SHANDS AT UF CAMPUS

MEDICAL STAFF RULES AND REGULATIONS

As Adopted by Shands Teaching Hospital and Clinics, Inc.
Board of Directors, July 1, 1998

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Shands at UF Campus
RULES AND REGULATIONS
OF THE MEDICAL STAFF

PREAMBLE

In compliance with Shands Teaching Hospital and Clinics, Inc. ("STHC") statutory mandate, the Shands at UF campus is maintained as the primary teaching hospital for the University of Florida Health Science Center colleges. In addition to providing quality patient care, the mission of the Shands at UF campus is to support the educational activities of the colleges of the Health Science Center, and to support and promote research related to the care of the sick and injured. When treating patients at the Shands at UF campus, the practice of all members of the Shands at AGH/UF Medical Staff will be subject to policies implemented to ensure the priority of the education and research mission of the campus.

ARTICLE I - MEDICAL STAFF OPERATIONS COMMITTEE

Section 1. **Composition**

The Committee shall consist of the Chair of the Operations Committee, the Associate Chair for Housestaff Affairs, the Chair of each of the Clinical Departments designated in Article II, Section 1, the Chief Executive Officer of STHC ("the CEO"), or designee, the Deans and the Executive Associate Deans of the Colleges of Medicine and Dentistry, the Senior Associate Deans of the College of Medicine, the Associate Dean for Clinical Affairs of the College of Dentistry, the Vice President of Nursing of Shands at UF, one representative from the College of Public Health and Health Professions and the College of Pharmacy, the Chair of the UF Department of Community Health and Family Medicine, and the Chair of the Rehabilitation Medicine Committee. The committee shall meet as required to perform its assigned functions and shall maintain a permanent record of its proceedings and actions.

Section 2. **Duties**

In support of the Medical Executive Committee ("MEC") and in fulfilling those duties outlined in the Shands at AGH/UF Bylaws, the Shands at UF Medical Staff Operations Committee shall assure that the following medical staff functions are performed:

a. Oversight for the following clinical quality functions

1. Monitoring indicators related to clinical care, as evidenced by performance in comparison to appropriate benchmarks (e.g. University HealthSystem Consortium, Centers for Medicare and Medicaid Services, Agency for Health Care Administration, Joint Commission, National Surgical Quality Improvement Program);

2. Establishment of quality, safety, and patient satisfaction priorities and accountabilities for inpatient care;

3. Approval and implementation of action plans developed by interdisciplinary teams;

4. Removal of barriers to implementation of action plans developed by interdisciplinary teams;

5. Review of ongoing results related to action plans and quality priorities and report to the MEC;

6. Resolution of issues identified by the Shands at UF campus medical staff committees and report to the MEC;

7. Communication of decisions and outcomes to the MEC for report to the Shands HealthCare Quality Safety Evaluation Committee (QSEC).

b. Provide oversight for the following Medical Staff operational functions:

1. Participate in the establishment of patient care priorities and long-term goals as related to patient care within the clinical setting at the Shands at UF campus, and advise the CEO, or designee, on campus priorities, including, recommendations on total numbers of housestaff positions, bed allocations, and staffing ratios for the clinical units.

2. Assist, and make recommendations where appropriate, in dealing with medicolegal affairs, long-range budgeting, facility planning, quality assurance and improvement recommendations from department and medical staff committees, and similar related functions.

3. Assure proper professional conduct on the part of all members of the medical staff, and initiate or participate in corrective action when warranted.

4. Implement and enforce the approved policies of the medical staff on the SUF campus.

Section 3. **Chair/Assistant Chair**

a. The Chair will be appointed jointly by the CEO, or designee, and the Dean of the College of Medicine, with confirmation by the Board of Directors. The term of appointment will be two years with the option of reappointment.

b. An Assistant Chair may be appointed in like manner. The Assistant Chair shall assist the Chair in carrying out the responsibilities designated below, and shall be empowered to act for the Chair in his or her absence. The term of appointment will be two years with the option of reappointment. The appointment may be terminated at any time by mutual consent of the Chair, the Dean of the College of Medicine, and the CEO, or designee.

Section 4. **Chair/Assistant Chair Responsibilities**

The Chair will be responsible for recommendations regarding the development and maintenance of standards of medical practice, for coordination of patient care at the campus, and for the

evaluation and supervision of such practice. In accomplishing these duties, the Chair may delegate responsibility and authority to appropriate individuals in defined patient areas to coordinate the delivery of patient care. Specific responsibilities shall be to:

a. Assist in coordinating the activities and concerns of the hospital administration and of the nursing and other patient care services with those of the Medical Staff.

b. Recommend, with appropriate consultation, to the UF Operations Committee, the Chairs and membership of the medical staff committees outlined in Article III.

c. Make recommendations, when appropriate, to the Credentials Committee regarding clinical privileges in the hospital, including methods of credentials review and mechanisms designed to assure the same level of quality of patient care by all individuals with delineated clinical privileges.

d. Develop rules and regulations relative to patient care.

e. Make recommendations to the MEC regarding the establishment of standards and measures of effectiveness in patient care by each of the respective health disciplines and the implementation of a coordinated patient care program, including review and analysis of the quality and efficiency of clinical services and performance and the effectiveness of patient care monitoring and evaluation activities.

f. Assist the CEO, or designee, in coordinating patient care through the Unit Chiefs who will have the responsibility for the assessment of patient care services.

g. Communicate and represent to the MEC, the opinions, policies, concerns, needs, and grievances of the Medical Staff.

h. Enforce Medical Staff Bylaws, Rules and Regulations, and implement sanctions when necessary and as appropriate.

i. Serve as a member of the MEC.

Section 5. **Associate Chair for Housestaff Affairs**

An Associate Chair for Housestaff Affairs shall be appointed jointly by the Chair of the Operations Committee, the CEO, or designee, and the Dean of the College of Medicine, with the approval of the Operations Committee and the Board of Directors. The appointment may be terminated at any time by mutual consent of the Chair, the Dean of the College of Medicine, and the CEO, or designee, with approval by the MEC and the Board of Directors.

The Associate Chair for Housestaff Affairs shall directly oversee the Housestaff Office in Shands at UF and shall serve as Chairperson of the Housestaff Advisory Group. This Group will serve an advocacy role for the housestaff's relations with Shands at UF. The Housestaff Office will consolidate the housestaff functions of the Chair's Office; will be a central source of information, advice,

and counseling; and will assist the Institutional Graduate Medical Education Committee in providing information for the Institutional Policy Review Document, needed to meet the General Requirements of the Accreditation Council for Graduate Medical Education.

Section 6. **Unit Chiefs**

Unit Chiefs will be appointed by the Chair of the Operations Committee after consultation with the respective department Chair . The Chair may terminate the appointment after consultation with the involved department Chair as appropriate. The Unit Chief will work with hospital staff to coordinate patient care service on the unit. In areas where appropriate, Co-Unit Chiefs may be appointed in the same manner.

ARTICLE II- CLINICAL DEPARTMENTS

Section 1. **Organization of Departments**

The following clinical departments shall be organized for the conduct of patient care: Anesthesiology, Dentistry, Emergency Medicine, Medicine, Neurology, Neurosurgery, Obstetrics/Gynecology, Ophthalmology, Orthopaedics, Otolaryngology, Pathology, Pediatrics, Psychiatry, Radiation Oncology, Radiology, Surgery and Urology. Each clinical department shall be organized as a separate part of the Medical Staff and shall have a Chair who shall be responsible for the overall supervision of the clinical work within the respective department.

Section 2. **Qualifications and Selection of Clinical Department Chairs**

a. Each Chair shall be a member of the active staff qualified by training, experience and demonstrated ability for the position. Each Department Chair shall be Board Certified by an appropriate specialty board, or shall establish comparable competence.

b. The Chair shall be recommended by the Dean of the College of Medicine or Dentistry as appropriate. The appointee will serve as the clinical department Chair in the hospital with the concurrence of the Operations Committee, MEC, and the Board of Directors.

