Desoto Memorial Hospital

RULES AND REGULATIONS

DESOTO MEMORIAL HOSPITAL
MEDICAL STAFF RULES AND REGULATIONS
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1.1 ADMISSIONS/TRANSFERS

1.1.1 Who May Admit Patients

Patients may be admitted only by practitioners (physicians, dentists, podiatrists, and clinical psychologists who have been granted admitting privileges as recommended by the Medical Executive Committee ("MEC") and approved by the DeSoto Memorial Hospital District Board of Directors.

1.1.2 Medical Staff Responsibility

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in DeSoto Memorial Hospital ("Hospital"), the prompt completion and accuracy of the medical record, the necessary special instructions and transmitting reports of the condition of the patient to the transferring practitioner and to relatives and/or other individuals as designated by the patient or the patient's representative/healthcare surrogate. Whenever these responsibilities are transferred to another member of the Medical Staff, a note covering the transfer shall be entered in the patient's medical record. (Refer to the Medical Staff Policy entitled "Physician Sign Out/Sign In Policy.")

1.1.3 Alternate Coverage

Each member of the Medical Staff shall provide assurance of immediate availability of adequate professional care for his/her patients in the Hospital by being available or having available an alternate member of the Medical Staff with whom prior arrangements have been made and who has clinical privileges at the Hospital sufficient to care for the patient. The Staff member must provide notification of his/her alternate coverage arrangement (Refer to the Medical Staff Policy & Procedure entitled "On Call and Attending Physician Call/Beep Policy.")

1.1.4 Priorities for Admissions

In any case in which the patient requires admission, the practitioner or his/her designee shall first contact the Admitting Department to ascertain where there is an available bed. Except in an emergency, no patient shall be admitted until a provisional diagnosis or valid reason for admission has been provided. In case of an emergency, such statement shall be entered in the patient's medical record as soon after admission as possible. The Admitting Department will process the patient's admission on the basis of the following order of priorities:

1.1.4.1 Emergency Admissions: This category includes those patients whose life is in immediate danger and whose condition is such that lack of immediate treatment could result in serious or permanent harm and any delay in admitting the patient for treatment would add to that harm or danger. On the day following an emergency admission the attending practitioner may be required to provide signed, complete documentation of the need for the admission to the Utilization Management Committee within forty-eight (48) hours. Failure to furnish this documentation, or evidence of willful or continued inappropriate use of this category of admission, will be brought to the attention of the MEC for appropriate action.

1.1.4.2 Urgent Admissions: This category includes patients so designated by the attending practitioner and shall be reviewed as necessary through mechanisms designated by the MEC. Patients in this category will be given first priority on available beds other than those needed for emergency patients.

1.1.4.3 Pre-Operative Admissions: This category includes all patients already scheduled for surgery. If it is not possible to accommodate all such admissions, the Chairman of the Department of Surgery, or his/her designee, will determine the urgency of any specific admission.

1.1.4.4 Routine Admissions: This category includes elective admissions involving all departments and sections.

1.1.5 Emergency Admissions

1.1.5.1 The History and physical examination must clearly justify any admission on an emergency basis and must be recorded in the patient's medical record within twenty-four (24) hours of admission.

1.1.5.2 Screening examinations for all patients presenting to the Hospital seeking emergency care will be performed by the emergency physician on duty in the Emergency Department, or a practitioner who is a member of the Medical Staff who is on call, or by a physician assistant who has been appointed to the AHP Staff provided he/she is working under the direct supervision of a practitioner member of the Medical Staff, and in accordance with Hospital policies.

1.1.5.3 Each clinical department shall submit an emergency call schedule for its specialties as appropriate. The department or section chairman will be responsible for coordinating with its members to develop these call schedules. Practitioners assigned to the department /section may be required to be on the call schedule in each clinical department/section in which he/she holds appointment and/or clinical privileges in accordance with the Rules and Regulations of the department/section.

1.1.5.4 If a practitioner is ill and unable to obtain coverage, he/she must inform the chairman of the department so that coverage can be obtained by the chairman. If a member cannot take call because of business or vacation, he/she must make arrangements to have coverage by a practitioner on staff at the Hospital with at least the same level of training. If there is no other practitioner on staff with privileges in that specialty, he/she must notify the Emergency Department when he/she will not be available and sign out to a member of the Hospital's Medical Staff with similar and appropriate training and experience.

1.1.6 Continued Hospitalization: The attending practitioner or appropriate practitioner coverage is required to routinely document the need for continued hospitalization after a specific period of stay as defined by the Utilization Management Committee, and/or the Case Manager.

1.1.7 Transfer Priorities: Transfer priorities shall be as follows:

1.1.7.1 From the Emergency Department to an appropriate patient bed;

1.1.7.2 From the Intensive Care Unit to a general care area;
1.1.7.3 From temporary placement in an inappropriate geographical or clinical service area to the appropriate area for that patient.

1.1.8 Transfer Authorizations: No patient shall be transferred without such transfer being approved by the responsible practitioner, except under emergency conditions.

1.1.9 Psychiatric/Substance Abuse Services: DeSoto Memorial Hospital does not primarily provide psychiatric or substance abuse services, therefore the Hospital will provide acute medical care for patients with these illnesses, and will transfer the patient to the appropriate facility for further treatment as necessary.

1.2 MEDICAL ORDERS

1.2.1 General Requirements:

1.2.1.1 Orders entered into the medical record must be timed, dated, clear and complete. If written, they must also be legible.
1.2.1.2 All orders, including those for medications shall be discontinued when a patient undergoes surgery or any invasive procedure and shall not be renewed unless and until re-entered in the medical record by the appropriate practitioner or AHP.
1.2.1.3 All orders must be reviewed completely and documented by the accepting practitioner when a patient is transferred from one practitioner to another.
1.2.1.4 All pre-printed routine orders must be approved by the appropriate Department, and by the Utilization Review Committee and the MEC.
1.2.1.5 Abbreviations listed in the Medical Staff's Do Not Use Policy shall not be used.
1.2.1.6 Practitioners must include relevant clinical information when ordering imaging studies.
1.2.1.7 The practitioner or allied health professional under his/her supervision shall include all medications, with dosages, that the patient is instructed to take upon discharge from the Hospital in the discharge orders.

