

**ST. PETERSBURG GENERAL HOSPITAL
MEDICAL STAFF
RULES AND REGULATIONS**

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PATIENT RIGHTS, ETHICS, & RESPONSIBILITIES

1. Advance Directives, Withdrawal of Life Support, and Do Not Resuscitate Order

The Medical Staff shall comply with Florida Statute 765.102 as follows:

The artificial prolongation of life for a person with a terminal or end-stage condition or in a persistent vegetative state may secure for him/her only a precarious and burdensome existence, while providing nothing medically necessary or beneficial to the patient. In order that the rights and intentions of a person with such a condition may be respected even after he/she is no longer able to participate actively in decisions concerning himself/herself, and to encourage communication among such patient, his/her family or Health Care Surrogate, and his/her physician, the Legislature declares that the laws of this State recognize the right of a competent adult to make an advance directive instructing his/her physician to provide, withhold, or withdraw life-prolonging procedures, or to designate another to make the treatment decision for him/her in the event that such person should be found to be incompetent and suffering from a terminal condition, an end-stage condition, or a persistent vegetative state.

NOTE: A Do Not Resuscitate orders shall be considered to be in writing if written directly by a physician or if issued as stated above and issued verbally to two licensed Registered Nurses and witnessed by both Registered Nurses (See “Continuum of Care” – “Verbal or Telephone Orders” and “Hazardous Verbal Orders”).

When a patient presents with a “Florida Do Not Resuscitate Order” on Florida Department of Health, Bureau of EMS yellow DH Form 1896, the Florida DNRO is to be honored by all hospital services and units upon confirmation by patient/family/surrogate that the DNRO is to remain in effect.

The patient/family/surrogate may revoke a hospital DNR or Florida DNRO at any time.

When a patient with a previously authorized Do Not Resuscitate (DNR or No Code) order or Florida DNRO is scheduled for surgery, an informed consent discussion regarding the management of the DNR status during the perioperative and postoperative periods must be conducted and documented by the attending physician or surgeon and/or anesthesiologist prior to surgery.

The Medical Staff shall comply with the “Life Prolonging Procedures Act,” Florida Statute 765.301 and with 765.401 F.S. “Absence of Advance Directive. Refer to Functional Policies # 2.9 “Advance Directives – Patient Self Determination Act and #2.10 “Withholding or Withdrawing of Life Prolonging Procedures.”

1. Determination of Patient Condition Prior to Withholding or Withdrawal of Life Prolonging Procedures

In determining whether the patient has a terminal condition, has an end-stage condition, or is in a persistent vegetative state or may recover capacity, or whether a medical condition or limitation referred to in an advance directive exists, the patient's attending or treating physician and at least one other consulting physician must separately examine the patient. The findings of each examination must be documented in the patient's medical record and signed by each examining physician before life-prolonging procedures may be withheld or withdrawn.

2. Determination of Capacity

The Medical Staff shall comply with Florida Statute 765.20 (2). If a patient's capacity to make health care decisions for herself or himself or provide informed consent is in question, the attending physician shall evaluate the patient's capacity and, if the physician concludes that the patient lacks capacity, enter that evaluation into the patient's medical record.

If the attending physician has a question as to whether the patient lacks capacity, another physician shall also evaluate the patient's capacity and enter that evaluation into the patient's medical record.

4. Transfer of Patient Care Responsibility - Refusal to Comply with a Patient's Treatment Decision

A physician who refuses to comply with the advance directives of a patients, or the treatment decision of his/her surrogate, shall make reasonable efforts to transfer the patient to another health care provider who will comply with the declaration or treatment decision. This rule does not require a physician to commit any act which is contrary to his/her moral or ethical beliefs concerning life-prolonging procedures, if the patient:

- a. is not in an emergency condition; and
- b. has received written information upon admission informing the patient of the policies of the hospital regarding such moral or ethical beliefs.

A physician who is unwilling to carry out the wishes of the patient because of moral or ethical beliefs must within 2 days either:

- a. transfer the patient to another physician; or
- b. if the patient has not been transferred, carry out the wishes of the patient or his surrogate.

5. Request for Change of Physician

When a hospitalized patient or his/her family or health care surrogate requests to change

physicians, Administration will provide the patient and/or family/surrogate with a list of members of the Medical Staff. It is the responsibility of the patient or his/her family/surrogate to notify the attending physician that he/she is off the case and that another physician on the staff has agreed to take the case.

The patient and/or family will contact the physician of their choice to take care of the case, if he/she decides to accept the patient, he/she will notify the nurse's station. The attending physician will document a verbal or written order for the transfer and will notify the nurses station that he/she has signed off the case.

6. Patients Leaving Against Medical Advice

A patient who proposes to leave the hospital against the advice of any Medical Staff member should, if at all possible, be required to sign a statement to this effect, (doctor should explain risks of signing out against medical advice), and to release the attending staff member or staff members and hospital from all responsibility in the matter.

PROVISION OF CARE

1. Admitting Diagnosis

Except in an emergency, no patient shall be admitted to the hospital until a provisional diagnosis has been stated. In cases of emergency, the provisional diagnosis shall be stated as soon after admission as possible.

2. Frequency of Physician Visits

The patient shall be seen by a physician every day.

3. Planning And Providing Care

a. Admissions by Dentists and Podiatrists

Any patient admitted for dental or podiatric service shall be admitted by the dentist or podiatrist in conjunction with a physician member of the Medical Staff. Patient must have a medical history and physical examination performed by a physician member of the Medical Staff within 24 hours of admission, in addition to the dental or podiatric history and physical. The care of the dental or podiatric patient is the dual responsibility of the dentist/podiatrist, as appropriate, and a physician member of the Medical Staff, each limited to his/her respective field.

b. Admission of Patients by Staff Members Only

A member of the Medical Staff shall be responsible for the medical care and treatment of each patient and for the prompt completeness and accuracy of the medical record. Whenever these responsibilities are transferred to another staff member, a note covering the transfer of the responsibility shall be entered on the order sheet of the medical record.

c. EKG Panel

All physicians who are credentialed to read EKGs are board certified Internal Medicine/ Family Practitioners, Anesthesiologists and Cardiologists. All other physicians, when writing orders for EKGs, must designate a credentialed physician to read/interpret their EKGs.

d. Life Threatening Emergencies

In an emergency, any staff member, regardless of departmental or staff status, shall be expected to do all in his power to save the life of a patient, including the calling of such consultations as may be available. An emergency in this instance is defined as a condition in which the life of the patient is in immediate danger and any delay in administering treatment will increase the danger.