Section 3. **Functions of the Clinical Department Chairs**

Each clinical department Chair is an essential element in the line of authority within the Medical Staff organization. As such, he/she shall be accountable to the Operations Committee and the MEC for the following:

a. The integration of the clinical and administrative activities of the department into the larger organization.

b. All clinically related activities of the department.

c. All administratively related activities of the department, unless otherwise provided for by the hospital.

d. Recommendations for the criteria for clinical privileges in the department's, area(s) of patient care; recommendations for clinical privileges of each member of the department and continuing surveillance of the professional performance of all individuals who have delineated clinical privileges in the department's area(s) of patient care. Chairs of staff members who provide trauma services shall seek the input from the Medical Director of the Trauma Service for forming this recommendation.

e. The determination of the qualifications and competence of department personnel who are not licensed independent practitioners and who provide patient care services.

f. The development and implementation of policies and procedures that guide and support the provision of services.

g. Recommendations for a sufficient number of qualified and competent persons to provide care/service.

h. The continuous assessment and improvement of the quality of care and services provided.

i. The assessment of, and recommendation to the relevant hospital authority regarding off-site sources for needed patient care services not provided by the department/service or the organization;

j. Maintenance of quality control programs, as appropriate.

k. The orientation and continuing education of all persons in the department or service.

l. Recommendations for space and other resources needed by the department or service.

Section 4. **Functions of Clinical Departments**

The functions of the clinical departments shall be to:

a. Implement and conduct specific peer review and evaluation activities that contribute to the preservation and improvement of the quality, appropriateness, safety and efficiency of patient care provided under the department, including providing for ongoing review of the quality and appropriateness of the care and treatment provided to patients served by the clinical department, and where appropriate, providing for surgical case review (for each surgical or medical division in which invasive procedures are performed), to continuously improve the selection and performance of surgical and other invasive procedures. Although reports of this review need not identify the names of physicians or patients discussed during the review, the department shall establish a tracking mechanism to identify the specific physician or ptient reviewed to facilitate any investigation or further review deemed appropriate by the Operations Committee, the MEC, the Quality Evaluation Committee, and/or the Board of Directors.

b. Submit written reports to the Operations Committee, through the Quality Evaluation Committee, concerning (1) findings of the department's review and evaluation activities, actions taken thereon, and the results of such action; and (2) recommendations for maintaining and improving the quality of care provided in the department and hospital.

ARTICLE III - ADDITIONAL MEDICAL STAFF COMMITTEES

The Chair of the Operations Committee shall triennially appoint the Chairs of all the Shands at UF Medical Staff Committees with the approval of the MEC, Chief Operating Officer, and the Board. Unless otherwise specified, the committees shall report to the Operations Committee. All appointments to the committees shall be made by the Chair of the Operations Committee upon recommendations made by the Committee and Department Chairs and Hospital Administration. Committee appointments shall be made for three-year staggered terms. Each Medical Staff committee shall submit an annual report of its activities to the Operations Committee in a prescribed format. Subcommittees may be established to assist the committee in meeting its duties and responsibilities. The Chairs and members of the subcommittees shall be appointed by the Committee Chair in the same manner as committees.

Section 1. **Cancer Committee**

a. **Membership**. This committee shall consist of at least representatives from Radiation Oncology, Medical Oncology, Pathology, Surgery, Nursing Services, Diagnostic Radiology, Patient and Family Resources, Hospice, Anesthesiology, Clinical Trials Office, Hospital Administration, Quality, Accreditation, and Licensure, and Tumor Registry.

b. **Duties and Responsibilities**. The Cancer Committee shall be concerned with the entire spectrum of care for cancer patients treated at the institution. It shall develop and evaluate annual goals and objectives for: the clinical, community outreach, quality improvement, and programmatic endeavors related to cancer care.

c. **Meetings**. This committee shall meet as often as necessary to fulfill its responsibilities, but at least four times a year as an entity separate from conferences. It shall submit a record of its activities which shall be submitted to the Operations Committee.

Section 2. **Code Blue Committee**

a. **Membership**. The committee shall consist of representatives including, but not limited to Medicine, Nursing, Pharmacy, Cardiopulmonary Services, and Risk Management.

b. **Duties and Responsibilities.** The Code Blue Committee shall have overall responsibility for providing a broadly understood, easily referenced institutional plan for Code Blue management. Specific responsibilities of the Code Blue Committee include the following:

1. To examine and determine the standards for code management including response and documentation;

2. To review, approve, and recommend hospital policies, procedures, and guidelines regarding emergency patient response issues;

3. To establish and evaluate standards for equipment used in Code Blue incidents;

4. To ensure ongoing emergency life support training for physicians, nurses, and other health care professionals, as appropriate; and,

5. To establish quality monitors and identify and implement improvements based on review of trends in codes, practices, outcomes, survival rates, and other relevant data.

c. **Meetings.** The committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year. It shall maintain a record of its activities.

Section 3. **Hospital Ethics Advisory Committee**

a. **Membership**. The committee shall function as a multi-disciplinary committee composed of physicians, nurses, and other individuals representing the staff in the hospital. Membership shall be made up of representatives from hospital services and/or clinical departments in which ethical issues are likely to arise.

b. **Duties and Responsibilities**. The committee's functions shall be:

1. Educational: The primary function is education of personnel on ethical issues involving patient care.

2. Consultation: Advisory consultations will be done on request, regarding issues of ethical concern. Requests will be channeled through the Chair of the Operations Committee and referred to the appropriate Ethics Committee consult team. Physicians, other members of the healthcare team or patient/family members may request a consult.

3. Policy Reviews: The committee may review and advise regarding ethical matters in the policies of the Hospital.

c. **Meetings**. The committee shall meet as often as necessary to fulfill its responsibilities, but at least four times a year. It shall maintain a record of its activities.

Section 4. **Human Use of Radioisotopes and Radiation Committee**

a. **Membership**. This committee shall consist of at least four representatives from the medical staff, the Radiation Control officers from the University of Florida and the Veterans Administration Medical Center and a representative from the UF Radiation Control Committee. Representatives from nursing, pharmacy, safety, and hospital administration may also be appointed to the committee.

b. **Duties and Responsibilities**. This committee shall ensure that human use of radioisotopes, ionizing, and nonionizing radiation is in accordance with standard radiation safety practice, sound medical practice, and Federal and State regulations. Specific responsibilities shall be to:

1. Review and grant permission for, or disapprove, human uses of radioisotopes and ionizing radiation.

2. Evaluate the training and experience of each physician who proposes to use radioactive materials or ionizing radiation in research, diagnosis or therapy in humans.

3. Maintain records of the actions taken in approving or disapproving the human use of radioisotopes and ionizing radiation and other transactions, communications, and reports involved in work of this committee.

4. Prepare and disseminate information on radiation safety for use and guidance of researchers, technologists, nurses, physicians and dentists.

5. Prescribe special conditions and requirements that may be necessary (such as additional training, physical examinations, designation of limited areas or locations of use, disposal methods, etc.) to assure radiation safety.

6. Comply with the requirements of 64E-5.606, F.A.C.

c. **Meetings**. This committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year. It shall maintain a record of its activities.

Section 5. **ICU Improvement Committee**

a. **Membership**. The membership of the Committee shall consist of at least the following: Medical Director of each critical care unit, Nurse Manager of each critical care unit, Associate Dean for Graduate Medical Education, Medical Director of Respiratory Care Services, Medical Director of Trauma, a representative from the key ancillary services involved in the care of critically ill patients (e.g. Respiratory Care, Infection Control, and Pharmacy), a representative from the Purchasing Department, an ICU staff nurse, and a representative from the Clinical Process Improvement Department. Other personnel involved in managing the care of critically ill patients may attend ex-officio. The Committee shall be co-chaired by a Medical Director of a critical care unit and a Nurse Manager of a different critical Care Unit.

b. **Duties and Responsibilities**. The ICU Improvement Committee shall:

1. Facilitate the identification, implementation, and evaluation of interventions to improve the care of patients in the intensive and intermediate care units.

a) Use internal and external benchmark data to identify improvement opportunities.
b) Recommend changes to improve the care and management of critically ill patients.
c) Use internal and external data to evaluate the impact of practice changes.
d) Provide the critical care perspective for proposed system changes that impact significantly upon patients in intensive and intermediate care units.
e) Serve as a clearinghouse to inform members of the critical care team about improvement initiatives cited in the literature, and those driven by professional and quality improvement organizations as well as regulatory agencies.

