

## GULF COAST MEDICAL CENTER RULES AND REGULATIONS

### 100     ADMISSION AND DISCHARGE OF PATIENTS

- 101    Although the medical services at the Gulf Coast Medical Center are available to the general public, the Medical Center need not accept all patients except for emergencies who apply for care and treatment.
- 102    A patient may be admitted to the Medical Center only by an appointee to the Medical Staff. All practitioners shall be governed by the official admitting policy of the Medical Center.
- 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 Medical Center, 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 Medical Center 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 Medical Center 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    Admission of patients with a local PCP:
1.       This policy pertains to those patients requiring admission for general medical care.
  2.       This policy applies to primary care physicians (PCPs), NOT to subspecialists who do not provide primary care services.
  3.       If a PCP practicing in Lee County does not practice in the hospital setting he or she must have an agreement with a physician on the medical staff to provide inpatient services.
  4.       The PCP is required to notify the Medical Staff Office, in writing, who will provide inpatient services to patients requiring admission to LMHS facilities. The PCP must specify both the campus and admitting physician.
  5.       The Medical Staff Office is to maintain a list of all PCPs and who will provide inpatient care for their patients.
  6.       The Medical Staff Office is to provide a copy of this list to all Emergency Department (EDs) that are a part of LMHS.
  7.       This list is to be updated quarterly and presented to the emergency Departments, with any revisions, on a quarterly basis.
  8.       PCPs can change who admits their patients on a quarterly basis. This request must be made in writing. Changes can be made only by the PCP.
  9.       The Emergency Departments are to ask each patient, at each encounter, to identify their PCP.
  10.      When a patient requires admission to the hospital for a general medical problem, the ED is to reference this list and contact the appropriate physician to arrange for inpatient admission.
  11.      If a patient request a different admitting physician than the one designated as above, the patient may be admitted to the physician requested if the physician agrees.

- 108 Unassigned medical patients presenting to the Emergency Department within 30 days of discharge for the same condition shall be assigned to the discharging physician.
- 109 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.
- 110 In a case in which it appears the patient will have to be admitted to the Medical Center, the practitioner shall, when possible, first contact the Admitting Department to ascertain whether there is an available bed.
- 111 Each practitioner must assure timely, adequate professional care for his patients in the Medical Center 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 Medical Center. Failure of an attending practitioner to meet these requirements shall result in loss of clinical privileges.
- 112 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.
- 113 The policy of this Medical Center 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
- 114 Assignment of patients will be in accordance with the Medical Center 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.
- 115 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.
- 116 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.
- 117 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. The decision to triage patients to the Intensive Care Units, when a bed shortage directly affects patient care, be given to the Intensivists.
  - c. Each attending physician will have an alternate to provide the patient with continuous medical care.
  - d. 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.
  - e. 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.
  - f. Organ donation procurement agency will be contacted when appropriate.

118 All patients admitted to the Intensive Care Units, followed by Critical Care Intensivist, will have a co-signature by a Critical Care Intensivist for sedatives and narcotics, prior to initiation. Those physicians consulted for pain management will be exempt from the co-signature by the Critical Care Intensivist

119 Upon admission of patients being cared for by hospitalist or primary care provider physicians to the ICU, the care of the patient shall become the responsibility of the Intensivist physicians. The care permitted by the hospitalists during the time the patient is in the ICU will be limited to transfer orders (in and out of the ICU) and consultations. All other orders during the ICU stay will be the responsibility of the Intensivist and the specialists that choose to manage their specific ICU care issues.

120 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 Medical Center.
- 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.

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

122 In the event of a Medical Center 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.

123 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.

124 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 continuing 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.

125 Pregnant patients whose fetus is of 20 weeks or greater gestational age, will be admitted by their primary obstetrician/gynecologist (or the Emergency Department on-call obstetrician if the patient is unassigned) regardless of their diagnosis. Pregnant patients presenting with non-obstetrical conditions whose fetus is of gestational age of less than 20 weeks, will be admitted to the appropriate medical or surgical physician according to the presenting diagnosis (i.e. acute appendicitis will be admitted to surgery and asthma exacerbation will be admitted by general medicine). If fetal age is unable to be determined by interviewing the patient or calculating estimated date of confinement based on the first day of last menstrual period, ultrasound may be ordered to determine fetal age. All consultations ordered for pregnant women are mandatory. The consulted physician is required to evaluate and treat the patient, and if requested by the attending physician, follow the patient until the time of her discharge from the hospital. This applied to ALL physician actively practicing in LMHS hospitals.