4. Anesthesia Care

a. Pregnancy Test Prior to General Anesthesia

All female patients of childbearing age (< 55 years old or cessation of menses for greater than one [1] year) shall have a pregnancy test performed by a State licensed laboratory prior to undergoing general anesthesia, with the exception of those patients who have previously undergone a total abdominal hysterectomy (TAH).

5. Operative and Invasive Procedures

a. Consent for Procedures

All operative and other procedures carrying substantial risk, including anesthesia and the administration of blood products, shall be fully explained to the patient by the physician and the consent of the patient obtained before the procedure takes place. The explanation shall include a description of the procedure and associated risks, benefits, and alternatives to the planned procedure and the anticipated outcome from the procedure. This shall be documented by way of a written informed consent signed by the patient and written evidence of the contents of this explanation should be reflected in the Medical Record. If the patient is unable to render informed consent, then informed consent shall be obtained from the next of kin, health care surrogate, court-appointed guardian, or attorney in fact under a durable power of attorney. The guardian or attorney in fact must have been delegated authority to make health care decisions.

A patient receiving analgesia prior to informed consent may still be deemed competent to participate in the informed consent process. The patient's orientation status and ability to comprehend and participate in the process should be documented in the medical record by the physician providing the informed consent discussion.

The definition of a procedure in this respect is any procedure which involves puncture or incision of the skin or insertion of an instrument or foreign material into the body, excluding venipuncture and IV therapy.

b. Pathology Specimens

All tissues and other specimens removed at time of a procedure, except for those exempted by the Medical Staff, shall be sent to the Pathology Laboratory. They shall be received, assigned numbers, described and examined in such detail as a pathologist may consider necessary to arrive at a pathological diagnosis. A signed report shall be issued for every specimen received.

The following surgical specimens need not be submitted to the Department of Pathology: (A notation should be made in the operative record documenting the specimen removed with the words "Pathology Exempt".)

- 1) Bone removed as part of corrective or reconstruction orthopedic procedures (Example: rotator cuff repair, spinal fusion) or to gain surgical access (rib during thoracotomy) in patients without history of malignancy.
- 2) Cataracts removed by phacoemulsification
- 3) Dental appliances
- 4) Fat removed by liposuction
- 5) Foreign bodies such as bullets, etc, that consist of medicolegal evidence (GIVEN DIRECTLY TO LAW ENFORCEMENT PERSONNEL)
- 6) IUD's without attached soft tissue
- 7) Foreskin from the circumcision of a newborn
- 8) Medical devices: Catheters, gastrostomy tubes, myringotomy tubes, stents and sutures that have not contributed to the patient's illness, injury to death
- 9) Middle ear ossicles
- 10) Orthopedic hardware and other hardware including radiopaque mechanical devices without tissue attached
- 11) Placentas not requiring microscopic examination as determined by the obstetrician
- 12) Skin or normal tissue removed during cosmetic or reconstructive surgery (i.e., blepharoplasty, rhytidectomy, abdominoplasty)*
- 13) Teeth without attached soft tissue
- 14) Therapeutic radioactive sources (seed implants, etc)
- 15) Toenails and fingernails that are grossly unremarkable

The following specimens may be given a gross diagnosis only unless, at the discretion of the pathologist, depending on clinical circumstances it is determined that a microscopic is necessary or unless the referring clinician requests a microscopic.

- 1) Nasal bone and cartilage from rhinoplasty or septoplasty
- 2) Hernia sacs
- 3) Scar of skin
- 4) Blood clots from body cavities
- 5) Accessory digits
- 6) Bunions and hammertoes
- 7) Prosthetic breast implants without attached tissue**
- 8) Varicose veins

9) Torn meniscus

*Breast tissue from reduction or reconstruction surgery is always examined.

**Tissue and tissue capsules of breast implants are always examined microscopically.

6. Education

Every practitioner is responsible for participation in the interdisciplinary provision of education to the patient and/or family including, but not limited to: the disease process, procedures, nutritional interventions and diet, safe and effective use of medications, food/drug interactions, treatments, pain management, activity level, expected outcomes, the patient/family role and responsibility in the plan of care, and discharge planning.

All education is to be documented in the patient's medical record.

7. Emergency Service

- a. Emergency Room Call at St. Petersburg General Hospital is voluntary. Executive Committee, at the recommendation of the Department, may mandate participation in order to insure that the hospital's Emergency Room coverage needs are met.

The responsibilities of the On-Call physician are as follows:

- 1) If the On-Call physician and the ED physician agree on the need for admission:

The ED physician will then write preliminary orders. The On-Call physician should admit the patient, assume care of the patient and personally evaluate the patient in a reasonable amount of time.

- 2) If the On-Call physician and the ED physician do not agree on the need for admission:

The On-Call physician should come in within a reasonable period of time and take over the care of the patient.

- 3) If the patient does not need to be admitted, but needs follow-up:

The On-Call physician should be available for follow-up with the patient at least once, regardless of the patient's payor source.

- 4) If the ED physician has discussed the care and follow-up of the patient with the On-Call physician:

The patient should be seen within the time frame agreed upon by the On-Call and the ED physicians.

- 5) A reasonable time for specialty consultation to be available to the emergency care area should be within 30 minutes of the time consultation is required with 20 minutes for STAT's.

Initial consultation may be through two-way voice communication.

When the consultant's presence is required in the emergency care area, the consultant is available to the emergency care area within approximately 30 minutes of the time consultation is required.

- b. Physicians who have a private practice within the geographical area of the hospital will not be allowed to establish emergency room practice.
- c. The On-Call physician must be available for Emergency Room calls on his/her scheduled on-call date(s). If the physician knows in advance that he/she will be unavailable for call, he/she must make arrangements for a substitute and must notify the Medical Staff Office in advance so that the Emergency Department can be notified in a timely manner.