2. Serve as the Value Analysis Committee for critical care units.

3. Address educational issues and allocation of resources for resident training programs in critical care settings.

c. **Meetings**. The Committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year. It shall maintain a record of its activities.

Section 6. **Infection Prevention and Control Committee**

a. **Membership**. The committee shall consist of at least representatives from medical staff, nursing services, clinical microbiology laboratories, and hospital administration. Other members may attend when appropriate; however, they shall be considered associate members.

b. **Duties and Responsibilities**. The duties of the committee shall be to:

1. Maintain surveillance of health care associated infections and other infection potentials. The medical staff shall be required to inform the committee of problems of infection.

2. Identify and analyze the incidence and cause of significant healthcare associated infection and communicable infections.

3. Develop and implement a preventative and corrective program designed to minimize infection hazards.

4. Supervise infection control in all phases of the hospital's activities including, but not limited to:

a) Operating rooms, delivery rooms, recovery rooms, and special care units.

b) sterilization procedures by heat, chemicals or otherwise (all methods).

c) standard universal precautions and transmission based isolation procedures.

d) prevention of cross-infection by anesthesia apparatus, or respiratory care and inhalation therapy equipment.

e) testing of hospital personnel for carrier status and infections; immunization recommendations, and maintaining records on employee health status.

f) management of biohazardous waste including methods of disposal of infectious material.

g) infection control risk assessments for maintenance, construction and renovation activities to minimize the risk of environmentally transmitted infections.

h) other situations as requested by the Operations Committee.

i) assurance of implementation and enforcement of all infection control policies and procedures as well as investigation and recommended resolutions of all reported infractions.

c. **Meetings**. This committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year and report its findings to the clinical department Chairs for review. A record of its activities shall be maintained.

Section 7. **Surgical/OR Policy Committee**

a. **Membership**. The membership of the Committee shall consist of the chair of each surgical department; the chair of the Anesthesiology department; the OR Medical Director; the Chair of the Medical Staff Operations Committee; the Shands Vice President for Operations and for Nursing; and the Administrative Director of the OR.

b. **Duties and Responsibilities**. The global charge to the Surgical/OR Policy Committee is to provide oversight and policy direction for all functions of surgical services, including pre-operative evaluation, operative management, post-operative bed placement, OR metrics and initiatives, budgetary review and recommendations, and policy and procedures. Specific charges for the Committee to address include:

1. Methods used to measure OR utilization
2. Procedure for assigning and re-allocating OR block time at current and future surgical sites
3. Number of ORs assigned for elective cases using block scheduling
4. Number of ORs un-assigned for urgent/emergency cases using open scheduling, especially as it relates to the trauma and transplant programs
5. Recommendations on staffing issues, including anesthesiology and nursing
6. Recommendations on patient safety issues
7. Analysis and recommendations on traditional OR efficiency measures, including time starts and turnover time

8. Recommendations on standardization issues, including equipment, scheduling and care processes
9. Prioritization of OR capital and staffing expenditures

c. **Meetings**. The Committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year. It shall maintain a record of its activities

Section 8. **Pain Committee**

a. **Membership.** The committee shall consist of at least representatives from medical staff, nursing services, and pharmacy.

b. **Duties and Responsibilities.** The duties of the committee shall be to:

a. Develop and implement strategies designed to improve/optimize pain management.
b. Maintain oversite of quality data related to pain management including:
   a) compliance with requirements for assessment, treatment and monitoring of patient pain.
   b) patient satisfaction with pain management.
   c) Medication errors and adverse patient events related to pain management.
c. Review and revise standards of care regarding pain management.
d. Recommend and support education of clinicians regarding pain management.

c. **Meetings.** This committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year and report its findings to the medical staff and Patient Safety, Quality, and Evaluation Committee.

Section 9. **The Patient Record Committee**

a. **Membership**. This committee shall consist of representatives from the medical staff, nursing services, hospital administration, information services, legal services and other services, as appropriate. The director of the Health Information and Record Management Department shall be a member of the committee and may be delegated to act as its secretary.

b. **Duties and Responsibilities**. The Patient Record Committee shall be responsible for the following:

1. Standards for Documentation of Patient Care – Ensuring that documentation in the Patient Record is consistent with established standards.

2. Patient Record – Advising on the content of the Patient Record including:

   a) Standards for encoded information and textual information
   b) Naming conventions
   c) The organization of the Patient Record
   d) The format of each item of the Patient Record

e) Presentation options for the Patient Record

3. Strategy – Defining the desired endpoint in the transition from paper to electronic records consistent with the guidelines for the Patient Record.

4. Security/Confidentiality/Privacy/Access – Adopt standards for maintaining the the confidentiality of the Patient Record while assuring reasonable and necessary access

5. Performance/Compliance – Establish mechanisms for reviewing the Patient Record to ensure compliance with regulatory and accreditation requirements.

c. **Meetings.** The committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year. A record of it's activities shall be maintained.

Section 10. **Pharmacy and Therapeutics Committee**

a. **Membership**. This committee shall consist of at least representatives from the clinical departments (recommended by the Chief of Service and appointed by the Chair of the Operations Committee), the Director of Pharmacy Services, and representatives from hospital administration and nursing services.

b. **Duties and Responsibilities**. The Pharmacy and Therapeutics Committee shall be responsible for the development and surveillance of the drug utilization policies and practices within the institution in order to assure optimum clinical results and a decreased potential for hazard. It represents the organizational line of communication and the liaison among the Medical Staff, Nursing Service and the Pharmacy Service relative to drug matters. This committee shall assist in the formulation of broad professional policies regarding the evaluation, appraisal, selection, procurement, storage, distribution, use, safety procedures, and other matters relating to drugs and diagnostic testing materials in the hospital. It shall also perform the following specific functions:

1. Serve as an advisory group to the Medical Staff and Pharmacy Service on matters pertaining to the choice of available drugs.

2. Make recommendations concerning drugs to be stocked at the nursing unit floors and by other services.

3. Develop and review periodically a formulary or medication's list for use in the hospital.

4. Prevent unnecessary duplication in stocking drugs and drugs in combination having identical amounts of the same therapeutic ingredients.

5. Evaluate clinical and pharmacological data concerning new drugs or preparations requested for use in the hospital and determine whether they should be added to the formulary.

6. Establish standards concerning the distribution and administration of investigational drugs after protocols are approved by the Institutional Review Board (IRB).

7. Establish or plan suitable educational programs for the professional staff on pertinent matters related to drugs and their use.

8. Study problems related to the administration of medications.

9. Review reported adverse reactions to drugs administered.

10. Evaluate periodically medical records in terms of drug therapy.

c. **Meetings**. This committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year and report its findings to the clinical department chairs for review. A record of activities shall be maintained.

Section 11: Sedation Committee

a. **Composition**: The Sedation Committee shall consist of a medical staff representatives from the following specialties: Anesthesiology, Emergency Medicine, Obstetrics & Gynecology, Gastroenterology, Interventional Radiology, Cardiology, Pulmonary Medicine, Pediatrics and other members of the Medical Staff as appointed. In addition, hospital representatives from Risk Management, Quality, Accreditation & Licensure, Nursing Services, Emergency Services, Radiology, Cardiology, Pharmacy, Cardiopulmonary, Surgery, Labor & Delivery and Endoscopy Services shall serve as members. The Chair shall be assigned by the Chair of the Operations Committee.

b. **Duties**: The duties of the Sedation Committee shall be to:

1. Set the standard for sedation and analgesia practices through the development of policies, procedures and guidelines for the administration of sedation and analgesia by non-anesthesiologists during the performance of a procedure at Shands at the University of Florida.

2. Receive and act upon quality data and information gathered through ongoing quality monitoring activities specific to the administration of sedation and analgesia by non-anesthesiologists during the performance of a procedure.

3. Submit recommendations to the Medical Staff Operations Committee on sedation and analgesia related issues specific to the administration of sedation and analgesia by non-anesthesiologists during the performance of a procedure.

4. Develop and implement educational programs specific to the administration of sedation and analgesia by non-anesthesiologists during the performance of a procedure.

