeguard both the record and its informational content against loss, defacement, tampering or use by unauthorized individuals. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute.

F. Content and Quality of Records

1. Responsibility of the Hospital:
   The Hospital shall maintain records that are documented accurately and in a timely manner for every individual assessed or treated.

2. Responsibility of the Practitioner:
   The Attending shall be responsible for the preparation of a complete and legible medical record for every individual assessed or treated. Its contents shall be pertinent and current. Each clinical event shall be documented as soon as possible after its occurrence.

3. Contents of the Inpatient Record:
   The medical record contains sufficient information to identify the patient, to justify admission and continued hospitalization, support the diagnosis, justify the treatment, describe the patient's progress and response to medications and services, and promote continuity of care among health care providers.

   The inpatient record shall include at least the following data:

a) The reasons for admission for care, treatment, and services

b) The patient's initial diagnosis, diagnostic impressions, or conditions

c) Any findings of assessments and reassessments

d) Any allergies to food

e) Any allergies to medications

f) Any conclusions or impressions drawn from the patient's medical history and physical examination

g) Any diagnoses or conditions established during the patient's course of care, treatment, and services (including complication and hospital-acquired infections)

h) Any consultation reports

i) Any observations relevant to care, treatment, and services

j) The patient's response to care, treatment, and services

k) Any emergency care, treatment, and services provided to the patient before his or her arrival

l) Any progress notes made by the medical staff and other authorized individuals

m) All orders

n) Any medications ordered or prescribed

o) Any medications administered, including strength, dose, and route

p) Any access site for medication, administration devices used, and rate of administration

q) Any adverse drug reactions

r) Treatment goals, plan of care, and revisions to the plan of care

s) Results of diagnostic and therapeutic tests and procedures

t) Any medications dispensed or prescribed on discharge

u) Discharge diagnosis

v) Discharge plan and discharge planning evaluation

w) The patient's name, address, date of birth, and the name of any legally authorized representative

x) The legal status of patients receiving mental health services

y) Evidence of known advance directives

z) Evidence of informed consent, when required by hospital policy

aa) All operative and other invasive procedures performed, using acceptable disease and operative terminology that includes etiology, as appropriate

bb) Medication reconciliation form

cc) Any referrals and communications made to external and internal care providers and to community agencies

dd) Conclusions at termination of hospitalization

ee) Discharge instructions to the patient and family

ff) Discharge summaries with outcome of hospitalization, disposition of case, final diagnosis, and provisions for follow-up care or a final progress note or transfer summary

4. Organization of the Medical Record:
The medical record content should be sufficiently detailed and organized to enable:

a) The responsible Practitioner to provide effective continuing care to the patient, to determine later what the patient's condition was at a specific time, and to review the diagnostic and therapeutic procedures performed and the patient's response to treatment;

b) A consultant to render an opinion after an examination of the patient and a review of the medical record;

c) Another Practitioner to assume the care of the patient at any time;

d) Pertinent information to be obtained for utilization review, quality assurance and risk management functions.

e) In all instances, a justification of the diagnosis and validation of the

treatment and outcome.

G. Consultation Reports

Each consultation report shall contain a documented opinion by the consultant that reflects, when appropriate, an actual examination of the patient and the patient's medical record.

H. Diagnoses

The medical record must include an admitting (provisional) diagnosis or reason for admission, a principal and secondary diagnosis if applicable, including complications and co-morbidities documented at the time of discharge and a final diagnosis. These diagnoses as well as all operative and procedures performed should be recorded in full using acceptable disease and operative terminology.

The responsible Practitioner must record and authenticate a preoperative diagnosis in the medical record prior to surgery or invasive procedure.

I. Diagnostic and Therapeutic Information

All diagnostic and therapeutic procedures are recorded and authenticated in the medical record as soon as completed. Any reports from outside the Hospital included in the record must have the source organization identified in the report.

J. Discharge Planning

Discharge planning shall be initiated as early as a determination of the need for such activity can be made, in order to facilitate discharge at that point in time when an acute level of care is no longer required. Criteria for initiating discharge planning are available from the Social Service Department to identify those patients whose diagnoses, problems or psychosocial or health-related circumstances usually require discharge activity. There must be cooperative communication and effort between the Utilization Management Department, the Social Worker, Nursing, and the Member to define the point at which discharge planning will be needed.