1.2.2 Who May Write Orders: All orders for medication and/or treatment shall be initiated by practitioners appointed to the Medical Staff or by allied health professionals appointed to the AHP Staff. A practitioner or AHP shall initiate only those orders permitted by his/ her clinical privileges. All orders written by an AHP must be confirmed and signed by the responsible practitioner. (Refer to the Hospital's Policy entitled Orders—Verbal, Written, Electronic in the Pharmacy cabinet in Meditech.

1.2.3 Verbal Orders

1.2.3.1 Verbal orders for medication and treatment shall be accepted only under circumstances when it is impractical for such orders to be given in written manner or entered into the electronic health record by the responsible practitioner or AHP. Verbal orders shall be taken only by qualified personnel as noted below, who shall transcribe

the orders in the proper place in the medical record of the patient. Verbal orders shall include the time and date they are received, and full signature of the person accepting them, and be signed by the practitioner as soon as possible. A verbal order must be signed by the practitioner who gave or is responsible for the verbal order unless that practitioner and the attending practitioner are both in the same group, in which case the attending practitioner may sign the verbal order instead, so long as their group has formally approved this policy.

1.2.3.2 Hazardous verbal orders must be signed within twenty-four (24) hours and include orders pertaining to:

1.2.3.2.1 Seclusion and restraint;

1.2.3.2.2 Code Blue/do not resuscitate status; and

1.2.3.2.3 Conscious sedation

1.2.3.3 A Behavioral Health Program attending psychiatrist must sign all verbal orders within seven (7) days for that program.

1.2.3.4 The practitioner is responsible for verbal orders given by himself/herself or by an AHP under his/her supervision.

1.2.3.5 Acceptance of a verbal order is limited to the following personnel, with noted restrictions:

1.2.3.5.1 A practitioner;

1.2.3.5.2 A registered nurse or advanced practice registered nurse;

1.2.3.5.3 A pharmacist who may accept verbal orders pertaining to drugs;

1.2.3.5.4 Qualified staff (as defined in department policies and procedures) in the laboratory, home health, hospice, nursing home staff, nutrition services, diagnostic imaging, rehab and respiratory, who may take verbal orders pertaining to regimens, diets, therapies or treatments in their respective departments;

1.2.3.5.5 Specially trained LPN's;

1.2.3.5.6 Unit secretaries may take simple verbal orders related to diet and activity changes;

1.2.3.5.7 Practitioners and AHP's giving verbal orders must allow time for nurses and other individuals taking the verbal orders to read the verbal orders back to him/her to verify accuracy.

1.2.4 Use of Restraints/Seclusion

All practitioners shall comply with the Hospital's Restraint Use Policy & Procedure, as approved by the Medical Staff, regarding the use of restraints and seclusion and the documentation required in the patient's medical record.

1.3 CONSULTATIONS

1.3.1 Who May Give Consultations

Any qualified practitioner with clinical privileges in the Hospital can be asked for consultation within his/her area of expertise and scope of clinical privileges. Each department or section shall provide a list of its subspecialists, and such subspecialists shall be responsible for

consultation in accordance with the Rules and Regulations and policies of the department, section, Medical Staff and Hospital.

1.3.2. Required Consultations

1.3.2.1 Consultation shall be required in all non-emergency cases whenever requested by the patient or his/her family, or by his/her healthcare surrogate or proxy; or in any case when required by the MEC.

1.3.2.2 Patients who have attempted suicide or have taken a chemical overdose with intent to do self-harm, will be transferred to facilities with which DeSoto Memorial Hospital has a transfer agreement, employing the provisions of the State of Florida Baker Act when needed.

1.3.2.4 The attending practitioner is responsible for requesting consultation whenever indicated, including all cases in which the patient is found to have a condition at the time of admission, or who subsequently develops a condition that is beyond his/her expertise, or in unusually complicated situations where specific skills of other practitioners may be needed.

1.3.2.5 The practitioner requesting consultation must contact the consultant personally on nights, weekends and holidays, and for consultations of an emergency or urgent nature. Optimally, he/she should personally contact the consultant for every consultation.

1.3.2.6 Each practitioner on call for the Emergency Department shall respond to phone calls from the Emergency Department immediately. Requests by the Emergency Department physician for the on-call physician to present in the ED to assist in the care of a patient must be responded to by the on-call physician physically presenting in the ED within thirty (30) minutes of receiving the request. (Refer to the Medical Staff Policy and Procedure entitled On-Call and Attending Physician Responsibilities)

1.3.2.7 For an Emergency Department consultation without a request for immediate assistance or for an inpatient consultation, the consultant should respond to the ED or nursing unit by phone within thirty (30) minutes and make some disposition within sixty (60) minutes. (see Policy and Procedure referenced in 1.3.2.6 above)

1.3.2.8 When an elective inpatient consultation is requested the patient shall be evaluated by the consultant within twenty-four (24) hours. (See the Policy & Procedure referenced in 1.3.2.6 above)

1.3.2.9 The consulting practitioner must specify the reason for consultation and whether the consultation is an emergency or elective.

1.3.2.10 All consultation notes shall be entered into the patient's medical record within twenty-four (24) hours of consultation.

1.4 MEDICAL RECORDS

1.4.1 General Requirements

The attending practitioner shall be responsible for the preparation of a complete, accurate, and legible medical record, preferably using the electronic health record ("EHR") system, for each patient under his/her care. Its contents shall be pertinent and current. A single attending

practitioner shall be identified in the medical record as being responsible for the patient at any given time. When a patient is transferred from the service of one practitioner to the service of another practitioner, the transfer must be documented by a written order on the order sheet or entered in the EHR. A practitioner's routine orders, when applicable to a particular patient, shall be reproduced in detail on the order sheet in the patient's medical record. Abbreviations listed in the Medical Staff's Do Not Use Policy shall not be used in the medical record. All final diagnoses and complications shall be recorded without the use of symbols or abbreviations. In the case of readmission of a patient, all previous records shall be available for use by the attending practitioner. This shall apply whether he/she is attended by the same practitioner or another. Office records may be appended to the medical record when desired, but shall not take the place of basic routine studies to be made in the Hospital. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis for admission has been stated. In case of emergency, such statement shall be recorded as soon as possible, but not to exceed twelve (12) hours following admission.

