

**GULF COAST HOSPITAL
RULES AND REGULATIONS**

100 ADMISSION AND DISCHARGE OF PATIENTS

- 101 Although the medical services at the Gulf Coast Hospital are available to the general public, the Hospital need not accept all patients except for emergencies who apply for care and treatment.
- 102 A patient may be admitted to the Hospital only by an appointee to the Medical staff. All practitioners shall be governed by the official admitting policy of the Hospital.
- 103 Each member of the Medical Staff who does not specifically request to opt out, will be part of the Organized Health Care Arrangement with the Hospital, which is defined in USC 164.520(d)(1) (HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. This arrangement allows the Hospital to share information with the provider and the provider's practice for purposes of the provider's payment and practice operations. The patient will receive one Notice of Privacy Practices at the time of Admission/Registration, which will include information about the Organized Health Care Arrangement with the Medical Staff.
- 104 An appointee to the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital, for the promptness, completeness and accuracy of the medical record for necessary special instruction, and for transmitting reports of the condition of the patient to the referring practitioner, the patient, and to those persons authorized by the patient. Whenever these responsibilities are transferred to another Medical Staff appointee, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.
- 105 Except in an emergency, no patient shall be admitted to the Hospital until provisional diagnosis or valid reason for admission has been stated. In the case of emergency, the diagnosis or reason for admission will be stated as soon as possible.
- 106 All patients admitted into the Hospital shall be seen by their practitioner or the practitioner on call within twenty-four (24) hours. Patients admitted to critical care areas shall be seen as soon as possible, but not later than eight (8) hours following admission.
- 107 Unassigned medical patients presenting to the Emergency Department within thirty (30) days of discharge for the same condition shall be assigned to the discharging physician.
- 108 Unassigned surgical patients presenting to the Emergency Department within ninety (90) days for a problem that is related to the surgery or within thirty (30) days if no surgery is performed, and is related to the initial complaint, shall be referred to the discharging physician.
- 109 In a case in which it appears the patient will have to be admitted to the Hospital, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.
- 110 Each practitioner must assure timely, adequate professional care for his patients in the Hospital by being available or having available through his office an eligible alternate practitioner with

whom prior arrangements have been made and who has at least equivalent clinical privileges at the Hospital. Failure of an attending practitioner to meet these requirements shall result in loss of clinical privileges.

- 111 The Medical Staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the Executive Committee.
- 112 The policy of this Hospital is not to save empty beds for potential patients. The Admitting Supervisor will admit patients on the basis of the following order of priorities:
- a. Emergency Admissions
 - b. Transfers to Intensive Care Unit
 - c. Transfers from the Intensive Care Unit
 - d. Urgent Admissions
 - e. Elective Admissions
- 113 Assignment of patients will be in accordance with the Hospital Bed Allocation Plan. Any deviations from the assigned areas as stipulated in the Bed Allocation Plan will be corrected at the earliest possible time, in keeping with transfer priorities.
- 114 Patient transfer priorities shall be as follows:
- a. From an intensive care unit to a medical/surgical unit.
 - b. From emergency room to appropriate patient bed.
 - c. A patient going to surgery requiring surgical unit placement.
 - d. A patient requiring reassignment in support of the bed allocation plan.
- 115 The admitting practitioner shall be held responsible for giving such information as may be necessary to assure the protection of the patient from self harm and to assure the protection of others whenever his patients might be a source of danger from any cause whatsoever.
- 116 Medical management of patients admitted to Critical Care Units:
- a. The attending physician will retain authority and responsibility for the admission to and discharge from the critical care units and for the medical management of the patient except where special problems are designated to the care of the consultants.
 - b. Each attending physician will have an alternate to provide the patient with continuous medical care.
 - c. Surveillance responsibilities for the Critical Care area(s) will be under the direction of the Physician Quality Committee. Problems arising in the care of patients are to be directed to the chairman of the appropriate committee.

- d. In the event life support is terminated, documentation should be made of the circumstances and family consent. This documentation will be the responsibility of the physician and will be in the physician's progress notes.
- e. Organ donation procurement agency will be contacted when appropriate.

117 The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Physician Quality Committee, and approved by the particular clinical department and the Executive Committee of the Medical Staff. This documentation must contain:

- a. An adequate written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.
- b. The estimated period of time the patient will need to remain in the Hospital.
- c. Plans for post-hospital care.

Upon request of the Physician Quality Committee, the attending practitioner must provide written justification of the necessity for continued hospitalization of any patient hospitalized for eighteen (18) days. This report must be submitted within twenty-four (24) hours of receipt of such request.

118 Patients shall be discharged only on a written or verbal order of the attending practitioner. Should a patient leave the Hospital against the advice of the attending practitioner, or without proper discharge, the patient should sign the proper form releasing the Hospital of responsibility. A notation of the incident shall be made in the patient's medical record, and the attending physician should be notified.