If sharing call with a group, the Medical Staff Office must be advised so that this information can be forward to the Emergency Department. It is the responsibility of the On-Call physician to assure that all covering physicians have clinical privileges at St. Petersburg General Hospital.

- d. The medical On-Call physician is expected to continue the care of any hospitalized patient whose physician is summarily suspended or unavailable for any reason.
- e. There will be an "X-tra Call List". The second On-Call is to be used only when the first physician on-call is not available.

When the second physician on-call is not available, the department chairman is to be notified.

8. Physician Response Time

1. Physician Response Time to Emergency Department:

A reasonable time to be available to the emergency care area is within approximately 30 minutes of the time consultation is required with 20 minutes for STAT's. If the attending has not responded in thirty minutes, the Emergency Department physician may call the on-call physician.

2. Physician Response Time to Critical Care Units:

- 1) All patients in Critical Care Units will be seen upon admission by the attending physician or designee as soon as possible, not to exceed twelve (12)

hours after admission.

- 2) Prior to direct admission to the units the patient shall be seen and evaluated by a physician in the office or in the emergency room. If not, the patient shall be evaluated by the emergency room physician prior to being admitted to the unit.
- 3) A reasonable time for the attending, designee or consultant to be available to the Critical Care Units is within 20 minutes for a STAT call and 90 minutes for a routine call.

9. Practitioners' Orders

All orders for treatment shall be in writing, entered upon the approved hospital form, and authenticated. Such orders may be written, typewritten, or printed. A blanket reinstatement of "Resume Previous Orders" is not acceptable.

10. Preprinted Orders

All preprinted orders shall be reviewed and revised as appropriate annually and shall be reviewed by the Utilization Management Committee and appropriate Medical Staff Department. The orders shall be authenticated and dated by the physician whenever used.

11. Verbal or Telephone Orders

All orders will be written on an order sheet and read back to the physician. Orders may be accepted from physicians and/or credentialed Health Professional Affiliates. The following hospital staff members may accept verbal or telephone orders: licensed Registered Nurses, licensed Practical Nurses, licensed Registered Pharmacists, licensed Registered Physical Therapists, licensed Occupational Therapists, licensed Speech Language Pathologists, licensed Registered Respiratory Therapists, licensed Certified Respiratory Care Practitioners, and licensed Registered Dietitians. Pharmacists, Physical Therapists, Respiratory Therapists/Practitioners, and Dietitians may only take orders relating to their respective specialties. The person taking the order shall sign his name, date, time, and the name of the physician dictating the order, and write RBV for Read Back Verified. Telephone orders will not be accepted from a physician's office nurse or office staff. Verbal or telephone orders from prescribers that are on-site in hospital are used only in true emergencies or during sterile procedures where ungloving would be impractical.

12. Hazardous Verbal Orders

Physician orders for any of the following must be authenticated by the prescribing / ordering physician within 24 hours of such order:

- DNR
- Chemotherapy
- Investigational drugs

Restraint Orders

13. Postoperative Orders

New orders are to be written after the patient has undergone surgery. Orders written prior to surgery will no longer in effect, and must be rewritten to assure continuation.

14. Availability of Consultation Services

Any qualified practitioner with clinical privileges in this Hospital can be called for consultation within his/her area of expertise.

The attending physician is primarily responsible for requesting consultation when indicated and for calling in a qualified consultant. Any attending physician whose patient has a condition not considered within the realm of his/her specialty is required to request the appropriate consultation within 24 hours of admission. He/she will provide written authorization on the order sheet of the medical record to permit another attending physician to attend or examine his patient, except in an emergency. If immediate consultation is necessary, the attending physician must call the consultant directly.

Consultation requests must include clinical information describing the purpose of the consult or a note that the attending physician has discussed the case with the consulting physician.

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

Pulmonologist consultation is recommended for all patients on ventilators. The pulmonologist should evaluate the patient within 48 hours of need for ventilatory assistance.

Cardiology consultation is recommended for all patients with MI's requiring thrombolytic therapy and recommended within 24 hours for all patients with acute MI's.

Psychiatric consultation is recommended for all suicidal patients suspected of self-inflicted harm within 24 hours of requested consult, unless the patient is under Baker Act, then the Psychiatric Consultation will be done at the receiving hospital.

Nephrology consultation is recommended for all patients with acute renal insufficiency and acute renal failure, and all patients receiving renal dialysis.

If a nurse has any reason to doubt or question the care provided to any patient or believes that appropriate consultation is needed and has not been obtained, he/she shall call this to the attention of her superior who in turn may refer the matter to the Chief Nursing Officer. If warranted, the CNO may bring the matter to the attention of the chairman of the department in which the practitioner in question has clinical privileges. In all situations which require it,

the chairman of the department can request a consultation after appropriate discussion with the attending practitioner.

15. Evaluation of Patients Who Present with or Develop, During Hospitalization, Behavior that is Emotionally Disturbed, Suicidal, or Chemically Dependent Patients, as described above, who are identified as potentially harmful to themselves or others will be assessed by the attending/Emergency Department physician. Determination of the need for psychiatric consultation will be made by the attending/Emergency Department physician and, if indicated, appropriate consultation will be requested. Findings shall be documented on the medical record. It is the responsibility of the attending/Emergency Department physician, when the patient is medically stable, to authorize discharge, or voluntary or involuntary transfer to another facility.

16. Transfer of Patients

Whenever a patient is transferred from one level of care to another, current orders will be reviewed for appropriateness in the new setting and revised as necessary. Orders written as "Continue" are not acceptable. When a patient is transferred from Critical Care to a less acute setting, the Critical Care Standing Orders will be automatically discontinued.

Except in cases of emergency, no patient shall be transferred from any unit without such transfer being approved by the responsible staff member.

17. Discharge of Patients

Patients shall be discharged on order by the attending practitioner. The attending practitioner shall notify the patient of anticipated discharge at or prior to the time at which the order for discharge is written. Discharge by Medical Staff approved discharge criteria in Outpatient Surgery is acceptable.