1.4.2 Authentication

All entries in the medical record shall be timed, dated and individually authenticated. Initials are acceptable authentication provided the initials are registered with the Hospital so they can be recognized as having been entered by a particular practitioner. Electronic and computer-generated signatures may be used provided such signature is registered with the Hospital and the practitioner agrees to be solely responsible for its use.

1.4.3 Content

A complete medical record shall include, as appropriate:

1.4.3.1 Identification data;
1.4.3.2 Dates of admission and discharge;
1.4.3.3 Provisional admitting diagnosis;
1.4.3.4 Pertinent medical history;
1.4.3.5 Physical examination;
1.4.3.6 Plan of care/course of action for hospitalization with periodic review as appropriate;
1.4.3.7 Diagnostic and therapeutic orders;
1.4.3.8 Evidence of appropriate informed consent;
1.4.3.9 Clinical observations, progress notes, nursing notes, consultation reports;
1.4.3.10 Reports of procedures, tests, and results;
1.4.3.11 Preoperative diagnosis and operative report;
1.4.3.12 Pathology reports;
1.4.3.13 Radiology and nuclear medicine examinations and treatment reports;
1.4.3.14 Anesthesia records;
1.4.3.15 Final diagnoses, condition on discharge, summary or discharge note, discharge instructions; and
1.4.3.16 Autopsy report, if performed.

1.4.4 History and Physical Examination

1.4.4.1 A complete history and physical examination shall be entered into the patient's EHR, dictated, typewritten, or completed using preprinted forms approved by the MEC for this purpose within twenty-four (24) hours by a practitioner appointed to the Medical Staff or by an allied health professional appointed to the AHP Staff. If provided by an AHP, it must be approved and signed by the supervising practitioner. When the history and physical examination is dictated, an admission progress note shall be placed in the medical record to that effect. This admission progress note shall contain information describing the reason for admission, a brief evaluation of the patient, and plans for diagnosis and treatment. This report shall reflect a date, time and a comprehensive and current physical assessment.

1.4.4.2 If a complete physical examination has been performed within thirty (30) days prior to admission, a dated, timed, durable, legible copy of this physical examination may be used in the patient's Hospital medical record provided these reports are recorded by a practitioner member of the Hospital's Medical Staff or an Allied Health Professional appointed to the Hospital's AHP Staff, and there has been no change subsequent to the original examination or the changes have been recorded at the time of admission.

1.4.4.3 History and physician examinations are valid for thirty (30) days. After thirty (30) days, the practitioner must perform and document a new and complete history and physical examination.

1.4.4.4 The medical record shall contain a current, thorough history and physical examination prior to the performance of any surgery or other invasive procedure whether the surgery or invasive procedure is performed on an outpatient or inpatient basis at the Hospital or any of its entities. This report shall be dated and dictated or entered in the patient's EHR. However, if circumstances prevent this report from being dictated or entered in the patient's medical record, a progress note shall be made outlining pertinent details. When appropriate information as outlined above is not recorded before a surgical procedure or any potentially hazardous diagnostic or therapeutic procedure, the procedure shall be cancelled. When the dictated note is not available before surgery, the adequacy of the written preoperative note will be judged by the attending surgeon and anesthetist. When the history and physical examination is performed by an AHP the findings, conclusions, and a risk assessment must be confirmed and signed by the practitioner prior to surgery or other invasive diagnostic or therapeutic intervention.

1.4.4.5. When the history and physician examinations are not recorded before the time stated for a surgical or other invasive or hazardous diagnostic or therapeutic procedure, the attending practitioner must enter a note in the patient's medical record stating that delaying the procedure would constitute a hazard to the patient.

1.4.5 Progress Notes

1.4.5.1 Progress notes made by practitioners appointed to the Medical Staff and allied health professionals appointed to the AHP Staff shall give a pertinent chronological report of the patient's course in the Hospital. Progress notes shall be legible, dated,

timed and recorded at the time of observation, and shall contain sufficient content to ensure continuity of care if the patient is transferred. Whenever possible, each of the patient's clinical problems shall be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. The attending practitioner or appropriate practitioner coverage is required to see the patient daily and to routinely document in a daily progress note. Pertinent progress notes may also be recorded by other individuals such as allied health professionals who have been granted privileges to do so, however such notes shall not replace the attending practitioner's responsibilities to see each patient and to enter a progress note each day.

1.4.5.2 Entries into the practitioner's progress notes will be made only by a practitioner or an allied health professional who is under his/her supervision except:

1.4.5.2.1 The intensive care unit(s) and telemetry, where registered nurses may make notations describing the EKG tracings without the practitioner's countersignature; and

1.4.5.2.2 For Case Management personnel and Ethics Committee consultants, whose entries do not require a practitioner's countersignature.

1.4.6 Operative and High-Risk Procedure Reports

An operative report or progress note must be entered in the medical record immediately after a surgical or high-risk procedure.

1.4.6.1 If the practitioner performing the procedure accompanies the patient from the operating room to the next unit or area of care, the report may be written or dictated in the new unit or area of care.

1.4.6.2 If circumstances prevent the practitioner from electronically entering or dictating a full operative report into the electronic health record (EHR), or if such report is dictated but cannot be placed in the EHR immediately after the procedure, he/she shall have the option of writing a post-operative progress note, and then shall electronically enter or dictate a complete operative report within three (3) days of the procedure.

1.4.6.3 If the progress note option is used, it must contain comparable operative report information that includes the following minimum elements:

1.4.6.3.1 The name of the primary surgeon and any assistants;

1.4.6.3.2 The procedure(s) performed;

1.4.6.3.3 A description of the findings of each procedure;

1.4.6.3.4 Any estimated blood loss;

1.4.6.3.5 Any specimens removed; and

1.4.6.3.6 The post-operative diagnosis.

1.4.7 Consultation Reports

Each consultation report shall contain a written opinion and recommendations by the consultant that reflect, when appropriate, the actual examination of the patient and a review of the patient's medical record. This report shall be made a part of the patient's medical record. When operative procedures are involved, the consultation note shall be recorded prior to the procedure(s), except in emergency situations so verified in the medical record.

