

**RULES AND REGULATIONS**

**OF THE**

**MEDICAL STAFF OF HALIFAX HEALTH**

Adopted by the Medical Staff on March 11, 2014  
Approved by the Board of Commissioners on April 7, 2014

**ARTICLE XVII -ADOPTION**

These Bylaws together with the appended Rules and Regulations, shall be adopted at any regular or special meeting of the Active Medical Staff, shall replace any previous Bylaws; Rules and Regulations and shall become effective when approved by the Governing Body of the Hospital.


Adopted by the Active Medical Staff of Halifax Health Medical Center.



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President, Medical Staff

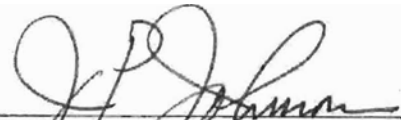
Date: March 11, 2014



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Secretary, Medical Staff

Approved by the Governing Body of Halifax Health Medical Center.



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Chairman, Board of Commissioners



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Secretary, Board of Commissioners

Date: April 7, 2014

## **APPENDIX I**

### **MEDICAL STAFF RULES AND REGULATIONS**

#### **ARTICLE I- ADMISSION AND DISCHARGE OF PATIENTS**

##### **1.1 ADMISSION**

A patient may be admitted to Halifax Medical Center only by members of its Medical Staff who have been granted privileges in accordance with the Medical Staff Bylaws. Qualified dentists and podiatrists who have been granted privileges may initiate the procedure for admitting a patient, however, a Physician member of the Medical Staff shall assume responsibility for the overall medical aspects of the patient's care throughout the hospital stay. All Practitioners shall be governed by the official admitting policy of the Hospital.

##### **1.2 RESPONSIBILITY FOR PATIENT CARE**

Each patient shall be the responsibility of a member of the Medical Staff. Such Practitioner shall be responsible for the medical care and treatment, for the prompt completeness and accuracy of the medical record, for necessary special instructions, and for transmitting reports of the condition of the patient to the referring Practitioner and to relatives of the patient. Whenever these responsibilities are transferred to another Staff Practitioner, a note covering the transfer of responsibility shall be entered on the order sheet of the medical record.

##### **1.3 DISCHARGE AGAINST MEDICAL ADVICE**

Patients shall be discharged only on a written order of the attending Practitioner. Should a patient leave the Hospital against the advice of the attending Practitioner, or without proper discharge, a notation of the incident shall be made in the patient's medical record.

##### **1.4 EMERGENCY ADMISSION**

In the case of an emergency admission, patients who do not have a private Practitioner may request a Practitioner in the Department or Service to which he/she needs to be admitted, or be assigned in rotation to members of the Active or Associate Staff on duty in the Department or service to which the illness or patients indicates assignment. The Chairperson of each Department shall provide an assignment schedule for attendance of such patients.

In case of an emergency affecting the patient of a member of the Medical Staff who is not immediately available, the President of the Medical Staff, the Chairperson of the Department concerned, or their designee, shall have the authority to call in any member of the Medical Staff with the appropriate privileges, to attend such patient until the member of the Medical Staff becomes available to assume responsibility for the patient.

##### **1.5 EMERGENCY DEPARTMENT CALL ROSTER**

All members of the Active and Associate Medical Staff shall actively participate in the Emergency Department service call roster and disaster on-call programs for their Department/subsection unless excused by their Clinical Department as provided in Departmental Rules and Regulations, the

Medical Staff Bylaws, or the Bylaws of the Governing Body. Practitioners in other categories may be required to participate in service call, as required by their Department/ subsection.

Physicians on Emergency call are expected to admit patients arriving at any Halifax facility to the Halifax Medical Center. Transfer shall not take place without approval of the administrator on call unless the service is not available at this facility. Patients shall have the right to request admission to the hospital of their choice.

Each Clinical Department Chair or his designee shall maintain a roster of Physicians on call for the Emergency Department and submit it to the President of the Medical Staff and Medical Staff Coordinator. On call Physicians will respond to Emergency Department call within fifteen (15) minutes for a STAT call, and forty-five (45) minutes for a routine call (unless otherwise specified by separate contract or agreement).