18. Absence of Attending Practitioner

Whenever an attending practitioner shall be absent from the city or for any reason be unavailable to attend his/her patients, he shall provide for a member of the Medical Staff to attend his patients at this facility, as delineated in the bylaws (section 3.5.2).

19. Chain of Command

Medical Staff and hospital staff have the responsibility to cooperate in their mutual efforts to assure delivery of patient care of the highest quality in accordance with the established policies, procedures, and standards of the hospital. Utilization of the Chain of Command facilitates problem resolution related to patient care concerns and problems.

When hospital staff encounter issues which cannot be resolved at the hospital level, the Department Director/designee will contact the Chief of Service or Medical Director. If the issue remains unresolved, the Chief of Staff will be notified.

When the physician encounters an issue requiring resolution, he/she will contact the Charge Nurse of the patient care unit (or Department Director for ancillary services). If the issue is not resolved, the physician will notify the clinical manager of the unit. If the issue remains unresolved, the physician will notify the Department Director, the Chief Nursing Officer, the Hospital Administrator on call, and the Chief of Service.

Refer to Functional Policy “Channel of Communication for Patient Care Concerns: Chain of Command.”

MEDICATION MANAGEMENT

a. Medication Orders

All orders for medications should give the following information:

Patient's Name	Strength of Drug
Date	Route of Administration
Time	Frequency of Administration
Name of Drug	Physician Signature

The use of leading decimal is discouraged on medication orders (e.g. 0.125 milligrams, not .125mg). Medications cannot be abbreviated, and all other abbreviations are discouraged. Upon admission to the hospital or transfer to a different level of care within the hospital prescribers write complete orders for drug therapy. Orders for “Resume Home Meds” are not acceptable.

b. Automatic Stop Orders for Medications

All medications will have a 30 day automatic stop order, except routine treatment antibiotics and controlled substances which have a 10 day automatic stop order. Oxytoxics are automatically discontinued after 24 hours unless the order is renewed or the original order specifies the number of doses. Parenteral nutrition will have a 24 hour stop order and will be reordered daily using the appropriate order form. Cancer chemotherapy will be limited to a one-time dose per order or the original order must specify a limited number of doses. Any medications to be continued post-operatively must be reordered following the surgical procedure.

Postoperative prophylactic antibiotic doses should be discontinued at twenty-four hours (forty-eight hours for cardiac surgery) unless there is a documented infection and a physician order for the treatment of the infection. This includes all antibiotics on postoperative order sets and those orders written specifically for prophylaxis for a short term following a surgical procedure. Documentation and treatment of an infection must be included on the post surgical order to ensure they are not treated as prophylactic doses. Physicians will be notified prior to discontinuation of antibiotics continuing for greater than twenty-four hours in an effort to get these medications discontinued.

c. Medications Brought into the Hospital by Patients

Medications brought to the hospital by the patients will not be administered, with the following exceptions:

- 1) Eye drops, Birth Control Pills
- 2) Other medications brought from home will only be used under certain circumstances (e.g., Pharmacy not able to supply) and with appropriate authorization from the physician and identification of medication by the Pharmacist.

IMPROVING ORGANIZATION PERFORMANCE

1. Autopsies

The Medical Staff recognizes the importance of the autopsy as a source of clinical information in quality improvement activities. Each member is expected to attempt to secure an autopsy in any case which meets Medical Staff criteria for the consideration of an autopsy. The physician is expected to document the consideration of autopsy, discussion with family/significant other, and consent or refusal in the medical record. With the exception of Medical Examiner cases, autopsies shall be performed by the hospital pathologist. The physician requesting the autopsy will be notified of the date and time the autopsy will be performed. The Pathologist is expected to communicate the performance of the autopsy and the results and pathological diagnosis to the attending physician and provide a written report for inclusion in the medical record. Data collected on performance of autopsies and results of autopsies is communicated to the Medical Staff departments.

When an autopsy is performed, provisional anatomic diagnoses are recorded in the medical record within 48 hours and the complete protocol is included in the record within sixty days, except in unusual or difficult cases.

2. Criteria for Consideration of an Autopsy

- a. Unanticipated death
- b. Death occurring while the patient is being treated under a new therapeutic trial regime
- c. Intraoperative or intraprocedural death
- d. Death occurring within 48 hours after surgery or an invasive diagnostic procedure, with the exception endoscopic procedures or Swan Ganz insertion
- e. Death incidental to pregnancy or within seven days following delivery
- f. Death where the cause is sufficiently obscure to delay completion of the death certificate
- g. Death in neonates/infants/children with congenital malformations

LEADERSHIP

1. Application Fees/Dues

Any new applicant or existing active, courtesy or consulting staff member who is seeking reappointment will be required to pay the following dues fee at the time of application or reapplication as follows:

New Applicant (Physician)	\$350
New Applicant (Allied Health)	\$ 50
Active Re-applicant	\$ 50

Courtesy Re-applicant	\$200
Consulting Re-applicant	\$200
Allied Health Re-applicant	\$ 30

Application Fees/Dues will be waived for any current or past Chief of Staff

ENVIRONMENT OF CARE

1. Mass Casualty Assignments

The Chief of the Medical Staff and the Chief Executive Officer/designee shall work to coordinate activities. In case of evacuation or movement of patients in an emergency, the Chief of the Medical Staff, acting with the Chief Executive Officer/designee, shall authorize such movement. All policies concerning patient care will be the joint responsibility of the above-named officers, and all physicians of the Medical Staff agree to relinquish to them direction of professional care of their patients for the duration of the emergency.

MANAGEMENT OF INFORMATION

1. Medical Record Preparation

The attending staff member shall be responsible for the preparation of a complete medical record for each patient (inpatient or outpatient) on the various medical records forms approved by the hospital and Medical Staff. The medical record shall include patient identification data recorded by hospital personnel, history and physical, conclusions or impressions drawn from the medical history and physical examination, special reports such as consultations, diagnostic and therapeutic orders, clinical laboratory, radiology services and others, provisional diagnosis, medical or surgical treatment, pathological findings, progress notes, final diagnosis, discharge summary and autopsy report when performed. In all instances the content of the medical record shall be sufficient to justify the diagnosis,

warrant the treatment and end results and to promote continuity of care among health care providers.

