

MEDICAL STAFF RULES AND REGULATIONS

PREAMBLE

The following rules and regulations are adopted by the Medical Executive Committee according to the provisions of ARTICLE XVII of the Bylaws of the Medical Staff of Holy Cross Hospital. These rules and regulations are adopted in an attempt to improve the quality of health care rendered to patients by the physicians, nurses and administrative personnel of the hospital.

No rules or regulations shall be adopted which do not clearly serve the above purpose, nor shall any rules or regulations be adopted merely for the convenience of the medical, administrative or ancillary personnel associated with the hospital.

The provision of ARTICLE XVII of the Bylaws shall be rigidly enforced to the extent that no department, committee or administrative authority shall modify these rules and regulations except on the approval of the Medical Executive Committee.

All statements contained in these rules and regulations and the proceedings and objectives outlined herein are informative only and represent that which is believed to be the highest performance and the maximum in hospital care, service or procedures relating to any particular set of circumstances. It is recognized that any specific procedure or service is always subject to modification, depending upon the circumstances of a particular case. Under no circumstance should these rules and regulations be interpreted as the standard or as any indication of standards specifying the duties or outlining the requirements of hospital personnel in the care and treatment of patients.

I. Admission and Discharge of Patients

- A. The hospital shall accept patients for care and treatment, including - on an emergency life support basis - disturbed mental patients, acute alcoholic, drug abuse, and acute contagious disease patients. In all cases, the hospital reserves the right to require the patient be attended by a private duty nurse, if in the hospital's opinion, such is necessary for the safety of the patient or other patients.
- B. A patient may be admitted to the hospital only by a physician, Podiatrist or qualified dentist member of the medical staff with admitting privileges. All practitioners shall be governed by the official admitting policy of the hospital.
 - a. Courtesy Staff members are limited to less than 18 patient contacts in a three (3) year period.
 - b. Staff physicians shall not serve as the physician of record for immediate family members but may serve as consultants on the case. Further, if it is mutually agreeable between the physicians and patient, the patient can choose to have his/her relative perform needed procedures.
- C. A physician, Podiatrist or qualified dentist member of the medical staff shall be responsible for the medical care and treatment of each patient in the hospital. Whenever these

responsibilities are transferred to another staff member, either temporarily or permanently, a note by the admitting physician covering the transfer of responsibility shall be entered on the order sheet of the medical record. The note shall include a number or some other method to reach the transferring practitioner in order to provide the opportunity for asking and responding to questions.

- D. The admitting physician is responsible for the overall management of the patient's care. The admitting physician (or the physician covering the admitting physician's service) will see the patient each day and document the visit on the patient's chart. Visits by consultants do not satisfy the required daily visit of the admitting physician. Unless otherwise seen on the day of admission (e.g. in the office or emergency room) new admissions will be seen within sixteen (16) hours. Patients admitted to a critical care unit will be seen within four (4) hours. If the admitting physician chooses to transfer care of the critical care admission to the on-call intensivist (electronic or telephone) at the time of admission, no visit is required. At the time of transfer out of the critical care unit, the original admitting physician will resume care of the patient.

Hospice patients should be seen, within 24 hours of admission, and then at the physician's discretion, on an as needed basis.

- E. Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of an emergency, such statements shall be recorded as soon as possible.
- F. Practitioners admitting emergency cases shall be prepared to justify to the Executive Committee of the Medical Staff and to the Administration of the hospital that the said emergency admission was a bona-fide emergency. The history and physical examination must clearly justify the patient being admitted on an emergency basis and these findings must be recorded on the patient's chart as soon as possible after admission.
- G. A patient to be admitted on an emergency basis who does not have a private practitioner, may select any practitioner in the applicable department or service to attend him. Where no such selection is made, a member of the Active or Provisional staff on duty in the department or service will be assigned to the patient on a rotation basis where possible. The Chairman of each department shall provide a schedule for such assignments.
- H. The medical staff shall define the categories of medical conditions and criteria to be used in order to implement patient admission priorities and the proper review thereof. These shall be developed by each clinical department and approved by the Executive Committee.
- I. The attending practitioner is required to document the need for continued hospitalization after specific periods of stay as identified by the Peer Improvement Committee of this hospital and approved by the particular clinical department and the Executive Committee of the Medical Staff. This documentation must contain:
 - a. An adequate electronic or written record of the reason for continued hospitalization. A simple reconfirmation of the patient's diagnosis is not sufficient.

- b. The estimated period of time the patient will need to remain in the hospital.
- c. Plans for post-hospital care.

Upon request, the attending practitioner must provide electronic or written justification of the necessity for continued hospitalization. This report must be submitted within twenty-four (24) hours of receipt of such request. Failure to comply with this policy will be brought to the attention of the Executive Committee for action. Any patient remaining in the hospital over two (2) months must have the stay approved by the Executive Committee of the Medical Staff and by the Administrator.

- J. Patients shall be discharged only on an electronic or written order of the attending practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.
- K. In the event of a hospital death, the deceased shall be pronounced dead by the attending practitioner or his designee within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record of the deceased by a member of the medical staff. Exceptions shall be made in those instances of incontrovertible and irreversible terminal disease wherein the patient's course has been adequately documented to within a few hours of death. Policies with respect to release of dead bodies shall conform to local law.

a. Legal Death

Section 382.085, Florida Statutes: Recognition of Brain Death

- 1. For legal and medical purposes, where respiratory and circulatory functions are maintained by artificial means of support so as to preclude a determination that these functions have ceased, the occurrence of death may be determined where there is the irreversible cessation of the functioning of the entire brain, including the brain stem, determined in accordance with this section.
- 2. Determination of death pursuant to this section shall be made in accordance with currently accepted reasonable medical standards by two physicians licensed under Chapter 458 or 459. One physician shall be a board eligible or board certified neurologist, neurosurgeon, internist, pediatrician, surgeon or anesthesiologist.
- 3. The next of kin of the patient shall be notified as soon as practicable of the procedures to determine death under this act. The medical records shall reflect such notice; if such notice has not been given, the medical records shall reflect the attempts to identify and notify the next of kin.
- 4. No recovery shall be allowed nor criminal proceeding be instituted in any court in this state against a physician or licensed medical facility that makes a determination of death in accordance with this section or which acts in reliance thereon, if such determination for such physician or facility as set forth in s.768.45. Except for

a diagnosis of brain death, the standard set forth in this section is not the exclusive standard for determining death or for the withdrawal of life support systems.

b. General Rules regarding Autopsy Criteria

This policy is instituted to ensure that the medical staff is alerted to cases meeting autopsy criteria. In these, post-mortem examination is recommended.

1. The medical staff of Holy Cross Hospital recognizes the importance of post-mortem examinations in ongoing performance improvement activities and resultant patient care. Autopsies are recommended in cases meeting established criteria and will be performed as an outsourced service when clinically indicated.

3. Selection Criteria: Post-mortem examinations should be considered in the following instances:

- a. Any unsuspected death.
- b. Death within 48 hours following invasive procedures.
- c. Death associated with adverse events.
- d. Death in the Emergency Department.
- e. Death in Outpatient settings.

Medical Examiner Cases will be established according to Florida Statute Chapter 406.

4. Responsibility: Attending physicians, Emergency Department physicians or physician consultants are responsible for recommending a post-mortem examination to family members in appropriate cases.

The nursing staff, being familiar with autopsy criteria, serves to remind the attending physician, Emergency Department physician or physician consultants of post-mortem examination recommendation when appropriate and in assisting and advising the family of available community options for autopsy service, in conjunction with the Pathology Department.

5. Obtaining Consent: It is the policy of the medical staff of Holy Cross Hospital to obtaining consent for post-mortem examination in cases meeting autopsy criteria for all cases as included in Standard Practice Guidelines NS-20-123, "Death of an Inpatient", and NS-50-801, "Emergency Room and DOA Cases." These written instructions are available throughout the hospital.

II. Medical Records

Responsibility for Medical Records

A. The physician on whose service the patient is admitted shall be responsible for dictating

the history and physical. The physician on whose service the patient is at the time of discharge shall be responsible for the discharge summary.

- B. The record shall, in all cases, include: 1) identification data, 2) provisional diagnosis, 3) final diagnosis and title of any operations performed entered on the face sheet, 4) no abbreviations permitted on the face sheet, 5) complete history and physical entered electronically, written or dictated within twenty-four (24) hours after admission.

- a. If Item 5 in the above paragraph is violated, the chart becomes delinquent, and the physician is suspended and restricted as outlined in Item D, Paragraph c, Page 6 of these Rules & Regulations.

C. Electronic Medical Records

- a. When Computerized Provider Order Entry (CPOE) and Electronic Medical Records (EMR) systems are in place, all healthcare providers covered by these Rules and Regulations shall utilize these systems, provided that appropriate mandatory on-site training available from the hospital has been completed. All efforts will be made to educate physicians with supplementary education as required. If written medical records and orders, as well as electronic CPOE and EMR are available in the same place, all healthcare providers are required to use CPOE and EMR.
- b. Exceptions related to disability may be granted by the Health Information Department with the approval of the Medical Staff President.
- c. All healthcare practitioners covered by these Rules and Regulations are required to follow hospital policy on verbal and telephone electronic orders.
- d. After the transitional period, failure by healthcare providers to utilize CPOE and EMR systems at Holy Cross or failure to follow hospital policy on verbal and telephone electronic orders will be monitored by the Medical Records Committee. Continued failure to utilize CPOE and EMR may be referred to the Department Chief, President of the Medical Staff or Medical Executive Committee as may be required.

D. Content of the Record

- a. Progress notes shall include: 1) initial admission notes, 2) medical and surgical treatment rendered, 3) pre-op anesthesia evaluation, 4) post-op anesthesia evaluation, if applicable, 5) laboratory work, CBC and urinalysis, which shall constitute the minimum laboratory work necessary and shall be obtained at the time of admission.
- b. Discharge summary shall include the following: 1) why the patient was put in the hospital 2) admitting and final diagnosis 3) hospital course 4) pertinent laboratory information 5) plan for follow-up care, and in particular, 6) what medication and instructions were given to the patient on discharge.
- c. Consultation, if any - reason for request and report of consultation.