The hospital's discharge planning activity shall not be limited to placement in long-term care facilities but shall also include provision for, or referral to, whatever services the patient may require in order to improve or maintain his health status.

K. Emergency and Ambulatory Care Documentation

An appropriate medical record shall be kept for every patient receiving emergency and/or ambulatory services.

When emergency, urgent or immediate care is provided, the time and means of arrival are

also documented in the medical record. The medical record notes conclusions at termination of treatment, including final disposition, the time, if a patient receiving emergency, urgent or immediate care left against medical advice condition at discharge, and instructions for follow-up care. When authorized by the patient or a legally authorized representative, a copy of the emergency services provided is available to the practitioner or medical organization providing follow-up care.

For patients receiving continuing ambulatory care services, the medical record contains a summary list of known significant diagnoses, conditions, procedures, drug allergies, and medications. This list is initiated for each patient by the third visit and maintained thereafter.

L. Forms

All paper and electronic forms and templates used in the patient medical record shall be approved by the Health Information Management Committee. The Committee will evaluate the forms and templates as to their content and appropriateness within the medical environment in accordance with the hospital forms control program.

M. Histories and Physicals

1. An inpatient History and Physical must include at a minimum:

    a) Problem list

    b) history related to the admission/surgery

    c) Examination of the heart, lungs, and mental status

    d) A specific examination related to the condition for which the patient is being treated

2. An outpatient History and Physical must include at a minimum:

    a) Problem list

    b) A problem-focused history

    c) A problem-focused examination

    d) Straightforward medical decision-making

3. Each department/section may define admission history and physical examination that are more comprehensive than identified above. In that situation, the department/section rules/regulations will supersede these rules/regulations.

4. A history and physical examination must be completed and in the chart prior to

(1) all surgical procedures, (2) invasive procedures that may require a 23 hr. admission/observation, (3) other invasive procedures at the discretion of the physician; and (4) any procedure that requires anesthesia services.

5. For surgical patients, in urgent/emergent cases the anesthesiologist's history and physical may serve as the updated examination. The history shall include the chief complaint, reason for admission and present illness, pertinent past, family and social history.

6. Obstetrical Histories and Physicals must include the complete prenatal history recorded on the chart prior to delivery. The prenatal record may be a legible copy of the Attending Practitioner's clinic or office record transferred to the hospital before admission. If the prenatal record has an examination of the patient noted within thirty (30) days of admission, an interval H & P note must be documented that includes pertinent additions or changes to the history with any subsequent changes in the physical findings, or a physical examination must be performed on the patient prior to delivery and documented.

7. Emergency Department Medical Screening Examination**.** Each patient who presents to the Emergency Department and/or Labor & Delivery in an emergency medical condition must receive medical screening from a qualified member of the healthcare team. Qualified members include physicians, nurse practitioners, physician assistants and certified nurse midwives.

8. Newborn Records must show that a complete physical examination was done within 24 hours of birth.

9. Qualified Oral Surgeons who admit patient without a history of medical problems may perform the history and physical examination on these patients if they are credentialed for such privileges and may assess the medical risks of the proposed surgical procedures.

10. Advanced Practice Professionals with admitting privileges are permitted to provide patient care services and may perform the History and Physical exam if granted such privilege.

11. Advanced Practice Professionals without admitting privileges who are permitted to provide patient care services may perform the history and physical examination if granted such privileges and if the findings, conclusions and assessment of risk are confirmed or endorsed by a qualified Physician prior to any diagnostic or therapeutic intervention or within 24 hours, whichever comes first.

12. Dentists are responsible for:

a) A detailed dental history justifying hospital admission;
b) A detailed description of the examination of the oral cavity and a

preoperative diagnosis;

c) A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and the specimen shall be sent to the Pathology Department for examination;

d) Progress notes pertinent to the oral condition;

e) Discharge summary statement.

13. Podiatrists are responsible for:

a) A detailed history and physical justifying hospital admission;

b) A detailed description of the history and physical examination, which IS related to podiatry.

c) A complete operative report describing the findings and technique. Tissue removed shall be sent to the Pathology Department for examination;

d) Progress notes written on the patient's chart;

e) Discharge summary.