2. History and Physical Examination

A. Required content:

1. Comprehensive history and physical shall include:

- chief complaint
- details of present illness
- past medical/surgical history
- allergies/medications
- relevant social and family history when appropriate
- review of systems
- comprehensive physical examination.
- clinical impression and plan of care (may also be documented in the progress notes)

2. History and Physical Examination for Outpatient Invasive Procedure shall include:

- Pre-Procedure Diagnosis
- Proposed Procedure
- Indications for Procedure
- Pertinent Past Medical History: Medical and Surgical
- Current Medications
- Allergies
- Physical Exam: HEENT, Cardiovascular, Lungs, Abdomen, Extremities, Other-specific to procedure
- May be documented on the “Outpatient Invasive Procedure History & Physical” form.

B. Timeframes for completion

1. Admits or patients placed in Observation Status

- i. Must be completed within 24 hours after admission
- ii. If an H&P has been completed within 30 days prior to admission, a durable, legible copy may be placed in the patient’s medical record. An update to this document must be done within 24 hours after admission.

2. Outpatient Invasive procedure patients

- i. Must be done within 24 hours prior to the invasive procedure.
- ii. If an H&P has been completed within 30 days prior to the procedure, a durable, legible copy may be placed in the patient’s medical record. An update to this document must be done within 24 hours prior to the procedure.
- iii. If an Outpatient Invasive Procedure patient is admitted as an inpatient, and the attending has not completed a comprehensive history and physical, the attending physician will be expected to do so within 24 hours after admission.

C. Additional Guidelines:

1. An H&P from a physician who does not have staff privileges can be used. The admitting physician must perform a second assessment to confirm the information and findings, update with any changes and sign and date the information as an attestation to it being current within 24 hours after admission.
2. In a surgical emergency in which a history and physical has not been completed prior to a procedure, the Consultation Report by the surgeon, containing a history and physical examination may serve as such for the procedure. The attending physician will still be expected to complete the comprehensive history and physical within the expected timeframe.
3. The prenatal record may be considered the comprehensive history and physical for Obstetric patients providing the record contains all the required elements. An update to this document must be done within 24 hours after admission if all elements are not addressed.
4. Pre-operative history and physicals for podiatrists and dentists will be completed by a medical physician.
5. Patients with ASA scores of I, II, III, IV, or V will require a complete and current history and physical by a medical physician.
6. In the event a patient expires shortly after admission or signs him/herself out against medical advice (AMA), prior to being examined by the attending physician/designee the following will be accepted as the history and physical:
 - i. If admitted through the Emergency Department, the ED H&P will be deemed the H&P for the medical record.
 - ii. For direct admissions, a detailed progress note is acceptable.

3. Progress Notes

Pertinent progress notes shall be recorded at the time of observation of the patient, sufficient to permit continuity of care and transferability. When ever possible, each 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 all patients.

4. Authentication

The attending physician, upon admission of the patient, shall be responsible for the prompt completeness and accuracy of the medical record. When these responsibilities are transferred to another physician, documentation of the transfer of responsibility shall be made in the patient's record preferably the physician's order. Each entry in the patient's

medical record shall be accurately dated and authenticated by the responsible staff member making the entry.

When entries are made by AHPs who perform their duties under the sponsorship of a Medical Staff member, the sponsoring medical staff member must countersign entries in the medical record. Certified Nurse Midwives, Ph.D.'s, CRNA's, ARNP's and their sponsors are exempt from this rule.

No medical staff member is permitted to complete a medical record on a patient unfamiliar to him/her. When it has been determined that a physician is unavailable permanently or protractedly, or in the event of death the Utilization Management Committee has the authority to grant permission to retire the medical record (s)

5. Operative Reports

Any Operative or other high risk procedure reports, dictated or written immediately after an operative or other high risk procedure, shall record the names of surgeon and assistants, procedure (s) performed and description of each procedure, findings, estimated blood loss, specimens removed, disposition of each specimen, and postoperative diagnosis. Operative reports are to be dictated or written immediately after surgery. When there is a transcription or filing delay, an operative progress note is entered in the medical record immediately after surgery to provide pertinent information for anyone required to attend to the patient.

6. Discharge Summary

A discharge summary shall be dictated or written on all patients hospitalized over forty-eight (48) hours. For those patients hospitalized for an illness of a minor nature, normal newborns, vaginal deliveries and tubal ligations, and require a stay of less than forty-eight (48) hours, a final progress note, which includes condition of patient at discharge, instructions given to the patient/family, and follow-up instructions, may be substituted. A death summary/note will be required on all deaths, irrespective of the duration of hospitalization.

The discharge summary should concisely recapitulate the reason for hospitalization, the significant findings, the procedures performed and treatment rendered, the condition of the patient at discharge and any specific instructions given to the patient and family.

7. Final Diagnosis

The final diagnoses/procedure shall be recorded using acceptable disease and operative terminology at the time of discharge. When this is not possible because final laboratory or other essential reports have not been received at the time of discharge, then the final diagnoses shall be recorded as soon as possible after all essential reports have been received by the responsible staff member.

8. Availability of Record for Readmitted Patient

In case of readmission of a patient, all previous medical records shall be available for the use of the attending staff member.

9. Release of Medical Record Information

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

10. Staff Member Access to Medical Records

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 information concerning the individual patients. All such projects shall be approved by the Executive Committee before records may be studied. Former members of the Medical Staff shall be permitted access to information from the medical records of their patients covering periods during which they attended such patients in the hospital

11. Custody of Medical Records

Records may be removed from the hospital's control and safekeeping only in accordance with a lawful subpoena, court order, or as otherwise provided by Federal or State Law.

12. Correction of Errors

When errors are made, a single line should be drawn through the error, correction made if needed and initial/date by person making correction.

a. Procedure for Making Changes or Amendments to Record Entries Prior to Patient Discharge:

Any individual who discovers an error or omission or his or her own shall immediately upon discovery correct it and do so in accordance with the procedures in this section.