- d. Physicians Orders may be electronically entered, written, verbal or given by telephone.
 - e. All telephone orders and verbal orders may be accepted and entered electronically by registered nurse. Discipline specific telephone and verbal orders may be accepted and entered electronically by any of the following hospital therapists: Registered Pharmacist, Registered Physical Therapist, Registered Occupational Therapist, Registered Speech and Language Pathologist, Registered Respiratory Therapist, Eligible Registered Respiratory Therapist, Certified Respiratory Therapist, Respiratory Care Practitioner with or without critical care licensing (RCP), or Registered Dietician. All verbal or telephone orders must be verified for completeness by having the person receiving the order “read back” the complete order or test result. All telephone orders and verbal orders must be authenticated promptly. However, all orders given to any of the above mentioned therapists to initiate an established hospital protocol will not require a physician authentication of any subsequent order entered by such therapist pursuant to said protocol.
 - f. Reports from; Clinical Laboratory; Radiology, E.C.G.; Anesthesia; Surgery; Physical Medicine and Rehabilitation, another departmental and special service reports.
 - g. Special instructions - the transfer of a patient into the service of another physician - shall be entered electronically or in writing by the admitting physician.
 - h. General - all entries in the record must be dated, timed and authenticated. A chart which another person cannot read is not valid for the hospital record, and will be rejected as being completed.
- E. Suspension of Privileges for Incomplete Medical Record
- a. All medical records shall be completed within thirty (30) days from discharge. If records remain incomplete at the end of that time, the physician’s privileges will be suspended, which means the physician will not be allowed to:
 - Schedule, perform or assist in surgeries at the Hospital, except for in-house cases already scheduled prior to suspension of privileges.
 - Perform consultations at the Hospital, unless a consultative relationship has already been established with patient currently in-house as of the time of the suspension.
 - Admit patients to the Hospital, whether through the ED or private practice.
 - Attend to patients, except for patients in-house at the time of suspension of privileges.
 - Perform deliveries or C-Sections.
 - Perform any and all other services previously approved through the

credentialing process at the Hospital.

Temporary loss of privileges does not relieve the physician of duties and responsibilities associated with being on-call for the Emergency Department that was scheduled prior to the suspension.

- b. The Director of Health Information Management will send a notification to all physicians at their office on a weekly basis regarding incomplete records.
 - c. Physicians with incomplete records greater than fifteen (15) days old will receive a warning letter via fax. This notice will include the number of records to be completed and the date by which records must be completed in order to avoid suspension of privileges.
 - d. Physicians with incomplete records greater than thirty (30) days old will receive a certified letter from the CEO stating that the physician's medical staff privileges have been suspended. The effective date will be included in the letter. Certified receipts are filed with a copy of the letter to verify receipt, as needed.
 - e. Any physician with records delinquent for two (2) months or longer shall be notified by the CEO that unless the records are completed within ten (10) days after receipt of such letter, the physician's membership on the medical staff will be suspended. Notification, as outlined above, shall be deemed to have occurred ten (10) days after a certified letter, return receipt request, has been mailed to the physician at his/her last known business address, or upon receipt of the return receipt form, whichever occurs earlier. If the physician does not complete the records within the ten (10) day period, he/she shall automatically be dropped from the Medical Staff.
 - f. Notification of removal from the Medical Staff will be made to the President of the Medical Staff, the Credentials Committee and the Florida Department of Professional Regulations.
 - g. Any physician who has been removed from the Medical Staff due to medical record suspension must again request membership and privileges as in the case of an initial appointment by completing a new application and request for privileges.
- F. The provision of this suspension can be lifted in whole or in part by the President of the Medical Staff or the Administrator on-call should circumstances arise where the inability of the physician to perform said services at the Hospital would jeopardize patient care in any manner.

In all other cases, the suspension shall be lifted as soon as the physician is in compliance with the established medical records completion protocol.

G. Reinstatement of Privileges

The Health Information Management Department shall have the responsibility of

immediately notifying, in writing, the physician, all nursing units, Medical Staff Services Department, Admitting Department, Outpatient Registration, and the Surgery Department of the reinstatement of full clinical privileges for the suspended physician.

H. Medical Record - General

- a. The medical record is the property of the hospital and may be removed from the hospital only on subpoena or in accordance with the statutes.
- b. On readmission of the patient, all previous records shall be available for the use of the attending physician.
- c. Medical records shall be confidential. Written consent by currently dated, signed authorization of the patient is required for release for medical information to persons not otherwise authorized to receive this information.
- d. Free access to all medical records of all patients shall be afforded to staff physicians in good standing, with consent of the patient, Administration (CEO and/or specified designee), for bona-fide study and research consistent with preserving the confidentiality of the individual record.

III. General Conduct of Care

Medical Staff Peer Improvement: All Medical Staff committees related to patient care shall be represented on and report to the Performance Improvement Committee of the Board in accordance with the hospital's Performance Improvement.

- A. A general consent form, signed by or on behalf of every patient admitted to the hospital, must be obtained at the time of admission. The admitting officer should notify the attending practitioner whenever such consent has not been obtained. When so notified, it shall, except in emergency situations, be the practitioner's obligation to obtain proper consent before the patient is treated in the hospital.
- B. All orders for treatment shall be entered electronically or in writing. A verbal order shall be considered to be entered electronically or in writing if dictated to a duly authorized person functioning within his or her sphere of competence and signed by the appropriately authorized person to who dictated with the name of the practitioner per his or her own name.
- C. The practitioner's orders must be entered electronically or written clearly, legibly and completely. Orders which are illegible or incomplete or improperly written will not be carried out until clarified and rewritten or understood by the nurse.
- D. All previous orders are canceled when patients go to surgery or receives monitored anesthesia care, general anesthesia, regional anesthesia and/or moderate/or deep sedation as part of the procedure.
- E. Consultations

- a. A consultation shall be required in cases in which according to the judgment of the attending physician, the patient is not a good risk for operation or treatment; the diagnosis is obscure; or there is no doubt as to the best therapeutic measures to be utilized. In addition, departments may formulate further requirements for consultation in their fields of responsibility.
- b. A consultant must be a physician, well qualified to give an opinion in the field in which his opinion is sought, on the basis of training, experience and competence.
- c. A satisfactory clinical consultation includes examination of the record and of the patient. An electronically entered or written opinion signed by the consultant must be included in the medical record. When operative procedures are involved, the consultant's note, except in emergency, shall be recorded prior to the operation.

When laboratory or radiographic procedures are involved, they shall be ordered by the consultant or attending physician and shall be performed and interpreted for the record by those physicians who are credentialed to provide this service.

- d. The attending practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. The attending practitioner will not only provide electronically entered or written authorization to permit another attending practitioner to attend or examine his patients, except in an emergency, but also an opportunity to ask and respond to questions.
- e. If a nurse has any doubt or question about the care provided to any patient or believes that appropriate consultation is needed and has not been obtained after discussion with the attending physician, he/she shall call this to the attention of their immediate supervisor who in turn may refer the matter to the Vice President, Nursing Services or the Administrator on-call. If warranted, the Vice President of Nursing Service may bring the matter to the attention of the Chief of the Department wherein the practitioner has clinical privileges. Where circumstances are such as to justify such action, the Chief of the Department may himself request a consultation.
- f. Consultations, unless emergency or urgent must be answered within 24 hours.
- g. Attending physicians will personally contact the consulting physicians either directly or in writing. Except in emergencies, the attending physicians shall have seen his/her patient on the day of the consultation request. Stat consultations need to be called physician to physician. Every effort should be made that the attending physician speaks directly to the consulting physician and the consultant reports back to the attending physician in order to maximize the transfer of information regarding the reason for the consultation, and urgency for the consult. Electronically entered or written orders for consultation will include the patient's diagnosis, the reason for the consultation, the urgency (i.e., emergency, as soon as possible, today, within 24 hours) and the attending physicians contact numbers

(office or home telephone number, cell telephone number or pager number).

F. No Smoking Policy

a. Purpose

To outline and explain the hospital's general guidelines and policy on smoking.

b. Policy

In compliance with Florida Clean Air Act F.A.S. 386.201, our Mission is to be leaders in the health care field and to provide a smoke/tobacco product free environment for all persons on the Holy Cross campus. The use of any tobacco products (which include but are not limited to cigarettes, pipes and chewing tobacco) is strictly prohibited on the Holy Cross Hospital campus. This policy will serve to facilitate the provision of a safe and healthy environment, support local ordinances and laws and meet regulatory standards.

c. Procedure

Individuals covered by this policy include, but are not limited to patients, Associates, visitors, private duty nurses/sitters, volunteers, physicians, residents, students, emergency medical staff, vendors, contractors and youths. At the time of admission patients will be advised that Holy Cross Hospital is a smoke free campus. Applicable patients will be offered information and products related to smoking cessation/nicotine replacement.

IV. Ongoing Professional Practice Evaluation (OPPE)

Ongoing Professional Practice Evaluation (OPPE) is the continuous evaluation of practitioners' professional performance in order to identify and resolve any potential problems with a practitioner's performance. Ongoing professional evaluation information is factored into the decision to maintain existing privileges(s), to revise existing privilege(s) or to rescind an existing privilege prior to or at the time of reappointment. Decisions regarding reappointment and continuing privileges is based on objective, measurable data. OPPE applies to all physicians and allied health professionals with clinical privileges.

The Medical Staff Office, Quality Department, Peer Review staff and respective Department Chairs are responsible for coordinating the Ongoing Professional Practice Evaluation review.

The indicators for evaluation for the practitioners' ongoing professional practice are approved by the Department Chair and the Medical Executive Committee. The Medical Staff will establish acceptable thresholds for identified criteria.

At each nine month interval every practitioner will be reviewed. The initial screening of data will be facilitated by the Quality Department and Medical Staff Office. Practitioners not meeting threshold will be forwarded to the Department Chairman. The Department Chairman or his/her designee will review OPPE data and may do one of the following:

- Determine that no problem exists at this time
- Discuss issues with individual practitioner and recommend review in six months
- Discuss issues with individual practitioner and refer concerns to MSPI for review and recommended action.

Practitioners with little or no hospital activity generate inadequate data to monitor performance. In these cases, the Medical Staff may recommend not to renew privileges due to lack of volume. In some cases, privileges may be renewed and 100% case review will be implemented.

Ongoing Professional Practice Evaluation Forms will be filed in the individual's quality file every nine months following review.

