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DEFINITIONS

The Definitions set forth in the Medical Staff Bylaws apply to the Rules and Regulations.

**APP Designee** – means an Advanced Practice Professional with delineated Clinical Privileges at Orlando Health who has been designated by a supervising Practitioner to make or respond to a consultation requested by the ED physician.

**Attending Physician** – means an independent licensed Practitioner who is a physician, podiatrist, or dentist, who has appropriate hospital credentials to treat patients admitted to the Hospital, and who is actively involved in the care of a patient.

**CIS** – means the Clinical Information System, also known as the electronic medical record.

**Deficient Medical Record** – means a medical record that is not completed within the required timeframe as outlined in these Rules and Regulations.

**Delinquent Medical Record** – means a Deficient Medical Record that is not corrected within 30 days of the patient’s discharge.

**ED** – means Emergency Departments within Orlando Health, including free standing Emergency Departments. Practitioners covering call for a Hospital Facility are also on call for all free-standing Emergency Departments associated with that campus, unless otherwise noted in the call schedule.

**ED Call Schedule** – means the official ED Call Schedule maintained by the Medical Staff Services Office.

**EMTALA** – means the federal Emergency Medical Treatment and Active Labor Act and related regulations.

**EMC** – means an Emergency Medical Condition as defined by EMTALA and section 395.002, Florida Statutes. An EMC is defined as a “condition manifesting itself by acute symptoms of sufficient severity, which may include severe pain, such that the absence of immediate medical attention could reasonably be expected to result in any of the following: serious jeopardy to patient health, including a pregnant woman or fetus; serious impairment to bodily functions; or serious dysfunction of bodily organs.”

**Emergent ED Response** – means the situation where a patient has an EMC that is threatening loss of life or limb and which requires an immediate response by the consultant, as determined by the ED physician.

**Urgent ED Response** – means a status in which the ED physician has determined that a patient with an EMC does not require an EMERGENT ED Response by the consultant.

**Florida Access To Emergency Services and Care Act** – means section 395.1041, Florida Statutes and related regulations.
Initial Call – means the first call, page or notification to a consultant that a consult is requested by the ED physician.

LAR or Legally Authorized Representative – means the patient or a person who, under applicable law, has the authority to act on behalf of a patient. A legal representative includes a healthcare surrogate, proxy, guardian, or parent, or other person acting in place of a parent (in loco parentis), for an unemancipated minor, or an executor or administrator of an estate.

MSE – means a Medical Screening Exam as defined by EMTALA and the Florida Access to Emergency Services and Care Act.

Provider – means a resident, fellow and/or advanced practice professional (APP).
ARTICLE 1

GENERAL STANDARDS OF PATIENT CARE

PART A. PATIENT MANAGEMENT

1. Responsibility for the Patient. For each patient admitted to a Hospital, an Attending Physician assumes responsibility for the patient upon admission. If a patient is transferred to another Hospital Facility or hospital system, then the Emergency Department physician maintains responsibility for the patient until the patient arrives at the other Hospital Facility or hospital system.

2. Admission Priority. The admitting physician determines the acuity of the patient’s medical condition and level of care required and enters the bed type, isolation requirement, if any, and level of care in the admission order.

3. Attending Physician. Each patient admitted to the Hospital must be assigned to an Attending Physician. The Attending Physician is responsible for the admission, care, and management of the patient in the Hospital. The Attending Physician:

   a. Rounds daily and documents the ongoing evaluation and treatment of the patient daily during the patient’s admission;

      i. Rounds by Allied Health Personnel and/or residents/fellows without the supervising Medical Staff member may not be substituted for rounds by a Medical Staff member. Independent rounds by APPs may supplement routine physician consultant rounds if mutually agreed upon with the Attending Physician.

   b. Orders and manages patient consultations;

   c. Communicates with the patient/the patient’s LAR;

   d. Evaluates the competency of the patient to make medical decisions on his/her own behalf;

   e. Responds to any change in the patient’s condition, including but not limited to Code Blue and Rapid Response, when the Attending Physician is in the Hospital;

   f. Is responsible for the discharge of the patient, including

      i. Developing and implementing discharge plans

      ii. Entering order for discharge

      iii. Documentation of discharge summary in the medical record

      iv. Documentation of a final diagnosis in the medical record at or before discharge

      v. Completing the medication reconciliation
vi. Completing and/or ensuring completion of the Death Certificate and documenting a death note in the medical record, if applicable

4. Change of Attending Physician. The Attending Physician may transfer care of the patient to another qualified physician to act as Attending Physician, so long as the patient does not object to the transfer. The new Attending Physician becomes responsible for all requirements of the Attending Physician as set forth in these Rules and Regulations.

   a. The current Attending Physician must ensure appropriate handoff communication with the accepting Attending Physician, enter an order for the transfer of care, and document the pending transfer of care in the medical record.

   b. The accepting Attending Physician must document acceptance of the patient in the medical record.

5. Covering Practitioner. All Medical Staff members with Clinical Privileges must designate a covering Practitioner to attend to the member’s patients when the member is unable to do so. The covering Practitioner agrees to perform all functions of the member as Attending Physician or consultant, as applicable. However, the Medical Staff member maintains full responsibility for a patient in the event that the member’s covering Practitioner fails to respond on behalf of the Medical Staff member he or she is covering.

6. Physician/Patient Relationships. The Medical Staff and Hospitals recognize the importance of maintaining existing physician/patient relationships when a patient presents to a Hospital for admission for continuity purposes and to determine the appropriate physicians to assign as the patient’s Attending Physician and/or consulting physician(s).

   a. Medical Staff members wishing to ensure continuity of existing physician/patient relationships should direct the patient to the appropriate Hospital Facility where the member can be timely assigned to the patient and provide any necessary care and treatment.

   b. Patient Request. If a patient requests a specific Medical Staff member to be the patient’s Attending Physician or to provide a consult, the requested member may decline to be the patient’s Attending Physician or to provide the consult if the requested member does not have a previously established relationship, with the patient and the requested member is not on call.

   c. Surgical Patients. Patients who have undergone surgery by a member of the Medical Staff within the previous thirty (30) days and are readmitted for the same surgical problem or complication associated with the surgery, shall be admitted to their surgeon of record, or have their surgeon of record consulted upon admission. For patients admitted for a non-surgical problem within thirty (30) days of surgery, the Attending Physician shall notify the surgeon of record.

7. Unassigned Patients. Patients who present to the Hospital and do not request or cannot identify a personal practitioner will be assigned to the Practitioner on call for the Emergency Department. No Medical Staff member shall refuse treatment of a patient because of lack of compensation. Assignments and consultation responsibilities shall be in accordance with these Rules and Regulations.
8. Pediatric Age Group. Patients under the age of eighteen (18) years shall be considered pediatric patients, and patients aged eighteen (18) years and older shall be considered adult patients, with the following exceptions:

a. For purposes of trauma care, in accordance with Florida Trauma Center Standards, pediatric patients shall be those patients with anatomical and physical characteristics of a person 15 years or younger;

b. For purposes of non-trauma orthopedic care and general surgery, patients under the age of sixteen (16) years shall be considered pediatric, and patients aged sixteen (16) and above shall be considered adult;

c. Further exceptions may be defined by mutual agreement of the applicable adult and pediatric Clinical Departments on file with the Medical Staff Services Office and in their respective Clinical Departmental Rules and Regulations.

