

CAPE CORAL HOSPITAL

MEDICAL STAFF

RULES AND REGULATIONS

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I. **GENERAL POLICY OF OPERATIONS UNDER BYLAWS**

1.1 **ADHERENCE**

In the event a physician does not comply with these Bylaws, Rules and Regulations, the President shall inform the Administration to discontinue admitting patients of this physician except in Emergencies.

1.2 **SUSPENSION**

If a physician incurs three (3) accrued suspensions during the calendar year, he will be subjected to the following:

- A. Reappointment to Active Medical Staff status for the following year will be denied; or
- B. Reappointment will be on a probationary basis. The probationary status will be subject to the action of Executive Committee.

II. **ADMITTING & EMERGENCY ROOM POLICY**

2.1 Except in emergency, no patient shall be admitted to the Hospital until after provisional diagnosis has been stated, and the consent of the Administrator or his delegate secured. In case of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2.2 Physicians admitting private patients shall be held responsible for giving such information as may be necessary to assure the protection of other patients from those who are a source of danger.

2.3 Overall responsibility for emergency services will rest with the President of the Medical Staff.

2.4 Any patient applying for medical aid at the Emergency Department must first be given the opportunity to choose his personal physician. In the event that he has none, or that his condition is such that he is not able to choose his physician, the patient shall be referred to the physician on call. There will be a call roster, designating one physician and a reserve physician to be available

to the Hospital within thirty minutes notice. When a patient is seen in the ER, has no personal physician, and requires follow-up he will be referred to the appropriate category back-up physician. It is the responsibility of that particular back-up physician to see the patient at least once for follow-up, in his private office, or in the ER. Any need for continued follow-up should be addressed at that time. When a previously unassigned back-up patient presents to the Emergency Department within 48 hours of discharge with a complaint related to the prior admission, the same physician shall accept the patient. Patients who sign-out "AMA" (against medical advice) from the hospital, then subsequently return, will be assigned to a new physician on call.

- 2.5 Any patient requesting a specific physician is to be considered a private patient until the physician is contacted, and the patient's status is classified.
- 2.6 No narcotics nor conditionally exempt narcotic preparation will be furnished to any patient for off-premises use, unless such drugs are required to maintain a patient until the Pharmacy opens.
- 2.7 Patients with contagious diseases will not be admitted unless they are suffering from complications of a serious nature.
- 2.8 The decision for isolation in any cases shall be left to the attending physician and/or the Infection Control Committee. Any disputed cases shall be referred to the Chief of the Department concerned and the President of the Staff.
- 2.9 The admission of patients to Cape Coral Hospital will be based on the need of medical care in the judgment of the attending physician, and continued presence of the patient in the Hospital will be de facto indication of the need for continuing hospitalization.
- 2.10 **EKG PRIVILEGES** - Physicians must have the following training in order to apply for EKG Privileges:
CLASS I - Physicians must have invasive or non-invasive cardiology training. These physicians will be allowed EKG interpretation

privileges on all patients.

CLASS II - Physicians must show proof of cardiology rotation as part of an accredited three year Internal Medicine/Family Practice/Anesthesia/Pediatric or ER residency program and documented training in EKG interpretation. These physicians will be allowed EKG interpretation privileges only on their patients. Another physician, who is part of the recognized practice group, with the same privileges, shall be equally acceptable to interpret the EKG.

A. **EKG INTERPRETATION** -

As a quality issue, the Attending physician or designated EKG interpreter has 48 hours in which to fulfill this responsibility.

1. If the EKG is not interpreted in 48 hours, the reading physician's office will be called and reminded of this fact.
2. If within 24 hours after this call the EKG is still not interpreted, the next available credentialed physician is to be asked to interpret that particular EKG.

2.11 **EKG STRESS TESTING PRIVILEGES** - Physicians must have the following training in order to apply for EKG Stress Testing Privileges:

CLASS I - Physicians must have invasive or noninvasive cardiology training. These physicians will be allowed EKG Stress Testing privileges on all patients.

CLASS II - Physicians must complete internal medicine residency and documented training in stress testing. These physicians will be allowed EKG Stress Testing privileges only on their own patients.

2.12 **FREQUENCY OF ATTENDING PHYSICIANS' VISITS TO INPATIENTS:**

An inpatient must be visited daily by the Attending Physician, or his/her designated representative, and a daily Progress Note written. Consultants may be considered designated physicians. However, when a patient is admitted or transferred to the ICU, the

admitting physician or his designate (i.e. Physician Assistant, covering physician, or requested early consulting physician) will be required to see that patient within 6 hours, unless the patient was seen by one of the physicians described above, or in the physician's office immediately prior to admission. A consultant accepting a consultation request shall visit the patient for whom the consultation was ordered within 24 hours of being notified of the consultation order, unless a "stat" consultation is ordered, in which case the visit shall be within 6 hours."

2.13 **PATIENT TRANSFERS:** Transfer priorities shall be as follows:

- A. Emergency Room to appropriate patient bed.
- B. From Intensive Care Unit to General Care Unit.
- C. From Cardiac Care Unit to General Care Unit.
- D. From temporary placement in an appropriate geographic or clinical service area to the appropriate area for that patient.

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

2.14 **DISCHARGING PATIENTS:**

The Attending Physician is not required to see the patient on the day of discharge. A Consultant can see the patient on the day of discharge. If the Consultant agrees that the patient can be discharged, he/she will so state in the Progress Notes, and may call the Attending at that time.

2.15 **ADMISSIONS TO INTENSIVE CARE AND CARDIAC CARE UNITS:**

If any questions as to the validity of admission to or discharge from the Intensive Care Unit or Cardiac Care Unit should arise, that decision is to be made through consultation with the Chairman of that Department and/or President of the Staff.

2.16 **PATIENT RESTRAINTS:**

Orders for the use of restraints shall be issued in accordance with hospital policy.

2.17 **PSYCHIATRIC/SUBSTANCE-ABUSE PATIENTS:**

The attending physician should consider obtaining a consultation by a member of the psychiatric staff on any patients known or suspected to be suicidal, violent in intent, emotionally ill, who suffers the results of alcoholism or drug abuse, or who may do harm to themselves or others.

2.18 **CONSULTATION POLICY**

A. A physician should seek consultation if requested by or on behalf of the patient, or when, in the opinion of that physician, the advice of a specialist or another physician would enhance the quality of care provided the patient.

B. No physician shall be required to accept a request to serve as a consultant, unless:

1. The physician is required to respond because assigned to the appropriate emergency room call roster; or

2. The physician specialist is called by the admitting or attending physician because:

a. The specialist has an ongoing professional relationship with the patient;

b. The consultation is requested during the post op management period following an invasive procedure performed by the specialist, and the professional judgment of the admitting or attending physician is that the patient requires the specialist to provide follow-up care and advice; or the patient's hospitalization is because of complications arising from the procedure performed by the specialist.

C. Consultations shall be divided into three categories:

1. Emergency Room Consultation - Consultations originating from the emergency room to a primary care or specialty physician on the backup call roster.

- a. The determination as to whether the patient needs to be seen in the emergency room or at a later time shall be decided by communication between the requesting and consulting physician. If there is a disagreement on this issue, the emergency room physician's opinion shall be the deciding factor.
 - b. Physicians consulted to the emergency room shall have thirty (30) minutes to communicate back to the emergency room physician.
 - c. Emergency department consults must be placed and responded to by physicians, not physician extenders. Communication will be between requesting and consulting physician, not physician extenders.
2. Routine In-House Consultation - Consultations requested on in-house patients that do not require urgent intervention by the consulting physician.
- a. No physician shall be required to accept an in-house consultation.
 - b. This category of consultation shall be seen within 24 hours.
 - c. This category of consultation shall be put into effect by the requesting physician writing an order with the following information:
 - Type of consult
 - Consulted physician
 - Reason for the consult
- Example: "Routine consult to Dr. John Doe for abdominal pain". If the consult is written without a modifier, it will be considered to be routine. If the physician's name or reason for

the consult is not given, then the patient's nurse shall contact the requesting physician to obtain the missing information.

d. In order to expedite patient care, if the consulted physician declines to accept the consult, then he/she must notify the patient's nurse and/or the requesting physician so other arrangements can be made.