V. Focused Professional Practice Evaluation

Focused Professional Practice Evaluation is the evaluation of competence of a practitioner who does not have documented evidence of competently performing the requested privileges or when a concern is raised about a physician's competence. FPPE applies to all physicians and allied health professionals with clinical privileges.

FPPE is implemented to monitor performance for:

- Newly credentialed practitioners
- Practitioners being granted an additional privilege
- Identification of medical staff defined triggers (peer review process)
- OPPE data that does not meet threshold or indicates an unacceptable trend.

Any practitioner granted a new privilege is placed in the Focused Professional Practice Evaluation process. The individual's performance is monitored through review of a minimum of five cases or procedures. Information for FPPE may include, but is not limited to, medical record review, proctoring and/or discussion with other individuals involved in the care of each patient. The method of review will depend on the type of privileges granted and will be established at the beginning of the focus review period. At the conclusion of the FPPE period, initial review of data will be evaluated by the Department Chair or his/her designee. The department chair may recommend conclusion of the focus review period or for practitioners not meeting evaluation criteria continued review or referral to MSPI.

Practitioners with performance problems identified through peer review indicators or the OPPE evaluation will be placed in the FPPE process. The individual's performance will be monitored for a period of time determined by the MSPI Committee. The MSPI Committee will also determine the monitoring mechanism – medical record review, proctoring and/or discussion with other individuals involved in the care of the patient. The MSPI Committee may recommend additional training or education in addition to monitoring. The timeframe and method of review will be determined by the MSPI Committee at the beginning of the focus review period. At the conclusion of the focus period, the MSPI Committee will make a decision regarding if the practitioner is providing safe, high-quality patient care. Any recommendations from the MSPI committee must be approved by the Medical Executive Committee.

Information from any FPPE process will be reviewed and considered at the time of reappointment.

VI. Behavior or Behaviors that Undermine a Culture of Safety Policy

Policy

If a physician or other independent practitioner fails to conduct himself or herself in a manner which the Medical Executive Committee considers to be consistent with the delivery of quality healthcare in the Hospital. It is the intention of this Hospital and Medical Staff that this policy is enforced in a firm, fair and equitable manner.

The Medical Executive Committee and/or the Medical Staff Peer Improvement Committee will deal with behavior or behaviors that undermine a culture of safety by physicians and other independent practitioners. Egregious incidents such as sexual harassment, assault, felony convictions, fraudulent acts, staling, throwing equipment/records or inappropriate physician behavior which adversely impacts or may reasonably be expected to adversely impact the quality of healthcare in the Hospital may result in corrective action pursuant to Medical Staff Bylaws Article IX.

Objective

The objective of this policy is to ensure optimum patient care by promoting a safe, cooperative, and professional health care environment and to prevent or eliminate, to the extent possible, conduct which disrupts the operation of the Hospital, affects the ability of others to do their jobs, creates a “hostile work environment” for Hospital employees or other medical staff members, or interferes with an individual’s ability to practice competently.

Guidelines

The term behavior or behaviors that undermine a culture of safety means conduct such as sexual harassment, assault, throwing equipment or medical records and any other inappropriate behavior on the part of physicians and any other practitioner which adversely impacts or may be reasonably expected to adversely impact the quality of healthcare in the Hospital.

Any instance of behavior or behaviors that undermine a culture of safety conduct shall result in initiation of investigatory action as more specifically set forth in the Medical Staff Bylaws.

The initializing offense must be substantiated in writing indicating the time, place and all parties aware and or present during alleged offense. Summary suspension may be appropriate pending the investigatory process. If, after investigation, disciplinary action is recommended, the Medical Executive Committee will be notified. If the Medical Executive Committee takes action limiting privileges or medical staff membership, the practitioner will be afforded their rights as defined in the medical staff bylaws, Article X, Hearings and Appellate Reviews.

Notwithstanding any conflicting provisions of the Medical Staff Bylaws to the contrary, disruptive conduct, as defined herein, may form the basis for corrective action.

Unacceptable behavior or behaviors that undermine a culture of safety may include, but is not

limited to behavior such as:

1. Attacks (verbal or physical) leveled at other appointees to the medical staff, hospital personnel, or patients, which are personal, irrelevant or may adversely impact or may reasonably be expected to adversely impact the quality of healthcare in the Hospital.
2. Impertinent and inappropriate comments (or illustrations) made in patient medical records or other official documents, impugning the quality of care in the hospital, or attacking particular physicians, nurses or hospital policies.
3. Non-constructive criticism, addressed to its recipient in such a way as to intimidate, undermine confidence, belittle or imply stupidity or incompetence.

Written documentation of behavior or behaviors that undermine a culture of safety is critical since it is ordinarily not one incident that leads to disciplinary actions, but rather a pattern of inappropriate conducts. That documentation shall include:

- a. the date and time of the questionable behavior;
- b. if the behavior affected or involved a patient in any way, the name of the patient;
- c. the circumstances which precipitated the situation;
- d. a description of the questionable behavior limited to factual, objective language as much as possible;
- e. the consequences, if any, of the disruptive behavior as it relates to patient care or hospital operations;
- f. record of any action taken to remedy the situation including date, time, place, action and names of those intervening.
- g. Individuals filing complaints are assured of confidentiality.

Any physician, employee, patient or visitor may report potentially disruptive conduct.

Course of Action

The report shall be submitted to the President of the Medical Staff or a facility administrator. It will then be forwarded to the Chief Executive Officer, the President of the Medical Staff and Chairman of the particular department.

Once received, a report will be investigated by the offending physician's Department Chief in conjunction with the administrative vice president responsible for that department. The President of the Medical Staff will be consulted throughout the investigation. Reports, which are not founded, may be dismissed by the President of the Medical Staff and the Chief Executive Officer. The individual initiating such report will be apprised of the result of the investigation. Those reports considered warranted will be addressed as follows:

- a. A single confirmed incident might only warrant a discussion with the offending physician, the President of the Medical Staff, the Department Chief, the Chief Executive Officer, or designee. These individuals shall initiate such a discussion and emphasize that such conduct is inappropriate and must cease. The initial approach should be collegial and designed to be helpful to the physician and the hospital.
- b. Reprisals against complainant shall be interpreted as continued behavior or behaviors

that undermine a culture of safety.

- c. If a pattern of behavior or behaviors that undermine a culture of safety is developing, the President of the Medical Staff, the Department Chief and the Chief Executive Officer or designee shall discuss the matter with the physician, and
 1. Emphasize that if behavior will continue to be monitored and disruptive repeated behavior continues, more formal action will be taken to stop it, which may include termination and/or removal of membership on the medical staff.
 2. All meetings shall be documented.
 3. A follow up letter to the physician shall state the problem and that the physician is required to behave professionally and cooperatively within the hospital.
 4. Pursuant to the existing policy, the involved physician may submit a rebuttal to the charge. Such rebuttal will be maintained as a permanent part of the record.

If the President of the Medical Staff is the subject of the complaint, the Chairman of the Medical Staff Peer Improvement Committee will participate.

If the Chairman of the Department is the subject of the complaint, the Vice Chairman shall participate.

VII. General Rules Regarding Surgical Care

- A. An Operating Room & Procedures Committee composed of representatives from the Departments of Anesthesiology, Obstetrics & Gynecology, Surgery, Pulmonary, Endoscopy, Pathology, Interventional Radiology, Nursing Service, and Administration shall formulate policies regarding the following:
 - a. General considerations
 - b. Scheduling operations
 1. Scheduling periods
 2. Assignment of priority
 3. Loss of priority
 - c. Reservations for operations
 - d. Information required to make reservations
 - e. Change of schedules
 - f. Emergency operations
 - g.
 - h. Starting time of operations
 - i. Outpatient operations requiring general anesthesia
 - j. Care and transporting of patients
 1. To the surgical suite
 2. Within the surgical suite
 3. To the recovery room
 - k. Efficient utilization of operating room

- l. Contaminated cases
 - m. Conductivity and environmental control
 - n. Radiation Safety
 - o.
 - 1. Identification of patient
 - 2. Pre-operative evaluation and documentation
 - a) Medical record content, including diagnosis
 - b) Pathology and Laboratory procedures
 - c) Informed Consent Forms
 - p. Other
- B. Except in severe emergencies, the pre-operative diagnosis and required laboratory tests must be recorded on the patient's medical record prior to any surgical procedure. If not recorded, the operation shall be canceled. In an emergency, the practitioner shall make at least a comprehensive note regarding the patient's condition prior to induction of anesthesia and start of surgery.
- C. A patient admitted for dental care may be a dual responsibility involving the dentist and physician member of the medical staff. If so, the responsibilities are as follow:
- a. Dentist's responsibilities:
 - 1. A detailed dental history justifying the hospital admission.
 - 2. A detailed description of the examination of the oral cavity and a pre-operative diagnosis.
 - 3. A complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed. All tissue including teeth and fragments shall be sent to the hospital pathologist for examination.
 - 4. Progress notes as are pertinent to the oral condition.
 - 5. Clinical resume (or summary statement).
 - b. Physician's responsibilities:
 - 1. Medical history pertinent to the patient's general health.
 - 2. A physical examination to determine the patient's condition prior to anesthesia and surgery.
 - 3. Supervision of the patient's general health status while hospitalized.
 - 4. Any patient 45 years of age or over who is to have the services of an anesthesiologist ordinarily will have an EKG done and reported no more than 30 days prior to the proposed procedure. This requirement may be waived at the discretion of the anesthesiologist involved.
 - 5. An outside EKG and report may be used as long as the procedure has been performed by a doctor currently on the hospital's medical staff, and has been performed within the 30 day period mentioned above. In this case both the report and the original EKG must be provided for the chart. An additional

interpretation may be provided by EKG Associates at the request of the surgeon or anesthesiologist.

6. An outside chest x-ray or report may be used at the discretion of the surgeon or anesthesiologist as long as the x-ray has been taken by, or the report has been prepared by, a doctor currently on the hospital's medical staff. Both the original x-ray and the report must be provided for the chart. An additional interpretation may be provided by the radiologists at the request of the surgeon or anesthesiologist.

- c. The discharge of the patient shall be an electronic or written order of the dentist member of the medical staff.