119 In the event of a Hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by an appointee to the Medical Staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

120 While autopsies are encouraged 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 encouraged 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 findings 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.

121 Medical Screening Examination is the process required to reach, with reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility's capabilities and available personnel, including on-call physicians. The medical screening examination is an ongoing process and the medical records must reflect continued monitoring based on the patient's needs and continue until the patient is either stabilized or appropriately transferred.

Certified Nurse Midwives (CNM's) or Labor & Delivery Registered Nurses (LDRN's) may perform Medical Screening Examinations. CNM's/LDRN's will follow screening protocols that outline the examination and/or diagnostic workup required to determine if an emergency medical condition exists for the laboring patient. The competencies for any CNM's/LDRN's performing Medical Screening Examinations shall be documented and validated by a qualified physician.

The Hospital deems the Emergency Physicians and the Physician Assistants contracted by the Emergency Physician Group to be qualified medical professionals for the purpose of providing appropriate medical screening examinations.

200 MEDICAL RECORDS

201 Practitioner shall be responsible for the preparation of a complete medical record for each patient. Its contents shall be pertinent and current. This record shall include identification data: complaint; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary of discharge note; and discharge summary.

202 A medical record is considered complete when it includes final diagnosis, any complications, identification of consultants, listing of operative procedures performed, condition on discharge,

signed history, physical examination, orders, progress notes, consultative reports, operative reports, pathological reports, discharge summary, and all other dictated reports.

- 203 A complete admission history and physical will be recorded within twenty-four (24) hours of admission or prior to surgery, whichever comes first. A history and physical shall be completed on inpatients and all patients undergoing outpatient/inpatient surgeries of invasive procedures. A history and physical should include chief complaint, details of present illness, relevant past medical/surgical history, allergies/medications, relevant social and family history, review of systems, comprehensive physical examination, conclusions/impressions, and plan for the patient. If a complete history and physical examination has been performed and/or verified by a member of the Medical Staff within thirty (30) days prior to the patient's admission to the Medical Center/Hospital, a reasonably durable, legible copy of these reports may be used in the record in lieu of the admission history and report of physical examination, provided any significant changes that may have occurred are recorded in the medical record at the time of admission. In such instances, an interval admission note that includes all additions to the history and subsequent changes in the physical findings must always be recorded in the medical record. In situations where the patient is going to surgery within the first twenty-four (24) hours of admission or outpatient surgery, the preanesthesia assessment may serve as the update to the history and physical examination. Outside record forms should be in a format approved by the Executive Committee and compatible with the Medical Center's/Hospital's current medical record keeping system. On a re-admission to the Medical Center/Hospital, an interval note may be used if the patient is readmitted no more than seven (7) days after the previous discharge and for the same condition.
- 204 All surgical patients shall have their history and physical examination, preoperative diagnosis and laboratory reports recorded prior to the surgery insofar as possible. If there is insufficient time for the typed history and physical examination to be placed in the patient's medical record, the attending physician shall make an entry on the progress note, which shall include a review of systems (if possible), a clearance for surgery, and an indication that the history and physical examination have been done and dictated.
- 205 All patients undergoing an invasive procedure and those undergoing procedures, including cardioversion, shall have a history and physical. This history and physical may be an office consultation or note recorded prior to the invasive procedure that will include a list of allergies and general medical clearance of the patient's ability to tolerate the procedure and IV sedation (if applicable) as outlined in the Patient Care Policy and Procedure #PCM.47B as approved by the Medical Staff Executive Committee.
- 206 A short form history and physical is acceptable for patients undergoing outpatient operative/invasive procedures or for patients placed in observation status. The short form history and physical should contain the following elements: Indications/reasons for procedure; procedure/plan; short history relevant to the procedure, medications and allergies; physical examination to include HEENT, cardiovascular, respiratory, abdomen, neurology and extremities.
- 207 When the provisions of Rules and Regulations 204 and 205 above have not been met prior to an elective surgical procedure or any potentially hazardous elective diagnostic procedure, the