1.4.8 Discharge Summaries

1.4.8.1 All relevant diagnoses established by the time of discharge as well as all operative procedure and other invasive procedures performed shall be recorded at the time of discharge using acceptable disease and operative terminology that includes topography and etiology as appropriate. For outpatient procedures the surgeon will document on the physician's order sheet "discharge when the patient meets established criteria" as outlined on the same day surgery outpatient treatment record. The final diagnosis shall be signed and dated by the attending practitioner at or near the time of discharge. The primary practitioner who provides the care to a particular patient shall be responsible for documenting, on the summary sheet, all diagnoses and procedures relevant to the care that he/she has provided. The practitioner shall have up to ten (10) days from the date of discharge to complete the discharge summary. The practitioner or his/her coverage will be notified by a phone call or text message and this notification shall be documented in writing by the Health Information Management (HIM) Department seventy-two (72) hours prior to the expiration of the tenth day. The practitioner shall then have seventy-two (72) hours in which to dictate the discharge summary, including the final diagnosis and severity of illness. A record of delinquencies in discharge summaries will be kept by the HIM Department and all delinquencies will be referred to the MEC and department chairman.

1.4.8.2 The attending practitioner or an allied health professional whom he/she supervises must prepare a discharge summary when his/her patient is discharged, regardless of whether the admission was short term, forty-eight (48) hours or less, or longer. However, in the case of short-term admission, a written final progress note, including the condition on discharge and any instructions given to the patient at discharge, may take the place of a discharge summary.

1.4.8.3 The discharge summary shall include the following: Reason for hospitalization, significant findings, procedures performed, other treatment rendered, and the condition of the patient on discharge. Also, it must document that the patient received appropriate discharge instructions including medications, diet, activity and return visit. This documentation may be accomplished in one of four ways:

1.4.8.3.1 The discharge summary may state the specific instructions;

1.4.8.3.2 The discharge summary may refer to the progress notes or order sheet where the discharge instructions are recorded;

1.4.8.3.3 The discharge summary may refer to preprinted instructions issued to the patient (a copy must be placed in the patient's medical record) or

1.4.8.3.4 The discharge summary may refer to the Hospital's Discharge Instruction for Patients/Caregivers; a copy of which is issued to the patient and a copy of which remains in the patient's medical record.

1.4.8.4 All discharge summaries must be authenticated by the attending practitioner.
1.4.8.5 The Emergency Department record must state the condition of the patient upon discharge and contain discharge instructions to the patient. This information may be entered in the patient's medical record, by the emergency physician, other attending practitioner or an allied health professional he/she supervises, or by an Emergency Department nurse.

1.4.9 Completion of Medical Records

1.4.9.1 Adequacy: Adequacy of medical records, in accordance with these Rules and Regulations will be considered at the time of reappointment. Consideration will be given to limiting or revoking the admitting privileges and/or Medical Staff appointment of any practitioner who is brought to the attention of the MEC, as outlined below.

1.4.9.2 Suspension: Any individual suspended as a result of medical record delinquencies will be required to complete all available delinquent medical records prior to reinstatement of admitting privileges. Only emergency admission for which there is no other qualified practitioner available, will be permitted during any period when a practitioner is suspended for medical record violations. Within twenty-four (24) hours following such an admission, the suspended practitioner shall provide written information justifying the emergency admission and explaining his/her attempts to contact another practitioner of similar training. This information will be forwarded to the appropriate department chairman and/or the Chief of Staff. Abuse of emergency admitting privileges, as determined by the department chairman will result in referral to the MEC. This section shall not excuse a practitioner from mandatory Emergency Department coverage during his/her period of suspension.

1.4.9.3 History and Physical Examinations: Histories and physical examinations shall be completed within twenty-four (24) hours of admission. A medical record shall be considered delinquent for lack of a completed history and physical examinations twenty-four (24) hours after admission. The HIM Department will record delinquent histories and physical examinations per practitioner. All delinquencies shall be referred to the Medical Executive Committee and department chairman. Refer to Article 1.4.4.3, 1.4.4.4, and 1.4.4.5 of these Rules and Regulations for information regarding history and physical examination requirements for surgical patients.

1.4.9.4 Final Diagnosis: Relevant final diagnoses (including a list of diagnoses and severity of illness) shall be entered in the medical record at the time of discharge. If the final diagnosis is not available at the time of discharge because the practitioner is waiting to receive reports necessary to complete the discharge summery, the practitioner shall have up to ten (10) days from the date of discharge to complete the discharge summary. The practitioner or his/her coverage will be notified by the HIM Department seventy-two (72) hours prior to the expiration of the tenth day. The practitioner shall then have seventy-two (72) hours in which to note the final diagnosis in writing. A record of delinquencies will be referred to the MEC and department chairman.

1.4.9.5 Operative Reports: These reports must be completed as described in Article 1.4.6 of these Rules and Regulations. Delinquent reports will be recorded by the HIM

Department and delinquencies will be referred to the Medical Executive Committee and the department chairman.

1.4.9.6 Reports of Invasive and Non-Invasive Diagnostic Procedures: These reports shall be dictated within twenty-four (24) hours after the procedure. When a final report cannot be dictated within twenty-four (24) hours of the procedure, a preliminary report will be dictated within this time including the reason for the delay in final reporting. A final report shall follow as soon as possible.