3. Urgent/STAT In-House Consultation - Consultations requested on in-house patients that, in the opinion of the requesting physician, requires urgent intervention by the consulting physician.

a. No physician shall be required to accept an in-house consultation.

b. This category of consultation shall be put into effect by the requesting physician writing an order with the following information:

- Type of consult
- Consulted physician
- Reason for the consult
- Phone number at which the physician can be reached directly. Preferably cell phone or home phone number.

Example: "Urgent or STAT consult to Dr. John Doe for abdominal pain. Please contact Dr. John Smith at 555-1212.

c. This category of consultation requires that the requesting physician personally speak to the consulted physician. The purpose of this is to accurately exchange information regarding the urgent nature of the problem, to determine if the consulted physician can see the patient in a

time frame acceptable to the requesting physician and to allow the consulted physician to accept or decline the consult.

III. **LABORATORY SERVICE AND ORDERS**

3.1 Laboratory services shall be provided by the Hospital to insure as complete service as possible. Examinations which cannot be made in the laboratory shall be referred to an outside laboratory which is under the direction of a physician, preferably a Pathologist. It will be charged to the patient. All requests shall emanate from the admitting physician. Each physician is required to order or have proof of a hemoglobin/hematocrit and urinalysis within 72 hours of the time of admission and all pre-operative lab work (CBC, urine) should be done within seven (7) days prior to surgery.

3.2 **WRITTEN ORDER/VERBAL ORDER**

All orders for treatment shall be in writing. A verbal order shall be considered in writing if dictated to licensed-certified personnel (such as R.N., L.P.N., Pharmacist., Labor/Delivery., Licensed Physical Therapist, Registered Physical Therapist, Registered Respiratory Therapist, Medical Technologist, American Society Clinical Pathologists, Registered Radiation Technician) functioning within their sphere of competence and signed by the responsible practitioner. All orders dictated over the telephone shall be dictated by the practitioner and shall be signed by the appropriately authorized person to whom dictated, with the name of the practitioner per his or her own name. Orders for restraint, shall be countersigned by the responsible practitioner within twenty-four hours. All other verbal orders shall be countersigned by a practitioner responsible for the care of the patient within forty-eight (48) hours. Those authorized to accept verbal orders shall be any licensed personnel immediately responsible for patient care in the area in which the patient is being treated. Orders accepted from state licensed practitioners who are not on staff for out-patient diagnostic testing or therapy shall be authenticated by

a physician member of the staff who shall assume accountability for the service and care provided.

3.2.1 - All orders for medication, whether written or verbal, shall be expressed by strength of drug per volume or dose (e.g. "25 mg per cc., 20 meq per cc, or 50 mg capsules."); unless pharmacokinetics is ordered, or unless the medication is available in only one form and there can be no ambiguity about the strength ordered. Nursing staff shall clarify any verbal medication order expressed by volume only with the prescribing practitioner before administration of medication. All elements of a complete medication order need to be present prior to medication order entry, dispensing, and administration. The elements of a complete medication order are: name (generic or brand), exact dosage strength (unless the medication is available in only one form and there can be no ambiguity about the strength ordered (Example: Lomotil 1 tablet), route, dose interval, and reason for administration of PRN medications (i.e., constipation, cough, diarrhea).

All medications will have an appropriate stop date. The physician will be notified prior to the stop date and asked to verify the need for continuation of the medication(s).

Certain classes of medications may be approved for dosing by Pharmacy. The Pharmacy & Therapeutics Committee will approve medication-dosing and/or guidelines with subsequent approval of the Executive Committee.

3.3 The Attending physician shall be held responsible for the preparation of a complete medical record for each patient. The record shall include identification data, chief complaint, personal history, family history of present illness, physician examination, consultation, provisional diagnosis, laboratory findings, roentgen findings, condition upon discharge, progress record, final

diagnosis and discharge summary or note. No medical record shall be filed until it is complete, except on the order of the Medical Records Committee.

- 3.4 Patient shall be discharged only on orders of the Attending physician. At the time of discharge the Attending physician shall see that the record is as complete as possible. The final diagnosis shall be written as soon as all data is received. The discharge summary shall be completed at time of discharge.

IV. **RECORDS AND CHARTING/SUSPENSION**

4.1 Medical records are to be completed promptly, preferably before the patient leaves the facility. Each practitioner receives a weekly list of incomplete records. The patient's medical record shall be completed within thirty (30) days of discharge. If the medical record remains incomplete on the thirtieth (30th) day after discharge, it will be considered delinquent and Health Information Management (HIM) will notify the practitioner.

4.1.1 If the practitioner's medical records remain delinquent at sixty (60) days from discharge, the practitioner will be contacted (letter with demonstrated proof of delivery and/or telephone call) by the Medical Director in collaboration with the Chairman of the Department, and may be given three (3) days to complete them. If the medical records remain delinquent at the end of the three (3) days, the practitioner will have the right of hospital admitting, consulting, and surgical privileges suspended until all records are completed. The affected practitioner may not admit, consult or do procedures under the name of another practitioner in his group practice. The practitioner may continue care of present patients, but care of new patients is not permitted. On completion of records, the practitioner will be reinstated.

4.1.2 Each LMHS facility is considered a separate entity for purposes of record completion. Privileges will only be suspended at the facility(ies) at which there are delinquent records.

- 4.1.3 "Administrator on Call" is responsible for supporting the loss of privileges and may grant limited exceptions when appropriate.
- 4.1.4 Receipt of three (3) requests to complete delinquent medical records under the threat of suspension by the Medical Director in collaboration with the Chairman of the Department during any given calendar year shall result in referral to the next Medical Executive Committee Meeting for suspension of Medical Staff membership and privileges. Ratification will be done in the same manner as other membership terminations pursuant to the Medical Staff Bylaws. Health System counsel will determine whether such action is reportable to the Agency for Healthcare Administration.
- 4.1.5 A practitioner whose medical staff membership and privileges are terminated may appeal, in writing, in accordance with the fair hearing procedures outlined in the Medical Staff Bylaws.
- 4.1.6 Practitioners terminated for delinquent medical records will be required to reapply to be reinstated to the Medical Staff.
- 4.1.7 All incomplete charts must be completed before being granted an application for reinstatement.
- 4.1.8 To avoid suspension, practitioners are responsible for notifying Health Information Management prior to vacations or other absences. Practitioners should complete records prior to absences. Practitioners will not be granted additional time for record completion if an absence occurs after the practitioner has been placed on suspension.
- 4.1.9 This rule may be administered in accordance with a policy and procedure established by the Executive Committee.

4.2 **HISTORY & PHYSICAL**

A physical examination and medical history shall be done no more than 30 days before or 24 hours after an admission or readmission. In addition, an updated medical record entry documenting an examination for any changes in the patient's condition when the medical history and physical examination are completed within 30 days before admission is required. The updated examination must be

completed and documented in the patient's medical record within 24 hours after admission. When medical histories and physicals are performed by non-physicians, authentication by the responsible physician shall be in accordance with the bylaws and rules.

For surgical services there must be a complete history and physical work-up in the medical record of every patient prior to surgery, except in emergencies. For surgical patients, the anesthesiologist's history and physical may serve as the updated examination. In an emergency situation in which there is inadequate time before surgery to record the history and physical examination, a brief note, to include the preoperative diagnosis is recorded prior to surgery. If dictated, but not yet on the chart, there must be a statement to that effect and an admission note in the chart is necessary.

- 4.3 Whenever a Medical or Surgical patient is admitted to Cape Coral Hospital for initial treatment of a condition diagnosed elsewhere by means of laboratory test, tissue biopsy or radiological/nuclear/ultrasound procedure, a copy of the original report of abnormality must be on the patient's chart before discharge.
- 4.4 No medical record will be filed if incomplete unless the Medical Director under the authority of the Executive Committee directs filing of an incomplete record because there is no reasonable method available for its completion.
- 4.5 All records are the property of the hospital, and shall be removed from the hospital's jurisdiction and safekeeping only in accordance with the court order, subpoena or statute. All x-ray films shall remain the property of the hospital and shall be kept on file as part of the record, and may be disposed of in accordance with law.
- 4.6 In any case of diagnostic or non-surgical therapeutic procedure which carries risk to the patient, or in any operation, the physician performing the procedure must validate the record of the procedure with his own signature except, however, that a physician professionally associated with the attending physician may sign

such a record provided he assisted the attending physician with the procedure. Orders, progress notes, and other notations on the record should be signed by the responsible physician in accordance with policy established by the Medical Staff consistent with this rule. The signature of another physician, who is part of a recognized practice group with the attending physician, shall be equally acceptable. Physicians wishing to be able to sign for each other shall complete and file the prescribed form available from the Medical Records Administrator.