9. Pharmacy. A hospital formulary shall be prepared and kept up to date by the hospital pharmacist with the approval and under the direction of the Pharmacotherapy Committee of the Medical Staff. Acceptance of the Medical Staff Bylaws and Rules and Regulations also specifically implies acceptance of this formulary and its use.

10. Treatment Of Family Members. Physicians are discouraged from providing medical care and treatment to family members. A physician who wants to provide non-emergent treatment to a parent, sibling, child, or spouse must request and receive approval from the Chairperson of the physician’s Clinical Department. If the Chairperson of the Clinical Department does not approve the request, then the physician may escalate the request to the Medical Executive Committee.

PART B: AUTOPSY

1. Autopsies. Please refer to the Expired Patient Care, Including Pronouncement and Disposition Policy #2200 for additional information.

a. Each member of the Medical Staff should attempt to secure autopsies in accordance with state and local laws, including all cases of unusual deaths and those of medical-legal and educational interest. The Attending Physician (or his or her designee) must be notified when an autopsy is to be performed.

b. Authorization for an autopsy must be obtained from the parent, legal guardian, or responsible person after the patient’s death. The Attending Physician (or his or her designee) must document in the medical record if permission for an autopsy was granted. If permission is refused by the authorized individual or if, in the opinion of the Attending Physician (or his or her designee), an autopsy should not be requested (e.g., the health and welfare of the next of kin or religious proscription), this should be documented in the medical record.

c. Any request for an autopsy by the family or legal guardian of a patient who died while at the Hospital will be honored, if at all possible, after consulting with the pathologist. The payment for such autopsies is the responsibility of the patient’s
family or legal guardian. Difficulties or questions that arise with the request will be directed to the Chief of Staff.

d. The Medical Staff will be actively involved in the assessment of the criteria for autopsies. Indications for performing autopsies include but are not limited to:

i. Deaths in which an autopsy may help explain unknown and unanticipated medical complications to the Attending Physician.

ii. All deaths in which the cause of death or a major diagnosis is not known with reasonable certainty on clinical grounds.

iii. Cases in which autopsy may help allay concerns of, and provide reassurance to, the family and/or the public regarding the death.

iv. Unexpected or unexplained deaths during the following: any dental, medical or surgical procedure and/or therapies.

v. Deaths of patients who have participated in clinical trials approved by the Institutional Review Board.

vi. Unexpected or unexplained deaths that are apparently natural and not subject to forensic jurisdiction.

vii. Natural deaths that are subject to, but waived by a forensic medical jurisdiction, such as persons dead on arrival at hospital; deaths occurring in hospitals within 24 hours of admissions; and deaths in which the patient sustained an injury while hospitalized.

viii. Deaths resulting from high-risk infections and contagious diseases.

ix. All obstetric, perinatal and pediatric deaths.

x. Deaths in which it is believed that an autopsy would disclose a known or suspected illness that may have bearing on survivors or recipients of transplant organs.

xi. Deaths known or suspected to have resulted from environmental or occupational hazards.

PART C: EMERGENCY MEDICAL SERVICES

1. Emergency services and care will be provided to any person who comes to the Hospital or Emergency Department requesting or in need of emergency services and care, provided that there are appropriate facilities and qualified personnel available to provide such services or care.

2. Emergency services and care will be provided without regard to the patient’s race, ethnicity, religion, national origin, citizenship, age, sex, pre-existing medical condition, physical or mental handicap, insurance status, economic status, sexual orientation or
ability to pay for medical services, except to the extent such circumstance is medically significant to the provision of appropriate care to the patient.

3. Assignment to Emergency Medicine Physician. Every patient who is treated in the Emergency Department will be assigned to the care of a physician from the Emergency Medicine Clinical Department.

4. Medical Staff Member Referrals to the Emergency Department. Medical Staff members may send their patients to the Emergency Department for evaluation and are encouraged to contact the Emergency Department physician to discuss the patient.

5. Medical Screening Examinations (MSE): A MSE will be performed on all individuals who come to the Hospital, within the capability of the Hospital, requesting examination or treatment to determine the presence of an emergency medical condition. The results of the medical screening examination must be documented upon completion of the examination.

   a. Qualified medical personnel who can perform medical screening examinations within applicable Hospital policies and procedures are:

      i. Members of the Medical Staff with Clinical Privileges in Emergency Medicine;

      ii. Other Active Staff members;

      iii. Appropriately credentialed Allied Health Personnel;

      iv. Members of the Medical Staff with Obstetrics and Gynecology Clinical Privileges; and

      v. Certified Nurse Midwives with Obstetrics Clinical Privileges.

   b. Necessary Stabilizing Treatment. If a patient has an Emergency Medical Condition, the patient must be provided further examination and treatment as required to stabilize the condition within the capabilities of the staff and facilities available, unless an appropriate transfer is made.

   c. Following a MSE, a patient may be discharged from the Emergency Department:

      i. To be seen at the on-call physician’s office for further examination and treatment in accordance with these Rules and Regulations. The Emergency Department physician and the on-call physician must agree that the patient’s condition is sufficiently stable to be discharged and seen at the on-call physician’s office; or

      ii. If the patient has received a MSE and the Emergency Department physician has determined that the patient does not have an Emergency Medical Condition; or
iii. If the Emergency Department physician has determined that the patient’s Emergency Medical Condition has been stabilized as defined by EMTALA; or

iv. For admission to the Hospital or an observation unit for further evaluation and/or treatment.

d. Transfer of Patients with Emergency Medical Conditions. Transfer of patients with Emergency Medical Conditions shall be in accordance with Hospital Policies and shall meet all requirements for an appropriate transfer. If a patient requires transfer to another facility for admission and/or treatment, the Emergency Department physician maintains responsibility for the patient until the patient arrives at the new facility.

6. Enforcement of ED Call Responsibilities for EMTALA Compliance. An on-call physician’s unavailability when on call, refusal to respond to a call from the Emergency Department, or any other violation of this Article or Article 2 is a serious matter. After reviewing the relevant information, if the Medical Executive Committee determines that there is a potential violation of this Article or Article 2, the physician will be notified and will be afforded an opportunity to meet with the Committee. After this meeting, the Medical Executive Committee will determine whether the physician violated this Article and/or Article 2. Confirmed violations of this Article and/or Article 2 that occur within a four-year time frame will result in the following disciplinary actions:

a. A complaint about a physician’s failure to comply with this Article and/or Article 2 shall be referred to the Hospital Chief of Staff and the Hospital President for a preliminary review. These individuals shall review the complaint and may discuss it with involved individuals. The complaint and related information shall then be referred to the System Chief of Staff and Medical Executive Committee to determine if further action is necessary, as described below.

b. A first violation will result in a letter of counsel.

c. A second violation will result in a letter of warning.

d. A third violation will result in a letter of warning and the immediate suspension of Clinical Privileges for 14 calendar days.

e. A fourth violation indicates an inability or unwillingness to fulfill Medical Staff responsibilities as set forth in the Medical Staff Bylaws and this Article. Accordingly, it will result in the automatic resignation of appointment and Clinical Privileges, without the right to a Hearing or Appeal as set forth in Article 7 of the Medical Staff Bylaws.
ARTICLE 2
CONSULTATIONS

PART A. EMERGENCY DEPARTMENT CONSULTATIONS

1. The assigned Emergency Department physician may contact one or more physicians to provide consultations in the Emergency Department or to admit the patient, in accordance with this Article.