Simple corrections may be made during the actual writing of a record entry and shall be lined through (not obliterated) and initialed.

Typographical errors noted in dictated reports may also be corrected any time prior to completion of the record. The error shall be lined through (not obliterated) and initialed.

Errors or omissions discovered at a later time shall be corrected by a separate entry to the appropriate portion of the record. The original entry shall be lined out (not obliterated). The person making the change shall sign and note the time and date of the change and the reason for the change. The new entry shall also state who was

notified of the change and time and date of such notification.

Any individual who discovers an error or omission of his or her own, or a possible error made by another individual, shall immediately upon discovery notify the person who made the initial entry, and the patient's attending physician, if he or she is not the person who made or discovered the entry, and any other physicians, nurses or other individuals who may have seen and relied upon the original entry.

b. Changes or Amendments to Record Entries After Patient Discharge

Changes or amendments to record entries after patient discharge but before final completion of the record shall be made in accordance with the procedures set forth. Under no circumstances shall any change or amendment be made to any patient record after the record has been filed as complete except as may be authorized by Administration or an officer of the Medical Staff

13. Incomplete Medical Records

Within thirty (30) days of the patient's discharge the medical records should be completed. Incomplete charts after thirty (30) days will be deemed delinquent.

a. Sixteen (16) days following the patient's discharge, if the medical record has not been completed, the Health Information Services Department will mail notices to the physicians reminding them of their incomplete records.

b. Thirty (30) days following the patient's discharge, if the medical record has not been completed, the physician will be notified that their medical records are incomplete and their immediate cooperation is required to complete the incomplete medical records.

c. If a physician fails to complete incomplete medical records within an additional 15 days (total of 45 days), the physician will be notified by certified mail to appear before the Executive Committee and explain the reason for the delinquent record (s). If the physician chooses not to attend Medical Executive Committee without reason, this may be deemed as an automatic suspension of all clinical privileges. If records are completed, all dictation is signed, prior to the meeting date, attendance will not be required.

d. If a physician does not complete the delinquent medical records for an additional 15 days after Medical Executive Committee (a total of 60 days), the physician will be sent a certified letter from the Chief of Staff giving him/her forty eight (48) hours from receipt of the letter to complete his/her delinquent medical records.

e. If any physician does not complete his/her medical records within 48 hours, the physician will have his Medical Staff privileges automatically suspended. A suspension

list will be posted in Admitting, Emergency Room, Administration, and Operating/GI Lab. Suspension of privileges will not in any way change the physician's responsibilities for their continued care of the patients already hospitalized and under his care, those previously scheduled for admission or surgery, or those patients presenting to the Emergency Department-

- If any physician is suspended for greater than 6 months or is suspended for more than twice in one calendar year, his membership will be automatically terminated.. To be reinstated, the physician must apply for appointment to the medical staff, as outlined in the Medical Staff Bylaws.

14. HIPAA/Organized Health Care Arrangement

Each member of the Medical Staff will be part of the Organized Health Care Arrangement with the Hospital, which is defined in USC 164.520(d)(1)(HIPAA Privacy Regulations) as a clinically-integrated care setting in which individuals typically receive healthcare from more than one healthcare provider. This arrangement allows the Hospital to share information with the provider and the provider's practice for purposes of the provider's payment and practice operations. The patient will receive one Notice of Privacy Practices in Admissions, which will include information about the Organized Health Care Arrangement with the Medical Staff.

15. Medical Record Form

All new and revised forms for use in the Medical Record are reviewed and approved by the Medical Staff via the Utilization Review Committee in order to prevent duplication and to provide for standardization and uniformity and assure necessity of all medical record forms. These forms include H.I.M. standardization Query forms.

DEPARTMENT OF MEDICINE

ARTICLE I

Effective 1/1/07

EMERGENCY ROOM COVERAGE

The purpose of these Rules and Regulations is to establish and define a mechanism to provide efficient, expedient and quality care for patients presenting to the Emergency Department, while creating a fair and manageable on-call schedule.

A. Guidelines:

Emergency Room Coverage for the Department of Medicine shall be managed in accordance with the Emergency Medical Treatment and Active Labor Act (EMTALA), SPGH Medical Staff Bylaws, SPGH Medical Staff Rules & Regulations, and other applicable regulatory agency guidelines. Responsibility for ensuring ER call coverage is delegated to the MEC, with the Department Chair in charge of oversight. Emergency Room coverage for the Department of Medicine is voluntary. An “on-call slot” is for 24 hours and runs from 7:00am to 7:00am. The ER on-call roster, schedules and all associated forms will be developed and distributed by the Medical Staff Office to appropriate physicians and departments in a timely manner. Once an on-call schedule is published, any changes must comply with the protocols delineated herein. As a member of the Department of Medicine, each physician has a privilege, but not a right, to serve on the ER call schedule. A decision to remove a physician from the call roster or schedule shall not constitute a denial or restriction of Privileges and does not give rise to recourse under this rule.

B. On-Call Roster:

The Medicine ER on-call roster is open only to Family Practice and Internal Medicine physicians who are in good standing and hold Active or Provisional status.

Allied Health Professionals (AHPs) may not be assigned to take or answer ER Calls.

Any physician who meets the requisite qualification and desires to be added to the “ER On-call Roster” shall notify the Medical Staff Office in writing and they will be placed into rotation on the next available on-call schedule. A physician who is on suspension of any type, with the exception of Medical Records Suspension, shall not be eligible to be on the on-call roster or schedule. If already on the ER on-call schedule at time of suspension, said physician will automatically be removed from the schedule until all suspensions have been removed, at which time s/he will be reinstated on the following month’s schedule.

A physician listed on the ER on-call roster may contact the Medical Staff Office in writing and withdraw their name at anytime. However, they must fulfill their current month’s on-call obligation if listed on the on-call schedule.

C. On-Call Schedule:

The Medical Staff Office is responsible for creating a monthly on-call schedule, to be published by the 25th of each month.

There will be a Medicine on-call physician available to the Emergency Department. Per EMTALA, the on-call rotation roster and schedule must include the specific name of the physician and their contact number. The identified physician is required to respond to the ER within a reasonable amount of time, not to exceed 60 minutes.