- 4.7 Informed consent to treatment, surgery or other procedures as may be required by Florida law shall be evidenced in the patient's medical record. Evidence may consist of the original or a copy of a signed consent form or a note by the physician indicating written informed consent has been obtained.
- 4.7.1 Patients and, when appropriate, their families are informed about the outcomes of care, including unanticipated outcomes, by the attending physician or the physician most closely related to the patient's care. Such conversations will be verified with appropriate documentation in the patient's medical record.
- 4.8 No physician shall inspect the current record of a hospitalized patient not his own unless he is acting as a consultant, as chairman of the clinical department, or as a representative of any committee of the Medical Staff which is charged with the duty of reviewing the quality of care rendered in the hospital.
- 4.9 The attending physician shall assist the Medical Records Administrator in coding charts in accordance with the International Classification of Diseases.
- 4.10 No blocking out or erasure should be made on the existing record. The physician may date and sign a correction at the end of a particular sheet, or on a supplemental form, giving the reason for the change and signing the note. If an error is made, it should be crossed through and a single line, the correction written above, and the correction initialed and dated. Incorrect report forms

(lab, x-ray, etc.) shall not be removed from the record; corrections shall be made by writing "corrected: see supplemental report". Such supplemental reports shall bear the date of submittal, not of the original report.

4.11 All writing on the medical record shall be legible, using black or blue ink. (No felt pens)

4.12 **DIRECTIONS FOR SPECIFIC MEDICAL RECORDS FORMS:**

A. **ATTESTATION/DRG SHEET:**

Review, sign, and date all Attestation/DRG sheets at time of discharge for Medicare, Medicaid and Champus patients.

B. **HISTORY AND PHYSICAL:**

Chief complaint, relative and past history, present illness, signed and dated. Vital signs (pulse, respirations, blood pressure - (blood pressure is required on all patients over six (6) years of age), ears eyes, nose, heart, lungs, abdomen, rectal, pelvic or genitalia, extremities, neurological, clinical impressions, dated and signed.

C. **LABORATORY REPORT:**

Only Cape Coral Hospital Laboratory reports should be attached unless, as provided in these bylaws, the test was referred to an outside approved laboratory (in which instance, that laboratory report form may be attached to the chart); each report must be dated.

D. **AUTOPSY REPORT:**

While autopsies are considered for the following indications, it is recognized that autopsies cannot be performed without consent of the next of kin. The following are appropriate indications for which requests for autopsies should be considered by the Medical Staff. In most cases, the attending physician and pathologist must agree that the autopsy would be of educational value to the medical staff and Lee Memorial Health System.

Autopsies may be performed consistent with provisions of the consent for:

1. Any patient with **sudden**, unexpected death under the age of 40 years, declined by the Medical Examiner's office.
2. Obstetrical or neonatal deaths.
3. Patients whose condition may potentially reveal significant occult conditions.
4. Patients whose death is **directly** associated with a drug or transfusion reaction as a major contributory event, if declined by the medical examiner's office.
5. Patients that die in the hospital within 48 hours of a surgical or invasive procedure without underlying chronic disease or major traumatic injuries, if declined by the medical examiner's office.

Therefore, any death when next of kin and/or physician requests and consent is given; an autopsy will be performed in accordance with the provisions of the consent. To facilitate use of autopsy finding in performance improvement activities, the chairperson of the appropriate department receives a copy of each autopsy report for use in morbidity/mortality conferences and any other department-wide performance improvement activities.

E. **ELECTROCARDIOGRAM REPORT:**

Official interpretation of electrocardiogram done at Cape Coral Hospital shall be done only by those members of the Medical Staff privileged to do so. All electrocardiographic interpretations should be signed by the physician doing the interpretation.

F. **X-RAY REPORT:**

Only Cape Coral Hospital reports are attached. All reports must be signed by the interpreting physician. (Electronic

signature acceptable)

G. **PROGRESS NOTES:**

A note within twenty-four (24) hours after admission and within twenty-four (24) hours after surgery; progress notes shall be recorded routinely as indicated by the condition of the patient. All notes must be dated, timed and signed.

H. **DOCTOR'S ORDERS:**

All orders must be dated, timed and signed by the physician giving the order; when a verbal or telephone order is given, it should be signed upon the next visit or within forty-eight (48) hours. The discharge order should be written, "DISCHARGE PATIENT", and dated. Written orders sent in with the patient should become part of the medical record for the doctor's signatures (as with verbal or telephone orders), and the loose slip destroyed after the physician signs the order on the chart.

I. **DRUG SENSITIVITIES:**

These are to be reported on the order sheet by the physician and labeled on the outside chart holder by the nurses.

J. **EMERGENCY SHEET:**

The attending physician is responsible for completion of the chart in an emergency admission by another physician. Emergency forms filled out in the Emergency Department should be filled out adequately in regard to diagnosis, treatment and physician's signature.

K. **SHORT STAY RECORD:**

Physicians are allowed to use the short stay form for patients who are in the hospital less than forty-eight (48) hours. The short stay record requires a pertinent physical, present illness, past history, progress notes, final diagnosis and signature.

L. **CONSULTATION FORM:**

Consultations should be completed when the attending physician calls in another physician for consultation and/or treatment. Consultations should be completed and signed in full before surgery, including brief history, physical findings, and recommendations. All consultations are to be completed in writing before patient's discharge.

M. **OPERATIVE RECORD:**

Preoperative diagnosis

Preanesthesia note

Postoperative diagnosis

Postanesthesia note

Postoperative condition

Operative titles

Gross findings

What was done (procedure)

Signature

All operative cases done in the operating room under general, local or spinal anesthesia must have a complete operative note written immediately after surgery. Operative reports are to be dictated immediately after surgery and contain a description of the findings, the technical procedures used, the specimen removed, the pre and post operative diagnoses, and the name of the primary surgeon and any assistants.

N. **OUTPATIENT SURGERY FORM:**

Physicians are allowed to use the Short Stay form for patients in the Outpatient Surgery Department, but must comply with the rules for operative record. This includes information required under (m) above, as well as informed consent as delineated in Rule (8).

- O. **OBSTETRICAL RECORD:**
To include information regarding prenatal care, past pregnancies, previous illness, family history, physical at the time of admission, presenting position at the time of initiation of delivery, and signature.
- P. **LABOR RECORD:**
To include stages of labor, delivery, progress and signature.
- Q. **NEWBORN RECORD:**
The newborn record should be completed, including physical examination, progress notes, discharge note, dated and signed. If circumcision is done, a note should be written on the newborn record.
- R. **DISCHARGE SUMMARY:**
A discharge summary shall be completed and signed by the attending physician on all patients except normal obstetrical patients and newborns. The discharge summary is to be completed within two (2) weeks of discharge and is to recapitulate concisely the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient discharge, and any specific instruction given to the patient and/or family, i.e., instructions relating to physical activity, medication, diet, and follow-up care.
- S. **DEATH SUMMARY:**
A dictated death summary shall be completed and signed by the attending physician on all patients. The death summary is to be completed within 2 weeks of discharge and is to recapitulate concisely the reason for hospitalization, the significant findings, the procedures performed and treatment rendered.
- T. **TUMOR REGISTRY:**
Completed in accordance with state law, to include TNM

Staging.

V. **RULES GOVERNING SURGICAL PROCEDURES AT CAPE CORAL HOSPITAL**

5.1 **STANDARD OPERATING PROCEDURES:**

- A. Surgery shall be scheduled with the surgery supervisor or the surgical nurse on call. This shall be recorded in the Surgery-Operating Schedule Book that remains in the Surgery Department. This Schedule Book will be the only official surgery schedule. Double posting cannot be done at this time. The first surgery shall be for 7:30 am. All subsequent procedures to the first morning surgery shall be posted "To Follow". If a cancellation becomes apparent to the surgeon, he should notify the operating room as soon as possible. The surgeon should be in the operating room suite and ready to begin prior to the start of the case.
- B. The surgeon shall be notified when the preoperative medication has been ordered.
- C. All surgery charts must contain:
 - 1. Complete history and physical examination and preoperative diagnosis.
 - 2. In cases of suspected or possible criminal abortion it is mandatory that a statement be signed by the patient or her legal representatives certifying that neither a Hospital employee nor the Attending physician is directly or indirectly responsible.
 - 3. Properly signed authorization for surgery, properly executed and witnessed.
 - 4. Properly executed preoperative preparation checklist.
- D. If the surgical supervisor or nurse in charge finds a discrepancy in the above, that person is to notify the operating surgeon. If there is noncompliance with the rules, the Chief of Surgery is to be informed immediately.
- E. The Chief of Surgery shall have full authority to enforce surgical rules, canceling a surgical procedure if the rules

have been violated.