- d. An informed surgical consent signed by the patient, legal guardian or parent of minor shall be obtained prior to the operative procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient. In the absence of the legal guardian or the minor's parent, if a signed informed consent cannot be obtained, the following procedures are hospital policy:

1. Emergency Consent - Hospital Policy and Procedure

When a medical procedure is deemed to be necessary because of life threatening circumstances, and a consent cannot be obtained from the patient, his legal representative or next of kin (either in person or by telephone), the physician performing the procedure must document these circumstances on the Physicians Progress Record in the patient's medical chart.

A form entitled "Consent for Operation(s) and Special Procedures" (#86) must be filled out with appropriate information and placed in the patient's medical chart.

2. Emergency Telephone Consent - Hospital Policy and Procedure

If, in an emergency, written consent cannot be obtained, permission may be received over the telephone from the next of kin (time permitting) with two (2) responsible persons monitoring the call.

◆ Written confirmation of the telephoned consent is to be obtained and placed on the Medical Record as soon as possible.

- e. Podiatry

1. The scope and extent of surgical procedures that a podiatrist may perform in this hospital shall be delineated and recommended to the Board in the same manner as clinical privileges for physicians and dentists. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chief of the Department of Surgery.
2. Podiatrists may arrange for the admission of a patient by a physician member of the

Medical Staff and prescribe within the scope of their privileges. All podiatric patients must receive the same basic medical appraisal as patients admitted to other surgical services. A physician member of the Medical Staff shall be responsible for the general history and physical and the care of any medical problems which may present at the time of admission, or that may arise during hospitalization, surgical procedure and the total health status of the patient.

3. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and extremity physical examination as well as all appropriate elements of the patient's record. The podiatrist may enter electronically or write orders within the scope of his privileges and consistent with the Medical Staff Rules and Regulations and in compliance with hospital and Medical Staff Bylaws.
 4. Podiatric privileges shall be determined on the basis of submitted qualifications. Qualifications for Podiatry privileges shall require completion of at least two (2) years of an approved Podiatry residency program (APMA/CPME). Applicants must be Board Qualified OR Board Certified by the American Board of Podiatry Surgery (ABPS) in Foot and Ankle Surgery; or the American Board of Ambulatory Foot Surgery (ABAFS) in Foot Surgery. Applicant must demonstrate current competence and continuing experience in the procedures requested, and document same with operative reports.
- F. The anesthesiologist or anesthetist shall maintain a complete anesthesia record to include evidence of pre-anesthetic evaluation and post-anesthetic follow-up of the patient's condition.
- G. All tissues and samples obtained during surgery and at non-surgical sites such as endoscopy suites , cancer center, radiology or at bedside shall be sent to Holy Cross Health Department of Pathology and Clinical Laboratory following established identification and chain of custody protocols where diagnostic examinations will be performed. e Authenticated report(s) shall be made a part of the patient's record. Exemptions to this rule per College of American Pathologist (CAP) recommendations apply.

VIII. General Rules Regarding Obstetrical Care

General rules regarding obstetrical care shall be formulated by the Department of Obstetrics and Gynecology.

IX. Emergency Services

- A. The Medical Staff shall adopt a method of providing medical coverage in the emergency service area. This shall be in accord with the hospital's basic plan for the delivery of such services, including the delineation of clinical privileges for all physicians who render emergency care.
1. Response to Emergency Room call must be made within thirty (30) minutes.

- B. An appropriate medical record shall be kept for every patient receiving emergency care and shall be incorporated in the patient's hospital record, if such exists. The record shall include:
1. An adequate patient identification.
 2. Information concerning the time of the patient's arrival, means of arrival, and by whom transported.
 3. Pertinent history of the injury or illness including details relative to first aid or emergency care given the patient prior to his arrival at the hospital.
 4. Description of significant clinical, laboratory, and roentgenology findings.
 5. Diagnosis
 6. Treatment given
 7. Condition of the patient on discharge or transfer.
 8. Final disposition, including written discharge instruction given to the patient and/or his family, relative to necessary follow-up care when applicable..
- C. Follow up Care: A patient who has been medically screened and treated by the Emergency Department Physician on duty, and has been stabilized for discharge from the emergency department but is recommended for urgent follow up care is referred in the following manner:
1. A patient with a known primary care or private physician is referred to his/her private physician for appropriate care and/or referral.
 2. A patient who presents to the Emergency Department without a primary care or private physician is referred to the appropriate on-call physician.
 - The on-call physician is expected to provide the patient with follow up care in a timely manner.
 - If the patient fails to contact the on-call physician within one (1) week of the ER visit, the physician is no longer obligated to provide follow up care to the patient.

X. Process for Evaluation On All Initially Requested Privileges

All initially granted privileges, either to a new member of the Medical Staff or a current Medical Staff member, will be subject to the peer review process as outlined in the Medical Staff Bylaws.

XI. GRADUATE MEDICAL EDUCATION: INTERNS, RESIDENTS AND FELLOWS

The terms “interns”, “residents,” and “fellows” (hereinafter referred to collectively as “House Staff”) as used in these Medical Staff Rules and Regulations, refer to Practitioners who are currently enrolled in a graduate medical education program, and who, as part of their educational program, will provide health care services at Holy Cross Hospital. House Staff shall not be considered Practitioner/Licensed Independent Practitioners, shall not be eligible for clinical privileges or Medical Staff membership, and shall not be entitled to any of the rights, privileges, or to the hearing or appeal rights under the Medical Staff Bylaws. House Staff shall be credentialed by the sponsoring medical school or training program in accordance with provisions in a written affiliation agreement between the Hospital and the school or

program; credentialing information shall be made available to Holy Cross Hospital upon request and as needed by the Medical Staff in making any training assignments and in the performance of their agreed to participation and supervisory function. The school or program shall provide a written description of the role, responsibilities and patient care activities of participants in the training program in a Graduate Medical Education manual and/or if applicable, the specialty-specific training manual. In compliance with federal laws, it shall not be necessary to submit a query to the National Practitioner Data Bank prior to permitting a House Staff to provide services at this Hospital. House Staff may render patient care services at the Hospital only pursuant to and limited by the following:

- A. House Staff who have completed the basic level of training for licensure shall be licensed in this State and shall be limited by applicable provisions of the professional licensure requirements of the State;
- B. A Graduate Medical Education Committee shall be responsible for overseeing House Staff and shall communicate to the Medical Executive Committee and the Board of Directors about the patient care provided by, and the related educational and supervisory needs of, the participants in the professional graduate education programs, including demonstrated compliance with any residency review committee citations as applicable to the program;
- C. While functioning in the Hospital, House Staff shall abide by all provisions of the Medical Staff Bylaws, Rules and Regulations, and Hospital and Medical Staff approved policies and procedures, and shall be subject to limitation or termination of their ability to function at the Hospital at any time in discretion of the Holy Cross Hospital Chief Executive Officer or designee, or Designated Institutional Officer of the Sponsoring Institution as advised by the Program Director. House Staff Practitioners may perform only those services set forth in the training program in a Graduate Medical Education manual and/or if applicable, the specialty-specific training manual developed by the applicable training program, to the extent that such services do not exceed or conflict with the Rules and Regulations of the Medical Staff or Hospital policies, and to the extent approved by the Board of Directors. All Medical Staff Physicians supervising House Staff are required to be Senior Active, Active, Courtesy or Provisional members of the Holy Cross Medical Staff in good standing. Any physician of the Medical Staff who is an Associate member may supervise House Staff only in the ambulatory setting. House Staff may be invited or required to attend meetings of the Medical Staff, Medical Staff Departments, Specialties or Committees but shall have no voting rights.
- D. House Staff are distinguished from Licensed Independent Practitioners who, although currently enrolled in a graduate medical education program, provide patient care services independently at the Hospital (e.g. “moonlighting”) and not as part of their educational program, such Licensed Independent Practitioners who provide independent services must meet the qualifications for Medical Staff membership and clinical privileges as provided in the Medical Staff Bylaws and shall be subject to the credentialing procedures specified in the Medical Staff Bylaws in the same manner as a Licensed Independent Practitioner seeking appointment to the Medical Staff.

XII. MEDICAL STUDENT EDUCATION: CLINICAL ROTATION FOR THIRD AND FOURTH YEAR MEDICAL STUDENTS

It is the policy of the Medical Staff of Holy Cross Hospital to permit third and fourth year Medical Students to participate in clinical rotations at Holy Cross Hospital, under supervision of authorized members of the Medical Staff. The express purpose and intent of medical student clinical rotations at Holy Cross Hospital is to further the education of the medical student in a community hospital setting, not for purposes of providing an alternative source of physician extenders, such as provided by categories in the Allied Health Section of the Medical Staff Rules and Regulations. A properly executed Clinical Affiliation Agreement must exist between the Hospital and the Medical School, before any Medical Staff physician may be granted permission to supervise a Medical student serving in a clinical rotation on the campus of Holy Cross Hospital. Medical Students shall not hold appointments to the Medical Staff and shall not be granted specific clinical privileges. All Medical Staff physicians supervising a Medical Student are required to be Senior Active, Active, Courtesy or Provisional members of the Holy Cross Medical Staff in good standing. Any Physician on the Medical Staff who is an Associate member may supervise students only in the ambulatory setting.

For purposes of this document, the term “Holy Cross Hospital” includes Holy Cross Medical Group offices and clinics.

A. Definitions:

1. Accredited School of Medicine: The entity that assumes final responsibility for a program of medical student education. For purposes of this document, a School of Medicine includes both Schools of Medicine and Schools of Osteopathic Medicine.
2. Clinical Affiliation: An institution that provides learning experiences for medical students limited to elective clinical rotation(s). A Clinical Affiliation Agreement must exist between and accredited School of Medicine or Osteopathy and Holy Cross Hospital defining and outlining the provision of services for medical student’s education that will occur on the campus of Holy Cross Hospital. Such arrangements must be approved by both entities in a written affiliation agreement.
3. Clinical Rotation: A unit of specialty training, comprising a graded series of learning experiences, occurring in the third or fourth years of medical school education, in which there is an assigned authorized Supervising Physician who is responsible for supervising a specified clinical rotation. These Clinical Rotations include clinical clerkships, elective clinical rotations and preceptorships.
4. Medical Student: An individual currently enrolled as a third or fourth year Medical Student in an accredited School of Medicine or Osteopathy.
5. House Staff: A Practitioner currently enrolled in a medical education and training program accredited by the Accreditation Council For Graduate Medical Education (ACGME), which has a Master Affiliation Agreement with Holy Cross Hospital to provide health care services at Holy Cross Hospital.
6. Supervising Physician: A physician member of the Holy Cross Medical Staff who is currently in good standing. The Supervising Physician accepts full responsibility for all actions of the Medical Student.