2. The consultant on call at the time the consult order is placed is responsible for the consultation.

3. The Emergency Department physician determines, and will specify in the Initial Call, whether the call is EMERGENT ED Response or URGENT ED Response. When possible, consult requests from the ED should be placed Practitioner to Practitioner.
   a. EMERGENT ED Response consultation: expected response by phone within 5 minutes.
   b. URGENT ED Response consultation: expected response by phone within 30 minutes.
   c. An in person response of the consultant may be requested by the Emergency Department physician when necessary, in the opinion of the Emergency Department physician, for care of a patient. The response time may be mutually agreed upon by the consultant and Emergency Department physician based on the condition of the patient. In the event that the Emergency Department physician and consultant do not agree on the response time, the Emergency Department physician’s requested response time will control.

4. The patient may be discharged to be seen at the consultant’s office for examination and treatment, provided the following conditions are met prior to the patient being discharged:
   a. The Emergency Department physician and consultant agree; and
   b. The patient has received a MSE and the Emergency Department physician has determined that the individual does not have an EMC; or
   c. The Emergency Department physician determines the patient’s EMC has been stabilized as defined by EMTALA.
   d. If necessary for the condition for which the patient initially presented to the ED, the consultant must provide follow-up medical care to the treated and discharged patient at the consultant’s office, regardless of the patient’s ability to pay.

5. The patient may be seen as an inpatient or in the observation unit as determined by the Emergency Department physician and/or the admitting physician and consultant.

6. The consultant may designate an APP Designee to present to the ED and provide further assessment and stabilizing treatment to a patient. However, the consultant is ultimately
responsible for providing the necessary services to the patient in the ED, regardless of who makes the in-person appearance. Furthermore, if the Emergency Department physician disagrees with the consultant’s decision to send an APP Designee and requests the appearance of the consultant, the consultant is required to appear in person.

7. If the consultant does not contact the ED within the required timeframe as outlined in this Article or does not come to the ED when requested to do so by the Emergency Department physician, escalation steps may occur in accordance with the Orlando Health Chain of Command Policy #0350. Risk Management will also be notified and further action may be taken in accordance with the Medical Staff Bylaws and/or Article 1, Part C of these Rules and Regulations.

8. In the event of any discrepancy between this Article, the Chain of Command Policy #0350, or the Medical Staff Bylaws, the order of priority is the Medical Staff Bylaws, the Chain of Command Policy #0350, and then this Article.

PART B. INPATIENT CONSULTATIONS

1. Only the Attending Physician may request inpatient consultations, except in emergency situations.

2. The Attending Physician may not request a consultation from a resident/fellow.

3. The consultant may write orders in the CIS and treat the patient unless the Attending Physician has specified that the consultant only make recommendations back to the Attending Physician. All recommendations shall be documented into the CIS. The consultant is encouraged to communicate directly to the Attending Physician after the consultation is complete.

4. The consultant is expected to see and evaluate the patient daily for the duration of the consultant’s course of care, unless otherwise mutually agreed upon by the Attending Physician and consultant and documented in the CIS. If the Attending Physician wishes to re-engage the consultant after the consultant has documented that the course of care is completed, then a new consult order must be requested following the below guidelines of STAT vs 24-hour consults.

5. Consultations may be requested to transfer the patient to another physician’s care as Attending Physician. Once the consultant accepts the transfer of service, the requesting Attending Physician should clearly indicate in the orders that the transfer has occurred. The consultant will then be designated in the CIS as the Attending Physician.

6. For unassigned patients, the consultant on call at the time the consult order is placed, as shown by the ED call schedule, is responsible for the consultation.

7. STAT Consults. A STAT consultation must occur no later than four (4) hours after the consultation order is entered into the CIS. The Attending Physician must speak directly to the consultant by phone or in person and explain the need for the consultation.

   a. The consult order must be placed into the CIS.
b. The consultant is responsible for responding to the Attending Physician within thirty (30) minutes after initiation of the consult request to confirm receipt of the consult.

c. If the consultant is unable to respond within thirty (30) minutes due to an urgent patient care need, then the consultant may designate another Practitioner or APP Designee to confirm receipt of the consult.

d. The Attending Physician is responsible for confirming that the consultant received the communication if the consultant has not responded within thirty (30) minutes after initiation of the consult request.

8. 24-hour Consults. The consultation must occur no later than twenty-four (24) hours after the consultation order is entered into the CIS. The Attending Physician is encouraged to communicate directly with the consultant and must include the indications for the consultation within the consult order.

a. Communication may be by phone, in person or by approved secure messaging methods.

b. At the direction of the Attending Physician, a resident/fellow may contact the consultant. The consultant has the right to request to speak directly with the Attending Physician, which must be honored by the resident/fellow and the Attending Physician.

c. The consult order must be placed into the CIS.

d. The consultant must respond to confirm receipt of the consult. If a call back is requested by the Attending Physician, the consultant must respond within one (1) hour of the time the consult order was entered into the CIS. However, if the call back is requested between 2200 and 0700, then the consultant must confirm receipt of the consult no later than 0800.

e. The consultant may designate another Practitioner or APP Designee to confirm receipt of the consult.

f. The Attending Physician is responsible for confirming that the consultant received the communication if the consultant has not responded within the applicable timeframe after initiation of the consult request.
ARTICLE 3

MEDICAL RECORDS AND HEALTH INFORMATION MANAGEMENT (HIM)

PART A. MEDICAL RECORDS

1. The following individuals are authorized to document in the medical record:
   
a. Attending Physicians, Residents and other Providers with appropriate Clinical Privileges who are involved in the care of the patient;

b. Nursing providers, including advanced practice registered nurses (APRNs) registered nurses (“RNs”) and licensed practical nurses (“LPNs”) making entries appropriate to their scope of practice or privileges;

c. Physicians with Clinical Privileges responding to a request for consultation;

d. Other health care professionals involved in patient care, including, but not limited to, physical therapists, occupational therapists, respiratory therapists, pharmacists, social workers, and case managers;

e. Volunteers, such as volunteer chaplains, functioning within their approved roles;

f. Students in an approved professional education program who are involved in patient care as part of their education process (e.g., acting interns) if that documentation is reviewed and countersigned by the student’s supervisor, who must also be authorized to document in the medical record;

g. A non-APP rounding nurse making an entry as a scribe for his or her supervising Attending Physician who dictated the note to the rounding nurse. A non-APP rounding nurse may only make entries in the medical record as a scribe, and may not enter a note that reflects their personal evaluation, assessment, or plan, even if discussed with or approved by their supervising physician; and

h. Non-clinical and administrative staff, if in accordance with job description.

2. Entries will be made in the medical record consistent with Documentation of Patient Care Policy #2150. Electronic entries will be entered through the CIS. Handwritten medical record entries will be legibly recorded in blue or preferably black ink and may be used where paper-based documentation has been approved by the Hospital (e.g., documentation of informed consents) or when is otherwise appropriate (i.e., an emergency situation or when the CIS or CPOE function is not available). All entries, including handwritten entries, must be timed, dated and signed.

3. Each individual who is authorized above to document in the medical record will be responsible for the timely, complete, accurate, and legible completion of the portions of the medical record that pertain to the care he or she provides.

4. Only standardized terminology, definitions, abbreviations, acronyms, symbols and dose designations will be used. Abbreviations on the unapproved abbreviations and/or symbols list may not be used. The Medical Staff will periodically review the unapproved
abbreviations and/or symbols list and an official record of unapproved abbreviations and/or symbols will be kept on file.