14. Anesthesia. A pre-anesthesia evaluation must be performed by a qualified Member of the anesthesia team prior to administration of anesthesia unless there is a documented emergency. The pre-anesthesia evaluation shall be completed and documented within 48 hours prior to surgery or another procedure requiring anesthesia services.

15. History and Physical Compliance

Audits for compliance with timely history and physical completion will be conducted by the Quality Improvement department. If the H & P, or the interim note, i s not on the chart within the required timeframes the chart is not in compliance, and the Attending and the admitting Practitioner will be notified.

N. Operative/Invasive Procedure Reports

1. The medical record thoroughly documents operative or other procedures and the use of anesthesia.

2. A preoperative/invasive procedure diagnosis 1s recorded before surgery by the Practitioner responsible for the patient.

3. The operative or other high-risk procedure report includes the following information:

    a) The name(s) of the licensed independent practitioner(s) who performed the procedure and his or her assistant(s) and a description of the tasks performed,

    b) The name of the procedure performed,

    c) A description of the procedure,

    d) Findings of the procedure,

    e) Any estimated blood loss,

    f) Any specimen(s) removed,

    g) The preoperative diagnosis and postoperative diagnosis,

    h) The type of anesthesia administered,

    i) Complications, if any, and

    j) Prosthetic devices, grafts, tissues, transplants or devices implanted.

4. When a full operative or other high-risk procedure report cannot be entered immediately into the patient's medical record after the procedure, a progress note is entered in the medical record before the patient is transferred to the next level of care. This progress note or Brief Post Op Progress Note includes:

    a) Name of primary surgeon and assistants

    b) Procedure performed and a description of each procedure finding

    c) Estimated blood loss

    d) Specimens removed

    e) Postoperative diagnosis

    If the procedure is done at the patient's bedside, the note must be done immediately following the procedure to make other members of the patient care team aware that a procedure was performed, any complications, or pertinent findings.

5. Options for complying with requirements for a postoperative/invasive procedure report are as follows:

- Enter an immediate brief Post Op note before transfer to the next level of care, and enter or dictate an operative or invasive procedure note within 24 hours and sign within 7 days

OR

- Enter or dictate a complete and signed postoperative/invasive procedure note before the patient transfers to the next level of care, or immediately following the procedure if done at the bedside

6. An intraoperative/intra-procedure anesthesia record is completed, authenticated and filed in the medical record as soon as possible after surgery.

7. Postoperative documentation records the patient's vital signs and level of consciousness; medications (including intravenous fluids), blood and blood components; any unusual events or postoperative complications; and management of such events.

8. Postoperative documentation records the patient's discharge from the post-anesthesia care area by the responsible practitioner or according to discharge criteria. Compliance with discharge criteria is fully documented in the patient's medical record. Postoperative documentation records the name of the Practitioner responsible for discharge.

9. Chart Requirements Prior to Operative Invasive Procedure:

    a) Properly and legally signed informed consent

    b) Complete history and physical except in cases of emergency (documented).

    c) A pre-anesthesia evaluation for procedures requiring anesthesia services except in documented cases of emergency

10. A post anesthesia evaluation is completed, documented, and authenticated by a qualified Practitioner no later than 48 hours after surgery or a procedure requiring anesthesia services.

O. Progress Notes

1. Progress notes provide a pertinent chronological report of the patient's course in the hospital and reflect any change in condition and the results of treatment.

2. Pertinent progress notes are also made by individuals so authorized by the medical staff, such as residents and individuals who have been granted clinical

privileges.

3. Pertinent progress notes shall be recorded at the time of observation sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems, as well as test results and treatments, shall be clearly identified in the progress notes and correlated with specific orders. Progress notes shall be written daily on all patients by a Medical Staff member or their authorized designee.

P. Complications

Whenever therapeutic intervention or the lack thereof results in an unexpectedly poor outcome, the responsible Practitioner shall inform the patient and/or family and document such a discussion in the medical record. Whenever a complication occurs that is reportable under State law, The Joint Commission standards, or Federal rules, the responsible Practitioner shall inform-Hospital Management.

Q. Release of Confidential Information

Written authorization of the patient or his legally qualified representative is required for the release of medical information to persons not otherwise authorized to receive the information.