5. Account to the Medical Staff Operations Committee and to the staff for the overall quality of patient care associated with the administration of sedation and analgesia by non-anesthesiologists during the performance of a procedure.

c. **Meetings:** The committee shall meet as often as necessary to fulfill its responsibilities but at least four times a year. A record of its activities shall be maintained.

Section 12. **Transfusion Committee**

a. **Membership**. In addition to the Medical Director of the Blood Bank, the Committee will include members selected to represent the appropriate clinical departments which frequently use blood products or require specialized services or components.

b. **Duties and Responsibilities**. The Transfusion Committee will conduct ongoing peer review of transfusion practices to insure proper utilization of blood and its components. Specific responsibilities shall be to:

1. Review transfusion practices for proper utilization of all blood products. The committee function includes review of transfusion reactions, crossmatch transfusion ratio per physician and service, review of suspected cases of transfusion transmitted infectious disease, analysis of problems and follow-up actions taken. Specifically the committee shall:

   a) Review transfusion statistics, which indicate the use of blood and blood products, the amount of blood requested, the amount used, and the amount outdated:

   b) Review each actual or suspected transfusion reaction and suspected cases of transfusion transmitted infectious disease; and

   c) Support patient-specific review of transfusion practices by the departments, by designing audit strategies to assess the utilization of blood products, developing appropriate criteria, and reviewing individual cases.

2. Influence current practice, formulate appropriate recommendations and carry out continuing education programs to inform the medical staff of these recommendations, or when changes in the cost or availability of certain components or changes in prevailing scientific understanding of good transfusion practice occurs.

3. Assure that the blood products are readily available, provided in a prompt manner, and at a reasonable cost to satisfy each clinical need.

c. **Meetings**. The Committee will meet as often as necessary to fulfill its responsibilities but at least four times a year. It shall report its findings to the clinical department chairs for review. A record of its activities shall be maintained.

Section 13: Trauma Quality Management Committee

a. **Membership:** The Trauma Quality Management Committee shall consist of the Trauma Medical Director, Trauma Program Manager, Hospital Administration, medical staff representatives from at least the following specialties: Emergency Medicine, Orthopaedic Surgery, Neurosurgery, Pediatric Surgery, Burn Surgery, Radiology, Anesthesiology, Physical Medicine and Rehabilitation; Nurse Managers from trauma-related units, and a representative from Quality Accreditation and Licensure. Other representatives may be invited as needed.

b. **Duties and Responsibilities:** The Trauma Quality Management Committee shall have the following responsibilities:

1. Review and discussion of quality improvement initiatives;

2. Review and approval of Trauma Program guidelines and policies; and,

3. Recommendation of actions needed to resolve system or performance issues that impact the Trauma Program.

c. **Meetings:** The Committee shall meet as often as necessary to fulfill its responsibilities but at least ten times a year. There shall be at least 75 percent attendance of the above committee members, along with attendance by another representative from the Trauma Program in addition to the Trauma Program Medical Director, present to constitute a quorum. A record of its activities shall be maintained .

Section 14. **Utilization Management**

a. **Membership:** This committee shall consist of physician representatives from the majority inpatient services, Nursing, Case Management, Utilization Management, Social Work Services, and Finance. Additional hospital divisions and medical staff departments may be included on an ad hoc basis.

b. **Duties and Responsibilities:** The Utilization Management Committee shall actively evaluate the utilization of inpatient hospital resources. Referrals and recommendations shall be made to the Hospital, and the Medical Staff regarding appropriateness of utilization.

c. **Meetings:** This committee shall meet as often as necessary to fulfill its responsibilities, but at least four times a year. It shall maintain a record of its activities.

ARTICLE IV -- MEETINGS

Section 1. **Committee and Department Meetings**

All meetings of clinical departments and committees shall be held with such frequency as is provided in these rules and regulations.

a. Departments and committees may, by resolution, provide time for holding regular meetings without notice other than such resolution. Departmental meetings shall be held at least quarterly to review and evaluate the clinical work of the practitioners of that department. Emphasis must be placed on the quality of patient care rendered by the respective department members, continuing education and other quality assurance functions.

b. Special meetings of departments and committees may be called by, or at the request of, the chair of the department/committee, the Chair of the Operations Committee, or one-third of the group's members.

Section 2. **Notice of Meetings**

Written or printed notice stating the place, day and hour of any special department or committee meeting shall be delivered either personally or by mail to each person entitled to be present not less than five (5) days prior to the date of such meeting. Notice of regular department or committee meetings may be given orally. Personal attendance at a meeting shall constitute a waiver of notice of such meeting.

Section 3. **Quorum**

a. Operations Committee - Fifty percent (50%) of the voting members of the committee shall constitute a quorum.

b. Department and Committee Meetings - Those present and voting shall constitute a quorum at any meeting.

Section 4. **Manner of Action**

Except as otherwise specified, the action of a majority of the members present and voting at a meeting at which a quorum is present shall be the action of the group. Action may be taken without a meeting by a department or committee if a unanimous consent in writing (setting forth the action so taken) shall be signed by each member of the department or committee entitled to vote.

Section 5. **Minutes**

Minutes of department and committee meetings shall be prepared and shall include a record of attendance of members and the vote taken on each matter. The minutes shall be signed by the presiding officer, and copies thereof shall be submitted to the Chair of the Operations Committee

and/or the Quality Evaluation Committee as specified in these rules and regulations. A permanent file of the minutes of each meeting shall be maintained.

Section 6. **Attendance Requirements**

Meeting attendance will not be used in evaluating practitioners at the time of reappointment.

Section 7. **Rights of Ex Officio Members**

Persons serving under these rules and regulations as ex officio members of a committee shall be non-voting members.

ARTICLE V - ADMISSION, TRANSFER AND DISCHARGE OF PATIENTS

Section 1. **Admission**

a. Authorization of Admissions

1. The physicians, podiatrists and dentists with practice privileges at Shands at UF may accept patients for medical/dental/podiatric care. The acceptance of patients and decisions regarding their care are the responsibility of each individual member of the Medical Staff who has admitting privileges.

2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the hospital, for the prompt completion and accuracy of the medical and other required records for all patients he/she admits or in any way provides care, and for transmitting reports of the condition of the patient to the referring practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another staff member, the transferring attending shall document the transfer of responsibility, including documentation of the acceptance of the patient by the accepting attending on the order sheet of the medical record. Transfers from one attending to another within the same service as a result of scheduled routine, service coverage changes do not require a transfer order. If care is being transferred temporarily (e.g., week-end, holiday, evening coverage), in accordance with an established department or service call schedule, **and** such schedule is made known to all appropriate and necessary care providers and hospital personnel, and maintained by the department in accordance with hospital policy for maintenance of medical records, the attending physician need not write a transfer order.

3. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency such statement shall be recorded as soon as possible.

4. Admissions should be notified of a pending admission as soon as possible. Except in emergencies, a physician order form must be completed in full and submitted to the Department of Admissions. In an emergency, a bed will be assigned upon verbal request by the attending physician or his/her representative, to be followed, within two hours, by the

written physician order form. All requests for admission must indicate any possible, suspected, or confirmed communicable infectious disease.

5. If the attending physician named on the admission order is not the correct attending physician when the patient presents for admission, the chart and online record must be corrected. The attending physician who is on service when the patient is admitted must record the correction in the chart in the form of a medical order. A copy shall be provided to the Admissions Department.

6. Practitioners admitting emergency cases shall be prepared to justify to the Operations Committee and to the Admissions Office, representing the administration of the hospital, that the said emergency admission was a bona fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded in the patient's medical record as soon as possible after admission.

7. A patient to be admitted on an emergency basis will be assigned a practitioner in the applicable department or service to attend him/her.

b. Admission Priorities

Patients will be admitted on the basis of the following order of priorities:

1. **Emergency** - An emergency admission is one in which the patient has a medical condition such that the absence of immediate attention could result in serious jeopardy to life or health; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part; or with respect to a pregnant woman, a threat to the health or safety of the woman or the unborn child.

2. **Elective** - All admissions not classified as emergency admissions are elective admissions.

c. Special Admissions

1. **Indigent Patients**

a) Emergency patients shall be screened and/or treated without regard to financial ability.

b) Elective indigent patients may be admitted upon request by the attending physician and, with administrative approval, if one of the following criteria is met: 1) the patient represents a case of unique teaching value as determined by the attending physician who is caring for the patient; or, 2) facilities for proper medical care are not available at a local level as determined by the attending physician responsible for the patient.

c) Exceptions to the above two conditions must be reviewed and approved by the Chair of the Operations Committee and the COO or designee.