- F. Everyone entering the operating suite will be properly dressed in a scrub garment, cap and mask, and shall observe all of the rules of sterile technique and safety precautions against explosive hazards.
- G. All tissues removed at operation shall be sent immediately to the pathological laboratory by the physician in charge to be examined and reported upon by the pathologist, either microscopically or macroscopically, according to the policies established between the Hospital and the pathologist. Any exception to this rule must be cleared through the Chief of Surgery.
- H. A report of the surgery (Operative Report) shall be properly executed (dictated or written) as soon as possible after surgery is completed. A short-stay form may be used only in cases of minor nature, which require less than forty-eight (48) hours' hospitalization.
- I. Except for emergency procedures, no patient in Cape Coral Hospital shall be operated upon by any visiting surgeon with temporary privileges, unless the patient's local Attending physician is present and will undertake postoperative care of the patient.

5.2 Written, signed, informed, surgical consents shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In emergencies involving a minor or unconscious patient in which consent for surgery cannot be immediately obtained from parents, guardian or next of kin, these circumstances should be fully explained on the patient's medical record. A consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.

Comment: Should a second operative procedure be required during

the patient's stay in the Hospital, a second consent specifically worded should be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may be described and consented to on the same form.

5.3 The Anesthesiologist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.

VI. **MASS CASUALTY PLAN**

All physicians shall be assigned to posts, either in the Hospital or in mobile stations, and it is their responsibility to report to their assigned stations. No physician will perform any duties other than those assigned. The Chief of the (Disaster Emergency) Medical and Surgical Departments in the Hospital and the Administrator of the Hospital will work as a team to coordinate activities and directions. In cases of evacuation of patients from one section of the Hospital to another or evacuation from hospital premises, the Chief of the Medical, Surgical, OB/GYN and Pediatric Departments during the disaster will authorize the movement of patients by direction of the Administrator of the Hospital and the Chief of Medical, Surgical, OB/GYN and Pediatric Departments. All policies concerning the patient care will be a joint responsibility of the Chief of the Medical, Surgical, OB/GYN and Pediatric Departments and the Administrator of the Hospital, and in their absence the Deputy Chief and alternate in Administration are next in line of authority, respectively. All physicians of the Medical Staff respectively agree to relinquish direction of the professional care of their patients, service and private, to the Chief of the (Disaster Emergency) Medical, Surgical, OB/GYN and Pediatric Departments in cases of such emergency.

VII. **DEATH**

In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time.

VIII. **VENTILATOR PRIVILEGES**

Privileges for all members of the Medical Staff to manage patients on

ventilators shall be delineated as follows:

CLASS I

All members of the Provisional, Courtesy, or Active Staff are considered to have Class I ventilator management privileges and may manage their own patients for up to 24 hours on the ventilator. At the end of 24 hours, an automatic consultation will be sent to the Medical Director of Respiratory Care or to another physician with Class III privileges as chosen by the Admitting physician.

CLASS II

Physicians may be granted Class II privileges which enable them to manage their own patients on a ventilator indefinitely if they make written application for such privileges and include in their written request a statement that they have training, experience, and expertise in ventilator management. Physicians with Class II privileges may not, however, receive consultations from physicians for ventilator management unless the patient for whom they are called is, or has been previously, a patient receiving direct care from the Class II physician; nor may they serve as designees for the Medical Director. Class II physicians may provide temporary coverage to consultative patients of a Class III physician who is a member of the Class II physician's own professional group or partnership.

CLASS III

Such physicians as can demonstrate special training, experience or expertise in management of ventilator problems. Such physicians may receive consultations from Class I or Class II physicians and may serve as designees for the Medical Director.

SEDATION AND ANESTHESIA CARE

Definitions of four levels of sedation and anesthesia:

1. **Minimal sedation** (anxiolysis):

A drug-induced state during which patients respond normally to verbal commands. Although cognitive function and coordination may be impaired, ventilatory and cardiovascular functions are unaffected.

2. **Moderate sedation/analgesia** ("conscious sedation"):
A drug-induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain a patient airway, and spontaneous ventilation is adequate. Cardiovascular function is usually maintained.
3. **Deep sedation/analgesia:**
A drug-induced depression of consciousness during which patients cannot be easily aroused but respond purposefully following repeated or painful stimulation. The ability to independently maintain ventilatory function may be impaired. Patients may require assistance in maintaining a patient airway and spontaneous ventilation may be inadequate. Cardiovascular function is usually maintained; and
4. **Anesthesia and Pain Management:**
Consists of general anesthesia and spinal or major regional anesthesia. It does not include local anesthesia. General anesthesia is a drug-induced loss of consciousness during which patients are not arousable, even by painful stimulation. The ability to independently maintain ventilatory function is often impaired. Patients often require assistance of maintaining a patent airway, and positive pressure ventilation may be required because of depressed spontaneous ventilation or drug-induced depression of neuromuscular function. Cardiovascular function may be impaired.

Moderate or deep sedation and anesthesia are provided by qualified individuals. Therefore, qualified individuals are trained in professional standards and techniques:

- a. to administer pharmacologic agents to predictably achieve desired levels of sedation, and

- b. to monitor patients carefully in order to maintain them at the desired level of sedation.

Individuals administering moderate or deep sedation and anesthesia are qualified and have the appropriate credentials to manage patients at whatever level of sedation or anesthesia is achieved, either intentionally or unintentionally.

Included in the qualifications of individuals providing moderate or deep sedation and anesthesia are competency-based education in, training and experience in:

1. evaluating patients prior to performing moderate or deep sedation and anesthesia and
2. performing the moderate or deep sedation and anesthesia to include methods and techniques required to rescue those patients who unavoidably or unintentionally slip into a deeper-than-desired level of sedation or analgesia.

Specifically, this will include the following:

- a. Practitioners who have appropriate credentials and are permitted to administer **moderate** sedation are qualified to rescue patients from deep sedation and are competent to manage a compromised airway and to provide adequate oxygenation and ventilation.
- b. Practitioners who have appropriate credentials and are permitted to administer **deep** sedation are qualified to rescue patients from general anesthesia and are competent to manage an unstable cardiovascular system as well as a compromised airway and inadequate oxygenation and ventilation.

Sufficient number of qualified personnel (in addition to the Licensed Independent Practitioner performing the procedure) are present during procedures using moderate or deep sedation and anesthesia to:

- Appropriately evaluate the patient prior to beginning moderate or deep sedation and anesthesia,
- Provide the moderate or deep sedation and anesthesia,
- Perform the procedure,
- Monitor the patient, and
- Recover and discharge the patient either from the post-sedation or post-anesthesia recovery area or from the facility.

IX. **CAPE CORAL HOSPITAL SPONSORSHIP GUIDELINES**

9.1 The Physician Performance Improvement Committee will review physician information regarding advancement from Provisional Staff status.

- A. Proctors may be assigned only if there is a problem during the Provisional period. He may be requested to scrub with that particular physician and evaluate his/her performance for a specified number of cases, be asked to review patient charts for a certain period of time, or indicate that a focus review be requested.
- B. If the Provisional Staff member does not have sufficient activity for Active membership, he/she may be advanced to either Courtesy or Consulting Staff. This decision is based on the level of activity during the Provisional year.
- C. Provisional Staff members shall remain on the Provisional Staff for one year.
- D. Two months prior to the end of the physician's Provisional period, Medical Staff Services will send a letter to the Provisional Staff member requesting he/she submit a status change request in writing.
- E. Medical Staff Services will obtain and assemble the following reports on each physician who is being considered for advancement:
 - Number of admissions, consults, and cases/procedures.