Written consent is not required for the use of medical records for treatment purposes, automated data processing of designated information, use in the hospital quality assurance monitoring and evaluation, departmental review of work performance, official surveys for hospital compliance with accreditation, regulatory and licensing standards for educational purposes (see research). Written policies and procedures for the release of information are available from the Health Information Management Department.

R. Research

The Health Information Management Department generates various required statistical indexes which may be used in medical research, i.e. Disease, Operative, Physician, Clinical Service Analysis, Death Registers, etc.

Requests for data from the above sources and requests for access to medical records by Practitioners and others not involved in direct care of that patient will be made in writing to the Institutional Review Board (IRB) and the Chief(s) of the relevant Department or Section in accordance with the Research Request Policy and Procedure. A TGH Data Request Form must also be submitted to the Office of Clinical Research. After required approval of the request is obtained, the Principal Investigator is responsible for providing a copy of IRB, Privacy Board and TGH approval letters to the designated person in the Health Information Management Department. The research can then be completed according to the specifications of the request. At all times, preservation of the confidentiality of personal

information concerning the patients will be required.

S. Transplant Records

When an organ or tissue is obtained :from a living donor for transplantation purposes, the medical record of the donor and recipient fulfill the requirements for any surgical inpatient medical record. When a donor organ or tissue is obtained :from a deceased patient, the medical record of the donor includes the date and time of death, documentation by and identification of the Physician who determined the death and documentation of the removal of the organ or tissue.

When an organ or tissue is removed for purposes of donation, the removal is documented in the donor's medical record.

SECTION VI

VI. GENERAL RULES REGARDING OPERATING ROOMS AND PROCEDURE SUITES (REV 01-01 SURGICAL SUITES COMMITTEE)

A. Policies

1. Policies are developed by the Hospital.

2. Medical Staff needs to be aware of policies relevant to procedure areas.

B. Scheduling of Surgery - as per policy of specific procedure area.

1. Procedure Scheduling (Extracted from Hospital policy and presented here for informational purposes only.

a) Add-on procedures will be prioritized as follows:

(i) Emergent: Will be placed into the first open room at the expense of elective cases. The Surgeon with an emergency case must communicate with the Surgeon being displaced to justify the nature of the emergency. The decision to alter the schedule for emergencies is the ultimate responsibility of the Director of Surgical Services (or designee) and/or Chair/Co-Chair of Surgical Suite Committee.

(ii) Urgent: In order of time scheduled.

(iii) In-House Elective: First come, first serve in order scheduled.

b) Cut off time for the following day's schedule will be determined by the Surgical Suite Committee.

c) Only emergent cases will be performed on days designated as official hospital holidays.

d) The cases on the add-on list are scheduled in chronological order. If the Surgeon cannot work at the time offered, his case position is exchanged with the next on the list.

e) e. Block Scheduling

(i) TGH utilizes block scheduling. Block time is allocated by the Senior VP of Patient Services, in conjunction with the Chair of Surgical Suites and the Director of Surgical Services.

(ii) All requests for additional changes in the allocations of block time should be made in writing to the Senior VP.

(iii) Block utilization is revised quarterly and revised as needed.

(iv) Utilization includes all block time allocated less any time released in advance. Surgeons must notify the Surgical Services Director in writing or via fax a minimum of 1 week in advance of block time which will be unused due to vacations or conferences, etc. Block utilization calculations will not be credited if such notification does not occur.

(v) Each block will have a designated automatic release time assigned at the time the block is allocated. Block release times indicate the number of business days prior to the day of surgery at which point the block releases. For example, a Thursday block with a 2-day release will release at 5:00 p.m. on Monday evening. Blocks with a designated "no release" will not release until 7:00 a.m. the day of surgery.

f) Scheduling of procedure length: The length of the procedure will be calculated from the last 10 procedures done by the Attending Surgeon. The time includes Anesthesia induction time, pre-incisional procedures (positioning, prepping and draping) surgical procedure, surgical closing, application of dressings, and emergence from anesthesia. Any disparity between the requested length and allocated length will be noted at time of scheduling and reviewed by the Director of Surgical Services prior to date of surgery.

g) OR turnover (room clean up and instrument setup) is individualized according to case type and approved by the Director of Surgical Services.