1.4.9.7 Completion of Medical Records: All medical records will be completed within twenty-one (21) days of the date of discharge, including all relevant final diagnoses, signatures, etc. (Refer to Article 1.4.3 of these Rules and Regulations). A practitioner who is leaving town or who is going on vacation will assure that medical records are current (i.e. no delinquent medical records) at the time he/she leaves. For purposes of this section, "vacation" and "going out of town" will be defined as absence from the Hospital for five (5) or more consecutive days. It is the responsibility of the practitioner to notify the HIM Department of the dates of his/her expected absence. All delinquencies which accrue during the period of the practitioner's absence, shall be completed within one (1) week following his/her return. Planned vacation/absence time shall not constitute an acceptable excuse at the time a practitioner is notified that he/she has forty-eight (48) hours in which to complete delinquent medical records as outlined below:

1.4.9.7.1 Notification of Delinquency/Suspension: The practitioner will be notified by the HIM Director or designee when a medical record is delinquent. If the practitioner is unavailable, his/her office will be notified. Written notification shall be provided to any practitioner having a delinquent medical record by FAX or other means seventy-two (72) hours prior to the expiration of the 21st day after discharge. The practitioner will have seven (7) days from receipt of the written notice of delinquency in which to complete the delinquent medical record. If the practitioner fails to complete the delinquent medical record within seven (7) days after written notification, this conduct will be reported to the Chief of Staff and the CEO. The Chief of Staff shall notify the practitioner that his/her admitting, surgical and procedural privileges will be automatically suspended, unless the delinquent medical record(s) are completed within forty-eight (48) hours. If the Chief of Staff is not available, this notification shall be made by the CEO. Notification of suspension of admitting privileges will be made by telephone and by written notice to the practitioner. All suspensions for medical records delinquencies will be reported to the MEC and department chairman.

1.4.9.7.2 Notification of Reinstatement: Appropriate notice of reinstatement will be forwarded to the Admitting Office and Administration by the HIM Department. However, should any practitioner have privileges suspended for more than thirty (30) consecutive days because of failure to complete medical records, his/her Medical Staff appointment and all clinical privileges shall then be revoked and he/she may be reinstated only by application for appointment as a

new applicant in accordance with the procedures set forth in Article IV of the Medical Staff Bylaws.

1.4.9.8 Failure to Complete Delinquent Medical Records: If the practitioner has not completed the delinquent records within forty-eight (48) hours of notification by the Chief of Staff and CEO, as defined above, the physician's admitting privileges shall automatically be suspended. Notification of suspension shall be made by the Chief of staff or CEO, to the individual practitioner, the HIM Director, the Admitting Department, the UM Committee, and Medical Staff Services.

1.4.9.9 A medical record shall not be permanently filed until it is completed by the responsible practitioner or is ordered filed by the UM Committee and the MEC.

1.4.9.10 In the event the physician leaves the Hospital Staff without completing all of his/her medical records the following procedure will be implemented:

1.4.9.10.1 The MEC cooperates with Administration and UM Committee and the HIM Department in a concentrated effort for medical record completion before departure.

1.4.9.10.2 All efforts and communications with the departing physician are to be documented and retained in the physician's file.

1.4.9.10.3 Another physician in the same practice group or specialty may complete the medical record(s) if he/she desires and the MEC approves.

1.4.9.10.4 Three (3) months from the date of the physician's departure, incomplete medical record(s) will be tagged with a permanent deficiency slip, which documents efforts made for completion. The medical record will be closed and permanently filed in this manner.

1.4.9.10.5 Not completing medical records will cause the physician to be considered "not in good standing" and letters of recommendation or verification of any kind will so state.

1.4.9.10.6 A practitioner who causes medical records to be permanently filed as incomplete, according to the above steps, will be reported by Hospital Administration to the Florida Board of Health and the National Practitioner Data Bank.

1.4.9.10.7 Practitioners joining the Medical Staff are to be made aware of the above stipulations before or at the time of request for Medical Staff privileges.

1.4.10 Possession and Access:

1.4.10.1 All medical records are the physical property of the Hospital. Medical records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a subpoena or court order. Unauthorized removal of medical records from the Hospital is grounds for suspension from the Medical Staff and shall require that the matter be referred to the Medical Executive Committee for appropriate action.

1.4.10.2 Upon written approval of the CEO, access to medical records of all patients shall be afforded to appointees to the Medical Staff for bona fide study and research, consistent with preserving the confidentiality of personal information concerning individual patients. Subject to the discretion of the CEO, former Medical Staff appointees shall be permitted access to information from the medical records of their

patients covering all periods during which they attended such patients in the Hospital. Any publication of compiled data from the Hospital's patients' medical records is forbidden without written approval of the CEO.

1.4.10.3 Written consent of the patient is required for release of medical information to those not otherwise authorized to receive this information. Patient data from sources other than DeSoto Memorial Hospital will remain a pertinent part of the Hospital medical record, and shall be maintained in a separate section of the medical record. The Hospital assumes no responsibility or liability for the accuracy, validity, or completeness of these documents, and shall not release them to third parties.

1.4.10.4 This section of these Rules and Regulations shall be applied within the confines of the privacy and security provisions of the Healthcare Insurance Portability and Accountability Act ("HIPAA") and in accordance with the Hospital's Policies and Procedures regarding privacy and security of personal health information.

1.5 PATIENT DISCHARGE

1.5.1 Who May Discharge

Patients shall be discharged only on order of the attending practitioner who may enter the order himself/herself or by giving a verbal order for the discharge to his/her APRN, who may then enter the order. Should a patient leave the Hospital against medical advice of the attending practitioner or without a proper discharge order, a notation of the incident shall be made in the patient's medical record, and the patient shall be asked to sign the Hospital's release form.

1.5.2 Discharge Planning

Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as reasonably possible after admission.

1.5.3 Transfer of Patients

A patient shall not be transferred to another medical care facility unless prior arrangements for admission to that facility have been made. Clinical records of sufficient content to assure continuity of care shall accompany the patient.

1.5.4 Autopsies

1.5.4.1 All deaths occurring in the Hospital and/or brought to the Emergency Department that meet the criteria under the Florida Statutes as Medical Examiner's cases are to be referred to the Medical Examiner's Office.

1.5.4.2 The attending practitioner of a decedent who does not meet the criteria of the Florida Statutes under the jurisdiction of the Medical Examiner may ask the legal next of kin for permission to have an autopsy, which may be performed by a pathologist selected by the Hospital. Autopsies may be performed in the following cases:

1.5.4.2.1 To explain unknown or unanticipated medical complications to the attending practitioner;

1.5.4.2.2 When the cause of death cannot be determined on clinical grounds;

1.5.4.2.3 In cases in which autopsy may allay the concerns of the family regarding the death and to provide reassurance to them regarding the same.