2. **Psychiatric Patients**

a) All involuntary admissions, shall be in accordance with provisions of the Baker Act.

b) All potential voluntary admissions shall be screened by psychiatry to determine whether they meet the guidelines for admission contained in the Psychiatry Unit policy.

c) All patient contact by Admissions staff to process the admission shall be coordinated with the psychiatry staff.

d) The admitting practitioner shall be responsible for providing such information as may be necessary to assure the protection of the patient from self-harm and to assure the protection of others whenever the patient might be a source of danger from any cause.

e) For the protection of patients, the medical and nursing staff, and the hospital, the following guidelines should be followed in caring for the potentially suicidal patient:

(1) Any patient known or suspected to be suicidal in intent shall be admitted to the Psychiatric Unit. If there are no accommodations available in this area, the patient shall be referred, if possible, to another institution where suitable facilities are available. When transfer is not possible, the patient may be admitted to a general area of the hospital, and, as a temporary measure, special safety precautions shall be taken and special nursing companionship provided. Such patients should spend the daytime hours in the area where special observation and therapy is available.

(2) Any patient known or suspected to be suicidal must have consultation by a member of the psychiatric staff.

3. **Prisoner Patients**

Prisoners may be admitted to the service of an attending physician, with approval of the attending physician or designee.

4. **Obstetrical Patients**

a) Elective obstetrical admissions and emergency obstetrical admissions shall be processed in the L & D area. A patient may be placed on observation as an outpatient until a decision is made, based on appropriate medical criteria, to admit.

b) Once the Admissions Department is notified that the physician in L & D has determined that the patient should be admitted, the patient shall be considered to be admitted and a discharge order shall be required when appropriate. The admission cannot be canceled.

5. **Court Ordered Admissions:** If a patient is admitted by a court order that does not designate an attending physician, the Chair of the Operations Committee or the chief of the admitting service shall designate an attending physician.

6. **Communicable, Infectious Disease Admissions:** A patient known to have a communicable, infectious disease shall be admitted directly to a room with isolation capabilities.

7. **Pediatric Patients**

   a) Any person under the age of 18 who has not been emancipated by a court, is not, nor never was married, or is not being treated for a pregnancy-related condition, shall be accompanied through the admissions process by his/her parent, guardian, or other person authorized to consent to his/her care by court order.

   b) When the parent, guardian, or other person authorized to consent for care of a minor is unavailable, a minor may be admitted upon documentation by two atending physicians that the care of the minor is an emergency and qualifies as an emergency admission.

8. **Outpatient Observation**

   a) Outpatient observation services, including the use of a bed, are available when it becomes necessary to evaluate an outpatient's condition or determine the need for admission as an inpatient. Outpatient observation services shall be provided when the admitting physician specifies "outpatient observation" on the admission order. Outpatient observation services may be used for medical observation beyond normally specified limits following complex diagnostic and therapeutic procedures, or outpatient surgical procedures, or for patients who arrive at the Emergency Department with acute symptoms.

   b) At the end of 48 hours, a patient in outpatient observation status must be either admitted as an inpatient or discharged.

d. Utilization Review

1. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Utilization Review Committee. 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.

2. In instances where the Utilization Review Committee determines that admission or continued stay is not justified based upon review of the medical record, the attending physician must provide written justification of the necessity for admission or continued hospitalization, including an estimate of the number of days of stay expected. This documentation must be accomplished within 24 hours of request. Should the attending physician be unable to provide justification for admission or continued stay, hospitalization will be denied and the attending physician must discharge the patient within 24 hours and/or notify the patient that third party payment will not fund the stay.

e. Admission Laboratory Screening

1. All patients being admitted shall have a laboratory admission screen performed in accordance with the physician's orders appearing on the "Request for Hospital Admission and Physician's Orders" form.

2. Reports of clinical laboratory admissions screen as described in number 1 above, may be accepted in lieu of the admission screen upon the approval of the attending physician and the Director of Laboratory Services if performed by licensed CAP approved laboratory facilities in the State of Florida. These test results must accompany the patient and be immediately available upon admission. Each such laboratory report should clearly state the patient's full name and other identifying information including laboratory of origin.

Section 2. **Inpatient Transfers**

a Transfers from one service to another must be documented in the medical record by the transferring attending. Documentation shall include a notation that the consent of the receiving attending was received. Once the patient is transferred, the receiving attending must write an order to continue all medications or make appropriate changes.

b. The transfer of patients who have been initially admitted to an "off service unit", to the home service unit, and transfer of responsibility from one attending to another, within the same service, due to scheduled routine changes in service coverage.do not require a physician's written order. Once the patient has been transferred to the home service, the responsible physician and nurse must review the orders for the patient with 24 hours of the transfer. If the transfer to the home service also involves transfer of care to another attending physician, the requirements set forth in Section 2 (a) shall be met.

Section 3. **Discharges**

a. Patients shall be discharged only on a written order of the patient's physician or dentist. Should a patient decide to leave the hospital against the advice of his physician or dentist, or without proper discharge order, the risks of such action shall be explained and documented by the physician, and the patient or guardian shall be requested to sign the form "Statement of Acceptance of Responsibility by Patient/Family for Leaving Hospital Against Medical Advice."

b. The discharge order shall be completed by the attending physician or his/her housestaff physician by 7:00 p.m. of the night before discharge. If extenuating circumstances exist, an order should be written as early as possible on the day of discharge.

c. Instructions given to the patient (and family when appropriate) of his/her condition, prognosis, and required continued medical care shall be documented on the Patient Disposition and Instructions form by the discharging physician.

NOTE: The obstetric patients are excluded from the established discharge policy

See also core policy and SUF guideline, CP1.10 and CP2.10g, Patient Acceptance, Admission, Transfer and Discharge.

Section 4. **Patient Deaths**

See also core policy and SUF guideline CP1.13 and CP1.13g, Death of a Patient – Required Procedures, Notifications and Consents and CP1.44 Autopsies.

a. **Pronouncement**: The deceased shall be pronounced dead by the attending physician or his/her designee within a reasonable time. The deceased body shall not be moved until an entry has been made and signed in the medical record of the deceased by the attending physician or his/her physician designee. Policies with respect to release of deceased bodies shall conform to state law.

b. **Autopsy**: It shall be the duty of all staff members to secure autopsies whenever appropriate and possible. An autopsy may be performed only with a legal consent, obtained in accordance with law. In particular autopsies should be performed in all cases of unusual deaths and of medical legal and educational interest. All autopsies performed in the hospital shall be performed by a pathologist, who is a member of the medical staff, or his/her designee. Provisional anatomic diagnosis shall be recorded in the medical record within three days and the completed autopsy protocol should be made a part of the medical record within sixty days. The following criteria have been developed to identify deaths in which an autopsy should be performed:

1. Unexpected deaths, including the following circumstances:

    a) admission for elective surgical procedure

    b) admission for trauma or acute medical condition where prognosis was considered favorable or initial course indicated favorable response to therapy

    c) admission for therapy of chronic condition where discharge was expected

    d) death during diagnostic or therapeutic procedures (if case waived by medical examiner).

2. Deaths where significant diagnostic uncertainties exist or where the cause of death is not clinically certain.

3. Deaths where family and/or public health concerns exist.

4. Deaths of patients on clinical study protocols.

5. Death on arrival (DOA), provided the case is waived by the medical examiner or death within 24 hours of admission.

6. All obstetrical deaths.

7. All perinatal and pediatric deaths.

8. Deaths where the illness may have a bearing on surviving family members or a transplant recipient.

9. Deaths from known or suspected environmental or occupational hazards.

These criteria are meant to provide guidance to the medical staff, rather than mandate that a request for autopsy be made in each of these cases. Medical staff are advised to document in the medical record when an autopsy is requested of family, but not approved.