h) Definition of 0730 start: Anesthesia induction commences at 0730

i) All patients will be brought into the operating room 15 minutes prior to the scheduled case start. Before anesthesia commences, the Surgeon or

his/her designee must identify the patient.

j) Consistent tardiness shall result in the loss of 0730 scheduling privileges.

k) In the event a surgeon is delayed, his scheduled operating room will be held for 30 minutes (see Block Scheduling/ Allocation Policy)

l) First cases should be scheduled to start at 0730 Monday-Thursday and 0830 Friday. Cases requested to start later than this may be preceded by regularly scheduled, add-on or emergency cases.

m) For maximum flexibility and utilization, whenever possible cases should be scheduled back to back without gaps in the schedule. Gaps may be filled with add-on cases.

n) The Nurse Manager has the authority to review the schedule daily and make changes in order to maintain efficient utilization of resources. Surgeons will be contacted before changes are made.

2. Cancellations and changes to the OR schedule should be submitted as soon as the cancellation or change is known:

a) Before 1700 the day prior to surgery: OR Scheduling Office 844-7803

b) After 1700 the day prior to surgery: OR Control Station 844-7485

c) Cancellation time and reason will be recorded.

3. Scheduling special instruments, equipment, and supplies:

a) In an effort to avoid conflicts, the scheduling office arranges for equipment I instrumentation which is in limited supply by utilizing the Shared Resources File. This file is a listing of all equipment/instrumentation available in the OR at Tampa General Hospital.

b) Special equipment and instrumentation not listed on the Surgeon's preference list must be requested at the time of scheduling in order to assure availability.

c) Such equipment/instrumentation is reserved upon specific request on a first-come, first-served basis.

d) Instrumentation, equipment, and implants that are special ordered for a booked case must be requested 72 hours prior to surgery in order for the Materials Department to obtain.

e) Failure to comply may require item substitution or case rescheduling.

C. Procedure Area Privileges (OR, Cath Lab, Interventional Radiology and Endoscopy)

1. Delineation of Privileges: Privileges for each Practitioner are delineated at the time of appointment or reappointment. At times other than appointment or reappointment, any Practitioner desiring to add procedures to his approved list shall make written application through the Medical Staff Office to the Professional Credentials Committee, stating reasons for the request and documenting his or her proficiency in the requested procedure. Notice of any change in delineation of privileges will be forwarded promptly by the Medical Staff Office to the Practitioner and the Nursing Director of Surgical Services.

2. Surgical Assistance: Surgical assistance may be performed by any Member of the Medical Staff, as appropriate. Physician Assistants and Surgical Assistants from outside the Hospital must be credentialed through Advanced Practice Professional processes as outlined in the Medical Staff Bylaws.

D. Requirements Prior to Start of Procedure

1. Preoperative Requirement: The preoperative diagnosis, history and physical and required laboratory tests shall be completed and recorded on the patient's medical record prior to any surgical procedure.

2. Recording Requirement: If not recorded, the operation shall be cancelled.

3. Emergency Note: In an emergency, the practitioner shall make a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery documenting that delay would be detrimental to the patient's health and wellbeing.

4. Safety Time Out/Pause for the Cause: Patient Identification Prior to Surgery must be performed pursuant to hospital policy.·

5. Informed Consents

   a) Written, signed, informed consent shall be obtained by a Physician or other credentialed Practitioner prior to an operative procedure except if the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. See Section IV.B.c.6 for additional guidance.

   b) In emergencies involving a minor or an unconscious or otherwise incapacitated patient, if consent for surgery cannot be immediately obtained from patient's guardian, or next of kin, these circumstances shall be fully explained on the patient's medical record. See Section IV.B.c.4

for additional guidance.

(i) If time permits, a consultation in such circumstances is desirable before the emergency operative procedure is under-taken.

(ii) The Attending physician shall be required to annotate the medical record as to the circumstances of the life-threatening emergency and the need for immediate surgery when consent cannot be obtained due to the condition of the patient.

c) If two (2) or more specific procedures are to be carried out at the same time by the same physicians and this is known in advance, each procedure should be described and consented to on the same form.

d) All patients shall be personally identified by the operating surgeon, designee, or his resident prior to initiation of surgery with verification of correct surgery site. There can be no exception to this rule. (Refer to OR Correct Site Policy).

e) Failure to comply with the policy: The Practitioner who willfully neglects to comply must appear before the next Medical Executive Committee following the first occurrence and shall be subject to corrective action.