- procedures shall be canceled unless the attending physician states in writing that such delay would be detrimental to the patient.
- 208 Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Wherever possible, each of the patient's clinical problems should be carefully defined in the progress notes and correlated with specific orders as well as results of tests and treatments. Progress notes shall be written at least daily on all patients. Failure to comply will be brought to the attention of the Executive Committee for possible corrective action.
- 209 Operative reports shall include the name of the primary surgeon and assistants, findings, technical procedures used, specimens removed, and postoperative diagnosis. Post-operative progress notes shall be written and operative reports shall be dictated immediately following surgery for both inpatients and outpatients, and the report promptly signed by the surgeon and made a part of the patient's medical record.
- 210 Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's medical record. A limited statement such as "I concur" does not constitute an acceptable report of consultation. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the procedure.
- 211 All clinical entries in the patient's medical record shall be legible, accurately dated, timed and authenticated.
- 212 Symbols and abbreviations may be used in the medical record only on approval of the Executive Committee. An official record of approved abbreviations shall be kept in Medical Information Services, and copies will be available in the patient care units.
- 213 The final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible practitioner at the time of discharge of all patients.
- 214 A discharge summary shall be completed on all medical records of patients hospitalized over forty-eight (48) hours and on patients hospitalized less than forty-eight (48) hours with significant medical problems. Patients hospitalized for less than forty-eight (48) hours with minor medical problems shall have a final summation type entry recorded in the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result. The discharge summary shall include instructions given to the patient and/or family member, particularly in regard to physical activity limitations, medications, diet, and follow up care. All summaries shall be authenticated by the responsible practitioner, or his associates or partners. All Hospital deaths shall have a dictated death summary.
- 215 Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

- 216 Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away. In case of readmission of a patient, previous records shall be available for the use of the attending practitioner. This shall apply whether the patient be attended by the same practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension by the Executive Committee of the Medical Staff.
- 217 No practitioner on the Medical Staff shall inspect the current medical record of a hospitalized patient while the patient is under the care of another practitioner unless he is acting in the capacity of a consultant, as the Chairman of the Clinical Department, or in the capacity of an authorized representative of the Physician Quality Committee or other standing or ad hoc committees of the Medical Staff, or has obtained authorization from the Chief Executive Officer or authorization of the attending practitioner.
- 218 Free access to all medical records of all patients shall be afforded to appointees to the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Executive Committee before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the medical records of their patients covering all periods during which they attended such patients in the Hospital.
- 219 A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the Physician Quality Committee.
- 220 The patient's medical record should be complete at the time of discharge including progress notes, final diagnosis and discharge summary. Where this is not possible because final laboratory or other essential reports have not been received at the time of discharge, the patient's chart will be available in the Medical Information Service Department.
- 221 The patient's medical record shall be completed within thirty (30) days of discharge. If the medical record remains incomplete, the practitioner's privileges shall be deemed to have been voluntarily relinquished in accordance with the provisions of Article VII, Part C, Section 2 of the Medical Staff Bylaws. The practitioner shall not be permitted to admit elective patients, see consultations, perform elective inpatient or outpatient procedures, or provide any medical management on patients admitted after that date until all incomplete delinquent medical records have been completed. The voluntary relinquishment of the practitioner's privileges due to delinquent medical records does not exempt the practitioner from fulfilling their on-call responsibilities.
- 222 The Chairman of the Department (or his designee) in consultation-with the administrator on call is responsible for supporting the loss of privileges and may grant limited exceptions when appropriate.
- 223 If the practitioner's medical records remain incomplete for a period of sixty (60) days, the practitioner will be requested to appear before the Executive Committee to show good cause for the failure to complete the medical records, and may be given a period not to exceed seven (7)

days in which to complete them, during which period the voluntary relinquishment of privileges as defined in paragraph 220 above will remain in effect. If the practitioner fails to complete the medical records during this period, the Executive Committee shall consider further corrective action.

224 Receipt of three (3) requests to appear before the Medical Staff Executive Committee for failure to complete medical records in any rolling twelve (12) month period, shall result in revocation of the practitioner's medical staff appointment and clinical privileges. Such revocation of appointment and privileges is an offense reportable to the National Practitioner Data Bank and the Department of Professional Regulation. A practitioner whose privileges are revoked for violation of this policy must reapply for medical staff appointment and privileges if he desires to resume practicing at the Hospital.

300 GENERAL CONDUCT OF CARE

301 A general consent form, signed by or on behalf of every patient admitted to the Medical Center, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. Except in an emergency situation, it shall be the practitioner's obligation to obtain proper consent before the patient is treated in the Medical Center.

302 In addition to obtaining the patient's general consent to treatment, informed consent that informs the patient of the nature and risks, benefits and alternatives inherent in any special treatment, surgical/invasive procedure or blood transfusion shall be obtained by the physician. Prior to beginning the procedure or blood transfusion, the physician shall document the fact that he/she obtained the patient's informed consent by:

- signing, dating and timing the appropriate section of the Operative and Invasive Procedure Consent form; or
- dictating the documentation into the history and physical examination or in a consultation report; or
- writing the documentation in the Progress Notes.

303 Only in cases of emergency shall treatment or surgical/invasive procedures commence when informed consent cannot be immediately given by the patient or next of kin.

304 Medication, treatments, diagnostic procedures, and operative procedures shall be administered or carried out only upon the order of an appointee to the Medical Staff.