7. “Direct Supervision”: Means that the Supervising physician or House Staff member is physically in attendance with the Medical Student and patient.
8. “Indirect Supervision with Direct Supervision Immediately Available”: Means that the Supervising physician or House Staff member is immediately accessible by telephone and is able to be physically present within 10 minutes if needed.
9. “Invasive Procedures”: are defined as those tasks or procedures which cause a break in the skin or enter a body cavity.
10. Other practitioners who may provide supervision of medical students include licensed practitioners who are approved by the Medical School and House Staff who are Post-Graduate Year 2 (PGY-2) and beyond.

B. The following requirements shall be made of the Medical Student:

1. Completion of a Medical Student Clinical Rotation Information Form that delineates personal and educational information. This form will include a portion for the Course Director and Supervising Physician to complete and sign.
2. A statement from the School of Medicine Office of Student Affairs or equivalent, that indicates that the Student is approved for the clinical rotation and is in good standing. Also to be included is a statement indicating that the Student is covered under their liability policy and also indicates limits of coverage on their policy.
3. A written description from the School of Medicine indicating the tasks that the Student is currently competent to perform, as well as learning objectives for the elective clinical rotation.

C. The following requirements shall be made of the Supervising Physician:

1. Acceptance of full responsibility for all actions taken by the Medical Student while in a clinical rotation at Holy Cross Hospital. The Supervising Physician is to direct, monitor and supervise all clinical activities of the Medical Student.
2. Obtain patient consent and acknowledgment of the Medical Student’s presence during any appropriate patient care activity. “Hands-on” invasive procedures require the written informed consent of the patient prior to the Medical Student’s participation. These consents may also be obtained by the House Staff member who is PGY-2 or beyond.

- D. Within the scope of privileges accorded the Supervising Physician, such functions may include, but not be limited to, performing tests and procedures for which such student has demonstrated acceptable competence, taking histories and performance of physical examinations, and participating as directed in activities in emergency rooms, intensive care facilities, operating rooms, labor and delivery rooms, and other areas as deemed appropriate. Medical Students may be allowed to record progress notes and operative notes, H&P’s and discharge summaries.

All entries made by the Medical Student will be reviewed and co-signed by the Supervising Physician or House Staff member as soon as practical, but within no later than 24 hours after the entry is made. In the event that an H&P is a component of a preoperative medical evaluation, the Supervising Physician or House Staff member shall review and co-sign the H&P prior to the patient's undergoing the operative or invasive procedure. The Supervising Physician or House Staff member is permitted to correct entries made by the Student, following proper procedures by drawing a single line through the incorrect entry, writing "error" above the entry and initialing it, then entering the corrected information followed by an electronic error entry or a signature. At no time is a medical student permitted to initiate a consultation or place an order but he/she may participate in the consultation or order entry while under direct supervision of the Supervising Physician or House Staff member.

Note: 1. All invasive procedures performed by the Medical Student must be performed under Direct Supervision of the Supervising Physician or House Staff member with is PGY-2 or beyond, with approval of the Program Director.

2. The limit to which a Medical Student may perform invasive procedures under Direct Supervision is restricted to those procedures for which such student has demonstrated acceptable competence prior to assignment for the clinical rotation at Holy Cross Hospital. The Medical Student's application will include a written description from the School of Medicine indicating the tasks that the Student is currently competent to perform. The list may be reviewed and approved by the Holy Cross Hospital Chief Executive Officer or designee, or the President of the Medical Staff, at their discretion, as a component of the Medical Student's application process.

- E. Medical Students are not allowed to admit or discharge patients.
- F. Under no circumstances will a Medical Student administer care to any patient other than one of the Supervising Physician's patients. Medical Students may not make the final determination of the disposition of Emergency Department patients.
- G. Medical Students are required to wear picture identification that identifies them as a Medical Student, and names the Medical School they are from as well as the starting and ending dates of the clinical rotation.
- H. Requests for an Elective Clinical Rotation as a Medical Student at Holy Cross may be reviewed at the discretion of the President of the Medical Staff and Hospital Administration.
- I. The clinical rotation of the Medical Student at Holy Cross Hospital is limited to the starting and ending dates as submitted on the Medical Student Elective Clinical Rotation Information Form, unless a request for extension is submitted by the Supervising Physician. Extension requests are to be submitted for approval in the same manner as the original request and are limited to a continuation of the clinical rotation only for the time frame indicated on the extension request.
- J. Once approval is granted, appropriate information (including duration of rotation and duties and responsibilities) will be communicated throughout the Hospital, notifying departments of

same.

- K. Medical Students are required to participate in and/or attend appropriate educational, quality assurance, risk management activities and other meetings conducted by the hospital and staff. The requirement to attend will be communicated to the Medical Student by the Supervising Physician.
- L. Approval of the Medical Student for an Elective Clinical Rotation at Holy Cross Hospital is continuous for the duration of the term requested. Ongoing monitoring of the individual performance of the Medical Student is the responsibility of the Supervising Physician. Any problems that are identified concerning the performance of the Medical Student shall be reported immediately to the Supervising Physician, President of the Medical Staff and the Chief Executive Officer or designee for review and investigation. All actions of the Supervising Physician and Medical Student are subject to the usual and customary quality, peer review procedures within the hospital.
- M. Medical Students are subject to removal from the institution pursuant to the terms and conditions described in the Clinical Affiliation Agreement between the School of Medicine and Holy Cross Hospital.
- N. The Supervising Physician and the Medical Student are expected to communicate and coordinate care with all members of the patient care team. This includes introduction of the medical student to the other members of the patient care team.

XIII. Allied Health Professionals

The terms as used herein refer to non-physicians who are functioning in a dependent relationship with a licensed physician having staff privileges wherein the physician supervises and is liable for the actions of the non-physician. The Allied Health Professionals include: Physician Assistant/Advanced Practice Registered Nurse, Anesthesia Assistant, Physician's Technical Assistant, Nurse Anesthetist, and First Surgical Assistant. Each Allied Health Professional must meet the educational, moral, and competence requirements hereinafter defined by category. All initial appointments and re-appointments shall be granted by the Board of Directors for a period not to exceed three years. Each Allied Health Professional on initial entry in the medical record must indicate the sponsoring physician for that particular case.

A physician may not actively supervise more than 4 other Allied Health Professionals at any one time.

All Allied Health Professionals must verbally introduce themselves upon initially entering a patient's room indicating their degree and sponsoring physician they are working with and be so identified by a conspicuous tag which shall state:

Name: _____

Degree: i.e.: Physician Assistant, Advanced Practice Registered Nurse, etc.

All Allied Health Professionals have obtained credentials and delineation of privileges reviewed and endorsed by the Medical Staff through the Credentials and Qualifications Committee and the

Medical Executive Committee. The Medical Staff, through the Medical Staff Performance Improvement Committee will monitor and seek corrective action regarding the quality of care provided by Allied Health Professionals.

A. Physician's Assistant/ Advanced Practice Registered Nurse (PA/APRN)

A Physician Assistant/Advanced Practice Registered Nurse is an individual who, upon successful completion of a program approved by the Florida State Board of Medical Examiners, has been approved by the Board to perform medical services under the supervision of a physician, or group of physicians, approved by the Board to supervise such assistant.

Application for Utilization of PA/APRN:

A physician or group of physicians, with staff privileges at Holy Cross Hospital, Inc. and Outpatient Ambulatory Offices who desires to supervise a physician's assistant/ advanced practice registered nurse within the hospital and Outpatient Ambulatory Offices must file an application with the Credentials & Qualifications Committee. Said application shall consist of the following:

1. The qualifications, including related experience, of the physician's assistant/ advanced practice registered nurse (PA/APRN) intended to be utilized.
2. A resume/application form submitted by the PA/APRN shall include his/her full name, date and place of birth, list of residences for the past ten years, educational institutions attended, complete PA/APRN employment history, and a statement as to whether or not the applicant is, or ever was, addicted to the use of drugs or alcohol.
3. A detailed delineation of the functions and duties (privileges) which the applying physician, or group of physicians, seeks to have granted to their physician's assistant/ advanced practice registered nurse.
4. Evidence of adequate malpractice insurance, as determined by Administration, covering the physician's assistant/ advanced practice registered nurse.
5. A written acknowledgment by the physician that he, solely, shall be held legally responsible for the actions of his physician's assistant/ advanced practice registered nurse.

Qualifications:

1. The Credentials Committee may approve an application by a licensed physician or physicians to employ a PA/APRN within the hospital when, in its discretion, the committee is satisfied that the proposed assistant is:
 - a. A graduate of any approved program.

- b. Fully qualified by reason of experience and education to perform the medical services under the supervision of the physician or physicians requested in the application.
 - c. An individual of good moral character.
- 2. The Credentials & Qualifications Committee may, in its discretion, recommend for approval to the Medical Executive Committee and the Board of Directors a request in whole, or in part, granting some but not all functions and duties requested.
- 3. The Credentials & Qualifications Committee may at any time for good cause recommend a rescission to the Medical Executive Committee and the Board of Directors its approval of the application and deny the physician's assistant/ advanced practice registered nurse permission to act within the hospital or Outpatient Ambulatory Offices.
- 4. Any privilege not explicitly requested in the application and not granted by the Credentials & Qualifications Committee is deemed denied, except as hereinafter provided.
- 5. The primary sponsoring physician and the physician's assistant/ advanced practice registered nurse applicant shall appear before the Credentials Committee for questioning prior to approval of the application

Duties and Privileges of Sponsoring Physician(s) and Physician's Assistants/Advanced Practice Registered Nurse :

- 1. All Physician's Assistants/ Advanced Practice Registered Nurse shall practice under the auspices of a Sponsoring Physician(s) according to the Scope of Practice and Delineation of Privileges as granted by the Board of Directors.

It shall be the duty of the physician or physicians employing a physician's assistant/ advanced practice registered nurse, to supervise such person. Except in the case of an emergency, supervision shall require the easy availability of physical presence by the sponsoring physician.