5. Access and Retention of Record.

a. Medical records are the physical property of the Hospital. They will be maintained and retained in accordance with federal and state laws and Hospital policies. Original medical records may only be removed from the Hospital in accordance with federal and state laws and Hospital policies.

b. Information from, or copies of, records may be released only to authorized individuals or entities (i.e., other health care providers) in accordance with federal and state law and Access to the Chart and Other Records Policy #8310.

c. A patient or his or her LAR may receive copies of the patient’s completed medical record, or an individual report, in accordance with state and federal law and Hospital Policy.

d. Access to all medical records of patients will be afforded to members of the Medical Staff for bona fide study and research consistent with Hospital Policy, applicable federal and state law. All such projects will be approved by the Institutional Review Board (IRB).

6. Authentication. Authentication means to establish authorship by signature or identifiable initials and may include computer entry using unique electronic signatures for entries entered through the CPOE.

a. Each individual who has authority to document in the medical record will provide a signed statement attesting that he or she alone will use his or her unique electronic signature code to authenticate documents.

b. A single signature on the face sheet of a record will not suffice to authenticate the entire record. Entries will be individually authenticated.

7. Content of Record.

a. The Hospital will maintain a medical record for each emergency patient, scheduled ambulatory care patient, inpatient, and outpatient encounter. For every patient treated as an inpatient, a medical record will contain information to justify admission and continued hospitalization, support the diagnosis, and describe the patient’s progress and response to medications and services.

b. Medical record entries will be legible, complete, dated, timed, and authenticated in written or electronic form by the person responsible for providing or evaluating the service provided, consistent with the Documentation of Patient Care Policy #2150. Stamped signatures are not permitted in the medical record.

8. General Requirements. All medical records for patients receiving care in the hospital setting or at an ambulatory care location will document the information outlined in this paragraph, as relevant and appropriate to the patient’s care. This documentation will be the joint responsibility of the responsible Practitioners and Providers and the Hospital.
a. Identification data, including the patient’s name, sex, address, date of birth, and name of LAR;

b. Legal status of any patient receiving behavioral health services;

c. Patient’s language and communication needs, including preferred language for discussing health care;

d. Evidence of informed consent when required by the Informed Consent – Patient Care Policy #1225 and, when appropriate, evidence of any known advance directives;

e. Records of communication with the patient regarding care, treatment, and services (e.g., telephone calls or e-mail) and any patient-generated information;

f. Emergency care, treatment, and services provided to the patient before his or her arrival, if any;

g. Admitting history and physical examination and conclusions or impressions drawn from the history and physical examination;

h. Allergies to foods and medicines;

i. Reason(s) for admission of care, treatment, and services;

j. Diagnosis, diagnostic impression, or conditions;

k. Goals of the treatment and treatment plan;

l. Diagnostic and therapeutic orders, procedures, tests, and results;

m. Progress notes made by authorized individuals;

n. Medications ordered, prescribed or administered in the Hospital (including the strength, dose, or rate of administration, administration devices used, access site or route, known drug allergies, and adverse drug reactions);

o. Consultation reports;

p. Operative procedure reports and/or notes;

q. Any applicable anesthesia evaluations;

r. Response to care, treatment, and services provided;

s. Relevant observations, diagnoses or conditions established during the course of care, treatment, and services;

t. Reassessments and plan of care revisions;
u. Complications, hospital acquired infections, and unfavorable reactions to medications and/or treatments;

v. Discharge summary with outcome of hospitalization, final diagnosis, discharge plan, discharge planning evaluation, disposition of case, discharge instructions, and if the patient left against medical advice;

w. Medications dispensed or prescribed on discharge;

x. If the patient was delivered to the Hospital by ambulance, a copy of the state required EMS report;

y. Social work services reports, if provided;

z. Autopsy findings, when performed;

aa. Certifications of transfer of the patient between hospitals; and

bb. Routine inquiry form regarding request for organ donation in the event of the death of the patient.

9. Continuing Ambulatory Care. For patients receiving continuing ambulatory care services, the medical record will contain a summary list(s) of significant diagnoses, procedures, drug allergies, and medications, as outlined in this paragraph. This documentation will be the joint responsibility of the responsible Practitioners and Providers and the Hospital:

a. Known significant medical diagnoses and conditions;

b. Known significant operative and invasive procedures;

c. Known adverse and allergic drug reactions;

d. Known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

e. Clinical observations, including the results of treatment;

f. Referrals to and communications with other healthcare practitioners and providers of services internal or external to the Hospital;

g. Growth charts for children and adolescents as needed when the service is the source of primary care; and

h. Immunization status of children and adolescents and others as determined by law and/or Hospital Policy.

10. Emergency Care. Medical records of patients who have received emergency care will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible Practitioners and Providers and the Hospital:

a. Time and means of arrival;
b. Record of care prior to arrival;

c. Results of the Medical Screening Examination;

d. Known long-term medications, including current medications, over-the-counter drugs, and herbal preparations;

e. Conclusions at termination of treatment, including final disposition, condition, and instructions for follow-up care;

f. Documentation notes of procedures and other aspects of emergency care adequate for continuity of care upon admission;

g. If the patient left against medical advice; and

h. A copy of any information made available to an outside practitioner or facility providing follow-up care, treatment, or services.

11. Obstetrics Records. Medical records of obstetrics patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible Practitioners and Providers and the Hospital:

a. Findings during the prenatal period;

b. The medical and obstetrical history;

c. Observations and proceedings during labor, delivery and postpartum period; and

d. Laboratory and x-ray findings.

e. The obstetrical record will also include a complete prenatal record, if available.

f. The prenatal record may be a legible copy of the Attending Physician’s office record transferred to the Hospital before admission. An interval admission note that includes pertinent additions to the history and any subsequent changes in the physical findings must be entered.

12. Infant Records. Medical records of infant patients will contain the information outlined in this paragraph. This documentation will be the joint responsibility of the responsible Practitioners and Providers and the Hospital:

a. History of maternal health and prenatal course, including mother’s HIV status, if known;

b. Description of labor, including drugs administered, method of delivery, complications of labor and delivery, and description of placenta and amniotic fluid;

c. Time of birth and condition of infant at birth, including the Apgar score at one and five minutes, the age at which respiration became spontaneous and sustained, a description of resuscitation if required, and a description of abnormalities and
problems occurring from birth until transfer from the delivery room;

d. Report of a complete and detailed physical examination within 24 hours following birth; report of a physical examination within 24 hours before discharge and daily during any remaining Hospital stay – provided that for any infant who was a term delivery, has no complications other than newborn physiologic jaundice, and is discharged within 36 hours of birth, the birth and discharge examinations can be the same;

e. Physical measurements, including length, weight and head circumference at birth, and weight every day; temperature twice daily;

f. Documentation of infant feeding: intake, content, and amount if by formula; and

g. Clinical course during Hospital stay, including treatment rendered and patient response; clinical note of status at discharge.