305 All orders for treatment shall be in writing. Any verbal order shall be considered to be in writing if dictated to and authenticated by a duly authorized professional. All verbal orders shall be signed by the appropriately authorized person to whom dictated with the name of the ordering practitioner. Only currently licensed RN's, LPN's, Pharmacists, Respiratory and Physical Therapists and other personnel indicated in the Patient Care Policies and Procedures #PCV.4, approved by the Executive Committee, may accept verbal orders. The responsible practitioner shall authenticate all high risk (i.e. DNR, restraint) orders within twenty-four (24) hours in accordance with Patient Care Policies #PCA.8 (Advanced Directives), and #PCR.5 (Restraints), as approved by the Medical Staff Executive Committee. All other verbal orders shall be

countersigned by a practitioner responsible for the care of the patient within forty-eight (48) hours. When more than one practitioner shares the responsibility of patient care, one may sign for another.

- 306 The practitioner's orders must be written clearly, legibly and completely including practitioner's printed name beneath the signature and/or four-digit identification number. Orders, which are illegible or improperly written, will not be carried out until rewritten or understood by the nurse.
- 307 All previous orders are canceled when patients go to surgery.
- 308 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 and Therapeutics Committee will approve medication-dosing protocols and/or guidelines with subsequent approval by the Medical Executive Committee.
- 309 Medications, treatments or corrective procedures shall be administered or carried out only upon the order of an appointee to the Medical Staff. No medications shall be left in the patient's room without the attending physician's order.
- 310 The use of restraints within the Hospital is limited to those situations with appropriate clinical justification and when the patient, due to his mental and/or physical condition, poses a safety threat to himself or to other individuals. The decision to restrain should be made only after other protective alternatives have been considered and found not to provide adequate protection. The ordering of restraints and observation of the restrained patient shall be done in accordance with the provisions of the Hospital's policies and procedures on the use of restraints, which shall be approved by the Medical Staff Executive Committee.
- 311 The Hospital is not a licensed psychiatric receiving facility; therefore patients admitted to in-patient status must have an admitting diagnosis other than psychiatric illness. Any patient who presents to the Emergency Department with a psychological diagnosis either by rescue or walk-in will be medically screened, treated and stabilized. If necessary, when the patient has been stabilized, transfer to an appropriate treating facility will be initiated. A patient that cannot be medically stabilized in the ED setting will be admitted as an inpatient and case management referral will be called.
- 312 The Hospital and its Medical Staff believes that all individuals have a right to work in an environment free of harassment, and has implemented policies to protect individuals in the facility from sexual and other forms of harassment. An individual who observes or has been the victim of conduct that constitutes harassment should report the incident to his supervisor, the Human Resource Department, a member of management, or the facility Ethics and Compliance Officer. When the incident involves a member of the Medical Staff or Allied Health Professional Staff, the Chief of Staff of the Medical Staff should be informed. Investigation and follow up action shall be in accordance with the provisions of the Hospital's policies and procedures on harassment, which shall be approved by the Medical Staff Executive Committee.

313 When an incident report or written complaint is filed which raises a question with regard to a physician's competence, the quality of care being provided or personal relationships the involved physician will be notified promptly. Such notification and any resulting investigation shall be conducted in accordance with the provisions of the Policy for Informing Physicians of Incident Reports/Complaints, R.M. 2.3, that has been approved by the Medical Staff Executive Committee.

400 CONSULTATIONS

401 The Medical Staff establishes a mechanism for determining when consultation by a qualified specialist is required as outlined in Patient Care Policies and Procedures #PCC.24, Consultations, as approved by the Executive Committee.

402 All members of the medical staff, including physicians with Active, Courtesy, and Consulting privileges, shall be required to provide medical consultation in the facility in a timely fashion. This will be in keeping with the accepted standards and principles of good medical practice in the community. This shall include both Emergency Department and inpatient requests for consultation. Refusal to provide medical consultation to a patient upon request from the attending and/or emergency department physician may be reported to the Department Chairman and/or Chief of Staff. Based on their evaluation of this event, further evaluation and/or action as per Article IX of the Medical Staff Bylaws may ensue.

403 An individual practitioner shall obtain consultation from another licensed independent practitioner who possesses the requisite privileges to admit, treat, or manage a patient whose needs exceed the attending practitioner's individual's privileges.

404 All patients admitted to the Intensive Care Units will have an automatic consult with the Acute Care Specialists of Fort Myers for intensive care management.

405 Children under age 14 who are admitted to a critical care unit will have a pediatric consultant available. Consultation may be obtained at the discretion of the attending physician.

406 A practitioner should seek consultation if requested by or on behalf of the patients; 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.

407 A second opinion may be requested by the patient, next of kin and/or legal guardian.

408 It is the responsibility of the attending physician to honor the second opinion request. A second opinion cannot be given by a physician from the same group unless patient or surrogate is aware.