E. Anesthesia

1. The Anesthesiologist shall maintain a complete anesthesia record including evidence of pre-anesthetic evaluation, intraoperative care, and post-anesthetic follow-up of the patient's condition with appropriate documentation of dates, times and signatures of the anesthesia provider including the administration of medications.

2. The Anesthesiologist or qualified designee shall see all patients within 48 hours prior to surgery or a procedure requiring anesthesia services to determine that the patient is an appropriate candidate for anesthesia. The patient will be reevaluated immediately before anesthesia induction.

3. A post anesthesia evaluation must be completed and documented by an individual qualified to administer anesthesia no later than 48 hours after surgery or a procedure requiring anesthesia. For those patients who remain in-house, the Anesthesiologist will also see the patient after anesthesia postoperatively as indicated.

4. The Post Anesthesia Care Unit is used to care for and observe anesthetized patients until they react and vital signs are stable.

a) General medical supervision and coordination of patient care in the PACU is the responsibility of the anesthesiologist.

b) The operating surgeon is responsible for post-operative orders.

5. Moderate (Procedural) Sedation

   Members of the Medical Staff that administer Moderate (Procedural) Sedation as defined in the revised policy TX-86 must complete the educational and competency requirements to be privileged. These educational requirements are in compliance with the Joint Commission and CMS. These requirements include:

   a) BLS and the following based on the population of practice
   b) Advanced Cardiac Life Support (ACLS) or
   c) Pediatric Advanced Life Support (PALS) or
   d) Neonatal Resuscitation Program (NRP) and

   e) Successful completion of the TGH on-line self-study procedural sedation course with an 80% score on the questions and answers (annually).

6. Deep Sedation

   Members of the Medical Staff that administer Deep Sedation (MAC- Monitored Anesthesia Care) as defined in the revised policy TX-86 must complete the educational and competency requirements to be privileged. The educational requirements are in compliance with the Joint Commission and CMS. These requirements include:

   a) BLS and the following based on the population of practice
   b) Advanced Cardiac Life Support (ACLS) or
   c) Pediatric Advanced Life Support (PALS) or
   d) Neonatal Resuscitation Program (NRP) and

   e) Successful completion of the TGH on-line self-study procedural sedation course with an 80% score on the questions and answers (annually).This includes a basic understanding of the pharmacology and physiology of medications being administered for Deep Sedation.

   f) Documented proficiency or attestation in management and securing of an airway by laryngoscope or fiber optic in five (5) patients in the last year for those providers who administer Deep (MAC) Sedation.

F. Tissue Removal

Several surgical specimens are of such a nature that only a gross description is required and no tissue need be routinely submitted. These tissues are noted in pathology policy.

If any tissues have any gross abnormalities or if the attending physician requests it, sections

of any tissue may be submitted and a microscopic examination will be performed.

Orthopedic hardware is not required to be submitted for pathologic examination. Each gross anatomical specimen sent to the Laboratory shall be examined by a Pathologist.

G. Miscellaneous Rules

1. In all cases in which sponges, needles or instruments are missing during surgery involving the opening of a body cavity, an x-ray search for the missing object will be made and reviewed by Physician while patient is under anesthesia, before the wound is closed, and before the patient leaves the room, except when the patient's condition is unstable and the procedure cannot be carried out.

2. All operations or procedures shall be fully described by the Practitioner within 24- hours, and the record shall become a part of the patient's Hospital medical record.

SECTION VII

VII. CRITICAL CARE AREAS

A. Organization

Critical Care is a grouping of multi-specialty units organized to provide a consolidation of acute critical care services into units for the critically ill, with a concentration of qualified professional staffing and supportive resources. Administrative and nursing direction is provided for administrative and management functions.

B. Admission Criteria to Intensive Care Units

Patients will be admitted to an Intensive Care Unit, upon a Physician's order, according to the following established admission criteria and bed availability:

1. Translaryngeal intubation and/or mechanical ventilation.

2. Instability or failing function of the .central nervous, cardiovascular, or respiratory system, multiple organ failure, or severe metabolic derangement that exceeds the patient care capability of the other areas of the hospital.