ARTICLE VI - MEDICAL RECORDS

1. The attending practitioner is responsible for the accurate, timely, and legible completion of a medical record for each patient. All records will be maintained under a medical record number that forms the basis for the unit record. Each medical record contains at least the following information as appropriate: the patient's name, address, date of birth, and the name of any legally authorized representative; for patient's receiving mental health services the patient's legal status; emergency care provided to the patient prior to arrival, if any; the record and findings of the patient's assessment; a statement of the conclusions or impressions drawn from the medical history and physical examination; the diagnosis or diagnostic impression; the reason(s) for admission or treatment; the goals of treatment and the treatment plan with episodic review as appropriate; evidence of known advance directives; evidence of informed consent when appropriate; reports of operative and other procedures, tests and their results; records of donation and receipt of transplants or implants; diagnostic and therapeutic orders, if any; all diagnostic and therapeutic procedures and tests performed and the results; progress notes that include the patient's response to medications and services made by the medical staff and other authorized individuals; all reassessments, when necessary; clinical observations, including the patient's response to medication and care provided; consultation reports; medications ordered or prescribed during treatment or upon discharge; all relevant diagnoses established during the course of care; conclusions at the termination of hospitalization; discharge summaries, or a final progress note or transfer summary; discharge instructions to the patient or family; any referrals and communications made to external or internal care providers and to community agencies; and

when performed, results of autopsy. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

2. A history and physical examination shall in all cases be dictated or electronically created and available in Shands Lifetime Clinical Record (exclusions: normal obstetrical and newborn cases) recorded within twenty-four (24) hours after admission of the patient and as soon as conditions permit for emergency admissions. In addition, a history and physical examination is required prior to the performance of any invasive procedure (whether inpatient or outpatient), and for outpatients who are observation patients. For inpatients, a valid H & P performed at admission may be used for all subsequent inpatient procedures. The attending physician shall confirm and countersign the history and physical examination documented by other health care professionals with privileges to perform these activities.

   In addition to the dictated history and physical, an admission note must be written for all inpatients and admitted observation patients. The admission note must include the reason for admission, pertinent findings, conclusions and plan of care. A handwritten update to a history and physical dictated within the past 30 days may be considered the admission note.

   a. For inpatients, the history and physical must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; social history; family history; review of systems including pain assessment; for children: immunizations and growth chart; and a relevant physical examination. A comprehensive assessment should integrate the elements from the history and physical examination that support the reason for admission or need for intervention followed by the treatment plan.

   b. For outpatient procedures, a history and physical must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; review of relevant systems including pain assessment and relevant physical examination that supports the need for intervention followed by the treatment plan.

   In addition, if anesthesia or sedation is planned, the anesthesia assessment shall include, at a minimum: medication history, including drug allergies, previous experience with sedation and analgesia, results of relevant diagnostic studies, physical status assessment, airway assess, and NPO status.

   c. If a history and physical examination has been performed by a Medical Staff member within thirty (30) days of the admission/procedure, a legible copy of it may be used in the patient's medical record; provided that, at the time of admission/the procedure, an appropriate assessment is performed and documented, including a physical examination of the patient to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed. The assessment and note must also confirm that the necessity for the care/procedure is still present and the H & P is still current. The update note must be on or attached to the full H & P; or when the H & P was accessed on-line by the practitioner, must refer specifically to the date of the H & P being updated. Updates may be done by the attending practitioner or his/her resident or appropriately privileged ARNP or PA.

d. If an H&P is performed and dictated within 24 hours after admission, the Medical Staff member performing the H&P must make an entry in the record stating the H&P has been completed and dictated.

e. Dentists are responsible for the part of their patients' history and physical examination that relates to dentistry. Podiatrists are responsible for the part of their patients' history and physical examination that relates to podiatry. A credentialed M.D. or D.O. must confirm the findings and conclusions of the H&P and assessment of risk(s) of a proposed operative or other procedure, requiring written informed consent pursuant to hospital policy, done by a Dentist (except Oral and Maxillofacial Surgeon) or Podiatrist, when the patient involved has a severe systemic disease that is considered a constant threat to the life of the patient.

f. A history and physical that has been performed by a non-credentialed physician must be reviewed by a credentialed physician and a note of concurrence entered into the medical record.

g. No anesthesia shall be given, nor invasive/significant risk procedure started, until the history and physical examination, pre-procedure diagnosis and indicated laboratory/diagnostic tests, are on the chart, unless the attending practitioner documents in the Medical Record that delay would be detrimental to the patient's health. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of procedure, including at a minimum, heart rate, respiratory rate, and blood pressure.

3. Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. An attending physician or his/her Resident, PA or ARNP shall enter a progress note in the medical record at least daily. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment.

4. A pre-anesthesia assessment of each patient for whom anesthesia is contemplated and a determination that the patient is an appropriate candidate to undergo the planned anesthesia shall be performed within 48 hours prior to the procedure and shall be recorded by the Anesthesiologist. Immediately prior to induction, an evaluation of the patient is completed and documented. The patient's postoperative status is assessed on admission to and discharge from the post-anesthesia recovery area. If discharge criteria are to be used for patient discharge from postanesthesia care, they must be approved by the Medical Staff. Postoperative documentation includes at least a record of vital signs and level of consciousness; medications (including intravenous fluids), blood and blood components; any unusual events or postoperative complications, including drug and transfusion reactions, and the management of those events; identification of who provided direct patient care; the patient's discharge from the post-anesthesia care area including documentation of the responsible physician or indication if discharge was by criteria. In addition, for inpatients, a post-anesthesia follow-up report by the individual who administered the anesthesia shall be written within 48 hours following anesthesia.

Sedation and analgesia for diagnostic, therapeutic and invasive procedures shall be ordered and supervised only by physicians/dentists/podiatrists credentialed to do so, and only in accordance with policy CP2.22, Sedation and Analgesia (a.k.a., Conscious Sedation) Procedures.

5. Operative reports shall include:
   - Name and medical record number of the patient
   - Dates and times of surgery
   - Pre and post operative diagnosis(es)
   - Name of the surgical procedure(s) performed
   - Type of anesthesia administered
   - Complications, if any
   - Surgeons or practitioners names
   - Findings
   - A description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices or altering tissues)
   - Prosthetic devices, grafts, tissues, transplants or devices implanted, if any
   - Specimens removed
   - Estimated blood loss

   Operative reports must be dictated for all procedures done in surgical areas. Procedures done at bedside may be handwritten or dictated. All tracheostomies, regardless of where performed must be dictated. Operative reports shall be dictated or written as soon as possible after surgery. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered in the patient's medical record immediately (before the patient moves to the next level of care). The immediate post-operative progress note must include at a minimum: date of procedure, pre-op diagnosis, post-op diagnosis, procedure(s) performed, surgeon(s) and assistant(s) names, findings, complications, estimated blood loss, specimens removed, surgeon's signature and provider ID number.

6. 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 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 operation. The name of the requesting physician and date must appear on all consultation forms.

   a. All consultation requests are to be responded to by physicians or other healthcare professionals, as appropriate, in one of the following two methods:

      1) The consultation report form is to be completed, or

2) The consultation is to be documented in the progress notes in the patient's medical record and labeled "Consultation".

b. In each situation listed above, the following information must be included:

1) The name of the requesting physician.

2) The name of the responding service.

3) Reason for the consultation.

4) The consultation must be signed by the attending consultant.

c. Follow-up consultations must be designated as such and again signed by the attending consultant.

7. The current obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the referring practitioner's office record transferred to the hospital before admission, but an admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

8. Medical records of patients treated for psychiatric illness shall include documentation of the use of any special treatment procedures. These special treatment procedures shall include but are not limited to:

a. Restraint or Seclusion.

b. Electroconvulsive and other forms of convulsive therapy.

c. Psycho-surgery or other surgical procedures to alter or intervene in an emotional, a mental, or a behavioral disorder.

d. Behavior modification procedures that use aversive conditioning.

e. Other special treatment procedures for children and adolescents.

When multidisciplinary treatment plans are determined to be appropriate, written policies which address multidisciplinary treatment plans shall be in effect on the Psychiatric Unit. The policies shall show appropriate physician involvement in and approval of the multidisciplinary treatment plan.

9. The Discharge Order and Instruction form shall include a principal and secondary diagnoses, major procedures, medications, and instructions to the patient, including medication instructions and prescriptions given. The form must be signed and dated by the discharging physician or attending physician before the record is returned to the Department of Health Information and Record Management after the patient is discharged.