409 The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written; authorization to permit another attending practitioner to attend or examine his patient, except in an emergency.

500 EMERGENCY SERVICES

501 The Hospital is equipped to render emergency resuscitative and life-support medical services for anyone under the care of one of our Medical Staff practitioners.

- 502 Appointees to the Medical Staff shall share in the responsibility for providing physician coverage on an emergency basis in the Emergency Department in accordance with the provisions of the Medical Staff Bylaws. Physicians who are on call in the Emergency Department shall respond to a call/page from the emergency physician on duty in the Emergency Department within thirty (30) minutes. Each department/specialty shall adopt its own set of criteria and parameters to provide this coverage. Those specialties which rotate call on a daily rather than case basis will be responsible for developing, maintaining (including notification of any/all changes) and distributing their ED call schedule on a monthly basis. The Executive Committee shall intervene if a particular department/specialty fails to provide adequate coverage. This applies to all members of the medical staff, including those with Active, Courtesy, and Consulting privileges as necessary to provide and maintain adequate Emergency Department coverage.
- 503 Follow-up care with the appropriate on-call physician will be assigned for patients who have no private physician based on the discretion of the Emergency Department physician. The on-call physician is obligated to accept and see for at least one (1) follow-up visit all patients referred to him by the Emergency Department. This visit must occur within a time frame commensurate with the severity of the illness.
- 504 An appropriate medical record shall be kept for every patient receiving emergency service and it shall be incorporated in the patient's hospital record, if such exists. The record shall include:
- a. Adequate patient identification.
 - b. Information concerning the time of the patient's arrival, means of arrival and by whom transported
 - c. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the Hospital
 - d. Description of significant clinical, laboratory and roentgenologic findings
 - e. Diagnosis
 - f. Treatment given
 - g. Condition of the patient on discharge or transfer
 - h. Final disposition, including instructions given to the patient and/or family, relative to necessary follow-up care
- 505 Each patient's medical record shall be signed by the practitioner in attendance who is responsible for its clinical accuracy.
- 506 The Medical Staff shall assist in providing practitioner coverage in time of a disaster. The care of mass casualties will be based upon the Hospital's capabilities in conjunction with other emergency facilities in the community. All policies concerning direct patient care will be a joint responsibility of the departmental chairman and the Chief Executive Officer.
- 507 A Medical Screening Examination is the process required, under the provisions of Federal and State law, to reach, with reasonable clinical confidence, the point at which it can be determined whether or not an emergency medical condition exists or a woman is in labor. Such screening must be done within the facility's capabilities and available personnel, including on-call physicians. The medical screening examination is an ongoing process and the medical records

must reflect continued monitoring based on the patient's needs and continuing until the patient is either stabilized or appropriately transferred.

The Hospital deems the Emergency Physicians and the Physician Assistants contracted by the Emergency Physician Group to be qualified medical professionals for the purpose of providing appropriate medical screening examinations.

600 **DEPARTMENT OF ANESTHESIA**

601 The Department of Anesthesia shall meet at least annually at a time and place designated by the Department Chairman.

602 The Department of Anesthesia shall consist of all anesthesiologists.

603 All Active and Provisional Active Medical Staff appointees assigned to the Department of Anesthesia shall be encouraged to attend department meetings.

604 The officers of the Department shall be:

- (a) A Chairman, whose qualification, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
- (b) A Vice-Chairman, whose qualification, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.

605 Only Active Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those Active appointees present and voting except on recommendations for advancement, discipline or expulsion, which will require a two-thirds (2/3) majority of those present and voting with a quorum present. A quorum will be defined as thirty (30) percent of the Active appointees of the Department.

700 **DEPARTMENT OF MEDICINE**

701 The Department of Medicine shall meet at least annually-at a time and place designated by the Department Chairman.

702 The Department of Medicine shall consist of all recognized medical specialists, and shall include psychologists.

703 If specialists desire to form a specialty section within the Department of Medicine, they may do so with the approval of the Executive Committee. A chairman shall be elected and meetings will be held at least annually. Minutes of specialty section meetings will be taken and forwarded to the Chairman of the Department of Medicine. The appointees of the specialty department shall attend regularly scheduled Department of Medicine meetings.

704 All Active and Provisional Active Medical Staff appointees assigned to the Department of Medicine shall be encouraged to attend all meetings.