C. Patients Customarily Admitted to ICU

The Attending Physician shall be responsible for the admission and management of the total care of the patient in accordance with his/her clinical privileges.

1. Priority Determination

Admissions are coordinated through bed file with the medical director and nurse manager or designee.

When requests exceed the number of beds, patients will be admitted according to the following triage classifications:

a) Priority 1:

Critically ill,unstable patients in need of intensive treatment such as ventilator support and continuous vasoactive drug infusion. No constraints are placed on therapeutic interventions.

b) Priority 2:

Patients who at time of admission are not critically ill but whose condition requires the technological monitoring services of the ICU, i.e., peripheral or pulmonary arterial lines, and are at risk for needing immediate intensive treatment.

c) Priority 3:

Critically ill, unstable patients whose previous state of health, underlying disease, or acute illness (either alone or in combination) severely reduce the likelihood of recovery and benefit due to ICU treatment. Priority 3 patients receive intensive therapy to relieve acute complications.

2. Resolution of Conflict
When there is conflict between health care team members utilizing the admission criteria or admission priorities, the Medical Director of ICU or the Chief Medical Officer, in consultation with the patient's Attending Physician, shall determine priority of admission.

D. Practitioner's Visits

All critical care patients must be seen by the attending physician, or an appropriate covering physician, at least daily or more frequently as required by the patient's condition or circumstances.

A progress note must be documented on each patient daily in sufficient detail to allow formulation of a reasonable assessment of the patient's clinical status at the time of observation.

E. Discharge Criteria

1. Priority Discharge Criteria
   Patients will be considered for discharge from the Intensive Care Unit using the following priority designations.

   a) Priority 1: Patients who no longer require intensive treatment or monitoring.

   b) Priority 2: Patients whose need for intensive monitoring is still present.

   c) Priority 3: Patients whose need for intensive treatment and/or invasive monitoring is still present.

2. Those patients designated as a Priority 1 discharge will require an Attending's note in the medical record justifying the reason(s) for continued stay.

3. In emergency situations patients will be transferred from the unit beginning with those patients in Priority 1 status. If there is a difference of opinion between the ICU Medical Director and the attending physician in non-urgent situations, the matter will be resolved in consultation with the Chief Medical Officer of Tampa General Hospital.

SECTION IX

IX. HOSPITAL SAFETY-DISASTER PLAN

A. Introduction

1. The Director of Safety/Security & Transportation annually develops a Comprehensive Emergency Management Plan. It is submitted to the Hillsborough Department of Emergency Management. This plan is based upon the Hospital's capabilities in conjunction with other emergency facilities in the community.

2. The plan shall be approved by the Medical Staff and Governing Body and is available in the Medical Staff Office.

SECTION X

X. GRADUATE MEDICAL EDUCATION PROGRAM

A. Affiliation with University of South Florida (USF) College of Medicine

Participants in · USF ACGME accredited graduate medical education programs are assigned to TGH for the primary purpose of receiving education and training in their respective specialties coincident with the provision of patient care pursuant to an affiliation agreement between Tampa General Hospital (TGH) and the University of South Florida (USF). College of Medicine. The program directors of all training programs and the Designated Institutional Official (DIO) are responsible to ensure that the

educational quality and supervision of patient care in these programs are maintained and that patient care delivered by participants is appropriate to their competency, pursuant to their education and training. The ultimate responsibility for patient care on the teaching services rests with the Attending Physician who must be a member of the Medical Staff.

B. Resident Scope of Practice

The roles, responsibilities and patient care activities of all participants in professional graduate education programs will be delineated by the postgraduate level of training. The scope of practice, as reviewed and filed annually with the Chief Medical Officer in the Department of Medical Staff Services, shall define the participant's involvement and independence in specific patient care activities. It is the responsibility of each Medical Staff Member who participates in GME program training activities to be knowledgeable of the scope of practice authorized for the appropriate level of training and to recognize that care provided1 which exceeds that authorized for the level of training may be cause for corrective action related to the Medical Staff Member.