10. Immediately prior to or within forty-eight (48) hours of discharge, a discharge/death summary shall be dictated for all inpatients and admitted observation patients, except for normal newborns and obstetrical patients with uncomplicated deliveries. In these cases a final progress note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the summary. The summary should recapitulate concisely a complete listing of final diagnoses, the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to patient and/or family, i.e., instructions relating to physical activity, complete current medication list, diet and follow-up care. All summaries shall be reviewed and signed by the responsible attending physician.

11. All entries in the medical record shall be legible, dated, timed and authenticated. Entries should be made in black ink. Authentication may be by handwritten signature, followed by the provider's unique provider number, or computer signature (unique computer code). When a computer key code is authorized, the individual signs a statement that he or she alone will use the computer key code. The use of signature stamps is not allowed.

    a. General Requirements

        1) All entries should be written legibly in black ink.

        2) The date and time of each entry will be included.

        3) The signature of the author will follow all entries. In addition, if the author's name and title are not printed/typed on the document, the unique practitioner identification number should be included when one has been assigned. If the author does not have a unique practitioner identification number, the title should follow the signature.

        4) Entries will contain essential information only, recorded in a scientific and professional manner.

        5) Only credentialed caregivers and Shands employees functioning within their designated role (or contracted individuals with an equivalent competency process) are authorized to document in the patient record.

        6) Non-physician authors will limit their subjects to those within their area of training.

        7) The patient's name and medical record number will appear on each page.

        8) Specific charting privileges of non-physician authors will be delineated and supervised by the department head or faculty member to whom the author reports.

    b. Locations of Entries Within the Medical Record

1) Departments with students or non-physician employees who make entries in medical records will have policies governing the location of these entries within medical records.

2) These policies will be conveyed to the Director of Health Information and Record Management.

c. Students

1) All students must work directly under the supervision of a licensed or registered professional. The term "student" includes individuals participating in internship or practicum phases of degree programs, including medical students. It does not include M.D.s, D.O.s, D.D.S.s.

d. Co-Signatures

1) Co-signature of a medical record signifies acknowledgement by the co-signer that the entry was made. It implies concurrence with the statements or conclusions contained in the entry. Orders written by medical students can not be executed without the co-signature of a physician.

2) If there is significant disagreement with the conclusion of the author, the co-signer should record such conclusions or expand on the entry as appropriate.

12. Symbols and abbreviations may be used with an approved reference source designated by the Patient Record Committee. A list of "Do Not Use" abbreviations will be maintained. Abbreviations on the designated "Do Not Use" list may not be used in any handwritten medical order, medication related documents or on pre-printed forms. See also core policy and SUF guideline CP2.53 and CP2.53g, Abbreviations.

13. Original records may be removed from the hospital only in accordance with court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed without permission of the Director of the Health Information & Record Management Department. Unauthorized removal of a record from the hospital is grounds for disciplinary action in accordance with the Medical Staff Bylaws and Policy on Appointment. Written consent of the patient or surrogate is required for release of medical information to persons not otherwise authorized to receive this information. Release of medical record information to external users, whether from the paper medical record or the electronic record, shall be in accordance with the policies of the Department of Health Information and Record Management.

See also core policy, CP3.42, Patient Medical Record Management and Disclosure of Information.

14. In case of readmission of a patient, all previous records shall be available for the use of the attending practitioner. This shall apply whether the patient is to be attended by the same practitioner or by another.

15. Access to medical records shall be afforded to members of the Medical Staff for bona fide study and research consistent with preserving the confidentiality of personal information concerning the individual patients

16. A medical record shall not be permanently filed until the responsible practitioner completes it. Medical Staff members shall not complete a medical record for a patient who has not been under his/her care. If the responsible practitioner is unavailable for completion of the record and no other physician is adequately familiar with the care to allow completion of the record, it wil be presented to the Patient Record Committee. Only the Patient Record Committee can authorize the filing in the permanent file of an incomplete medical record.

17. Medical records of discharged patients are to be completed promptly. Physicians are expected to electronically complete all medical records including dictations, physician queries, and electronic signatures in all systems at least once every seven days. Failure to do so may be cause for disciplinary action including the suspension of clinical privileges according to the policies of the Medical Staff Policy on Appointment and Reappointment and the procedures established by the Department of Health Information and Record Management.

ARTICLE VII - GENERAL CONDUCT OF CARE

1. A general consent form, authorizing routine treatment and diagnostic procedures, signed by or on behalf of every patient admitted to the hospital must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.

2. Specific consent is obtained prior to any non-routine treatment or procedure except in emergency situations when the patient is incapacitated, and a surrogate/proxy cannot be immediately reached. Specific written informed consent shall be obtained in conformance with Hospital procedure CP2.10p (*Consent for Treatment*) and prior to any medical/surgical diagnostic or therapeutic procedure or treatment (1) that entails significant risk to the patient or (2) for which it is otherwise required by law, regulation or Hospital policy. The patients or his/her surrogate/proxy, shall be informed of the procedure, its substantial risks or hazards, and medically acceptable alternatives and asked to sign the appropriate consent form prior to a the procedure/treatment. The physician/podiatrist/dentist scheduled to perform the procedure or a M.D./D.P.M./D.M.D. designee is required to obtain such consents.

3. Orders for treatment may only be given by attendings, housestaff and by ARNPs and/or PAs within the authority of their clinical privileges to practice within Shands at UF/AGH. Such orders must be written clearly, legibly, and completely. Those which are illegible or improperly written shall not be carried out until rewritten and understood by the healthcare professional responsible for implementing the order. The use of "renew", "repeat" and "continue orders" is not acceptable. Orders written by medical students can not be executed without the co-signature of a physician.

4. All entries, including medical orders made by a PA shall be co-signed by one of his/her supervising physician/dentist/podiatrists within seven (7) days for the first six months of his/her association with the supervising physician/dentist/podiatrist and thereafter, PA entries must be co-signed within thirty (30) days.

5. Final authority in orders for patient care will remain the prerogative of the attending physician/dentist/podiatrist.

6. Verbal medical orders (a.k.a. telephone orders) may be taken by a licensed or registered health care professional in an emergent situation or when the physician/podiatrist/dentist/ARNP/ PA is not present in the nursing unit to write an urgently required order. The verbal order taken must be related to the area of professional responsibility of the person taking the order. A Registered Nurse may take any verbal order related to the care of the patient. When a verbal order is taken, the health care professional receiving the order shall record the order in the medical record, indicating the date and time the order was received, the name of the physician/podiatrist/dentist/ARNP/PA giving the verbal order, the unique provider ID number of the individual giving the order, and the health care professional receiving the order. The verbal order shall then be read-back to the ordering practitioner by the healthcare professional receiving the order to verify the accuracy of the transcription. In an emergent situation, the patient's nurse must be informed of the contents of the verbal order by the person receiving that order. The verbal order, shall be authenticated (i.e., signed and dated) within 48 hours. Verbal orders for restraint or seclusion of psychiatric patients shall be authenticated and dated within 24 hours of the initiation of the restraint/seclusion.

See also core policy, CP2.58, Medical Orders.

7. A licensed physician's verbal or written order shall be obtained for each incident of restraint or seclusion, unless restraint is used in accordance with a physician approved protocol, pursuant to hospital policy, CP2.21, Use of Physical Restraints and Seclusion. The use of seclusion shall be limited to the Inpatient Psychiatric unit and shall follow the parameters established in the Inpatient Psychiatric Unit Policy entitled "Seclusion". This order shall be obtained within one hour of placing the patient into seclusion or restraints. The order shall be dated and timed. It shall indicate the specific circumstances for implementation, and shall indicate the specific period of time, not to exceed 24 hours, for which the restraint may be used. Orders for the continued use of restraints shall be re-written upon expiration of the previous order. The patient will receive a face-to-face reassessment by a physician prior to the continuation of the restraint order. Specific requirements for use of restraints on patients in the Inpatient Psychiatric Unit or in the Emergency Department pending transfer after execution of a physician's emergency examination or admission "Certificate" pursuant to the Baker or Marchman Act, are set forth in hospital policy, CP2.21, Use of Physical Restraints and Seclusion.