- NPDB - National Practitioner Data Bank Report
- Florida medical licensure verification.
- Quality Report

F. The Department Chairperson shall review the reports and complete a Proctorship Review form. The information on each physician advancing from Provisional Staff shall be referred to the Physician Performance Improvement Committee for recommendation to the Medical Staff Executive Committee and to the Board of Directors for approval.

X. **AFFILIATED HEALTH PROFESSIONALS**

10.1 **PODIATRISTS**

A. **DEFINITION**

An individual licensed by the Florida Department of Professional Regulation as a Podiatrist, who has successfully completed an advanced Podiatric Surgical Residency program approved by the Council on Podiatric Medical Education of the American Podiatric Medical Association.

B. **PRIVILEGES**

Podiatrists who meet requirements in Item (a.) above and who have a current license to practice Podiatry, may apply for Podiatric privileges at Cape Coral Hospital. Such privileges shall be limited to surgical and medical care of the foot as defined by the Medical Staff, and shall be subject to all applicable ByLaws of the Medical Staff. Responsibilities are listed under Article II, Dental/Podiatry Staff, of the Surgical Department Rules and Regulations.

C. **DEPARTMENT AFFILIATION**

Podiatrists will be members of the Department of Surgery.

10.2 **PSYCHOLOGISTS**

A. **DEFINITION**

A psychologist is an individual currently licensed by the Florida State Board of Examiners of Psychology.

- B. **PRIVILEGES** Psychologists who have a current Florida license, may apply for the privilege of doing consultations and treatment in Cape Coral Hospital, when asked to do so by the patient's Attending physician.
1. Psychologist may not admit patients.
 2. They may not write orders on the chart.
 3. They may write consultations and progress notes after a consultation has been ordered by the Attending physician.
 4. They may not under any circumstances assume primary patient care responsibility.
- C. **APPLICATION**
1. A psychologist applies by submitting an application, designated by the Executive Committee of the Medical Staff, to the Hospital Administrator.
 2. The application is reviewed by the Credentials Committee of the Medical Staff, the Executive Committee and the Board of Trustees. Each review subject to approval or disapproval.
- D. **SUPERVISION**
1. If approved for privileges in psychological consultation, the psychologist will be under the supervision of the Chairman of the Department of Medicine or his designee.
 2. The psychological consultation privileges can be revoked by the Executive Committee upon the recommendation of the Chairman of the Department of Medicine, the President of the Medical Staff or the Hospital Administrator, when approved by the Board of Trustees of the Hospital.

3. The psychological consultation privileges can be revoked by the Executive Committee upon the recommendation of the Chairman of the Department of Medicine, the President of the Medical Staff or the Hospital Administrator, when approved by the Board of Trustees of the Hospital.

10.3 **PRIMARY DENTISTS**

A. **DEFINITION**

A Primary Dentist is an individual currently licensed by the Florida Department of Professional Regulation as a Dentist, but not having qualification for full Medical Staff membership.

B. **PRIVILEGES**

A Primary Dentist will have privileges consistent with Article II, Dental/Podiatry Staff, Paragraph 2S-1 of the Surgical Department Rules and Regulations.

XI. **PHYSICIAN ASSISTANTS**

11.1 **PREREQUISITE FOR APPLICATION**

- A. Persons approved by the Board of Medical Examiners as Physician Assistants shall be allowed to perform only such professional duties or acts within this Hospital as are specifically authorized in the case of each person so approved by the Credentials Committee of the Medical Staff, the Executive Committee and the Board of Trustees. The Physician Assistant (P.A.) will have no privileges in the Hospital except by virtue of his association with a member of the Active Medical Staff. A Physician Assistant trained in anesthesia shall have all the same privileges and limitations as a Certified Nurse Anesthetist as outlined in the Medical Staff Rules and Regulations and the Department of Surgery Rules and Regulations.
- B. Before making any recommendation granting the privilege to a physician to employ a P.A. in the Hospital, the Credentials

Committee shall be provided with an application which will enable the Committee to establish to its satisfaction at least the following:

1. That the proposed P.A. is approved and in good standing as a Physician Assistant pursuant to the laws of the State of Florida.
2. That the scope of practice proposed to be carried out by the proposed P.A. is within the scope of such practice authorized by the Board of Medical Examiners.
3. The educational qualifications and experience of the proposed P.A.
4. The name of the P.A. physician employer who shall be responsible for his supervision.
5. What entries, by way of observation or orders, the supervising physician proposes to allow to be entered upon the patient's chart by the P.A.

11.2 **APPLICATION PROCEDURE**

A. Each such application shall include a written request signed by the proposed P.A.'s supervising physician stating those duties and acts which the P.A. will be authorized to perform in the Hospital. Each such request shall include a statement by said physician, together with necessary additional documentation to establish the following:

1. The supervising physician accepts full legal and ethical responsibility for performance of all such duties and acts of the P.A.
2. Specific duties and acts (including histories and physical examinations) that the supervising physician requests the P.A. be permitted to perform outside the immediate supervision and control of the supervising physician.
3. That the proposed P.A. is covered by the employing physician's professional liability policy and the

limits thereof. This fact shall be established by a verification of such coverage in a form acceptable to the Hospital Board of Trustees; requiring a rider from the insurance company acceptable to the Hospital Board of Trustees.

B. The supervising physician shall also sign a statement in a form acceptable to the Credentials Committee to be approved by the Executive Committee and the Hospital's Board of Trustees which shall indicate his willingness to honor the following agreements:

1. Agreement that he will immediately notify the Hospital's Board of Trustees and the Executive Committee in the event his approval to supervise the P.A is revoked, limited, or otherwise altered by action of the Board of Medical Examiners, or in the event of any notification of investigation of his supervision of the P.A.
2. Agreement to comply with all regulations of his Board of Medical Examiners with respect to his supervision of the P.A., specifically including (but not limited to) such regulations as have been (or may, from time to time, be) adopted by said Board with respect to (i) billing for the services of such P.A. and (ii) requirements for supervision of said P.A. with respect to the type and scope of services such assistant is approved to perform by the Board. It shall be understood, however, that compliance with such regulations shall be considered a necessary but not sufficient condition for the continuing approval by the Executive Committee and the Board of Trustees of the performance of service by a Physician Assistant in the Hospital.

- C. After consultation with the supervising physician any approval pursuant to this section may be temporarily limited or suspended by the Executive Committee at any time. A Physician Assistant shall not have the rights and privileges of a member of the Medical Staff.
- D. Physician Assistants will be reappointed at the same time as their supervising physician.
- E. It shall be the general policy of the Hospital that uniform standards and rules be adopted throughout the Hospital as regards Item (d) Specific Functions, Section (2), and that general guidelines be established delineating the general scope of practice privileges that may be requested for such personnel by their supervising physician. Initial responsibility for drafting such standards, rules and guidelines shall rest with the Executive Committee. Its recommendation shall be forwarded to the Staff for approval and shall then be submitted to the Hospital's Board of Trustees for final approval.

11.3 **SUPERVISION**

- A. In addition to the rules governing the use of P.A.'s in the Hospital, appropriate individual limitations may be placed in the use of particular P.A.'s by recommendation of the Medical Staff and the Board of Trustees.
- B. Functions not specifically granted to P.A.'s in the Hospital will be considered as specifically denied.
- C. Each P.A.'s credentials will be reviewed, by the Credentials Committee of the Medical Staff, the Executive Committee and the Board of Trustees prior to authorization being granted for his use in the Hospital by his supervising physician.
- D. **SPECIFIC FUNCTIONS:**
 - 1. Take medical histories and perform physical examinations on all admissions.

2.

2. Write admission orders and initiate plan for diagnosis and treatment after confirming directly with supervising physician. The supervising physician shall confirm and personally validate the plan outlined and orders written in writing or by phone prior to implementation of same. In such situations the supervising physician shall assume direct personal control with maximum expediency. After initiation of plan for diagnosis, management, and special studies, to include laboratory procedures, the P.A. may write minor modifying orders on daily on-going schedule. All such orders will be executed when written, and must be counter-signed by the supervising physician within twenty-four (24) hours. Unless otherwise specified, any major modifying orders must be validated by the supervising physician prior to execution.
3. Perform routine admission procedures (history & physical) commonly done by P.A. or other technical procedures such as starting I.V.'s, drawing blood specimens, etc.
4. P.A.'s may examine but not treat patients, private or otherwise, in the Emergency Department of the Hospital, until the patient has been seen by the Emergency Room physician or private physician.
5. The P.A. may serve as surgical assistant, if qualified and given Staff approval.
6. Make daily rounds on patients. Such rounds will not be considered to substitute for rounds made personally by the physician, or change the physician's responsibilities in this request.
7. Record progress notes in the chart.
8. Dictate, but not sign, discharge summaries.