Unless care occurs in an Outpatient Ambulatory Office a physician's assistant/ advanced practice registered nurse shall not do initial consultations unless the patient is an established patient of the sponsoring physician. They may review the patient's medical record and order routine non-invasive diagnostic imaging and laboratory studies to expedite information gathering for their sponsoring physician. They cannot enter electronically or write orders to initiate treatment until the patient has been seen by the sponsoring physician and that physician has electronically entered, written or dictated the consult.

- 2. A physician's assistant/ advanced practice registered nurse may only care for the patients who have been admitted to the hospital by their sponsoring physician, and those patients seen initially in consultation by the sponsoring physician in order to

provide follow up care. They may also care for an established patient of their sponsoring physician in the Outpatient Department of the hospital or Emergency Department.

3. The supervising physician shall, in all cases, designate another physician who is a member of the Medical Staff, to assume responsibility for the physician's assistant/ advanced practice registered nurse, when he/she is not immediately available.
4. A physician's assistant/ advanced practice registered nurse may do patient histories and physicals and electronically enter or write routine progress reports for patients admitted to the hospital by their own supervising physician.
5. A physician's assistant/ advanced practice registered nurse may dictate discharge summaries for patients discharged by their own supervising physician, but it is the duty of the supervising physician to sign such summaries when completing the patient's chart.
6. The Physician Assistant/ Advanced Practice Registered Nurse may write orders for routine noninvasive laboratory and routine noninvasive x-ray procedures on the doctor's order sheet for patients admitted by their own sponsoring physician, or in follow up care of those patients consulted by their supervising physician. Physician Assistants/ Advanced Practice Registered Nurse may order medications and therapies for patients admitted by their supervising physician or in follow up care of those patients consulted by the supervising physician that have been approved during the application process via the Credentials & Qualifications Committee. A Physician Assistant/Advanced Practice Registered Nurse may electronically enter or write orders for invasive procedures for patients admitted by their supervising physician or in follow up care of those patients consulted by their supervising physician, but all such orders shall be confirmed by direct communication with the sponsoring physician and documented in the medical record.
7. Physician Assistants/Advanced Practice Registered Nurses may see patients in the Emergency Department in conjunction with the Emergency Department physicians. Physician's Assistants/Advanced Practice Registered Nurse may not make final disposition of Emergency Department patients.
8. Physician's Assistants/ Advanced Practice Registered Nurses will be required to attend all appropriate educational programs and meetings carried on by the hospital and staff.

Disciplinary Proceedings:

Complaints lodged against a physician's assistant/ advanced practice registered nurses shall be in writing and shall be evaluated by the Allied Health Professional Committee, a sub-committee of the Credentials & Qualifications Committee. The supervising physician shall be notified of the complaint prior to the investigation, and shall be required to defend said complaint should the investigation so warrant.

The subcommittee's recommendation shall be forwarded for review to the Credentials & Qualifications Committee. The Credentials & Qualifications Committee will then make a recommendation to the Medical Staff Peer Improvement Committee. Discipline may vary, including censure, warning against further similar actions and/or loss of previously granted privileges. If the sponsoring physician disagrees with any action taken, the sponsoring physician may appear before the Medical Executive Committee to discuss. The decision by the Medical Executive Committee is final.

Annual Review:

There shall be an annual review of physician's assistants/ advanced practice registered nurses by the Credentials & Qualifications Committee. This committee shall have the task of evaluating the privileges granted each physician's assistant/advanced practice registered nurse to ascertain whether each assistant is properly performing his/her permitted tasks and is being properly supervised. At the option of the Credentials & Qualifications Committee, the employing physician and the PA/APRN applicant shall appear for questioning prior to approval of the application. The committee will issue a recommendation that either the physician's assistant's/ advanced practice registered nurse privileges should be restricted, left as is or expanded. The supervising physician shall be responsible for submitting a written report on his physician's assistant/advanced practice registered nurse to the committee, giving an objective summary of the performance of the physician's assistant/ advanced practice registered nurse and requesting deletion or addition of privileges. However, written request for deletion of privileges or expansion of privileges may also be submitted to the Credentials & Qualifications Committee during the interim between annual reviews.

B. Physician's Technical Assistant

A Physician's Technical Assistant may have an R.N. degree conferred by an accredited school of nursing, or must have undergone specialized training in an area, or areas, of medical service. Such person shall perform under the supervision of a sponsoring physician.

Application for Utilization of Physician's Technical Assistant:

The physician, or physicians, desiring to employ a physician's technical assistant at Holy Cross Hospital must file an application with the Credentials & Qualifications Committee. Said application shall consist of the following:

1. The qualifications, including related experience of the physician's technical assistant intended to be utilized.
2. A resume/application form submitted by the physician's assistant including his/her full name, date and place of birth, list of residences for the past ten years, educational institutions attended, complete physician technical assistant employment history, and a statement as to whether or not the applicant is, or ever was, addicted to the use of drugs or alcohol.

3. A detailed delineation of the functions and privileges which the applying physician or group of physicians seeks to have granted to their physician's technical assistants. Standards for delineation of functions and granting of privileges will be those used by the hospital for a hospital employee of comparable training doing a comparable service. In no case shall a physician's technical assistant be granted privileges not permitted to a hospital employee of comparable training doing a comparable service.
4. A description by the physician of his practice and the way in which the physician's technical assistant is presently being utilized.
5. Evidence of adequate malpractice insurance, as determined by Administration, covering the physician's technical assistant.
6. A written acknowledgment by the physician that he shall be held legally responsible for the actions of his physician's technical assistant.

Qualifications:

The Credentials & Qualifications Committee shall receive a recommendation from the Allied Health Credentials Sub Committee and based upon said report, and its own evaluation, the Credentials & Qualifications Committee shall approve in whole, or in part, said application if it appears the proposed physician's technical assistant is:

1. The holder of an R.N. degree conferred by an accredited school of nursing and/or possessing a current experience or education to perform the medical services, or some of them, under the supervision of the physician or physicians making application, and the physician(s) making application have sufficient expertise in the various tasks to provide adequate supervision.
2. That the proposed physician's technical assistant shall be of good moral character.

The Credentials & Qualifications Committee may at any time, for good cause, rescind its approval of the application and deny the physician's technical assistant permission to act within the hospital. A physician's technical assistant may perform only those tasks specifically permitted by the Credentials & Qualifications Committee - no other tasks may be performed by a physician's technical assistant within the hospital, except as granted by the Credentials & Qualifications Committee.

Duties of Sponsoring Physician and Physician's Technical Assistant:

1. It shall be the duty of the physician(s) employing a physician's technical assistant to supervise their employee.
 - a. Supervision means responsible supervision and control, with the licensed physician(s) assuming legal liability for the services rendered by the

physician's technical assistant. Except in case of emergency, supervision shall require the easy availability of physical presence of the licensed physician for consultation and direction of the physician's technical assistant.

2. The supervising physician shall, in all cases, designate another physician who is a member of the Medical Staff, to assume responsibility for the physician's technical assistant when he is not immediately available. Such designation does not remove the supervising physician's legal liability, or transfer any part of the liability to said designated physician.
3. It shall be the duty of the supervising physician to obtain a separate and specific written informed consent of his patient that a portion of his, or her, treatment may be given by a physician's technical assistant.
4. A credentials file shall be kept in the Medical Staff Office for each physician's technical assistant delineating the tasks he/she may perform.
5. Prior to undertaking any action, a physician's technical assistant will present him or herself at a nursing station and make known his/her intended course of action to the nurse on duty.
6. A physician's technical assistant, who is an RN may electronically enter or write verbal or telephone orders on the physicians order sheet only if those privileges are granted to that technical assistant, but it is the duty of the supervising physician to see the patient and countersign any order signed, or action taken by a physician's technical assistant, within twenty-four (24) hours.
7. In the event of a life threatening emergency, when no physician is available, the physician's technical assistant may respond accordingly. Under no circumstances will a physician's technical assistant administer to any patient other than one of their supervising physician's patients, who has consented in writing to same upon admission to the hospital.
8. The physician's technical assistant may not see patients in the Emergency Room before they are examined by the Emergency Room Physician, or responsible physician. Physician's technical assistants may not make final disposition of Emergency Room patients.
9. Physician's technical assistants will be required to attend all appropriate educational programs and meetings carried on by the hospital and the staff and to maintain continuing medical education as determined by their parent organization.

Disciplinary Proceedings:

Complaints lodged against a physician's technical assistant shall be in writing and shall be evaluated by the Allied Health Professional Committee, a sub-committee of the Credentials

& Qualifications Committee. The supervising physician shall be notified of the complaint prior to the investigation, and shall be required to defend said complaint should the investigation so warrant.

The sub-committee's recommendation shall be forwarded for review to the Credentials & Qualifications Committee. The Credentials & Qualifications Committee will then make a recommendation to the Medical Staff Peer Improvement Committee. Discipline may vary, including censure, warning against further similar actions and/or loss of previously granted privileges.

Annual Review:

There shall be an annual review of physician's technical assistants by the Credentials Committee. This committee shall have the task of evaluating the privileges granted each physician's technical assistant annually to ascertain whether each assistant is properly performing his permitted tasks and is being properly supervised. At the option of the Credentials & Qualifications Committee, the employing physician and the PA/APRN applicant shall appear for questioning prior to approval of the application. The committee will issue a recommendation that either the physician's assistant's privileges should be restricted, left as is or expanded. The supervising physician shall be responsible for submitting a written report on his physician's assistant to the committee, giving an objective summary of the performance of the physician's assistant and requesting deletion or addition of privileges. However, written request for deletion of privileges or expansion of privileges may also be submitted to the Credentials & Qualifications Committee during the interim between annual reviews.

C. Nurse Anesthetist

1. A nurse anesthetist is an individual with proof of Florida licensure, who upon completion of an accredited nurse anesthetist training program has been approved by the Board to perform anesthesia services under the sponsoring physician anesthetist or a sponsoring group of physicians approved by the Board to supervise such nurse anesthetist.
2. An applicant must supply a list of cases done during the previous year to the Credentials & Qualifications Committee, including the operations performed and the type of anesthesia used.
3. The Credentials & Qualifications Committee will delineate privileges on the basis of the applicant's experience and recommendations by the Department of Anesthesiology.
4. The nurse anesthetists work will be reviewed annually by the Chairman of the Department of Anesthesia. The review will then be submitted to the Credentials & Qualifications Committee and their privileges extended on the basis of the review.
5. Any nurse anesthetist will be under the supervision of the Chief of the Anesthesiology Department and may attend departmental meetings by invitation.