## **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, and 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 written or dictated admission history and physical examination shall be performed within twenty-four (24) hours after admission or prior to surgery, whichever comes first. A history and physical shall be completed on inpatients and all patients undergoing outpatient/inpatient surgeries or 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, 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 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 pre-anesthesia 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 current medical record keeping system.

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 and HBO 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 LMHS Patient Care Policy and Procedure Manual #M03-05-811.
- 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 A pre-anesthesia evaluation must be performed for each patient who received general, regional or monitored anesthesia. The evaluation must be performed by someone qualified and credentialed to administer anesthesia. The pre-anesthesia evaluation must be performed within 48 hours prior to any in-patient or outpatient surgery or procedure requiring anesthesia services. The pre-anesthesia evaluation of the patient includes, at a minimum: Review of the medical history, including anesthesia, drug and allergy history, interview and examination of the patient, notation of anesthesia risk according to established standards of practice (e.g., ASA classification of risk), identification of potential anesthesia problems (i.e., difficult airway, ongoing infection, limited intravascular access), additional pre-anesthesia evaluation (i.e., additional specialist consultation, tests) and development of the plan for the patient's anesthesia care, including the type of medications for induction, maintenance and post-op care and discussion with the patient (or patient's representative) of the risks and benefits of the delivery of anesthesia. There must be an intra-operative anesthesia record or report for each patient who receives general, regional or monitored anesthesia. The record, at a minimum, includes: Name and hospital identification number of the patient, names of practitioners who administered anesthesia and as applicable, the name of the supervising anesthesiologist or operating practitioner, techniques used and patient position, including the insertion/use of any intravascular or airway devices, name and amounts of IV fluids, including blood or blood products if applicable, time-based documentation of vital signs as well as oxygenation and ventilation parameters, and any complications, adverse reactions, or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient's response to treatment. A post-anesthesia evaluation must be completed and documented no later than 48 hours after surgery or a procedure requiring anesthesia services. The evaluation is required at any time general, regional, or monitored anesthesia has been administered to the patient. The evaluation must be completed and documented by any practitioner who is qualified to administer anesthesia. The calculation of the 48 hour time frame begins at the point the patient is moved in the designated recovery area. The evaluation may not begin until the patient is sufficiently recovered from the acute administration off the anesthesia so as to participate in the evaluation. The elements of the post-anesthesia evaluation should be documented, including: Respiratory function (including respiratory rate, airway patency, and oxygen saturation), cardiovascular function (including pulse rate and blood pressure), mental status, temperature, pain, nausea and vomiting, and post operative hydration.

- 211 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.
- 212 All clinical entries in the patient's medical record shall be legible, accurately dated, timed and authenticated.
- 213 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 Health Information Management Department and copies will be available in the patient care units.
- 214 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.
- 215 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. All Medical Center deaths shall have a dictated death summary.
- 216 Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.
- 217 Records may be removed from the Medical Center's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Medical Center 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 is attended by the same practitioner or by another. Unauthorized removal of charts from the Medical Center is grounds for suspension by the Executive Committee of the Medical Staff.
- 218 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 Administrative Officer or authorization of the attending practitioner.
- 219 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 Administrative 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 Medical Center.
- 220 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.
- 221 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 Health Information Management Department.
- 222 The patient's medical record shall be completed within thirty (30) days of discharge. If the medical record remains incomplete on the thirtieth (30<sup>th</sup>) day after discharge, it will be considered delinquent and Health Information Management (HIM) will notify the practitioner.

- a. 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 practitioners 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.
- b. 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.
- c. "Administrator on Call" is responsible for supporting the loss of privileges and may grant limited exceptions when appropriate.
- d. 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 the Medical Staff membership and privileges. Ratification will be done in the same manner as other corrective actions pursuant to the Medical Staff Bylaws. Health system counsel will determine whether such action is reportable to the Agency for Healthcare Administration.
- e. A practitioner whose Medical Staff membership and privileges are terminated may appeal, in writing, in accordance with the fair hearing procedure outlined in the Medical Staff Bylaws.
- f. Practitioners terminated for delinquent medical records will be required to reapply to be reinstated to the Medical Staff.
- g. All incomplete charts must be completed before being granted an application for reinstatement.
- h. 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.
- i. This rule may be administered in accordance with a policy and procedure established by the Executive Committee.
- j. 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.