1.5.4.3 The autopsy may be a limited autopsy designed to answer only specific clinical questions

1.5.4.4 An autopsy request form from the practitioner and an autopsy permission form in accordance with Florida law shall be completed prior to the autopsy.

1.5.4.5. The attending practitioner will be notified prior to the autopsy and provided with information regarding the date, time and place the autopsy will be performed, and preliminary autopsy results will be discussed with him/her after the autopsy. When completed, the final autopsy report will be made available to the attending practitioner and to the department chairman when deemed appropriate by the Chief of Staff, CEO or Risk Manager. Provisional anatomic diagnoses shall be recorded in the medical record within seventy-two hours and the complete protocol shall be made a part of the medical record within sixty (60) days.

1.5.4.6 Any untoward findings of clinical significance shall be referred to Chief of Staff, the attending practitioner, and the Risk Manager for review.

1.6 GENERAL RULES REGARDING PRACTICE IN THE HOSPITAL

1.6.1 Informed Consent

1.6.1.1 General and Legal Aspects: Section 766.103, Florida Statutes, the Florida Medical Consent Law, sets forth the guiding principles regarding informed consent. All consents obtained shall be in conformance with said statutes and shall contain the following:

1.6.1.1.1 A general understanding of the procedure and the beneficial effects to be expected from the procedure;

1.6.1.1.2 The medically acceptable alternative procedures or treatments, and

1.6.1.1.3 The substantial risks and hazards inherent in the proposed treatment or procedure.

1.6.1.2 Consent to Admission: An admission consent form must be signed by the patient or his/her representative/healthcare surrogate at the time of admission. The Admitting Office shall notify the attending practitioner whenever such signature has not been obtained.

1.6.1.3 Consent to Surgical and Other Invasive Procedure: Prior to any surgical and/or any invasive procedure, including blood transfusions, the responsible practitioner shall document in the patient's medical record that he/she has explained to the patient, or to the patient's representative/healthcare surrogate the indications for the methodology, the alternatives to and the complications and risks of the planned procedure, and the risks associated with not undergoing the planned procedure.

1.6.1.3.1 Non-Emergency Procedures: Prior to the performance of a non-emergency surgical or other invasive procedure, including blood transfusions, an approved Hospital consent form must be signed by the patient or his/her representative/healthcare surrogate and by a Hospital representative who shall

be a registered nurse or other appropriate medical personnel, to serve as a witness to the patient's or his/her representative /healthcare surrogate's signature. Consent forms for minors (individuals under eighteen years of age) must be signed by his/her parent or guardian (for exceptions refer to Articles 1.6.1.4.4 through 1.6.1.4.9). Except in emergencies, failure to include the completed consent form in the patient's medical record prior to the performance of a procedure shall result in automatic cancellation of the procedure.

1.6.1.3.2 Emergency Procedures: In an emergency involving a minor or unconscious/incompetent adult patient in which consent for surgery cannot be immediately obtained from minor patient's parents, guardian, or from the incompetent adult's representative/healthcare surrogate the circumstances shall be fully documented in the patient's medical record. A consultation shall be obtained before the operative procedure is undertaken, if possible.

1.6.1.3.3 Should a second procedure be required during the patient's stay in the Hospital, a second informed consent shall be obtained.

1.6.1.3.4 If two or more procedures are to be done at the same time, and this is known in advance, both may be designated and consented to on the same form.

1.6.1.3.5 The anesthesiologist/CRNA shall obtain the informed consent of the patient for the administration of anesthesia.

1.6.1.4 Who May Consent:

1.6.1.4.1 A competent adult (individual eighteen years of age or older) may authorize any surgical and/or invasive medical procedure, including blood transfusions, to be performed upon his/her body and the consent of no other person is required or valid.

1.6.1.4.2 Authorization for any non-emergency surgical or invasive medical procedure, including blood transfusions, involving a minor shall be signed by the patient's parent(s) or guardian (See exceptions I provided under Florida Statutes ("FS") in Articles 1.6.1.4.4 through 1.6.1.4.9 below.)

1.6.1.4.3 Authorization for all non-emergency situations involving consent for an incompetent adult shall be obtained from the patient's Representative/healthcare surrogate.

1.6.1.4.4 FS 743.0650: An unwed pregnant minor may consent to the performance of medical and surgical care or services related to her pregnancy by a hospital, clinic, practitioner, or nurse midwife and such consent is binding as if she had achieved her majority.

1.6.1.4.5 FS 743.0650 also provides the same right for an unwed minor mother in that she may consent to the performance of medical and surgical care or services for her child.

1.6.1.4.6 FS 743.064 provides that emergency medical care or treatment to any minor injured in an accident, suffering from an acute illness or condition in which delay of emergency medical care would endanger the health of the minor, and provided such emergency treatment or care is administered in a hospital, then

such emergency treatment can be rendered in the absence of parental consent if such is not readily available.

1.6.1.4.7 FS 384.30 provides that performance of medical or surgical care or services by a physician when afflicted with or exposed to infectious, contagious, communicable disease, i.e. venereal diseases, and such consent shall be valid and binding as if the minor has achieved his/her majority.

1.6.1.4.8 FS 381.0051 provides that maternal health and contraceptive information and services of a non-surgical nature may be rendered to any minor by a licensed practitioner provided the minor is either married, a parent, pregnant, or may, in the opinion of the practitioner suffer probable health hazards if such services are not provided.

1.6.1.4.9 FS 743.01 removes the disability of non-age of a minor who is married or has been married or subsequently becomes married, including one whose marriage is dissolved or who is a widow or widower.

1.6.2 Infection Prevention

All practitioners shall comply with the Hospital's infection prevention practices, including proper hand hygiene techniques, the use of standard and transmission-based precautions to reduce risks for and/or prevent health-associated infections.

1.6.3 Security

The admitting practitioner shall be held responsible for whenever his/her patients may be a source of danger from any cause whatsoever. When special security measures appear to be needed, the patient or family may be required to employ a special duty attendant on all shifts.

1.6.4 Nursing Service

All nursing services will be furnished through the Nursing Department of the Hospital when possible. An approved list of special duty nurses is available in the office of the Director of Nursing and must be utilized. The Hospital reserves the right to deny any special duty nurse from the privilege of working in the Hospital.