Disciplinary Proceedings:

Complaints lodged against a Nurse Anesthetist shall be in writing and shall be evaluated by the Allied Health Professional Committee, a sub-committee of the Credentials & Qualifications Committee. The Chief of the Department of Anesthesiology shall be notified of the complaint prior to the investigation, and shall be required to defend said complaint should the investigation so warrant.

The subcommittee's recommendation shall be forwarded for review to the Credentials & Qualifications Committee. The Credentials & Qualifications Committee will then make a recommendation to the Medical Staff Peer Improvement Committee. Discipline may vary, including
censure, warning against further similar actions, and/or loss of previously granted privileges.

D. First Surgical Assistant

A First Surgical Assistant is a health care professional who, by licensure in the State of Florida or by nationally recognized certification as a first surgical assistant is granted permission to first assist at surgical procedures. These individuals function as dependent Allied Health Professionals, sponsored by an Active member of the Medical Staff. Categories of health care professionals who may be in this category include: Licensed physicians seeking permission to only assist at surgery, RNFA's, Certified First Surgical Assistants and Certified Scrub Technicians who meet the above criteria.

1. An applicant must provide proof of current Florida licensure as a MD, DO, RN or provide proof of current certification by a nationally recognized certification program in first surgical assisting.
2. An applicant must provide a list of cases done as a primary surgeon or a first surgical assistant during the previous year to the Credentials & Qualifications Committee.
3. The Credentials & Qualifications Committee will delineate duties and responsibilities on the basis of the applicant 's experience and qualifications.
4. The performance of a first surgical assistant will be reviewed annually by the sponsoring physician(s) and forwarded to the Credentials & Qualifications Committee for review and recommendation. At the option of the Credentials & Qualifications Committee, the employing physician and the first surgical applicant shall appear for questioning prior to approval of the application. The duties and responsibilities may be extended or restricted on the basis of the review.
5. The first surgical assistant will be under the direct supervision of the sponsoring physician at all times.
6. Any complaint concerning an AHP-D First Surgical Assistant must be presented in writing to the Credentials & Qualifications Committee via the Allied Health Professional Subcommittee of the Credentials & Qualifications Committee. The sponsoring physician shall be notified of the complaint prior to the investigation, and shall be required to

defend said complaint should the investigation so warrant.

7. Recommendations for corrective and/or disciplinary action shall be recommended to the Medical Staff Peer Improvement Committee of the Medical Staff. This may include letters of warning or reprimand, restriction of duties, probationary status imposed, or possibly removal from the Allied Health Professional Staff.

XIV. NURSE MIDWIFERY FUNCTIONS AND PROTOCOLS

A. DEFINITION

A Certified Nurse-Midwife (CNM) is an individual educated in the two disciplines of Nursing and Midwifery who possesses evidence of certification according to the requirements of the American College of Nurse - Midwives and the Florida Board of Nursing.

B. ROLE OF THE CERTIFIED NURSE-MIDWIFE

The CNM, in collaboration with the attending physician will assure the responsibility for the care of the maternity patient. The attending obstetrician on call will be responsible for immediate assistance and backup for the CNM as needed.

1. NURSE-MIDWIFERY FUNCTIONS WILL INCLUDE:

- a. Assessment of antenatal patients presenting to the labor and delivery area @ 34 weeks.
- b. Antepartum assessment of High Risk patients with physician supervision.
- c. Intrapartum Management, including vaginal delivery.
- d. Postpartum Management.

Certified Nurse-Midwives will consult with the attending physician for plan of management for patients with antepartum, intrapartum, or postpartum complications.

The Certified Nurse-Midwife will collaborate with the physician in management of patients with complications through mutual agreement. Nurse-midwives will be available to participate in the care of such patients when requested by the physician only to the level of their predetermined skills and ability, after the patient has been examined by the OB/GYN Attending

The Certified Nurse-Midwife may transfer primary care of the patient to physician management, of any patient whose condition, in the opinion of the nurse-midwife, is beyond the scope of practice of the Nurse-Midwifery.

Certified Nurse-Midwives will work with the medical and nursing staffs utilizing all established policies and protocols for obstetrical care as described in the Policy manuals for L&D, and Maternal and Infant Unit.

C. INTRAPARTUM

1. L&D nurse will notify the CNM on-call when patient arrives in L&D unit. An L&D nursing assessment will be performed utilizing physical examination, pertinent laboratory evaluation, and fetal heart monitoring.
- D. The following functions and procedures are not viewed as exhaustive, but are intended to clarify the role of the CNM and to identify functions and procedures usually not included in nursing practice.
1. Labor
 - a. Admits and discharges patient with physician consultation
 - b. Performs complete history/physical exam
 - c. Manages patient=s progress and condition during labor and delivery
 - d. Performs sterile speculum exam
 - e. Performs vaginal and/or rectal exams
 - f. Initiates treatment with appropriate medication
 - g. Performs Amniotomy
 - h. Applies external and internal fetal and uterine monitoring equipment
 - i. With medical collaboration, may monitor patients on:
 1. IV Oxytocin for induction or augmentation of labor,
 2. IV Magnesium Sulfate for mild PIH
 - j. Follows labor and delivery routine admission orders individualizing according to patient's needs consulting on intrapartum management as needed.
 - k. Amnio-infusion with physician supervision
 - l. Inserts prostaglandin gel for induction of labor with physician consultation
 2. Delivery
 - a. Makes decision regarding location of patient=s delivery (LDR or DR)
 - b. Performs local infiltration, pudendal block
 - c. Performs and repairs median or mediolateral episiotomy
 - d. Repairs 1st and 2nd degree lacerations after satisfactory supervisory period
 - e. Conducts single spontaneous deliveries of vertex presentation from OA or OP positions
 - f. May participate in twin, breech, and premature deliveries with physician in attendance.
 - g. Manages third stages of labor
 - h. Performs cervical and vaginal inspections
 - i. Repair vaginal and perineal lacerations after satisfactory supervisory period
 - j. The CNM may request the NICU team in cases of need and per L&D protocol.
 - k. The CNM stabilizes infant - see below
 - l. Performs immediate appraisal of newborn
 - m. Transfers newborn to requested physician
 - n. Manages immediate postpartum period
 - o. Writes postpartum orders for patients to be followed.
 - p. Orders laboratory tests as indicated in protocols
 3. Routine newborn management

- a. Immediate: establish respirations, suction with bulb, clamps, and cut cord. Will give Apgar score at one and five minutes if providing newborn care.
 - b. Perform newborn evaluation and physical inspections when neonatologist or pediatrician not present at birth.
 - c. Records pertinent data on record
 - d. Notifies infant's physician of any abnormalities in heart rate, respirations, color etc.
 - e. Administers O₂ via oxygen face mask or ambu bag when necessary.
4. NICU is to be notified for attendance at delivery of the following:
- a. Meconium stained fluid
 - b. Abnormal fetal heart rate pattern
 - c. In event of operative delivery
 - d. Newborn resuscitation
 - e. Prematurity
 - f. Suspected IUGR
 - g. Suspected abruption or previa
 - h. Prolonged rupture of membranes greater than twenty-four hours at the time of delivery
5. Emergencies
In the event of an obstetrical emergency, the CNM will notify the consulting physician STAT and proceed with appropriate emergency measures as indicated.

E. PHYSICIAN MANAGED COMPLICATIONS

The CNM will notify the physician when a deviation from the routine occurs. This implies that the physician will see and examine the patient. A plan of management will be outlined by the physician and documented on chart.

A mutually agreed upon plan of management will determine the CNM 's involvement in the case. Careful communication and clear documentation is required of both the physician and the CNM.

The physician will directly manage the patient whenever the following conditions are present:

1. Abnormal lie (breech/transverse lie after 36 weeks)
2. Abruptio placenta
3. Asthma (requiring recent medical supervision)
4. Cardiac or valvular disease
5. Diabetes, insulin dependent
6. Heavy or unexplained bleeding
7. Hemoglobinopathies (sickle cell disease, thalassemia, etc.)
8. Herpes (suspicious vulvar lesion)
9. Intrauterine fetal demise
10. Multiple gestations
11. Pelvic tumor or abnormality
12. Placenta previa - either partial or complete
13. Pre-existing medical conditions

14. Pregnancy induced hypertension
15. Premature labor to the thirty sixth week of gestation or less
16. Prolapsed cord
17. Psychotic disorders
18. Seizure disorders (currently on medication or history of)
19. Retained placenta (greater than thirty minutes of duration from the time of delivery)
20. Rh sensitization
21. Macrosomia or history of Shoulder Dystocia
22. Non reassuring pattern:
 - a. Any Abnormal baseline fetal heart rate below 100 or above 170 of loss of variability
 - b. Persistent late or variable decelerations (unresponsive to conservative management)

F. SITUATIONS REQUIRING PHYSICIAN MANAGEMENT

These situations may ultimately require physician management depending on severity.

1. Abnormal vaginal bleeding
2. Complicated urinary tract infection
3. Drug abuse, current
4. Dysfunctional labor
5. Estimated fetal weight > 4000 grams
6. Fever of 100.4 or above (after ruling out dehydration)
7. Fetal stress
8. Induction or augmentation of labor
9. Intrauterine growth retardation (suspected)
10. Indeterminate fetal presentation
11. Mild to moderate PIH
12. Multiple gestations
13. Platelets less than 100,000
14. Postpartum hemorrhage, unresponsive to treatment
15. Premature or prolonged rupture of membranes for twelve hours or more without labor
16. Presence of thick particulate meconium
17. Previous uterine surgery (excluding D&C 's and cone biopsies)
18. Previous C/Section
19. Premature labor to the 36th week or less
20. Prolonged pregnancy greater than forty-two weeks
21. Prolonged or abnormal labor curve
22. Severe anemia (Hgb. less than 9 grams)
23. Untreated sexual transmitted disease that does not present with a specific plan of management
24. Any other complication or symptoms which have the potential for causing morbidity or mortality for the mother, fetus, or neonate

G. POSTPARTUM

1. Nurse midwives will be responsible for management of all CNM delivered patients who have no serious complications.

2. Postpartum Protocols

The following functions of the CNM 's are intended to be inclusive but not limited to:

1. Initiates routine postpartum orders
2. Makes postpartum rounds
3. Provides postpartum teaching and counseling as needed
4. Monitors postpartum physical changes
5. Obtains physicians' consultation for any abnormal findings
6. Completion of medical records
7. Discharge with instructions including plans for following care of contraception and voluntary sterilization as indicated.
8. Discharges patients after MD approval

3. Postpartum Conditions Requiring Physician Consultation

The CNM will consult whenever the following conditions are present:

- a. Abnormal laboratory findings
- b. Any medical or surgical condition considered obstetrically significant
- c. Pain, swelling, or inflammation associated with varicosities
- d. Pain, swelling or inflammation of breast not normally associated with engorgement or lactation
- e. Significant changes in vital signs
 1. Temperature of 100.4 on two consecutive readings four to six hours apart, 24 hours after delivery
 2. Respirations greater than twenty-four or less than twelve
 3. Pulse greater than 120 or less than 60
- f. Persistent evaluation of blood pressure at or above 140/90 on two consecutive readings four to six hours apart on left side
- g. Delayed postpartum hemorrhage
- h. Hematoma of vulva or perineum
- i. Pain unrelated to minor discomforts of postpartum period

H. CHARTING

The supervising physician's co-signature with the CNM on the face sheet of the chart indicates that the CNM has followed the approved protocols and procedures.