13. History and Physical or H&P: Medical histories and physical examinations must be completed in accordance with the Medical Staff Bylaws and meet the additional requirements in this section.

a. The H&P examination, the update (if required), the results of any indicated diagnostic tests, and a provisional diagnosis must be recorded prior to any surgery or any potentially hazardous diagnostic procedure, with the exception of emergencies, by the physician responsible for the patient. Emergent cases do not require a history and physical examination to be available in the chart prior to the start of the case; however, the H&P must be completed as soon as possible after the surgery or other procedure has ended.

b. The H&P shall include:

i. The chief complaint

ii. Details of the present illness (including, when appropriate, assessment of the patient’s emotional, behavioral and social status)

iii. Current medications, allergies, relevant past, social and family histories, and

iv. An inventory of pertinent body systems.

v. The physical examination shall reflect a current physical assessment of pertinent body systems.

c. The history and physical must also include a statement of the conclusions or impressions drawn from the history and physical, and a statement of the course of action planned for the patient while in the hospital. The medical history and physical examination, and any update must be signed, dated and timed. An update may also be described in a progress note that is signed, dated and timed.
d. Newborn records must include a complete physical examination on birth and again prior to discharge, unless the infant is discharged within 36 hours of birth with the diagnosis of Term Male/Female Delivery and with no additional diagnosis other than newborn physiologic jaundice, in which case only the birth physical examination is required.

e. Patients admitted for dental care must have a history and physical and evaluation of overall medical risk by a physician member of the Medical Staff. The dentist is responsible for that part of the history and physical related to dentistry. Qualified oral-maxillofacial surgeons who admit patients without medical problems may perform the medical history and physical examinations on those patients if they have appropriate Clinical Privileges.

f. Patients admitted for podiatric care must have a history and physical and evaluation of overall medical risk by a physician member of the Medical Staff. The podiatrist is responsible for that part of the history and physical related to podiatry.

g. If a supervising physician has delegated the responsibility of completing or updating an H&P to qualified Allied Health Personnel, then the H&P or update must be countersigned by the supervising physician within 24 hours.

h. The following procedures do not require an H&P to be completed in advance of the procedure.

i. Low risk/Invasive Radiologic Procedures that do not require moderate/procedural sedation

ii. Outpatient non-invasive procedures without sedation

iii. Other outpatient therapies (examples include blood transfusion, chemotherapy, and other infusions)


a. Progress notes will be entered by the Attending Physician (or his or her covering Practitioner) at least every 24 hours for all hospitalized patients or more often as needed to reflect changes in the status of a patient.

b. Progress notes must be legible, dated, and timed. When appropriate, each of the patient’s clinical concerns should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments.

c. Progress notes may also be entered by Allied Health Personnel as permitted by their Clinical Privileges or scope of practice.

15. Pathology Reports.

a. All surgical specimens shall be sent to the pathologist, who shall make such examinations as he or she considers necessary to arrive at a pathological diagnosis. The pathologist is responsible for the preparation of a descriptive diagnostic report of gross specimens received from surgical procedures and of
autopsies performed. These reports will be authenticated by the pathologist and made a part of the medical record.

b. When an autopsy is performed, a provisional anatomic diagnosis should be recorded in the medical record within three days and the complete protocol should be made a part of the medical record within 60 days. The pathologist shall sign these reports.

16. Radiology Reports. The radiologist is responsible for the preparation of all radiology reports of examinations performed. These reports will be signed by the radiologist and made a part of the medical record.

17. Informed Consent. Informed consent will be obtained in accordance with Informed Consent-Patient Care Policy #1225 and documented in the medical record.

a. The medical record shall contain evidence of the patient's informed consent for any procedure or treatment for which it is appropriate, including use of blood products. The physician, podiatrist or dentist who informs the patient and obtains the consent should be identified in the medical record.

b. This information should include: identity of the patient, the procedure or treatment to be rendered, the name(s) of the individuals who will perform the procedure or administer the treatment, the authorization for any required anesthesia, an indication that alternate means of therapy and the possibility of risks or complications have been explained to the patient by the physician, podiatrist or dentist, the authorization for disposition of any tissue or body parts as indicated, the signature of the patient or other individual empowered to give consent (should be witnessed), the date and time of the consent.

c. Informed consent must be documented prior to the procedure or treatment. It is the responsibility of the Practitioner obtaining consent to determine if a patient lacks the capacity to understand their medical condition and proposed treatment to a reasonable degree of medical certainty. If a patient lacks capacity, consent must be obtained from a LAR, unless an emergency or other exception applies.

d. Refer to Hospital Policy and procedures for specific forms of documentation of informed consent for various procedures and treatment.

18. User Access Code. Each medical staff member who is granted a User Access Code (UAC) shall be subject to hospital policies and procedures regarding the use of such UAC and shall be required to sign and comply with such user responsibility statements and user confidentiality statements as required by the hospital. Each medical staff member is responsible for all entries made using that member’s UAC.

19. Medical Record Requirements For Organ Donation.

a. When the donor organ is obtained from a brain death patient, the medical record of the donor includes the date and time of brain death, documentation by and identification of the physician who determined the death, the method of transfer of the organ and the method of machine maintenance of the patient for organ donation, as well as an operative report.
b. When a cadaver organ is removed for purposes of donation, there is an autopsy or operative report that includes a description of the technique used to remove and prepare or preserve the donated organ.

20. Delinquent Medical Records. It is the responsibility of all individuals who are authorized to document in the medical record to prepare and complete medical records in a timely fashion in accordance with the specific provisions of these Rules and Regulations and other Hospital policies.

a. Deficient Medical Records.

i. Procedural reports, if not completed within 24 hours after the completion of the procedure;

ii. H&P’s, if not completed within 24 hours of the patient’s admission or as otherwise set forth in the Bylaws and these Rules and Regulations;

iii. Discharge summary/Clinical Resume, if not completed within 48 hours of discharge.

iv. All other medical records, if not completed at the time of discharge.

b. Deficient Medical records are considered Delinquent Medical Records if not completed within 30 days of discharge.

c. Delinquent Medical Records Disciplinary Process. Health Information Management will provide Practitioners and Providers with a list of any Delinquent Medical Records on a weekly basis, which will be considered the Initial Notification by HIM for purposes of this Section.

i. Level 1. If records remain Delinquent for 30 days after the Initial Notification by HIM, then the Practitioner/Provider will receive a reminder notification email from the HIM Senior Director.

ii. Level 2. If records remain Delinquent for 45 days after the Initial Notification by HIM, then the Practitioner/Provider’s badge access will be revoked, and the Practitioner/Provider will receive a reminder notification email from HIM Senior Director. Badge access will not be reinstated until the Practitioner/Provider has completed all current Delinquent Medical Records.

iii. Level 3. If records remain Delinquent for 60 days after the Initial Notification by HIM, then the Practitioner/Provider will receive a reminder notification letter from the Hospital Chief of Staff, a copy of which will be placed in the Practitioner/Provider’s Credentialing file.

iv. Level 4. If records remain Delinquent for 75 days after the Initial Notification by HIM, then the Practitioner/Provider’s Clinical Privileges will be suspended without right to the Hearing and Appeal process set forth in Article 7 of the Medical Staff Bylaws. Privileges will not be reinstated until the Practitioner/Provider has completed all current Delinquent Medical Records.
v. Level 5. If records remain Delinquent for 90 days after the Initial Notification by HIM, then the Practitioner/Provider’s Clinical Privileges and Medical Staff membership will be automatically relinquished without right to the Hearing and Appeal process set forth in Article 7 of the Medical Staff Bylaws. Only upon completion of all Delinquent Medical Records and payment of the application fee may the individual reapply as a new applicant for Medical Staff appointment and Clinical Privileges.

vi. If the individual has three or more Level 3 delinquencies within one Ongoing Professional Practice Evaluation cycle, then the Practitioner/Provider will be referred to the Hospital Medical Leadership Committee for further action.

d. A Medical Staff member who is ill or on vacation for longer than three days, or on an approved Leave Of Absence, will not be penalized for having incomplete medical records. Upon return, the Medical Staff member will be given three days to complete any Deficient or Delinquent Medical Records.

e. Medical records shall not be filed until complete, except on order of the Medical Records Committee and/or Administration.

f. When a Practitioner/Provider is no longer a member of the Medical Staff or Allied Health Staff and his or her medical records are filed as permanently Delinquent, this will be recorded in the Practitioner/Provider’s credentials file and may be divulged in response to any future credentialing inquiry concerning the Practitioner/Provider.

g. Any requests for exceptions to the above requirements will be submitted by the Practitioner/Provider to HIM Director, who will then forward the request with any pertinent comments to the applicable Hospital Chief of Staff for consideration.

h. The chart completion requirements for ambulatory care will be the same as for other medical records.