9. Participate in appropriate educational programs and meetings carried on by Hospital and its Staff.
10. Initiate orders for the use of restraints in accordance with hospital policy.

11.4 **PHYSICIAN ASSISTANT IN TRAINING**

- A. Under the present training programs for P.A.'s, the situation exists in which a P.A., during the final three months of his formal training, may work in an on-the-job training situation with the physician whom he is considering as a prospective supervising and employing physician. Such physician shall be considered a preceptor during such a period of time as he and the prospective P.A. shall elect to remain associated in this relationship.
- B. During such a preceptorship period the prospective P.A. is in a training situation and has not fulfilled the requirements for licensure by the State Board of Medical Examiners. Therefore, he cannot be considered a licensed P.A. eligible for privileges as outlined previously in Section (d) - Specific Functions, (2).
- C. He shall function only in the personal presence of his preceptor who shall closely supervise his every activity, in any situation involving treatment or in writing orders, which will be immediately countersigned by his preceptor.
- D. He may do routine history and physical examinations without personal immediate supervision, but all such examinations must be confirmed by his preceptor prior to initiating any treatment or management program based upon his initial working diagnosis.
- E. These rules and regulations are promulgated and adopted under and by the authority of Florida Statute 458.347 and the Rules and Regulations of the State of Florida Board of Medical Examiners as to Physician Assistants.

- F. No rule hereunder shall be construed to grant to Physician Assistants any right or privilege not granted them by the said Florida Statute 458.135 and the Rules and Regulations of the said Board of Medical Examiners.

XII **CERTIFIED NURSE PRACTITIONER**

XII-A **CERTIFIED NURSE MIDWIFE**

12.1 **GENERAL GUIDELINES**

- A. The Certified Nurse Midwives (C.N.M.) will function under the direction of any Attending Staff physician obstetrician, performing clinical tasks for essentially healthy women during the childbearing cycle. The patient must meet the criteria for C.N.M. management, or may be approved for C.N.M. care at the discretion of the obstetrician. The obstetrician will assure that the proper certification procedures with the Florida State Board of Nursing, Department of Professional Regulation, are followed and that the job description outlines are actual duties performed by the C.N.M. The Credentials Committee of the Medical Staff, the Executive Committee, and the Board of Trustees must approve the C.N.M.'s delineation of privileges. The performance of the C.N.M. will be evaluated by the Attending Staff physician obstetrician. These evaluations will assist in determining continuation of employment.

12.2 **SPECIFIC GUIDELINES**

- A. The C.N.M. must have written proof of graduation from an accredited school of Nurse Midwifery and must be licensed and certified by the appropriate State agencies. Clinical privileges are under the auspices of the Department Section and in accordance with the

Bylaws of the Medical Staff of Cape Coral Hospital. The Physician-Employer will provide evidence of Professional Liability Insurance coverage for the employee, in amounts required by the Hospital.

B. Specific duties which may be performed by the Certified Nurse Midwife as part of his/her specific delineation of privileges may include:

1. Complete the history and perform the physical examination of antepartum, intrapartum and postpartum patients.
2. Prescribe medication according to standing orders.
3. Interpret laboratory data.
4. Manage essentially healthy antepartum patients.
5. Collaboratively manage high-risk antepartum patients.
6. Manage the high-risk parturients in a collective management role.
7. Utilize external and internal fetal monitoring for intrapartum patients.
8. Utilize intrauterine pressure monitoring for intrapartum patients.
9. Conduct spontaneous vaginal deliveries with vertex presentation.
10. Perform amniotomy when vertex engaged.
11. Administer local infiltration and pudendal nerve block anesthesia.
12. Cut and repair median episiotomies.
13. Repair first and second degree perineal lacerations.
14. Repair third degree perineal lacerations.
15. Repair fourth degree perineal lacerations.
16. Repair cervical lacerations.

17. Repair vaginal lacerations, labial and/or periurethral lacerations.
18. Manage postpartum patients.
19. Discharge patients from the Family BirthPlace.
20. Collaboratively manage "trial of labor" for the VBAC candidate.
21. Conduct spontaneous multiple deliveries with M.D. in attendance.
22. First assist on Cesarean Sections.
23. Perform and interpret NST's and CST's.
24. Perform necessary ultrasound examinations to verify fetal presentation.
25. Initiate and manage patients on oral contraceptives.
26. Complete antepartum, intrapartum and postpartum charts.
27. Perform any function of a Registered Nurse.

XII-B **ADVANCED REGISTERED NURSE PRACTITIONER**

12.1 **GENERAL GUIDELINES**

- A. The Advanced Registered Nurse Practitioner with current Florida State Board of Nursing Certification and Licensure will function under supervision of an Attending Staff physician, who will provide a job description outlining the actual duties to be performed. The Credentials Committee of the Medical Staff, Executive Committee and the Board of Trustees must approve the Advanced Registered Nurse Practitioner delineation of privileges.
- B. Advanced Registered Nurse Practitioner licensure allows management of selected medical problems; ordering of physical and occupational therapy; initiation, monitoring and alteration of therapies for certain uncomplicated acute illnesses; diseases; and

establishing diagnosis and treatment recommendations for behavioral problems.

- C. The Physician-Employer will provide evidence of Professional Liability Insurance coverage for the employee, in amounts required by the Hospital.

12.2 **SPECIFIC GUIDELINES**

- A. With this institution, the Advanced Registered Nurse Practitioner may have the following general and specific privileges under supervision of the employing physician(s):

- 1. Write admission orders and initiate plan for diagnosis and treatment after confirming directly with supervising physician. The supervising physician shall confirm and personally validate the plan outlined and the written or phoned orders, prior to implementation of same. In such situations the supervising physician shall assume direct personal control with maximum expediency. After initiation of a plan for diagnosis, management and special studies, including laboratory procedures, the Advanced Registered Nurse Practitioner may write minor modifying orders on a daily on-going schedule. All such orders will be executed when written and must be countersigned by the supervising physician within twenty-four (24) hours, except in the case of psychiatrist physicians supervising psychiatric Advanced Registered Nurse Practitioners, who shall not be required to countersign such orders, but who shall review such orders on a daily basis, consistent with applicable state and federal law. Any major

modifying orders must be validated by the supervising physician prior to execution.

2. Perform routine admission procedures commonly done by nursing or other technical personnel, such as starting IV's, drawing blood specimens, etc.
3. The Advanced Registered Nurse Practitioner may serve as a surgical assistant, if qualified and given Staff approval.
4. Make daily rounds on patients. Such rounds will not be considered to substitute for rounds made personally by the physician, or change the physician's responsibilities in this request.
5. Record progress notes in the chart, to be countersigned by the supervising physician within twenty-four (24) hours, except in the case of psychiatrist physicians supervising psychiatric Advanced Registered Nurse Practitioners, who shall not be required to countersign such notes, but who shall review such notes on a daily basis, consistent with applicable state and federal law.
6. Participate in appropriate educational programs and meetings carried on by the Hospital and its staff.
7. Other privileges may be requested for consideration by the authorizing officials.

XIII-C **SURGICAL FIRST ASSISTANTS**

12.1 **GENERAL GUIDELINES**

- A. The **Registered Nurse First Assistant** with current Florida Board of Nursing licensure will function under the supervision of the surgeon engaging the services of the

Registered Nurse First Assistant. The Credentials Committee of the Medical Staff, Executive Committee and the Board must approve the Registered Nurse First Assistant delineation of privileges.

- B. The **Surgical Technician First Assistant** with approved training and certification will function under the supervision of the surgeon engaging the services of the Surgical Technician First Assistant. The Credentials Committee of the Medical Staff, Executive Committee and the Board must approve the Surgical Technician First Assistant delineation of privileges.
- C. Each Surgical and Technician First Assistant shall provide evidence of professional liability insurance coverage in amounts required by the Medical Staff.