705 The officers of the Department shall be:

- a. A Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
 - b. A Vice-Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
- 706 Only Active Medical Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those Active appointees present and voting except on recommendations for advancement, discipline or expulsion, which will require a two-thirds (2/3) majority of those present and voting with a quorum present. A quorum will be defined as thirty (30) percent of the Active appointees of the Department.
- 707 Practitioners admitting patients shall be responsible for issuing proper orders and the information necessary to protect the patient and other patients in cases where any danger exists.
- 708 Medical Staff coverage of the Emergency Department by practitioners assigned to the Department of Medicine shall be provided as follows:
- a. A rotating call list of Internal Medicine and Family Practice shall be maintained for patients who do not have a family physician with admitting privileges. All other specialties and subspecialties shall maintain their own specialty call rotation.
 - b. Physicians maintaining "Hospitalist" privileges shall be exempted from the call rotation as they do not maintain an office practice for patient follow-up and their primary responsibility is coverage of patients while in the hospital setting.
 - c. Any physician on the call list is responsible for taking his own call for at least the first year. After one (1) year that physician is responsible for filling his obligation by either taking the call himself or arranging in writing with another appointee to fulfill the obligation.
 - d. No single physician shall be listed on the call list greater than thirteen (13) percent of the total call list at anytime.
 - e. When a patient's condition requires a specialist, the patient's attending physician or the patient will be given the choice of which specialist to be called. The exception would be the emergency situation when on-call specialist is called first.
- 709 EKG's kept in physician boxes greater than forty-eight (48) hours are to be taken out of the physician boxes and given to the EKG panel.

800 DEPARTMENT OF PEDIATRICS

801 The Department of Pediatrics shall meet at least quarterly at a time and place designated by the Department Chairman

802 The Department of Pediatrics shall consist of all recognized specialists who limit their practice to Pediatrics.

803 If six (6) or more specialists desire to form a specialty section within the Department of Pediatrics, they may do so with approval of the Executive Committee. A Chairman will be elected and meetings will be held at least annually. Minutes of specialty section meetings will be taken and forwarded to the Chairman of the Department of Pediatrics. The appointees of the specialty department shall attend regularly scheduled Department of Pediatrics meetings.

804 All Active and Provisional Active Medical Staff appointees assigned to the Department of Pediatrics shall be encouraged to attend all meetings.

805 The officers of the Department shall be:

a. A Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.

b. A Vice Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.

806 Only Active Medical Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those Active appointees present and voting except on recommendations for advancement, discipline or expulsion, which will require a two-thirds (2/3) majority of those present and voting with a quorum present. A quorum will be defined as thirty (30) percent of the Active appointees of the Department.

807 Physicians will cooperate with the pre-admission review requirements for CMS.

808 Physicians admitting patients will be responsible for issuing proper orders and information necessary to protect the patient and other patients in cases where danger exists.

809 All pediatric subspecialties will be required to follow the Medical Staff Rules and Regulations defined under the Department of Surgery related to their specialties.

900 DEPARTMENT OF OBSTETRICS/GYNECOLOGY

901 The Department of Obstetrics/Gynecology shall meet at least quarterly at a time and place designated by the Department Chairman

902 The Department of Obstetrics/Gynecology shall consist of all recognized specialists who limit their practice to Obstetrics/Gynecology.

903 If six (6) or more specialists desire to form a specialty section within the Department of Obstetrics/Gynecology, they may do so with approval of the Executive Committee. A Chairman will be elected and meetings will be held at least annually. Minutes of specialty section meetings will be taken and forwarded to the Chairman of the Department of Obstetrics/Gynecology. The appointees of the specialty department shall attend regularly scheduled Department of Obstetrics/Gynecology meetings.

- 904 All Active and Provisional Active Medical Staff appointees assigned to the Department of Obstetrics/Gynecology shall be encouraged to attend all meetings.
- 905 The officers of the Department shall be:
- c. A Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
 - d. A Vice Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
- 906 Only Active Medical Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those Active appointees present and voting except on recommendations for advancement, discipline or expulsion, which will require a two-thirds (2/3) majority of those present and voting with a quorum present. A quorum will be defined as thirty (30) percent of the Active appointees of the Department.
- 907 Physicians admitting patients will be responsible for issuing proper orders and information necessary to protect the patient and other patients in cases where danger exists.
- 908 ABORTIONS:
- A. It shall be the policy of the Hospital that interruption of pregnancy by a physician performing or in charge of the procedure shall be in accordance with the following:
 - 1. Incomplete spontaneous abortion shall require medical indications as evaluated by a physician appointee to the Medical Staff.
 - 2. Therapeutic abortions performed in the first trimester shall be at the request of the patient and with the approval of her physician.
 - 3. Therapeutic abortions performed in the second trimester:
 - a. Vaginal approach, including hypertonic solution induction, shall require consultation with two (2) physician appointees to the Medical Staff.
 - b. Abdominal approach shall require consultations with (2) physician appointees to the Medical Staff.
 - 4. Therapeutic abortions in the third trimester shall not be performed.