PART B. ORDERS

1. Orders, Generally. Orders will be entered using Computerized Provider Order Entry (“CPOE”) whenever possible. If an error is made while making a handwritten recording in the record, the error should be crossed out with a single line and initialed. Written or paper-based orders should be documented on appropriate forms as approved by the Hospital. Any such written or paper-based orders will be scanned and entered into the patient’s CIS via the CPOE in accordance with the Documentation of Patient Care Policy #200.311.

   a. All orders (including verbal/telephone orders) must be:

      i. Dated and timed when documented or initiated;
ii. Authenticated by the ordering Practitioner. Authentication must include the time and date of the authentication. All orders entered into the CPOE are electronically authenticated, dated, and timed, except for handwritten and paper-based orders that have already been authenticated via written signatures or initials; and

iii. Documented clearly, legibly and completely. Orders which are illegible or improperly entered will not be carried out until they are clarified by the ordering Practitioner and are understood by the appropriate health care Practitioner, Provider, or other staff.

b. Orders for tests and therapies will be accepted only from:

i. Members of the Medical Staff; and

ii. Allied Health Personnel who are granted Clinical Privileges by the Hospital, to the extent permitted by their licenses and Clinical Privileges.

c. The use of the summary (blanket) orders (e.g., “renew,” “repeat,” “resume,” and “continue”) to resume previous medication orders is not permitted.

d. All orders will be reviewed and reconciled when a patient is transferred from one level of care to a different level, whether the new level is a higher or lower level of care.

e. No order will be discontinued without the knowledge of the Attending Physician or his or her designee, unless the circumstances causing the discontinuation constitute an emergency.

f. All orders for medications administered to patients will be:

i. Reviewed by the Attending Physician or his or her designee at least weekly to assure the discontinuance of all medications no longer needed;

ii. Reconciled by the Attending Physician or his or her designee when the patient goes to surgery, is transferred to a different level of care, or when care is transferred to another clinical service; and

iii. Reviewed by the pharmacist before the initial dose of medication per the Medication Ordering/Prescribing Policy #200.243.

g. All medication orders will clearly state the administration times or the time interval between doses.

h. Abbreviations will not be used for medication names.

i. Medication orders and chemotherapy orders should include the height, weight, and allergies of the patient, when applicable.

j. Allied Health Personnel may be authorized to issue medical and prescription orders as specifically delineated in their privileges that are approved by the
2. Verbal Orders. A verbal order (via telephone or in person) for medication, biological, or treatment will be accepted only under circumstances when it is impractical for such order to be entered by the ordering Practitioner (e.g., when the ordering physician is involved in a procedure, or when the ordering physician is unable to access CPOE) or if a delay in accepting the order could adversely affect patient care. See Verbal Orders Patient Care Policy #0500 for additional information. Only those Practitioners or Providers identified in the Verbal Orders Patient Care Policy #0500 may receive and record verbal orders within their scope of practice and delineation of privileges.

3. Standing Orders, Order Sets, and Protocols. For all order sets and clinical protocols, review and approval of the Medical Executive Committee, with input from nursing and the Hospital’s Pharmacy Department when appropriate, is required. Prior to approval, the Medical Executive Committee will confirm that the order set or clinical protocol is consistent with nationally recognized and evidence-based guidelines. The Medical Executive Committee will also take necessary steps to ensure that there is periodic and regular review of such order sets and clinical protocols. All clinical protocols will identify clinical scenarios for when the protocol is to be used.

   a. If the use of an order set has been approved by the Medical Executive Committee, the order will be initiated for a patient only by an order from a Practitioner responsible for or involved in the patient’s care in the Hospital and acting within his or her scope of practice. Orders initiated by a clinical protocol will be deemed to have been initiated by a Practitioner responsible for the patient’s care in the Hospital and acting within his or her scope of practice.

   b. When used, order sets must be dated, timed, and authenticated promptly in the patient’s medical record by the ordering Practitioner or another Practitioner responsible for the care of the patient.

   c. A clinical protocol is defined as a course of treatment which may be initiated by a member of the Hospital’s clinical staff (e.g., a nurse) without a prior specific order from the treating Practitioner or other Provider when a patient’s condition meets certain pre-defined clinical criteria.

   d. An order set consists solely of menus of treatment or care options for common clinical scenarios designed to facilitate the creation of a patient-specific set of orders by a Practitioner or other qualified Provider authorized to write orders.

   e. Standing order/ sets may be used by individual physicians, podiatrists or dentists after approval by the Executive Committee of the Medical Staff. These orders shall be followed insofar as proper treatment of the patient will allow, and when the Attending Physician does not write specific orders, they shall constitute the orders for treatment. Standing orders shall not, however, replace or cancel those written for the specific patient.

4. Orders for Drugs and Biologicals. Orders for drugs and biologicals may only be ordered by Medical Staff members and other authorized individuals with Clinical Privileges at the Hospital.
Hospital.

5. Orders for Radiology and Diagnostic Imaging Services. Radiology and diagnostic imaging services may only be provided on the order of an individual who has been granted privileges to order the services by the Hospital, or, consistent with state law, other healthcare practitioners authorized by the Medical Staff and governing body to order services.

6. Orders for Outpatient Services. Outpatient orders for physical therapy, rehabilitation, laboratory, radiology, or other diagnostic services may be ordered by healthcare practitioners who are not affiliated with the Hospital in accordance with Medical Staff Bylaws and Federal and State law.

   a. Orders for outpatient services must be submitted on a prescription pad, letterhead, or an electronic order form and include: the patient’s name, the name and signature of the ordering individual, the type, frequency, and duration of the service, and the diagnosis (and diagnostic code if known), as applicable.

7. Medical Staff members and other Providers with Clinical Privileges are not permitted to prescribe or order drugs and biologicals, radiology and diagnostic imaging services, and/or outpatient services for themselves.

**PART C. PROCEDURES**

1. Pre-Procedural Protocol. The Practitioner performing the procedure will ensure the performance and documentation in the medical record of the following:

   a. A complete history and physical examination (or completed short-stay form, as appropriate);

   b. The provisional diagnosis related to the planned procedure;

   c. A properly executed informed consent;

   d. The results of any relevant diagnostic tests; and

   e. All appropriate plans of care for the patient, including anesthesia and nursing, prior to transport to the procedure room, except in emergencies.