12.2 **SPECIFIC GUIDELINES**

A. **Registered Nurse First Assistants**

Allied Health Practitioners designated as Registered Nurse First Assistants (RNFAs) shall meet the following guidelines"

- (1) Medical Staff members may contract with or employ registered nurses qualified as RNFAs to assist at surgery, subject to the Medical Staff bylaws.
- (2) Education and Training Requirements: All Registered Nurse First Assistants are required to have three (3) years recent Perioperative nursing experience with proficiency in both circulating and scrubbing roles; must be CNOR (Certified Nurse Operating Room); have BLS Basic Life Support); and have RNFA certificates of competency and college course credits from an approved RNFA program utilizing AORN (Association of Operating Room Nurses) curriculum guidelines.
- (3) Scope of Activities: Specific duties which may be

performed by the RNFA upon specific order of physician are outlined in the delineation of privileges application as Category A and Perioperative duties to be performed by the RNFA as Category B.

B. Surgical Technician First Assistants:

Allied Health Practitioners designated as Surgical Technician First Assistants (STFAs) shall meet the following guidelines:

- (1) Medical Staff members may contract with or employ limited practitioner employees qualified as STFAs to assist at surgery, subject to the Medical Staff bylaws.
- (2) Education and Training Requirements: All STFAs are required to have two (2) years recent perioperative surgical technician experience; have BLS (Basic Life Support); and have completed training in an approved STFA program and obtained a certificate of proficiency from such program.
- (3) Scope of Activities: The duties and procedures which the STFA may perform shall be based on proof of training and experience to the Credentials Committee at the time of appointment. The delineation of privileges shall be made by the Department of Surgery on a case-by-case basis. Any duty or procedure not explicitly outlined and approved shall be presumed to be denied and prohibited.

XIII. PHYSICIAN EMPLOYEES

13.1 Members of the Provisional and Active Staffs may employ non-physicians to assist in the care of hospitalized patients.

13.2 The Employer-Physician shall submit to the Medical Staff Office:

- A. A letter requesting approval for the employee to assist in the care of his patients to the Medical Staff Office.
- B. A list of the scope of duties and procedures for which the non-physician employee is requesting.

- C. A completed application with copies of all valid and current State and Federal professional licenses held by the employee.
All information will be presented to the Credentials Committee, Medical Executive Committee and Board of Trustees for approval.
- D. The Physician-Employer will provide evidence of Professional Liability Insurance coverage for the employee, in amounts required by the Hospital.
Each department shall, through its chairman, ascertain that the following rules pertaining to all non-physician employees are strictly followed:
 - A. Non-physician employees of members of the Provisional or Active Medical Staff may assist the physician-employer with clinical duties in Cape Coral Hospital, within the guidelines herein established, and with any further restrictions imposed by the clinical department to which the physician-employer is assigned.
 - B. Non-physician employees shall not touch any patient in Cape Coral Hospital, nor perform any diagnostic or therapeutic procedure upon such patients, unless such examination or procedure has been approved as proper by the department to which the physician-employer is assigned, and/or the physician-employer, or his clinical associate is physically present in the room where the examination or procedure is being done.
 - C. Non-physician employees may write in the official clinical record; however, no such writing shall be valid until it is countersigned by the Physician-Employer or his clinical associate. No order written by a non-physician employee shall be carried out until it has been countersigned, or until the physician-employer, or his clinical associate, has verbally approved the order by telephone; in the latter instance the order shall be treated as a verbal telephone

order as elsewhere specified within these Bylaws.

13.3 **PATHOLOGIST'S ASSISTANTS**

May review the patient's chart and shall assist the Pathologist in the gross dissection of the postmortem examination and in the preparation of the body for the release to the funeral home. If the Pathologist must leave the morgue in order to perform a frozen section, a bone marrow examination, or perform other important functions with regard to live patients, he may leave the Pathologist's Assistant alone for a few minutes. In all cases, the Pathologist shall return to the morgue to complete the gross dissection and to personally indicate that the body is ready for release to the funeral home upon completion of the postmortem examination.

13.4 **CERTIFIED REGISTERED NURSE ANESTHETIST/ANESTHESIOLOGIST ASSISTANTS**

May be utilized by Anesthesiologists within the Hospital, in accordance with the provisions of the bylaws, and subject to the following additional conditions and requirements:

- A. CRNAs and Anesthesiologist Assistants must work under the direct on-site supervision of an Anesthesiologist.
- B. A CRNA or Anesthesiologist Assistant must be an employee of an Anesthesiologist who is an Active Staff member of Cape Coral Hospital.
- C. The supervising Anesthesiologist shall not, except in case of an emergency, be involved in the administration of anesthesia at the same time that any of the employed CRNAs or Anesthesiologist Assistants are administering anesthesia. The supervising Anesthesiologist may personally relieve the CRNA or Anesthesiologist Assistant for short durations (i.e., breaks) if the CRNA or Anesthesiologist Assistant remains immediately available. The Anesthesiologist may not supervise more than four (4) Allied Health Practitioners assigned to concurrent cases at any one time, of which not more than two (2) practitioners may be Anesthesiologist

Assistants, pursuant to Florida Statutes, the exception being in the event of a trauma or life-threatening emergency.

- D. The Anesthesiologist who employs CRNAs will make all preoperative evaluations and select the anesthetic to be administered by the CRNA or Anesthesiologist Assistant. The Anesthesiologist or his/her designee shall make routine postoperative evaluations.
- E. The supervising Anesthesiologist must disclose to the patient in advance that a supervised CRNA or Anesthesiologist Assistant will administer the anesthetic, and the consent of the patient to the administration of the anesthetic shall be obtained. In extenuating circumstances, such disclosure and consent may be waived.

Current Anesthesia Consent for states, "Your physician has requested that the Anesthesia Department provide care to you during your operation/procedure. The method of anesthesia will be decided by your Anesthesiologist after discussion with you. The anesthesia will be administered by an Anesthesiologist, or a certified registered nurse anesthetist under the supervision of an Anesthesiologist.

- F. The supervising Anesthesiologist shall at all times during the administration of anesthesia be immediately available (i.e., physically inhouse) to the Allied Health Practitioner in the operating room, except in dealing with an emergency of short duration. The supervising Anesthesiologist may be relieved by another Anesthesiologist. For purposes of this subsection, "operating room" shall include all anesthetizing locations within the facility.
- G. During the course of regional anesthesia for pain during childbirth (other than by Cesarean Section), the supervised CRNA or Anesthesiologist Assistant shall remain with the patient until vital signs are stable. The patient must be

observed at regular intervals by a qualified anesthesia provider or a licensed and trained obstetrical nurse. The supervising Anesthesiologist shall remain available (i.e. physically inhouse). The supervising Anesthesiologist may be relieved by another Anesthesiologist.

H. The supervising Anesthesiologist shall be responsible to ensure that the CRNA or Anesthesiologist Assistant maintains records of all anesthetics, which shall contain periodic entries of all monitoring data.

13.5 The Physician-Employer shall be expressly accountable to the Staff and to the Administration for all actions, whether acts done or failure to act, of his employee; misconduct by the employee shall be deemed misconduct to the Staff and Administration as elsewhere set forth in these Bylaws.

13.6 The regulations herein stipulated shall apply equally to inpatients and outpatients, including patients in the Emergency Department; no examinations or procedures shall be performed by non-physician employees upon outpatients or Emergency Department patients except within the guidelines herein, and no orders given to Emergency Department personnel by non-physician employees will be considered approved by physician-employer or his clinical associate, until such orders are verbally approved by telephone by the physician-employer or his clinical associate.

13.7 In the event of conflict between this section of the Bylaws and Department regulations concerning non-physician employees, the Bylaws will prevail, and the departmental rules will be modified to conform hereto.

13.8 **PHYSICIAN'S ATTENDING NURSE**

A licensed Registered Nurse who is employed by a physician on the Medical Staff of Cape Coral Hospital may be credentialed to have the following privileges in the hospital:

A. Nurse may make patient rounds with the named Physician-Employer and perform the following functions:

1. Present to the patient such instruction/teaching information, discharge planning and other significant information as directed by the Physician-Employer.
2. Physician's Attending Nurse may enter verbal orders in the patient chart, as well as progress notes, all to be individually signed by the Physician-Employer.
3. Physician's Attending Nurse may serve as the physician's liaison with the Laboratory, Radiology Department or other Hospital departments, as the Physician-Employer so directs. The Physician-Employer will provide evidence of professional liability insurance coverage for the Physician's Attending Nurse, in amounts required by the Hospital.