The on-call Physician shall accept the evaluation of the emergency physician and follow his/her advice regarding admission, or come to the Emergency Department, or Hospital, and evaluate the patient and make a medically appropriate disposition. Patients seen and evaluated in the Emergency Department, who, in the opinion of the emergency Physician, require specialty evaluation or on-going treatment by an on-call member of the Medical Staff shall be accepted by that member or his associate without regard to the patient's ability to pay for services rendered.

If a Physician is unavailable when on call, or is unable to take call for an assigned time, it is that Physician's responsibility to arrange for another Physician member of the Medical Staff with the appropriate privileges to assume the Physician's call responsibilities. The Medical Staff Coordinator must be notified of all such instances as soon as possible.

In the event a Physician does not respond to a call from the Emergency Department concerning a patient, the Chairperson of the requisite Department/subsection shall direct a member of the Medical Staff, with the appropriate privileges, to attend to such patient. Such instances shall be reported to the Credentials Committee.

The Rules and Regulations of each Clinical Department will specify the arrangements for how service call obligations will be met.

## **1.6 AUTOPSIES**

Criteria for autopsies shall be recommended by the Department of Pathology and approved by the Hospital Performance Improvement Committee. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed by the Hospital Pathologist, or by a Practitioner delegated this responsibility. The attending physician and consultants shall be notified of the scheduled time of the autopsy, to facilitate viewing if desired. Provisional anatomic diagnoses shall be recorded on the medical record as soon as possible and the complete protocol should be made a part of the record as expeditiously as possible.

## **ARTICLE II- MEDICAL RECORDS**

### **2.1 MEDICAL RECORDS**

#### **2.1-1 Contents of Record**

The attending Practitioner shall be responsible for the preparation of a complete and legible

medical record for each patient. Its contents shall be pertinent and current. This record shall include identification date; complaint; personal history; family history; history of present illness; physical examination; special reports such as consultations, clinical laboratory and radiology services, and others; provisional diagnosis; plan of action; periodic, appropriate reassessment of the patient's condition and response to treatment as determined by the patient's symptoms and test results; medical or surgical treatment; operative report; pathological findings; progress notes; final diagnosis; condition on discharge; summary or discharge note; and autopsy report, when performed.

### **2.1-2 Admission History and Physical Examination**

A patient admitted for inpatient care shall have a complete admission history and physical examination within twenty-four (24) hours of admission and prior to any procedure. Said history and physical examination shall be the responsibility of a licensed independent practitioner (i.e. physicians, oral and maxillofacial surgeons, dentists, podiatrists, PA's and some ARNP's). Dentists shall be responsible for the part of their patient's history and physical examination that relates to dentistry, and podiatrists are responsible for the part of their patient's history and physical examination that relates to podiatry. This report should include all pertinent findings resulting from an assessment of all systems of the body, to include a physical assessment which has been completed within the first twenty-four (24) hours of admission. If a complete history has been recorded and a physical examination performed within thirty (30) days prior to the patient's admission or registration to the Hospital, a reasonably durable, legible copy of these reports may be used in the patient's Hospital medical record in lieu of the admission history and report of the physical examination, provided these reports were recorded by a member of the Medical Staff. In such instances, an update note indicating any changes or no changes to the history and/or physical findings must always be recorded prior to any procedures requiring anesthesia services or conscious sedation and within 24 hours of admission. An exception to these rules will be granted when the record is prepared by a resident physician in which instance the attending physician countersigns the record.

### **2.1-3 History and Physical Required Prior to Procedure**

When the history and physical examination are not recorded before an operation or any potentially hazardous diagnostic procedure, the procedure shall be canceled, unless the attending Practitioner states in writing that such delay would be detrimental to the patient.

### **2.1-4 Progress Notes, Routine Orders**

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatment. Progress notes shall be written at least daily on critically ill patients, and those where there is difficulty in diagnosis or management of the clinical problem.

A Practitioner's routine orders, when applicable to a given patient, shall be reproduced in detail on the order sheet of the patient's record, dated, timed, and signed by the Practitioner.