2. Except in an emergency, the following will also occur before an invasive procedure or the administration of moderate or deep sedation or anesthesia occurs:

   a. The anticipated needs of the patient are assessed to plan for the appropriate level of post-procedural care;

   b. Pre-procedural education, treatments, and services are provided according to the plan for care;

   c. The physician performing the procedure is in the Hospital; and
d. The procedure site is marked and a “time out” is conducted immediately before starting the procedure, as described in the Surgical Invasive Procedure Verification (Universal Protocol) Policy #2725.

e. When another physician has completed the H&P on a patient scheduled for a procedure, the physician performing the procedure must still do the following:

i. Introduce himself/herself to the patient prior to the procedure, verify the procedure to be performed and answer any patient questions;

ii. Ensure consent is accurate, then sign and date;

iii. Mark the surgical site, if appropriate, and ensure agreement with surgical consent;

iv. Review the H&P and insert addendum in medical record if additional information needed or inaccuracies noted; and

v. Ensure the surgical diagnosis and planned procedure are noted in the medical record.

3. Post-Procedure Protocol. An operative procedure report must be entered into the record (either dictated, typed into EHR, or handwritten) immediately after an operative procedure. The operative procedure report shall include:

a. The patient’s name and Hospital identification number;

b. Pre- and post-operative diagnoses;

c. Date of the procedure;

d. The name of the surgeon/proceduralist(s) and assistant surgeon(s) responsible for the patient’s operation;

e. Procedure(s) performed and description of the procedure(s);

f. Findings, where appropriate, given the nature of the procedure;

 g. Estimated blood loss, if any;

h. Amount of blood transfused, if any;

i. Any unusual events or any complications, including blood transfusion reactions and the management of those events;

j. The type of anesthesia/sedation used;

k. Specimen(s) removed, if any;

l. Prosthetic devices, grafts, tissues, transplants, or devices implanted (if any);
m. The patient’s condition upon leaving the procedure area; and
n. The signature of the surgeon/proceduralist.

4. If a full report cannot be entered into the record immediately after the operation or procedure and prior to transfer to the next level of care, then a brief post-op note must be entered by a physician (Attending Surgeon/Proceduralist or resident only) in the medical record immediately after the procedure. In such situations, the full operative procedure report must be entered or dictated within 24 hours. The brief post-op note will include:

   a. The names of the physician(s) responsible for the patient’s care and physician assistants;
   b. The name and description of the procedure(s) performed;
   c. Findings, where appropriate, given the nature of the procedure;
   d. Estimated blood loss, when applicable or significant;
   e. Specimens removed; and
   f. Post-operative diagnosis.

PART D. ANESTHESIA SERVICES

1. General “Anesthesia” means general or regional anesthesia, monitored anesthesia care or deep sedation. “Anesthesia” does not include topical or local anesthesia, minimal, moderate or conscious sedation, or deep sedation.

2. General anesthesia, major conductive anesthesia (spinals and epidurals), and monitored anesthesia care (MAC) may only be administered by the following:

   a. Anesthesiologist;
   b. CRNA who is supervised by the operating Practitioner or an anesthesiologist who is immediately available;

3. Deep sedation may only be administered by the following:

   a. Anesthesiologist;
   b. CRNA who is supervised by the operating Practitioner or an anesthesiologist who is immediately available;
   c. Critical Care physician;
   d. ED physician;

4. Procedural sedation may only be supervised by physicians specifically privileged to do so
and according to the Adult Moderate/Deep Sedation/Analgesia for Procedures Policy #5150 and/or the Pediatric Moderate/Deep Sedation/Analgesia for Procedures Policy #5152.

5. Because it is not always possible to predict how an individual patient will respond to moderate or deep sedation, a qualified Practitioner with expertise in airway management and advance life support must be available to return a patient to the originally intended level of sedation when the level of sedation becomes deeper than initially intended.

6. General anesthesia for surgical procedures will not be administered in the Emergency Department unless the surgical and anesthetic procedures are considered lifesaving.

7. Pre-Anesthesia Procedures. A pre-anesthesia evaluation will be performed for each patient who receives anesthesia, by an individual qualified to administer anesthesia, within forty-eight hours immediately prior to an inpatient or outpatient procedure requiring anesthesia services. The evaluation will be recorded in the medical record and will include:
   a. A review of the medical history, including anesthesia, drug and allergy history;
   b. An interview, if possible, preprocedural education, and examination of the patient;
   c. Notation of any anesthesia risks according to established standards of practice (e.g., ASA classification of risk);
   d. Identification of potential anesthesia problems that may suggest complications or contraindications to the planned procedure (e.g., difficult airway, allergies to anesthesia);
   e. Development of a plan for the patient’s anesthesia care (i.e., discussion of risks and benefits); and
   f. Any additional pre-anesthesia data or information that may be appropriate or applicable.
   g. The elements of the pre-anesthesia evaluation in (a) and (b) must be performed within the 48-hour time frame. The elements in (c) through (f) must be reviewed and updated as necessary within 48 hours but may be performed during or within 30 days prior to the 48-hour time-period.
   h. The patient will be reevaluated immediately before induction to confirm that the patient remains able to proceed with care and treatment.

8. Monitoring During Procedure. All patients will be monitored during the administration of anesthesia at a level consistent with the potential effect of the anesthesia. Appropriate methods will be used to continuously monitor oxygenation, ventilation, and circulation during procedures that may affect the patient’s physiological status. All events taking place during the induction and maintenance of, and the emergence from, anesthesia will be documented legibly in an intraoperative anesthesia record, including:
   a. The name and Hospital identification number of the patient;
b. The name of the Practitioner or Provider who administered anesthesia and, as applicable, any supervising Practitioner;

c. The name, dosage, route time, and duration of all anesthetic agents;

d. The technique(s) used and patient position(s), including the insertion or use of any intravascular or airway devices;

e. The name and amounts of IV fluids, including blood or blood products, if applicable;

f. Time-based documentation of vital signs, as well as oxygenation and ventilation parameters; and

g. Any complications, adverse reactions or problems occurring during anesthesia, including time and description of symptoms, vital signs, treatments rendered, and patient’s response to treatment, and the patient’s status upon leaving the operating room.

9. Post-Anesthesia Evaluations. In all cases, a post-anesthesia evaluation will be completed and documented in the patient’s medical record by an individual qualified to administer anesthesia no later than 48 hours after the patient has been moved into the designated recovery area.

a. The post-anesthesia evaluation should not begin until the patient is sufficiently recovered to participate in the evaluation, to the extent possible, given the patient’s medical condition. If the patient is unable to participate in the evaluation for any reason, the evaluation will be completed within the 48-hour time frame and a notation documenting the reasons for the patient’s inability to participate will be made in the medical record (e.g., intubated patient).

b. The elements of the post-anesthesia evaluation will conform to current standards of anesthesia care, including:

i. Respiratory function, including respiratory rate, airway patency, and oxygen saturation;

ii. Cardiovascular function, including pulse rate and blood pressure;

iii. Mental status;

iv. Temperature;

v. Pain;

vi. Nausea and vomiting; and

vii. Post-operative hydration.

c. Patients will be discharged from the recovery area by a qualified Practitioner
according to criteria approved by the American Society of Anesthesiologists ("ASA"), using a modified Aldrete Recovery Score or similar post-anesthesia recovery scoring system. Post-operative documentation will record the patient’s discharge from the post-anesthesia care area and record the name of the individual responsible for discharge.

d. Patients who have received anesthesia in an outpatient setting will be discharged to the company of a responsible, designated adult.

e. When anesthesia services are performed on an outpatient basis, the patient will be provided with written instructions for follow-up care that include information about how to obtain assistance in the event of post-operative problems. The instructions will be reviewed with the patient or the individual responsible for the patient.

10. Minimal, Moderate or Deep Procedural Sedation. All patients receiving moderate or deep sedation will be monitored and evaluated before, during, and after the procedure by a Practitioner with appropriate Clinical Privileges in accordance with applicable policies.