XIV. **AMBULATORY SURGERY**

14.1 **MEDICAL DIRECTION**

- A. The medical direction of Ambulatory Surgery will be assigned to the Department of Surgery.

14.2 **STAFF REQUIREMENTS**

- A. All members of the Medical Staff must abide by the policies established in the Bylaws and Rules and Regulations of the Cape Coral Hospital.
- B. Anesthesiologists will be available at the Ambulatory Surgery in time to evaluate their patients adequately before surgery, and be available until the last patient under their supervision is discharged.
- C. Surgeons shall be in the operating room and ready to commence the operative procedure at the time scheduled as outlined in the Department of Surgery Rules and Regulations.
- D. Assistants: The use of an Assistant Physician in the Operating Room is at the discretion and direction of the Attending Surgeon. The assistant must be a member of the

Medical Staff.

- E. Paramedical Assistants must be credentialed as required under the Bylaws of Cape Coral Hospital, Article V.

14.3 **ADMISSION REQUIREMENTS**

- A. Patients who will have general anesthesia or who have been medicated must be accompanied upon admission and discharge by a "responsible adult".
- B. It is the responsibility of the Admitting physician, Dentist, or Podiatrist to obtain informed consent from the patient, and if the patient is a minor, from the patient's parent or legal guardian, prior to and for any procedure performed in Ambulatory Surgery.
- C. A history and physical examination shall be performed on all patients by a physician. This may be sent in with the patient.

14.4 **ANESTHESIA REQUIREMENTS**

- A. The administration of preoperative medications, local, topical, etc., and/or intraoperative medications for local cases shall be the sole responsibility of the surgeon, dentist, or podiatrist regardless of route of administration.
- B. Anesthesia will not be started until the surgeon is present in the operating room suite.

14.5 **PATHOLOGY REQUIREMENTS AND ANCILLARY DIAGNOSTIC TESTS**

- A. Pathology services will be performed by the Pathologist at the Cape Coral Hospital. All specimens are to be handled in accordance with the Rules and Regulations. Preoperative laboratory services will be provided by Cape Coral Hospital laboratory or a state accredited laboratory. Lab values will be accepted when performed from 2-7 days prior to surgery. Tests include CBC and urinalysis. Electrolytes will be obtained at the discretion of the Anesthesiologist. Glucose on diabetics may be ordered at the discretion of the Anesthesiologist.

- B. Chest x-rays, when performed up to six months prior to surgery and reviewed by a Radiologist, will be acceptable. A copy of the report and x-ray are to be obtained by the patient. This will be required for all patients 45 years of age and older.
- C. An EKG performed within six months of surgery and reviewed by a physician who has hospital privileges to interpret same is required on patients 45 years of age and older. Those patients who have known cardiac problems must have an EKG 2-7 days prior to surgery. A copy of a normal EKG report must be obtained by the patient.

14.6 **DRUGS**

- A. Drugs used shall meet the standards of the US Pharmacopoeia and the Cape Coral Hospital.

14.7 **DISCHARGE**

- A. A discharge note shall be written by the Anesthesiologist on his patients only. Patients shall be discharged on written order of the Anesthesiologist or the Attending surgeon. The Attending surgeon's order may be taken by telephone.
- B. Discharge from Ambulatory Surgery is based on the patient's ability to leave the area safely, having met discharge criteria, and must be accompanied by a responsible adult. The patient will not be allowed to drive his own vehicle if given any general anesthesia or sedation.
- B. All patients will be given written postoperative instructions.
- D. TRANSFER OF THE PATIENT TO INPATIENT STATUS:
Prior to discharge from Ambulatory Surgery, if post-operative complications or response require further care, the patient's surgeon shall be notified. The surgeon must make

arrangements for discharge from Ambulatory Surgery to inpatient status.

14.8 **MEDICAL RECORDS REQUIREMENTS**

- A. The requirements for Medical Records are in accordance with established Rules and Regulations.
- B. An abbreviated medical record will be used throughout the patient's stay. This record is designated for use by the clerical and Medical Staff and meets all applicable professional, administrative and legal requirements.

14.9 **CRITERIA FOR SCHEDULING PROCEDURES**

The following guidelines will be followed for all cases scheduled for surgery:

- A. Only procedures with expected minimal bleeding and minor physiological trauma during and/or after the procedure will be performed on an ambulatory basis.
- B. Only local anesthesia cases requiring less than five hours procedural times will be booked. General anesthesia cases extended beyond two hours must be cleared with the Anesthesiologist at the time of booking. All general cases should be completed by 2:00 pm.

14.10 **SCHEDULING**

- A. Scheduling will be accomplished in accordance with the established Rules and Regulations of the Department of Surgery.
- B. Patients for surgical procedures will be admitted no later than 45 minutes before the scheduled operation.
- C. Preoperative orders can be given in any of the following manners:
 - 1. Verbally via telephone to a Registered Nurse in the Ambulatory Surgery or operating room suite prior to the patient's admission.

2. In writing, duly signed by the Attending surgeon. Written orders may be given to the patient for delivery during the preoperative visit or may be mailed to Ambulatory Surgery.

14.11 **PATIENT CRITERIA FOR SCHEDULING**

- A. Patients who are candidates for outpatient surgery should meet the following criteria:
 1. The patient should be in stable health and no more than A.S.A. Class III. It will be at the discretion of the Anesthesiologist whether a patient with mild systemic disease, whose condition is under good control may require special management.
- B. Patients not acceptable for admission to Ambulatory Surgery:
 1. Infection: Patients having infections which require isolation and additional professional help in surgical or recovery room services unless it is scheduled as the last case of the day.
- C. The patient and/or legal guardian signing the consent for surgery must agree with the concept of outpatient surgery/ anesthesia and must exhibit the ability to use judgment and follow instructions.
- D. The patient's physical and emotional environment must be conducive to a successful outcome.
- E. All patients for general anesthesia will be scheduled for a preoperative visit at least 48 hours and up to 7 days prior to surgery. Under certain circumstances preoperative visits will be done 24 hours prior to the surgery date, and the same day of surgery. The patient must arrive at Ambulatory Surgery approximately one hour prior to the scheduled time.
- F. Additional tests, other than those specifically outlined in Section 5, may be ordered at the discretion of the Anesthesiologist.

14.12 **INTERNAL RISK MANAGEMENT PROGRAM**

The facility's Internal Risk Management will follow the program guidelines for the Medical Center under the direction/supervision of the Risk Management Program.

14.13 **INFECTION CONTROL PROGRAM**

The facility's Infection Control Program will follow the program guidelines for the Medical Center under the direction/supervision of the Infection Control Committee.

14.14 **OUT-OF-STATE PRACTITIONERS/OBSERVERS**

A practitioner who is licensed to practice medicine in another jurisdiction, but not in this state, may participate as an observer in patient care. The out-of-state practitioner must be recommended to, and approved by, the Chief of Staff. The practitioner must accompany the physician making the recommendations, who will be responsible for his activities.

14.15 **MEDICAL STUDENTS**

When medical students act as preceptees with preceptors who are members of the medical staff, the preceptees may do those limited procedures which the staff has deemed appropriate for that level of student, only if the preceptor is also so privileged, and in the presence of the preceptor(s). Medical students may have access to patients, but must identify themselves as a student; and may record findings, but not orders, on charts; any entries are to be countersigned by preceptors. Prior to working within the hospital, the preceptor shall inform the Chief of Staff and CEO that they will be working with a preceptee, to allow for the notification of hospital personnel. A curriculum vitae of the student, with a letter from the school acknowledging the student assignment to the preceptor, must be on file at Cape Coral Hospital before the preceptee begins.

14.16 **EDUCATIONAL PRIVILEGES**

Upon request of a member of the active, courtesy or consulting

medical staff, a practitioner-in-training may be accorded the privilege of working with that medical staff member with the approval of the medical staff member's department chairman and the Medical Executive Committee. Specific privileges for each practitioner-in-training shall be consistent with the policy and procedure for educational privileges approved by the Medical Executive Committee. The medical staff member requesting educational privileges for a practitioner-in-training shall be responsible for the actions of the practitioner-in-training. Educational privileges shall be granted only for a specific time.