Each ER on-call slot is assigned to an individual physician who is to personally respond to the ER without deferring the Call to another physician outside their call group.

Physicians who are listed on the Medicine ER on-call schedule MUST either:

- Personally take Call on their assigned days, OR
- Exchange their on-call slot with another physician eligible to take Medicine ER call.

D. Reassignment of an On-call Slot:

In the event a physician cannot personally take their assigned on-call slot, then s/he can exchange their on-call slot with another physician on the ER on-call roster, only by using the following protocol:

A “Reassignment of ER On-Call” form should be in writing, specify the on-call date, be signed by both physicians and filed with the Medical Staff Office at least 24 hours in advance of the start of the on-call slot. After hours, a physician should call the ER personally to make a switch

If the on-call slot to be reassigned falls between 7am Saturday and 7am Monday or on a national holiday, then the specified form must be received in the Medical Staff Office no later than 1pm on the Friday before the on-call date; otherwise the on-call slot will not be reassigned. The exception to this weekend/holiday rule would be in the event the on-call physician has a personal or family emergency (sudden illness, accident, etc.), then the on-call physician may reassign their call slot to another physician by communicating directly with the ER. In each such event, the physician should notify the Medical Staff Office of the circumstances surrounding the change within 7 days.

Any physician who is removed from the ER on-call roster or schedule for any reason will have their on-call slots reassigned on a rotational basis.

It is the responsibility of the on-call physician to assure that all covering physicians have corresponding or greater clinical privileges at St. Petersburg General Hospital.

E. Chain of Command:

In the event the on-call physician cannot/does not respond, then the ER will systematically call physicians who have signed up for “Extra Call” until a physician is found who will take the Call. The Extra Call list is maintained by the Medical Staff Office and updated monthly. If no physician is found who will take the call, the Department Chairman is called. If the Dept. Chairman is not available, the Chief of Staff is called. If the Chief of Staff is not available, the Administrator on Call is called.

Redirection from the on-call physician to another physician will not be accepted unless the physician is a member of a group that functions under the same Tax ID #. Also, the on-call

medicine physician, or a member of their group as defined by a common tax ID, must examine the patient and dictate the H&P for that patient. After the patient has been admitted for 24 hours, the attending physician may transfer the patient to another physician. This includes “observation” patients. Any requested exception to this rule shall be individually presented in writing to the MEC for consideration and approved/disapproved on a case by case basis.

Medicine Admissions/Referrals:

Patients without a Primary Care Practitioner (PCP) on SPGH Staff:

Any patient presenting to SPGH needing admission or outpatient referral under the following circumstances will be admitted or referred to the On-Call Medicine Physician following the Chain of Command as outlined above:

- Patient does not identify their PCP.
- Patient has a PCP who is not on staff, and there is no letter on file from the physician indicating to whom which SPGH physician s/he wants his/her patients admitted to. *
- Patient verbalizes a request for change in PCP.
- Patient does not have a PCP.

* A database shall be maintained and updated monthly with this information. It is the SPGH PCP’s responsibility to have the non-SPGH physician forward this letter to the Medical Staff Office.

Patients with a PCP on SPGH Staff:

Any patient presenting to SPGH needing admission or outpatient referral and having a PCP on SPGH Staff will be admitted to his/her SPGH PCP with the following guidelines:

- A call will be placed to the SPGH PCP.
- The SPGH PCP is required to respond to the ED within 60 minutes from the time the call is placed by the ED. In addition, the ED shall attempt to call the physician up to 3 times. These attempts shall be documented. If no response, the Chain of Command will be implemented (Section E).

* If patient presenting is incoherent, efforts will be made to elicit PCP verification from family, Meditech history, ambulance run sheet, or skilled nursing facility documentation accompanying the patient/by phone.

F. Compliance:

Medical Staff members who participate in the ER on-call schedule will be monitored for compliance by the Hospital.

Unavailability, refusal to respond to call assignments, or refusal to arrange for coverage as delineated in Section D, shall be considered conduct reasonably likely to be detrimental to patient safety or delivery of quality patient care within the Emergency Department and shall automatically precipitate corrective action as set forth in Section G.

G. Corrective Action:

1. The practice of being on the on-call schedule with the intention of reassigning the on-call slot is not allowed and will be a violation of these rules. Any physician, who, in any 12-month period, transfers their on-call slot(s) to other physicians, without personally taking call themselves, will be referred to the MEC.
2. For any calendar 2-month period, the number of days that a physician personally takes Call must be equal to or greater than the number of on-call slots they were assigned for that same period; if they are not, then the physician will automatically be removed from the on-call roster and schedule for a period of 3-months.
3. Corrective Action:

Each pattern indicated below shall require the corresponding corrective action:

Physician personally takes Call	Physician reassigns Call via prescribed protocols	Physician reassigns Call NOT via prescribed protocols	Automatic Corrective Action (for ER call)
Yes	No	No	None
No	Yes	No	None
No	No	No	3-month suspension
No	No	Yes	1 st time: Warning letter 2 nd time: 3-month suspension 3 rd time: 3-month suspension

(Note: Read chart horizontally)

- 4) If a physician is removed from the ER on-call roster or schedule for a 3-month period, then that physician must file a written request to be reinstated on the Medicine ER on-call roster. If thereafter, the physician is removed from the Medicine ER on-call roster for any reason, then that physician may become permanently ineligible to take Medicine ER Call.

DEPARTMENT OF OBSTETRICS AND GYNECOLOGY

ARTICLE I

MEMBERSHIP REQUIREMENTS

A. Section of Obstetrics

The Section of Obstetrics shall be divided into two categories:

1. Full Obstetrical Privileges

Full obstetrical privileges may be granted to physicians who have completed a residency program approved by the American Board of Obstetrics and Gynecology and successfully complete the retrospective review and/or sponsorship requirements for the Section of Obstetrics.

2. Limited Obstetrical Privileges

Limited obstetrical privileges may be granted to physicians who do not meet the above qualifications.