1.6.5 Utilization Management

The attending practitioner shall be required to adhere to the Hospital's Utilization Management Plan as approved by the Medical Executive Committee and the Board of Directors.

1.6.6 Reporting Change of Address and Contact Information

Each member of the Medical Staff and the Allied Health Professional Staff is required to provide his/her home and office addresses and contact information, including home, office, and cell phone numbers, and e-mail address at the time of initial appointment to the Medical Staff. Any change(s) to this information shall be reported to the Medical Staff Office as soon as possible, but not more than ten (10) days of said change(s).

1.6.7 Disaster Plan

There shall be a disaster plan for the care of mass casualties prepared by the Hospital's

Disaster Preparedness Committee. This plan shall be available in the Hospital's Administration Office and in each department and nursing unit of the Hospital. The Medical Staff will cooperate fully with the Plan in accordance with departmental policy. The Disaster Plan will be amended periodically in conjunction with Hospital Administration. Disaster drills will be conducted at least two (2) times each year, and a written report and evaluation made.

1.6.8 Anesthesia Department

1.6.8.1 The anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition. In the event these reports are not entered on the anesthesia graph per se, the information required shall be entered in the Progress Notes in the patient's medical record.

1.6.8.2 The anesthetist shall be in the operating room and ready to start the anesthesia at least fifteen (15) minutes before the scheduled time for the procedure. The anesthetic record is to be maintained during surgery and is to be completed before leaving for the day.

1.6.8.3 The anesthetist shall make a pre-anesthetic visit, so recorded in the patient's medical record. A post-anesthetic follow-up examination will be made on the patient's condition following the procedure and noted in the patient's medical record.

1.6.9 Emergency Services

1.6.9.1 The emergency services will be under the supervision of the contract service assigned to perform this function.

1.6.9.2 Clinical privileges and responsibilities of all practitioners and allied health professionals who render care in the Emergency Department are maintained in Meditech, and are readily available to all clinical departments in the Hospital, including the Emergency Department.

1.6.9.3 An Active, Associate and Courtesy Staff member at DeSoto Memorial Hospital may be expected to take his/her turn in rotation for the Emergency call roster, unless exempted by the Board of Directors. Physicians may seek exemption after serving twenty (20) years on the Emergency Room Roster and having attained the age of sixty (60) years. For the convenience of the Medical Staff and to assure proper notification to all necessary Hospital departments/personnel, the Medical Staff Coordinator in consultation with the Medical Staff department chairmen, will prepare and distribute the monthly Emergency Department call rosters. If a practitioner is unable to take assignment when scheduled, it shall be that practitioner's responsibility to arrange for a qualified substitute and to notify the Medical Staff Coordinator in a timely manner. Failure of an assigned practitioner to respond to an emergency call shall be reported immediately to the Medical Executive Committee and to the CEO for appropriate review and action.

1.6.9.4 When a patient requires admission on an emergency basis and does not have a local practitioner, he/she will be assigned to the practitioner on emergency call for the particular service determined to be appropriate by the Emergency Physician or to the Hospitalist on call. If the patient can be cared for more appropriately at another facility, it will be the responsibility of the on-call practitioner to assist the Emergency Physician in

arranging the transfer of care of the patient to the practitioner specialist at the other facility.

1.6.9.5 Patients who present to the Emergency Department shall receive a medical screening examination by physicians who are provided to the Hospital by contract to provide emergency care. This medical screening examination shall be sufficient to permit the physician to determine whether or not the patient has an emergency medical condition, and shall, whenever possible, be performed without first inquiring into the patient's method of payment or insurance status. Any inquiry into the patient's method of payment or insurance status shall not delay or influence the determination of whether or not an emergency condition exists, or provision of stabilizing (emergency) treatment, transfer, or hospital admission. Whereas an initial triage examination may be done by a paramedic, LPN, or RN employed by the Hospital, the medical screening exam will be done by a physician, APRN or Physician Assistant as more specifically set forth in the Hospital's Policies and Procedures. Further, any demographic or financial data obtained shall not provide basis for discrimination, bias or selective treatment.

1.6.9.6 All patients requiring admission to the Hospital through the Emergency Department shall have admitting orders specifying their initial care, treatment, and/or further diagnostic workup. These initial admission orders may be written by the attending or on-call practitioner. Between the hours of 10:00 PM and 7:00 AM the Emergency Physician will function as the Hospitalist on duty. After the medical screening examination has been completed and the patient's emergency condition(s) have been stabilized, and the EP on duty determines that further care/treatment is needed, he/she will contact the patient's private care physician or the Arcadia Medical Associates ("AMA") hospitalist on call to discuss his/her findings and the patient's additional care needs. The Emergency Physician ("EP") will document this transition discussion in the patient's medical record, including the patient's clinical status, abnormal lab values, findings from imaging studies and any other relevant information, and enter an order admitting the patient to the service of the Attending Practitioner("AP") or AMA hospitalist on call, who will assume care of the patient at 7:00 AM. The EP will enter admission orders in the patient's medical record and retain responsibility for care of the patient and respond to call from the nursing staff regarding the patient's needs. He/she will contact the AP/AMA hospitalist on duty at the change of shift (7:00 AM) providing him/her a report including all the information needed to ensure a safe transition of the care of the patient, and shall document this communication in the patient's medical record. (Please refer to the Medical Staff Policy & Procedure entitled "Emergency Department Admissions to the Hospitalist Program."

1.6.9.7 Appropriate medical records will be kept for each patient treated in the Emergency Department. The record shall include:

1.6.9.7.1 Adequate patient identification;

1.6.9.7.2 Information concerning the time and means of the patient's arrival, and by whom transported;

1.6.9.7.3 Pertinent history of the injury or illness, including details relative to first aid or emergency care given to the patient prior to his/her arrival at the Hospital, and physical findings;

1.6.9.7.4 A description of significant clinical laboratory or roentgenologic findings, and those of an electrocardiographic nature;
1.6.9.7.5 Treatment given;
1.6.9.7.6 Diagnosis;
1.6.9.7.7 Condition of patient on discharge or transfer; and
1.6.9.7.8 Final disposition, including all necessary follow-up care instructions given to the patient and/or his/her representative/healthcare surrogate.