### **2.1-5 Operative Reports/Notes**

Operative reports shall include a detailed account of the findings at surgery as well as the details of the surgical technique. Operative reports shall be dictated immediately following surgery for outpatients as well as inpatients and the report promptly signed by the surgeon and made a part of the patient's current medical record. An operative progress note shall be entered into the medical record immediately after surgery to provide pertinent information for patient care.

### **2.1-6 Reports of Consultation**

Consultations shall show evidence of a review of the patient's record by the consultant, pertinent findings on examination of the patient, the consultant's opinion and recommendations. This report shall be made a part of the patient's record. Except in emergency, so verified on the record, when operative procedures are involved, the consultation note shall be recorded prior to the operation. Routine consultations will be completed within 24 hours. STAT consultations will be requested by direct physician to physician communication and completed in a timely manner appropriate to the clinical setting. In instances where a pre-existing protocol is in place to facilitate the consult (e.g. radiographs, lab work) the direct physician to physician requirement will be waived. Physician Assistants may see patients for Routine Consults and dictate a note, but the physician must see the patient and dictate a consult within 24 hours.

### **2.1-7 Dated Entries**

All clinical entries in the patient's medical record shall be accurately dated, timed, and authenticated.

### **2.1-8 Final Diagnosis**

Final diagnosis shall be recorded in full, without the use of symbols or abbreviations, and dated and signed by the responsible Practitioner at the time of discharge of all patients. The attending Practitioner has the responsibility to establish the final diagnosis.

### **2.1-9 Discharge Resume**

A discharge clinical resume shall be written or dictated on all medical records of patients hospitalized over forty-eight (48) hours except for normal obstetrical deliveries and normal newborn infants. In addition, a discharge clinical resume should be written or dictated on medical records of a patient where hospitalization is less than forty-eight (48) hours and are of a complicated nature. This determination should be made by the attending Practitioner and a clinical resume prepared, as appropriate. For cases where no discharge clinical resume is prepared, a final summation type progress note shall be sufficient. In all instances, the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result and shall include instructions to the patient relative to activity, diet and medication. All discharge clinical resumes shall be authenticated by the responsible Practitioner.

### **2.1-10 Release of Medical Information and Records**

Written consent of the patient is required for release of medical information to persons not otherwise authorized to receive this information.

Records may be removed from the Hospital's jurisdiction and safekeeping only in accordance with a court order, subpoena or statute. All records are the property of the Hospital and shall not otherwise be taken away without permission of the Chief Executive Officer. In case of readmission of a patient, all previous records shall be available for the use of the attending Practitioners. This shall apply whether the patient be attended by the same Practitioner or by another. Unauthorized removal of charts from the Hospital is grounds for suspension of the Practitioner for a period to be determined by the Executive Committee of the Medical Staff.

Free access to all medical records of all patients shall be afforded to members of the Medical Staff for *bona fide* study and research consistent with preserving the confidentiality of personal information concerning the individual patients. All such projects shall be approved by the Institutional Review Board (IRB) before records can be studied. Subject to the discretion of the Chief Executive Officer, former members of the Medical Staff shall be permitted free access to information from the

medical records of their patients covering all periods during which they attended such patients in the Hospital.

### **2.1-11 Completion of Medical Records**

A medical record shall not be permanently filed until it is completed by the responsible Practitioner or is ordered filed by the Quality Council.

All of the patient's medical records shall be completed within thirty (30) days from the date of discharge; failure to do so will result in suspension of physician admission privileges. The procedure for the handling of practitioners with incomplete medical records is outlined in the "Chart Completion: Physician Notification for Record Completion" policy.

## **ARTICLE III- GENERAL CONDUCT OF CARE**

### **3.1 INFORMED CONSENT**

Informed consent forms for treatment should be prepared by the Hospital taking into account all special procedures. These are to be adopted by the Medical Staff and the Governing Body with the aid of legal counsel.

### **3.2 PRACTITIONERS' ORDERS**

All orders shall be in writing. A verbal order shall be considered to be in writing if dictated to a registered nurse, licensed practical nurse, pharmacist, dietician, respiratory therapist, or any other licensed professional who is authorized to take orders under their licensure requirements and functioning within their sphere of competence. All orders dictated over the telephone shall be signed by the appropriately authorized persons to whom dictated, and include the name of the Practitioner. All verbal orders must be authenticated by the responsible Practitioner or if allowed by law, his alternate within 48 hours. Telephone and verbal orders should not be used routinely.