8. All previous orders, except Do Not Resuscitate (DNR) orders, are cancelled when patients go to surgery. A physician member from the surgical team and an anesthesiologist from the anesthesia team shall discuss the status of a previously written DNR order with the patient and/or surrogate, if one has been appointed, prior to the perioperative period and determine

the status of the DNR order during surgery. Appropriate documentation shall be made. If the attending physician and the patient/surrogate cannot agree about the status of the DNR order, then the procedures for conflict resolution outlined in core policy CP2.12, Do Not Resuscitate Orders, or CP2.13, Withholding or Withdrawing Life Prolonging Treatment or Measures, should be followed. See also core policy CP2.58, Medical Orders.

Orders for Schedule II controlled substances shall be rewritten every 72 hours. Nursing personnel are responsible for notifying the physician prior to the 72-hour expiration time.

All medication orders shall be cancelled automatically when a patient is transferred from one service to another or is postpartum unless the orders are rewritten in full.

8. The ordering physician shall use the following approved blood utilization tools when placing all non-emergent orders:

   a) For non-preoperative patients, the "Physician's Order for Transfusion Service" (Shands Form #15-0373-0), shall be completed utilizing the Shands at UF Approved Transfusion Indicators, available from the Blood Bank or at http://intranet.shands.org/shandslab/shandsuf/bloodbank.

   b) For pre-operative surgical patients, the "standardized Surgical Order" (SSO) shall be consulted.

See also Medical Laboratories policy, MLUT 5.1.04, Blood Utilization Process and Monitoring of This Process

9. Advance directives should be reviewed by the attending physician or his/her physician designee with the patient and his/her representative at the time of each admission, when there is a significant change in the patient's condition, or at the patient's request. This discussion should be documented in the progress notes and, if appropriate, a new advance directive should be executed. Unless otherwise provided for by law, advance directives or a surrogate's decision on behalf of a patient shall be honored. See also Core Policy, CP 2.29, Advance Directives.

10. All drugs and medications administered to patients shall be those listed in the latest edition of "United States Pharmacopoeia", "National Formulary", "American Hospital Formulary Service", or "A.M.A. Drug Evaluations". Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the "Statement of Principles Involved in the Use of Investigational Drugs in Hospitals" and all regulations of Federal Drug Administration. All drugs used for patient care will be issued or verified by the hospital Pharmacy Department. All compounded injectable medication and narcotics will be supplied by the Pharmacy. A patient may bring in his or her own formulary or non-formulary medications for use during his/her hospitalization provided the conditions provided in hospital policy, PM02-37, Patient Medication Brought into Shands at the University of Florida, are met.

11. In any surgical procedure with unusual hazard to life, there must be a qualified assistant present and scrubbed, except when there is no qualified physician available and in the opinion of the attending practitioner, the surgical procedure must be performed immediately.

12. All tissues removed at the operation, except those approved by the Surgical Case Review Committee and the Operations Committee as not requiring examination, shall be sent to the hospital pathologist who shall make such examination as he may consider necessary to arrive at the tissue diagnosis. His authenticated report shall be made a part of the patient's medical record.

13. When an organ is obtained from a live donor for transplantation purposes, the medical records of the donor and recipient should contain the same information as any other surgical medical record.

14. Any qualified practitioner with clinical privileges/scope of practice in this hospital can be called for consultation within his area of expertise.

15. Psychiatric consultation shall be obtained in all instances of attempted suicide and drug overdose.

16. The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized medical staff through its department chairs and executive committee to see that those with clinical privileges do not fail in the matter of calling consultations as needed. Each clinical service should exercise its judgement regarding the specific medical, surgical, dental, obstetrical, gynecological, pediatric, psychiatric, etc., conditions for which consultations are to be held. Except in an emergency situation, consultation should be considered in the following situations:

    a. When the patient is not a good risk for operation or treatment.

    b. Where the diagnosis is obscure after ordinary diagnostic procedures have been completed.

    c. Where there is doubt as to the choice of therapeutic measures to be utilized.

    d. In unusually complicated situations where specific skills of other practitioners may be needed.

    e. In instances in which the patient exhibits severe psychiatric symptoms.

    f. When requested by the patient or his/her family.

    g. When ethical issues arise, including, but not limited to, issues related to DNR orders, withholding treatment, disagreements between the healthcare team and the patient and/or patient's surrogate on issues related to withdrawal of treatment and/or DNR orders, etc.

17. Practitioners must, in accordance with Medical Staff Bylaws be located in sufficient proximity

to the Hospital to be able to provide continuity of quality of care to their patients at the Hospital. Sufficient proximity to the Hospital means that the practitioner can be on site in approximately 30 minutes when required to attend to an urgent need of his/her patient or when on-call.

18. Physicians generally should not treat themselves or immediate family members[1], however there may be occasions where this is acceptable and appropriate.

Any physician, who desires to provide treatment to him/herself or a family member at Shands at UF, must first contact the Chairman of his/her assigned department or the Chairman of the Operations Committee. The physician will disclose to the Chairman the nature of the problem and/or the intended treatment and advise the Chairman the reason a non-related physician is not providing the care. The Chairman will offer counsel to the requesting physician, referencing the American Medical Association's Code of Ethics statement on this issue, which is appended (Appendix A) to these Rules and Regulations. Documentation of this conversation shall be submitted by the Chairman at his/her earliest convenience and maintained by Quality Assurance.

In situations where the physician chooses to proceed with the delivery of care to self or family members, contrary to the advice of the Chairman, concurrent chart review will be conducted.

ARTICLE VIII - GENERAL RULES REGARDING DENTAL CARE

1. A patient admitted for dental care is a dual responsibility involving the dentist and physician or oral and maxillofacial surgeon member of the Medical Staff. Surgical procedures performed by dentists shall be under the overall supervision of the Chief of Surgery. The scope and extent of surgical procedures each dentist may perform must be specifically defined and recommended in the same manner as all other surgical privileges.

   a. Dentist's Responsibilities

      (1) A Detailed Dental History Justifying Hospital Admission.

      (2) A Detailed Description of the Examination of the Oral Cavity and Pre-Operative Diagnosis.

      (3) A Complete Operative Report, Describing the Finding and Technique. In Cases of Extraction of Teeth, the Dentist shall clearly state the number of teeth and fragments removed. All tissue and teeth fragments shall be sent to the Pathologist, who is a member of the medical staff, or his/her designee, for examination, unless approved by the Surgical Case Review Committee and the Operations Committee as not requiring examination.

[1] For purposes of this rule, parents, sibling, children (whether natural or by law) and spouses are considered to be immediate family members.

(4) Clinical Resume (or Summary Statement).

b. Physician's or Oral and Maxillofacial Surgeon's Responsibilities:

(1) Medical History Pertinent to the Patient's General Health.

(2) A Physical Examination to Determine the Patient's Condition Prior to Anesthesia and Surgery.

(3) Supervision of the patient's general health status while hospitalized.

c. The Discharge of the Patient Shall be on Written Order of the Dentist member of the Medical Staff.

ARTICLE IX – REVIEW OF RULES AND REGULATIONS

Section 1. **Campus Rules and Regulations**

The medical staff shall adopt such rules and regulations as may be necessary to implement more specifically the general principles found within these bylaws. These shall relate to the proper conduct of medical staff organizational activities as well as embody the level of practice that is to be required of each member of the medical staff.

The campus Rules and Regulations will be reviewed and recommendations for changes shall be made at least biennially. Such changes shall become effective when approved by the Operations Committee, the MEC and the Board of Directors.

Section 2. **Departmental Rules and Regulations**

Each department may formulate its own rules and regulations for the conduct of its affairs and the discharge of its responsibilities. Such rules and regulations shall not be inconsistent with the Medical Staff Bylaws, the campus Rules and Regulations, or other medical staff and hospital policies of the hospital.

APPENDIX A

American Medical Association's Code of Ethics

Self-Treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the physician is the patient; the physician's personal feelings may unduly influence his or her professional medical judgment, thereby interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the physician.

Concerns regarding patient autonomy and informed consent are also relevant when physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another physician or decline a recommendation for fear of offending the physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified physician available, physicians should not hesitate to treat themselves or family members until another physician becomes available. In addition, while physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.