**300 GENERAL CONDUCT OF CARE**

- 301 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, or surgical/invasive procedure or blood transfusion shall be obtained by the practitioner. Prior to beginning the procedure or blood transfusion, the practitioner shall document the fact that he/she obtained the patient's informed consent by:
  - a. signing, dating and timing the appropriate section of the Operative and Invasive Procedure Consent form; or
  - b. dictating the documentation into the history and physical examination or in a consultation report; or
  - c. 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 M03-03-922, Verbal Orders, 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 #RI.03.00, Advance Directives, and M03-01-768, Restraints-Patient Safety, as approved by the Medical Executive Committee. All other verbal orders shall be countersigned by a practitioner responsible for the care of the patient within forty-eight (48) hours. Failure to do so shall be brought to the attention of the Executive Committee of the Medical Staff for appropriate action. 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 Medical Center 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 Medical Center'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 in-patient and case management referral will be called.
- 312 The Medical Center 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 President of the Medical Staff should be informed. Investigation and follow up action shall be in accordance with the provisions of the Medical Center'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, which 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 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.
- 403 All patients admitted to the Intensive Care Units will have an automatic consult with the Intensive Care Specialists for Intensive Care management.
- 404 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.
- 405 A second opinion may be requested by the patient, next of kin and/or legal guardian.
- 406 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.
- 407 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.

**(NOTE: Dept. Rule & Regulations removed – this is why rule #s skip frm 400 to 1300)**

**1300 ISOLATION POLICY**

- 1301 To prevent the spread of communicable diseases within the Medical Center, 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.
- 1302 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 Medical Center.
- 1303 The practitioner shall be responsible for identifying patients who may have an infectious process upon admission.

**1400 PROVISIONAL STAFF REVIEW**

- 1401 Provisional Medical Staff appointees shall be assigned to a specific clinical department where their performance shall be observed by the Chairman of the Department.
- 1402 Each provisional appointee will be evaluated through the CQI process (Physician Quality Committee) to determine the eligibility of such appointees for advancement to Active Medical Staff appointment and for exercising the clinical privileges provisionally granted to them.
- 1403 Each provisional appointee will be placed on one hundred (100) percent retrospective review for his first twelve (12) patient contacts, with reports to the Department Chairman for review and evaluation at reappointment or more often, as needed.
- 1404 If the provisional appointee's caseload at the Medical Center is inadequate to meet the requirements of this Section 1200, his provisional status may be extended for one (1) additional year, unless the Governing Board, after receiving the recommendation of the Executive Committee, determines such extension is inappropriate. The maximum length of time an appointee is permitted to retain the provisional status shall be two (2) years. Failure to advance to Active, Courtesy or Consulting Medical Staff status after twenty-four (24) months shall result in automatic termination from the Medical Staff.

**1500 SAFETY & DISASTER**

1501 The Emergency Codes at Gulf Coast Medical Center include:

Code Black	=	Bomb Threat
Code Blue	=	Cardiac/Respiratory Arrest
Code Brown	=	Severe Weather/Tornado Alert
Code Green	=	Mass Casualty Incident
Code Grey	=	Violence/Security Alert
Code Orange	=	HazMat/BioTerrorism Incident
Code Pink	=	Infant/Child Abduction
Code Red	=	Fire (Follow R.A.C.E.)
Code White	=	Hostage Situation
Code Yellow	=	Facility Lockdown
Nurse STAT	=	Medical Emergency/Inquiry
Manpower STAT	=	Additional Personnel Needed

1502 Fire

- A. Familiarize yourself with the location of fire exits and fire alarm pull stations, and with evacuation 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.

1503 Internal/External Disaster

- A. Implementation of Disaster Emergency Privileging will be in accordance with Part III Credentialing Procedures, Section 7.7.8 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 physicians lounge for assignment. The coordination of all physician services during a disaster will be the responsibility of the Medical Staff Services.
- 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 the 28<sup>th</sup> day of November 2005**  
**Revisions approved by the Governing Board:**

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