1000 DEPARTMENT OF RADIOLOGY

- 1001 The Department of Radiology shall meet at least annually at a time and place designated by the Department Chairman.
- 1002 The Department of Radiology shall consist of physicians credentialed for radiological interpretation and procedures, including use of the department equipment and facilities.
- 1003 All Active and Provisional Medical Staff appointees assigned to the Department of Radiology shall be encouraged to attend all department meetings.

- 1004 The officers of the Department shall be:
- (c) A Chairman, whose qualification, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
 - (d) A Vice-Chairman, whose qualification, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
- 1005 Only Active Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those Active appointees present and voting except on recommendations for advancement, discipline or expulsion, which will require a two-thirds (2/3) majority of those present and voting with a quorum present. A quorum will be defined as thirty (30) percent of the Active appointees of the Department.

1006 The Radiology Call list will be maintained in the Radiology Department, and will be available when needed.

1100 DEPARTMENT OF SURGERY

- 1101 The Department of Surgery shall meet at least annually at a time and place designated by the Department Chairman.
- 1102 The Department of Surgery shall consist of all recognized surgical specialists, dentists and podiatrists.
- 1103 If specialists desire to form a specialty section within the Department of Surgery, they may do so with the approval of the Executive Committee. A chairman shall be elected and meetings will be held at least annually. Minutes of specialty section meetings will be taken and forwarded to the Chairman of the Department of Surgery. The appointees of the specialty department shall attend regularly scheduled Surgery Department meetings.
- 1104 All Active and Provisional Active Medical Staff appointees assigned to the Department of Surgery shall be encouraged to attend all Department and specialty section meetings.
- 1105 The officers of the department shall be:
- a. A Chairman, whose qualifications, selection tenure and functions will be as specified in the Medical Staff Organizational Policies.
 - b. A Vice-Chairman, whose qualifications, selection, tenure and functions will be as specified in the Medical Staff Organizational Policies.
- 1106 Only Active Staff appointees are eligible to vote at Department meetings. All actions of the Department will be decided by majority vote of those Active appointees present and voting except on recommendations for advancement, discipline or expulsion, which will require a two-thirds (2/3) majority of those present and voting with a quorum present. A quorum is defined as thirty (30.) percent of the Active appointees of the Department.

- 1107 All tissue removed at surgery shall be referred to the Hospital's pathologist for interpretation except those tissues specifically addressed in the patient Care Policy #27 as approved by the Executive Committee. All tissue removed at surgery and all specimens from patients will be the property of the Hospital.
- 1108 The Department of Surgery shall be responsible for tissue review. This tissue review shall include an evaluation of preoperative and postoperative diagnoses, the indications for surgery, and actual diagnosis of tissue removed at surgery. Similar review shall be performed with respect to those situations in which no tissue was removed at the time of surgery.
- 1109 All operations shall be scheduled by the attending surgeon with the operating room supervisor whenever possible. The surgeon must be in the operating room and ready to begin surgery at the time scheduled. The operating room will not be held longer than fifteen (15) minutes after the time scheduled. The case will be placed at the end of the schedule or must be rescheduled.
- 1110 In case of major elective surgery where it is deemed there is an unusual hazard to life, there shall be another appointee in the Department of Surgery as an assistant. The surgical assistant may also be an Allied Health Professional who has been credentialed as a surgical assistant.
- 1111 Only members of the medical, dental, podiatric and nursing professions involved in the case may be present in any of the operating rooms during the performance of an operation without specific permission of the attending practitioner, attending anesthesiologist (if involved) and Director of OR/PAC.
- 1112 All appointees to the Medical Staff and all visitors shall abide by the rules for prevention of explosion hazards and the sterility rules of the surgical suites.
- 1113 Dentist appointees with privileges in general practice shall perform all procedures, which by local custom and periodic review by the Department of Surgery fall into the realm of the general practice of dentistry with the following limitations:
- a. Periodontics: Those dental staff appointees with privileges in general practice shall be limited to those surgical procedures necessary for the completion of restorations on the individual teeth that are being treated at the time.
 - b. Oral Surgery: Those dental staff appointees with privileges in general practice shall not be permitted to remove more than two erupted teeth per quadrant or any bone impactions.
- 1114 Privileges in all recognized specialties of dentistry shall be limited to those dentists who are certified by the appropriate specialty boards, or who have completed approved residency training programs.
- 1115 Qualified oral surgeons who admit patients without medical problems may perform the history and physical examinations on those patients if they have such privileges, and may assess the medical risk of the proposed surgical procedure. For this provision, non-physician members of the Medical Staff shall be identified as dentists and podiatrists. Non-physician members of the

Medical Staff are granted privileges to admit patients to inpatient services provided consultation is made for medical evaluation of these patients by a qualified physician.