I. MEDICATIONS

Medications may be ordered, prescribed and/or administered by CNM per protocol

The following are not viewed as exhaustive, but are intended to be medication examples:

Per Florida Pharmacology, CNM may not prescribe scheduled medications. Per this protocol CNM may order and/or administer scheduled medications under standing orders. The physician and CNM signature on the chart cover sheet will indicate such approval.

1. Iron and vitamins
2. Other approved medications as needed
3. Outpatient OB Checks -

- Antepartal protocols for minor pregnancy problems, e.g., urinary tract infections, prodromal labor, pre-term labor assessment, apply to OB evaluations by the CNM on call at the hospital.
4. Labor and Delivery:
Analgesia, intravenous fluids, anesthetics and oxytocics are individualized according to the patient needs and at the CNM 's discretion.
 5. Postpartum:
Rubella vaccination, Rhogam, Tobin
 6. Collaborative management cases:
Any medication as ordered by the physician. Standard medication protocols after physician consultation, e.g., Pitocin augmentation/induction, MgSO₄, antibiotics, steroids.

APPROVALS:

Medical Records section revised and Nurse Midwifery added to Allied Health Professional section.

Approved: Medical Executive Committee: 01-09-97

Board of Trustees: 01-27-97

Addendum to Allied Health Professional Section – Graduate Medical Education Clinical Preceptorship: Residents/Fellow and Research Associates.

Approved: Medical Executive Committee: 3/13/97

Board of Trustees: 3/31/97

Miscellaneous Changes to Pages 1-12

Approved: Medical Executive Committee: 5/8/97

Board of Trustees: 5/19/97

Addition to Allied Health Professional Section – First Surgical Assistant

Approved: Medical Executive Committee: 11/6/97

Board of Trustees: 11/24/97

Addition to Medical Staff Rules & Regulations: Medical Student Education: Elective Clinical Rotation Preceptorship: Third and Fourth Year Medical Students

Approved: Medical Executive Committee: 5/14/98

Board of Trustees: 5/18/98

Addition to Emergency Services, Section VI: Follow-up Care:

Approved: Medical Executive Committee: 9/10/98

Board of Trustees: 9/28/98

Addition of Mercy Manor and Pavilion, Section VII

Addition of Hospice to Admission and Discharge, Section I, Item D.

Approved: Medical Executive Committee: 4/8/99

Board of Trustees: 4/26/99

Addition of Item g to Section D, Section E and Section F to Section II - Medical Records

Approved: Medical Executive Committee: 4/8/99

Approved by Board of Trustees 4/26/99

Addition of Autopsy Criteria to Section K, Article I

Delete AHP Independent Category

Approved: Medical Executive Committee: 5/13/99

Approved: Board of Trustees: 5/25/99

Misc. Revisions

Approved: Medical Executive Committee: 11/11/99

Approved: Board of Trustees: 11/22/99

Allied Health Professional Section revised/Telephone Orders

Approved: Medical Executive Committee: 4/13/2000

Approved: Board of Trustees: 4/17/2000

Physicians Orders re: Telephone and verbal orders, Medical Record Suspension

Approved: Medical Executive Committee: 12/7/00

Approved: Board of Trustees: 1/29/01

Midwifery Functions & Protocols, pages 39, 40

Approved: Medical Executive Committee: 7/12/01

Approved: Board of Trustees: 7/30/01

Allied Health Professional Section revised, Duties of PA's & ARNP's

Approved: Medical Executive Committee: 8/9/01

Approved: Board of Trustees: 8/13/01

Delete reference to Psychologists, Revise Medical Record Suspension policy

Approved: Medical Executive Committee: 9/13/01

Approved: Board of Trustees: 9/24/01

Disruptive Medical Staff Member Policy and Physician Code of Conduct

Approved: Medical Executive Committee: 12/12/02

Approved: Board of Trustees: 1/27/03

Allied Health Professionals Section revised, Recredentialing every two years

Approved: Medical Executive Committee: 1/16/03

Approved: Board of Trustees: 1/27/03

Delete References to Chief Medical Officer and Amend Reference to the Responsibilities

Approved: Medical Executive Committee: 3/13/03 and 4/10/03

Approved: Board of Trustees: 4/21/03

Change References regarding Medical Staff Performance Improvement to Medical Staff Peer Improvement and generalize radiology requests on page 14

Approved: Medical Executive Committee: May 13, 2004
Approved: Board of Trustees: May 25, 2004

Clarify Physicians Responsibility of Seeing Patients, page 2(D)
Approved: Medical Executive Committee: August 9, 2004
Approved: Board of Trustees: October 25, 2004

Clarify Consultations and History and Physical Examinations for Non-Inpatient Services
Approved: Medical Executive Committee: May 12, 2005
Approved: Board of Trustees: May 23, 2005

Remove Nurse Midwives Medication List and Other Minor Clarifications
Approved: Medical Executive Committee: March 9, 2006
Approved: Board of Trustees: March 27, 2006

Add to Allied Health Professional Introduction – Each Allied Health Professional on initial entry in the medical record must indicate the sponsoring physician for that particular case.
Approved: Medical Executive Committee: August 17, 2006
Approved: Board of Trustees: August 18, 2006

Clarify the Number of Allied Health Professionals a Sponsoring Physician May Actively Supervise at one time.
Approved: Medical Executive Committee: October 12, 2006
Approved: Board of Trustees: October 16, 2006

Remove Mercy Manor North References, Orders Authentication
Approved: Medical Executive Committee: September 20, 2007
Approved: Board of Trustees: September 24, 2007

Add Primary Sponsoring Physicians must attend Credentials and Qualifications Meeting
Approved: Medical Executive Committee: October 11, 2007
Approved: Board of Trustees: October 16, 2007

Add All Entries in the Medical Records must be Timed
Approved: Medical Executive Committee: November 8, 2007
Approved: Board of Trustees: November 9, 2007

Change specialist to intensivist on Page 2 – I. Admission and Discharge of Patients, Letter D
Approved: Medical Executive Committee: August 14, 2008
Approved: Board of Trustees: August 18, 2008

Change contacting of consultants on Page 9 – III. General Conduct of Care, Letter G
Approved: Medical Executive Committee: November 20, 2008
Approved: Board of Trustees: November 24, 2008

Change consultants contacting attending physicians on Page 9 – III. General Conduct of Care, Letter G
Approved: Medical Executive Committee: December 9, 2008

Approved: Board of Trustees: December 16, 2008

Revise Physician Assistants/ARNP information on page 26 and page 27

Approved: Medical Executive Committee: January 8, 2009

Approved: Board of Trustees: January 12, 2009

Revise Physician Assistants/ARNP initial consult information

Approved: Medical Executive Committee: July 9, 2009

Approved: Board of Trustees: July 10, 2009

Remove Supervising Physicians from signing Physician Assistant Orders

Approved: Medical Executive Committee: November 12, 2009

Approved: Board of Trustees: November 23, 2009

Clarify Telephone Orders to Therapists and Physician Signature Requirements

Approved: Medical Executive Committee: March 11, 2009

Approved: Board of Trustees: March 22, 2010

Re-establish Timeframe Admitting Physician Has to See a New Admit

Approved: Medical Executive Committee: April 8, 2009

Approved: Board of Trustees: April 9, 2010

Allied Health Professional Quality Issues Reviewed by MSPI and Remove Psychologists as AHP

Approved: Medical Executive Committee: June 3, 2010

Approved: Board of Trustees: June 7, 2010

Add OPPE/FPPE Information and Non-Smoking Campus

Approved: Medical Executive Committee: April 12, 2012

Approved: Board of Trustees: April 16, 2012

Authenticated Orders Timeframe Changes from 48 Hours to Promptly

Approved: Medical Executive Committee: July 12, 2012

Approved: Board of Trustees: July 13, 2012

Revise wording eliminating Disruptive Physician and adding “Behavior or Behaviors that Undermine a culture of safety”, per The Joint Commission

Approved: Medical Executive Committee: October 11, 2012

Approved: Board of Trustees: November 19, 2012

CPOE and EMR Wording Added

Approved: Medical Executive Committee: February 21, 2013

Approved: Board of Trustees: March 25, 2013

Revisions to Interns & Residents and Medical Students

Approved: Medical Executive Committee: March 12, 2015

Approved: Board of Directors: April 27, 2015

Revisions to Responsibility for Medical Records

Approved: Medical Executive Committee: August 11, 2016

Approved: Board of Directors: August 16, 2016

Revisions to Duties and Privileges of Sponsoring Physician(s) and Physician's Assistants/Advanced Registered Nurse Practitioner

Approved: Medical Executive Committee: May 10, 2018

Approved: Board of Directors: May 15, 2018

Advanced Practice Registered Nurse Wording Updated

Approved: Medical Executive Committee: June 13, 2019

Approved: Board of Trustees: June 18, 2019

Pathology Procedure Updates

Approved: Medical Executive Committee, November 11, 2021

Approved: Board of Trustees: November 22, 2021

Changes from two-year reappointment period to a three-year reappointment period and physicians are not required to sign off on PA records within 24 hours was removed.

Approved: Medical Executive Committee: 8-8-2024

Board of Trustees: 8-12-2024