The Practitioner's orders must be written clearly, legibly and completely. Orders which are illegible or improperly written will not be carried out until rewritten or understood by the nurse. The use of "Renew", "Repeat", and "Continue" telephone orders are not acceptable.

### **3.3 ADMINISTRATION OF DRUGS AND MEDICATIONS**

All drugs and medications administered to patients shall be those listed in the Hospital Formulary. Drugs for bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles Involved in the Use of Investigational Drugs in Hospitals and all regulations of the Federal Drug Administration.

### **3.4 TIMELY USE OF CONSULTATION**

The good conduct of medical practice includes the proper and timely use of consultation. Judgment as to the serious nature of the illness, and the question of doubt as to the diagnosis and treatment, rests with the Practitioner responsible for the care of the patient. On the other hand, it is the duty of the organized Medical Staff through its departmental Chairperson and Credentials Committee to see that those with clinical privileges do not fail in the matter of calling consultants as needed.

Any qualified Practitioner with clinical privileges in this Hospital can be called for consultation

within his area of expertise.

The attending Practitioner is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. He will provide written authorization to permit another attending Practitioner to attend or examine his patient, except in an emergency.

### **3.5 LABORATORY PROCEDURES**

A Laboratory shall be provided in the Hospital so that all types of laboratory examinations may be done.

Outside laboratory reports in acute cases will be accepted but are to be discouraged. Reports must be on forms as used by the Hospital. In surgical cases the reports must accompany the patient.

### **3.6 PREPRINTED ORDERS**

Preprinted orders may be formulated by a Department in conference with the administration. These orders shall be followed insofar as the treatment of the patient will allow and when specific orders are not written by the attending Practitioner, they shall constitute the orders for treatment.

### **3.7 PRACTITIONER'S VISITS**

The attending Practitioner shall visit the hospitalized patient a minimum of once daily. Departmental Rules and Regulations may specify exceptions with appropriate cause. Patient visits must be documented. If the attending Practitioner is unable to visit a hospitalized patient or cover his Emergency Department call roster responsibility, it shall be his responsibility to arrange with a qualified member of the Medical Staff to do so.

### **3.8 MISCELLANEOUS PROVISIONS**

The President of the Medical Staff may be relieved from rotation from his respective service, duty in the clinics and membership of Committees except from one he serves as Chairperson.

Consultation, methods and restrictions regarding termination of pregnancy shall comply with the prevailing Statutes of the State of Florida.

Rapid response time for critically ill patients is expected.

### **3.9 ETHICS**

For guidance on non-medical issues related to regulatory compliance or business ethics, members may, at their option, refer to the Hospital's Code of Conduct, or consult with the Hospital's General Counsel or Compliance Officer.

## **ARTICLE IV- FAMILY PRACTICE RESIDENTS**

All patients seen by Family Practice residents whether in the hospital Family Health Center, private office or other setting are ultimately under the care of a licensed non-resident supervising physician. This supervising physician might be the assigned "attending physician" during an inpatient rotation, a community preceptor during an outpatient elective, a Family Health Center preceptor during



Family Health Center hours or the Family Health Center Medical Director for a non-hospitalized Family Health Center patient during non-Family Health Center hours.

Within HMC, all licensed family practice residents, except those suspended from clinical activities due to residency disciplinary or probationary actions are eligible to be members of the Resident Affiliate staff per the Medical Staff bylaws (section 3.6-1) and are subject to the rules and regulations under those bylaws.

Residents may, with the approval of the non-resident supervising physician execute the clinical privileges with the exception of admitting privileges of the non-resident supervising physician.

The non-resident supervising physician shall assign the resident only those patient care responsibilities which are commensurate with the resident's level of training, experience and competence.

The Residency Program faculty under the leadership of the Residency Program Director will maintain an ongoing evaluation program that will monitor resident "competency" per guidelines established by the ACGME and assure that residents not meeting expected competency standards will receive higher levels of supervision.

The non-resident supervising physician must co-sign the documents written or dictated by residents per policy of the site where patient care is delivered.