- 1116 Medical Staff coverage of the Emergency Department by practitioners assigned to the Department of Surgery shall be provided as follows:
- a. A rotating call list shall be maintained for patients who do not have a physician in accordance with the provisions of the Medical Staff Bylaws.
 - b. Any physician on the call list is responsible for filling his obligation by either taking the call himself or arranging with another appointee to fulfill the obligation.
 - c. When a patient's condition requires a specialist, the patient's attending physician will be given the choice of specialist to be called, except in emergency situations when an on-call specialist is called first.
 - d. All Provisional and Active Staff general surgeons are required to take at least three (3) shifts of day call and three (3) shifts of evening/weekend call per month. A general surgeon may be relieved from Emergency Department call responsibility, upon written request, after ten (10) years of service.
 - e. All Provisional and Active Staff vascular surgeons are required to take at least three (3) shifts of day call and three (3) shifts of evening/weekend call per month. A vascular surgeon may be relieved from Emergency Department call responsibility, upon written request, after twenty-five (25) years of service.

1200 ISOLATION POLICY

- 1201 To prevent the spread of communicable diseases within the Hospital, special procedures shall be followed for patients with these diseases. Isolation procedures shall be designed to interrupt the transmission of infection according to the epidemiology of specific disease processes.
- 1202 The extent of isolation shall be determined according to the guidelines set up in the current manual, "CDC Guidelines for Isolation Precautions in Hospitals." In that it is safer to "over isolate" than "under isolate" in questionable cases, the more stringent category shall be used until a definitive diagnosis has been established, general isolation techniques shall be performed according to procedures as outlined in the Infection Control Manual of Gulf Coast Hospital.
- 1203 The practitioner shall be responsible for identifying patients who may have an infectious process upon admission.

1300 PROVISIONAL STAFF REVIEW

- 1301 Provisional Medical Staff appointees shall be assigned to a specific clinical department where their performance will be monitored through the quality improvement process. Each provisional appointee will be placed on one-hundred percent (100%) retrospective review for his/her first twelve (12) patient contacts, with quarterly reports to the appropriate medical Staff Peer Review Committee.

1302 If the Provisional appointee's case load at the Hospital is inadequate to meet the requirements of this Section, the Provisional status may be extended for one (1) additional year unless the Board, upon recommendation of the Executive Committee, determines such extension is inappropriate.

1400 SAFETY & DISASTER

1401 The Emergency Codes at Gulf Coast Hospital include:

Code Black	=	Bomb Threat
Code Blue	=	Cardiac/Respiratory Arrest
Code Brown	=	Severe Weather
Code Green	=	Mass Casualty
Code Grey	=	Violence/Security Alert
Code Orange	=	Hazmat/Bioterrorism
Code Pink	=	Infant/Child Abduction
Code Red	=	Fire (Follow R.A.C.E.)
Code White	=	Hostage
Code Yellow	=	Lockdown

1402 Fire

- A. Familiarize yourself with the location of fire exits and fire alarm pull stations, and with evaluation routes.
- B. Familiarize yourself with the medical facility's Code Red fire plan formula (R.A.C.E.)
 - R - Rescue (remove from danger)
 - A - Alarm (call Extension 3333)
 - C - Contain (close doors, turn off appliances, etc.)
 - E - Extinguish or Evacuate
- C. To report a fire, call 3333, alert a hospital employee, or pull the nearest fire alarm pull station to activate the alarm.
- D. Assist the staff in taking measures to protect the patients as requested by the individual in charge of the area or the Safety Officer.
- E. In the event of a fire alarm, remain in the area where you are presently located until the "all clear" is given by overhead page.
- F. Do not use elevators once the alarm has sounded.

1403 Internal/External Disaster

- A. Implementation of Disaster Emergency privileging will be in accordance with Article IV, Part C, Section 2.c. Temporary Clinical Privileges for Non-Applicants – Temporary Disaster Privileges
- B. There shall be a plan (Disaster Plan which is located in the Safety Manual on each unit) for the care of mass casualties at the time of any major disaster, based upon the hospital's

capabilities in conjunction with other emergency facilities in the community. The plan is the responsibility of the safety director and all updating and distribution will be made through his office. The plan shall be reviewed and approved by the medical staff.

C. In time of disaster, the Emergency Physician on duty shall be the chief medical officer. All physicians present in the hospital will report to the Control Center (Administrative Conference Room) for assignment. The coordination of all physician services during a disaster will be the responsibility of the Control Center.

D. The disaster plan shall be rehearsed at least twice a year and will involve the medical staff, as well as administrative, nursing and other hospital personnel.

Adopted by the Medical Staff on September 24, 2003
Revisions approved by the Governing Board:

Rules & Regulations revisions:

April 26, 2005
October 31, 2005
November 30, 2005
September 27, 2006
February 22, 2007
January 31, 2008
April 24, 2008
August 11, 2008
January 29, 2009