C. Resident Supervision

The Medical Staff of Tampa General Hospital recognizes its overall responsibility for the quality and management of each patient's care. The Medical Staff assures that each participant in a professional graduate medical education program is supervised in his/her patient care responsibility. Members of the TGH Medical Staff shall supervise graduate medical education program participants in their patient care responsibilities and ensure that appropriate entries in the medical records, including a daily progress note, by these individuals are within their scope of practice and in accordance with hospital policy. The Medical Staff Member responsible for the patient assumes responsibility for assuring medical assessment and documentation of the plan of care in the medical record provided by residents and fellows.

The medical record must document that a Member of the medical staff is actively participating and supervising in the patient care. The Medical Staff Member must also demonstrate his/her continued supervision of the resident by appropriate documentation on the chart including additional progress notes as appropriate and is responsible to convey to the training program director concerns with regard to any deficiencies of specific competencies of a resident physician promptly.

D. Patient Care Orders

Residents may document patient care orders under the direct or indirect supervision of their attending Physician. Members of the Tampa General Hospital Medical Staff may document appropriate patient care orders on a patient cared for by an attending and their resident staff.
The supervising Physician will countersign the resident's history and physical within 24 hours and will review and may countersign resident orders and progress notes consistent with requirements for billing compliance, if any. When the providers authenticate the

documentation they are responsible for reviewing and validating the accuracy and appropriateness of the data.

E. Communication about Programs

Program directors of the respective professional graduate education programs and the Medical Staff will regularly communicate about the safety and quality of patient care provided and related educational and supervisory needs of the participants through discussion at department/section meetings, grand rounds, graduate medical educational committee and resident meetings.

The Senior Associate Dean for Graduate Medical Education/DIG will present an annual review of the residency programs at the hospital to the hospital board and Executive Committee.

The hospital's Chief Medical Officer will be a member of the USF's COM's Graduate Medical Education Committee which shall allow communication about the quality of care, treatment, and services provided. The Chief Medical Officer and the Senior Associate Dean for Graduate Medical Education are members of the monthly Clinical Affairs meeting which TGH's Senior Management team and Dean's staff attends. The Clinical Affairs meeting is another venue to discuss concerns related to the residency programs.

F. Resident Behavior

While functioning in the Hospital, house staff shall be subject to and abide by the Medical Staff Bylaws, Rules and Regulations, and hospital and Medical Staff policies, and shall be subject to limitation or termination of their ability to function at the hospital at any time at the discretion of the administration or the Chief of Staff.

SECTION XI

XI. ADVANCED PRACTICE PROFESSIONALS

Advanced Practice Professionals shall be subject to the Medical Staff Bylaws, Medical Staff Rules and Regulations, and any and all Hospital policies and procedures in accordance with the Medical Staff Bylaws.

Advanced Practice Professionals may perform history and physical examinations and consultations. These reports must be cosigned by the supervising physician within one (1) day. Advanced Practice Professionals may dictate the discharge summary pursuant to their protocol. This discharge summary must be cosigned by the supervising physician within thirty (30) days of discharge. Progress notes and orders written by the Advanced Practice Professional do not require co-signature by the supervising physician.

Advanced Practice Professionals must be supervised by a physician. The supervising

physician must be able to physically respond in the same time frame as that required for the physician in other circumstances, based on the acuity of the patient.

SECTION XII

XII. DEPARTMENTAL MEDICAL STAFF RULES AND REGULATIONS

Department and Section Medical Staff Rules and Regulations are appended as a part of the general Medical Staff Rules and Regulations upon adoption by the Medical Executive Committee, and shall not be inconsistent with the Medical Staff Bylaws or the General Medical Staff Rules and Regulations of the Medical Staff, or other policies and procedures of the hospital.

Advanced Practice Professionals may perform history and physical examinations and consultations. These reports must be cosigned by the supervising physician within one (1) day. Advanced Practice Professionals may dictate the discharge summary pursuant to their protocol. This discharge summary must be cosigned by the supervising physician within thirty (30) days of discharge. Progress notes and orders written by the Advanced Practice Professional do not require co-signature by the supervising physician.

Advanced Practice Professionals must be supervised by a physician, except for certified nurse midwives who are taking care of non-Medicare patients. The supervising physician must be able to physically respond in the same time frame as that required for the physician in other circumstances, based on the acuity of the patient.

MEDICAL STAFF RULES AND REGULATIONS:

Medical Staff Bylaws Committee approved: 07/19/18

Medical Executive Committee approved: 08/20/18