11. Direction of Anesthesia Services. Anesthesia services will be under the direction of a qualified Doctor of Medicine (M.D.) or doctor of osteopathy (D.O.) with the appropriate Clinical Privileges and who is responsible for the organization and oversight of all activities of the anesthesia service and evaluating the quality and appropriateness of anesthesia patient care.

PART E. DISCHARGE PLANNING AND DISCHARGE SUMMARIES

1. Patients will be discharged only upon the order of the Attending Physician. At the time of discharge, the discharging Practitioner will review the patient’s medical record for completeness, state the principal and secondary diagnoses (if one exists) and authenticate the entry.

2. Identification of Patients in Need of Discharge Planning. All patients who are likely to suffer adverse health consequences upon discharge if there is no adequate discharge planning will be identified at an early stage of hospitalization. The Hospital should reevaluate the needs of the patients on an ongoing basis, and prior to discharge, as they may change based on the individual’s status. Criteria to be used in making this evaluation include:

   a. Functional status;
   b. Cognitive ability of the patient;
   c. Family support; and
   d. Patient safety.

3. Discharge Planning. Discharge planning will be an integral part of the hospitalization of each patient and an assessment will commence as soon as possible after admission.
The discharge plan and assessment, which includes an evaluation of the availability of appropriate services to meet the patient's needs after hospitalization, will be documented in the patient's medical record. The Attending Physician is expected to participate in the discharge planning process.

a. Discharge planning will include determining the need for continuing care, treatment, and services after discharge or transfer.

4. Clinical Resume/Discharge Summary. A concise, dictated clinical resume/discharge summary will be prepared by the Practitioner discharging the patient unless alternative arrangements are made (and are documented in the medical record) with another Practitioner who agrees to assume this responsibility. Clinical resumes/discharge summaries must be completed within 48 hours of discharge. All clinical resumes/discharge summaries will include the following:

a. Reason for hospitalization;
b. Significant findings;
c. Procedures performed and care, treatment, and services provided;
d. Condition and disposition at discharge;
e. Information provided to the patient and family, as appropriate;
f. Provisions for follow-up care; and
g. Discharge medication reconciliation.

5. A discharge progress note may be used to document the discharge summary for patients with problems of a minor nature that require less than a 48-hour period of hospitalization, and in the case of normal newborn infants and uncomplicated obstetrical deliveries. The final progress note should include any instructions given to the patient and/or the patient's family.

6. A death summary is required in any case in which the patient dies in the Hospital, regardless of length of admission.

7. Discharge of Minors and Incompetent Patients. Any individual who cannot legally consent to his or her own care will be discharged only to the custody of parents, legal guardian, or another responsible party unless otherwise directed by the parent, guardian, or court order. If the parent or guardian directs that discharge be made otherwise, that directive will be documented and will become a part of the permanent medical record of the patient.

8. Discharge Instructions. Upon discharge, the Attending Physician, along with the Hospital staff, will provide the patient with information regarding why he or she is being discharged and educate that patient about how to obtain further care, treatment, and services to meet his or her identified needs, when indicated. The patient and/or those responsible for providing continuing care will be given written discharge instructions. If the patient or LAR cannot read and understand the discharge instructions, the patient or LAR will be
provided appropriate language resources to permit him or her to understand.

a. The Attending Physician, along with the Hospital staff, will also arrange for, or help the family arrange for, services needed to meet the patient's needs after discharge, when indicated.

b. When the Hospital determines the patient's transfer or discharge needs, the Attending Physician, along with the Hospital staff, promptly will provide appropriate information to the patient and the patient's family when it is involved in decision-making and ongoing care.

c. When continuing care is needed after discharge, the Attending Physician, along with the Hospital staff, will provide appropriate information to the other health care practitioners, including the reason for discharge, the patient's physical and psychosocial status, a summary of care provided and progress toward goals, community resources or referrals provided to the patient, and discharge medications.
ARTICLE 4

CLINICAL DEPARTMENT RULES AND REGULATIONS

Each Clinical Department may enact departmental Rules and Regulations subject to the approval of the Medical Executive Committee. Departmental Rules and Regulations and policies may not be less restrictive than the Medical Staff Governing Documents, or the Hospital Bylaws, policies, and procedures. Copies of Departmental Rules and Regulations and policies shall be provided to each member of the Department and to applicants seeking membership in the Department. Departmental Rules and Regulations and policies shall be reviewed by the Clinical Department at least every two (2) years.
ARTICLE 5

ALLIED HEALTH PROFESSIONALS (AHP)

1. Except where otherwise required by law, services provided by an AHP shall be at the request of a supervising physician, who shall supervise and be responsible for all activities of the designated AHP at Orlando Health.

2. AHPs shall not admit patients but shall provide specified patient care services under the supervision or direction of a member of the Medical Staff. The Board of Directors shall adopt standards for each category of AHP which shall govern the minimum qualifications for provision of services, including the extent of supervision required, and the services to be provided by the AHP at Orlando Health. Such standards shall be in writing and made available to all applicants.

3. Orlando Health employed AHPs must be supervised by a Medical Staff member. Proof of malpractice coverage is not required.

4. AHPs who are employed by a non-employed Medical Staff member must be supervised by a Medical Staff member and must provide Orlando Health with the AHP’s current malpractice coverage.

5. AHPs who are not employed by Orlando Health or in a Medical Staff member’s practice must be supervised by a Medical Staff member and must provide Orlando Health with the AHP’s current malpractice coverage.

6. An AHP who does not have malpractice coverage must provide a Supervising Medical Staff Member Indemnification agreement and an Alternate Supervising Medical Staff Member Indemnification Agreement signed by each Supervising Medical Staff Member who will be supervising the AHP at Orlando Health.

7. A Medical Staff member who supervises an AHP at Orlando Health shall participate in the evaluation of the AHP in accordance with the policies and procedures of Orlando Health.

8. Please refer to the Allied Health Policy and Procedure for additional information and requirements related to AHPs.
ARTICLE 6

RESIDENT SUPERVISION AND COUNTERSIGNATURES

1. Supervision of participants in graduate medical education programs by Medical Staff members in accordance with the requirements of the Accreditation Council for Graduate Medical Education shall be as specified in the policies and procedures of the Division of Graduate Medical Education.

2. Residents Countersignatures. The following entries in the medical record by residents require countersigning by the supervisory or attending medical staff within 24 hours:
   a. History and Physical Examinations;
   b. Consultation;
   c. Operative Report;
   d. Labor and Delivery Record;
   e. Clinical Resume or Final Progress Note;
   f. Final Diagnosis on Face Sheet;
   g. Do Not Resuscitate (DNR) Order
ARTICLE 7

TRAUMA SERVICES

1. The Medical Trauma Director is responsible and accountable for administering all aspects of trauma care.

2. Issues related to trauma that are not able to be resolved by the Medical Trauma Director through the normal hospital organizational structure shall be referred to the Chief of Staff for recommendation and resolution using the powers delegated to the Chief and/or those vested in the respective hospitals and/or Clinical Departments.

3. Any physician whose credentials or care is considered below standard by the Medical Trauma Director shall be dealt with through the appropriate contractual stipulation in the case of the contracted physicians or when a member of the Medical Staff at large, referred to the Chief of Staff or Medical Executive Committee with recommendations. The Chief of Staff and Medical Executive Committee shall address the issue in accordance with the Medical Staff Bylaws.