1.6.9.8 Each patient's medical record shall be signed by the practitioner in attendance, who is responsible for its clinical accuracy.

1.6.9.9 The Emergency Department physician shall be required to complete the medical record if a patient dies prior to the attending practitioner's arrival at the Hospital.

1.6.9.10 Standing orders for administration of controlled substances to any individual on a PRN basis shall not be left in the Emergency Department by any practitioner or allied health professional.

1.6.9.11 The medical records of patients receiving care in the Emergency Department will be reviewed to evaluate the quality of care in accordance with the processes established in the Medical Staff Bylaws 8.2 Performance Improvement Functions and 8.3 Focused/Ongoing Professional Practice Evaluation, and in the provisions of the Hospital's Quality/Performance Improvement Plan. The results of these reviews shall be reported to the Credentials Committee for the purpose of evaluating current clinical competence at the time of reappointment to the Medical Staff or AHP Staff and in other circumstances as deemed appropriate by the Medical Executive Committee.

1.6.9.12 Each practitioner granted admitting privileges shall maintain a residence and practice located close enough to the Hospital to fulfill his/her Medical Staff responsibilities and to provide continuous and timely care for his/her patients at the generally recognized professional level of quality and efficiency established by the Hospital, and in his/her absence shall delegate the responsibility for care of his/her patients only to a practitioner who is a member in good standing of the Medical Staff and who is qualified and approved by the Hospital to undertake this responsibility by the granting of appropriate clinical privileges.

1.7 REPORTING BREACHES OF CONDUCT

1.7.1 It shall be the responsibility of each appointee to the Medical Staff to report, in writing, to the Medical Staff President and/or the CEO acts or omissions by appointees to the Medical Staff of which he/she, in good conscience, believes to be detrimental to the health or safety of patients or to the proper functioning of the Hospital, or which violate professional standards or ethics.

1.7.2 Variance reports involving practitioners will be reviewed by the appropriate Medical Staff department chairman or his/her designee and by the Risk Manager or his/her designee in accordance with Hospital policies. The department chairman/designee may discuss the issues and his/her response to the report with the practitioner involved as indicated.

1.7.3 If the variance is of a serious nature or repetitive episode, the department chairman/designee or the Risk Manager/designee shall notify the CEO who will initiate and follow the process set out in Article XII of the Medical Staff Bylaws as appropriate. All documents related to this process will be maintained in the Medical Staff office for consideration during the process of reappointment. These documents will be kept in the Medical Staff office for three (3) years. After that time, the practitioner may petition for removal of the documents from the file. This request will then be presented to the MEC for their review and action.

1.7.4 All variance reports will be maintained in the office of the Risk Manager.

1.7.5 Practitioner response reports will be maintained in the office of the Quality Director.

1.8 POSSSIBLE ADVERSE DRUG REACTIONS

An adverse drug reaction is defined as "any response to a drug that is undesirable, unexpected, and occurs at doses normally used in humans for the prophylaxis, diagnosis, or therapy of disease." Such reactions are further defined by the American Society of Health-System Pharmacists as any unexpected, unintended, undesired, or excessive response to a drug that:

- Requires discontinuing the drug (therapeutic or diagnostic);
- Requires changing the drug therapy;
- Requires modifying the dose (except for minor dosage adjustments);
- Necessitates admission to a hospital;
- Prolongs stay in a health care facility;
- Necessitates supportive treatment;
- Significantly complicates diagnosis;
- Negatively affects prognosis; or
- Results in temporary or permanent harm, disability, or death.

1.8.1 Specific types of adverse drug reactions include side effects, toxic reaction hypersensitivity reactions, and idiosyncratic reactions. Each type is further defined below.

1.8.1.1 Side Effects: usually dose-related phenomenon, and often correlate with a serum drug level of the product in question. These can be expected to occur with relative frequency in any individual receiving that particular drug product. If high enough doses are given, any patient taking the drug will exhibit the characteristic side effect.

1.8.1.2 Toxic Reactions: dose-related effects often present as a result of a drug overdose. These reactions occur in addition to the side-effects of a drug.

1.8.1.3 Allergic Reactions: an immunologic hypersensitivity, occurring as a result of unusual sensitivity to a drug (via antibody production). Allergic reactions may vary in severity, from a rash with or without pruritus to anaphylaxis.

1.8.1.4 Idiosyncratic Reactions: an abnormal susceptibility to a drug that is peculiar to the individual. These reactions are usually severe, unpredictable, and difficult to

diagnose since they typically mimic a pathological state which is usually caused by other factors.

1.8.2 If a practitioner suspects an adverse drug reaction has occurred, he/she will contact Pharmacy and Risk Management.

1.8.3 Nurses shall complete the Admission Data, Health Assessment/History Form, indicating in the "Allergies and Reactions" section of that form any allergies or any other adverse drug reactions stated by the patient. An allergy bracelet shall be applied and the front of the chart tagged appropriately. The pharmacy shall be made aware of this information and include it in a database that is retained for all future patient visits. If the attending practitioner or consulting practitioner decides that the patient is indeed not allergic to the medication noted by the nurse, then the practitioner shall document this in the progress notes in the chart and write an order for the nurse to remove the allergy warning for this medication from the allergy bracelet and the tag on the chart. The warning bracelet and tag should then read: "Possible Adverse drug Reaction" for this medication instead of allergy. The pharmacy will then note in the database that this is a "Possible Adverse Drug Reaction."

The foregoing Medical Staff Rules and Regulations have been ADOPTED, as amended by Active Medical Staff of DeSoto Memorial Hospital, on this 16th day of January, 2019.

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Gregory Arov, D.O.	Ana Hernandez, M.D.
President, Medical Staff	Secretary, Medical Staff

The foregoing Medical Staff Rules and Regulations, as amended, and adopted by the Medical Staff, have been APPROVED by the Board of Directors of DeSoto Memorial Hospital on this 23rd day of January, 2020.

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Robert Heine, Jr.
Chairman, Board of Directors