- a. All physicians applying for limited obstetrical privileges must have a collaborative agreement for supervision by two (2) active members of the Medical Staff who have full obstetrical privileges in the Department of Obstetrics and Gynecology

B. Section of Gynecology

Privileges in the Section of Gynecology may be granted to those physicians who:

1. Have completed a residency program approved by the American Board of Obstetrics and Gynecology and successfully complete the retrospective review and/or sponsorship requirements for the Section of Gynecology.
2. At the time of the institution of these regulations are members of the Medical Staff of this Hospital with full privileges in Gynecology.

ARTICLE II

SPONSORSHIP

A. Sponsorship

The Chairman of the Department of OB/GYN or his designee does retain the right to recommend sponsorship if deemed appropriate.

Consultations are encouraged when dealing with unusual problems or critically ill patients and shall be obtained when required under Hospital or Medical Staff Rules and Regulations.

B. Sponsorship Regulations for Limited Obstetrical Privileges

For all physicians or certified nurse midwives applying for obstetrical privileges who are not certified or eligible to become Board certified by the American College of Obstetrics and Gynecology.

1. The applicant is to meet with the Chairman or the Vice-Chairman of the Department of Obstetrics and Gynecology for his review.
2. Five (5) cases will then be reviewed by the Chairman and/or Department for approval prior to submission of the cases to the Standards and Credentials Committee.

ARTICLE III

CONSULTATION REQUIREMENTS

Those physicians with limited obstetrical privileges are required to have consultations on the following:

1. Medically complicated pregnancies.
2. Proposed induction and/or augmentation of labor with oxytoxics.
3. Fetal malpresentations, including breech.
4. Lack of normal progress during labor (refer to Friedman curve).
5. Any patient on labor suite over twelve (12) hours.
6. Complications of labor; prolapse of the umbilical cord, fetal distress, abnormal monitor tracing, amnionitis, intrauterine infection, etc.
7. Any operative procedure other than outlet forceps.*

* Outlet forceps is defined as "any time the vertex is visible and the occiput is in the anterior position".
8. Extensive vaginal or cervical surgery.
9. Third trimester bleeding, of a significant degree, or prolonged ruptured membranes of twelve (12) hours or longer.

ARTICLE IV

ENUMERATED POLICIES AND REGULATIONS

A. Response Requirement

All members with obstetrical privileges shall be available to report to the hospital within a 30-minute response time.

B. Procedure for Emergency Obstetrical Patients

The following procedure is to be followed for all emergency obstetrical patients:

1. The Delivery Unit is to notify the private physician who is to come and see the patient.
2. If a delay occurs, the Chairman of Obstetrics is to be notified.
3. If the Chairman of Obstetrics cannot be reached, then any private obstetrician is to be called.

C. Cross Coverage

Any physician with privileges in the Department of OB/GYN must have cross-coverage by a physician with the same or greater privileges.

ARTICLE V

LABOR AND DELIVERY MEDICAL SCREENING EXAM (MSE) PROCESS

- XX. All patients presenting to the Labor & Delivery Department for care will receive a Medical Screening Exam and Assessment when requested regardless of their ability to pay for this service.
- a. Obstetric physicians have delegated initial Labor Medical Screening Examination to qualified nursing personnel.
 - b. Following examination and assessment of the patient, the RN will communicate with the physician by telephone to apprise him/her of the findings. Based thereon, the physician will determine disposition and give appropriate orders. These orders are to be signed by the physician within 24 hours.
- II. Medical Screening Examination Protocol

PREGNANT PATIENT ENTERS LABOR AND DELIVERY UNIT

- A. Immediate assessment of status of labor is made.
- i. If delivery is imminent - CALL THE PHYSICIAN/CNM and prepare for immediate delivery.
 - ii. If delivery is not imminent continue assessment which will include but is not limited to:
 1. gravida, parity, EDC, maternal age, chief complaint
 2. prenatal preparation, determine physician/patient relationship
 3. partner support needs
 4. obstetric history, risk factors
 5. labor status, vital signs (T, P, R, BP), reflexes/clonus, fetal monitoring, frequency of contractions, presentations, status of membranes
 6. any other associated information
- 2) Continue evaluation to assess maternal hydration, labor progress and fetal well being.

ASSESSMENT OF MATERNAL HYDRATION

- A. If temperature is elevated:
1. Assess for bladder distention
 - a) encourage to void
 - b) if unable to void, continue to assess bladder and include this information with report to physician when total assessment is completed Suspect infection - CALL ATTENDING PHYSICIAN/CNM
- 1) Assess for other abnormal findings and call PHYSICIAN/CNM if present:
- elevated blood pressure (greater than or equal to 140mm Hg systolic or 90mm Hg diastolic)
 - excessive bleeding
 - reflexes > +1-2, clonus
 - presence of edema (specifically hands and face)
- B. If hydration status & temperature are normal:
1. Encourage to void
 2. Include this information with report to physician/CNM when total assessment is completed.

ASSESSMENT OF LABOR PROCESS

- A. Abdominal palpation
 - 1. Assess contractions noting:
 - 7. frequency
 - 8. duration
 - 9. intensity
 - 10. uterine relaxation
- Include this information with report to physician/CNM when total assessment is completed.
- B. Assess position of presenting part
 - 1. Potential complications may include but are not limited to:
 - a) hypertonia
 - b) hypotonia
 - c) tonic contraction
 - 2. If potential complications are present, CALL THE PHYSICIAN/CNM
- C. Vaginal Examination
 - 1. Determine the status of membranes
 - a) intact or ruptured (if ruptured, determine date, time and character of fluid)
 - b) odor and clear
 - c) include this information with report to physician/CNM when total assessment is completed.
 - d) NO DIGITAL EXAM IF PRETERM.
 - 2. Determine descent of presenting part
 - a) if normal, include this information with report to physician/CNM when total assessment is completed.
 - b) if abnormal, CALL THE PHYSICIAN/CNM
 - 3. Determine the state of the cervix
 - a) effacement
 - b) dilatation
 - c) station
 - d) if normal, include this information with report to physician /CNM when total assessment is completed.
 - e) if abnormal, CALL THE PHYSICIAN/CNM
 - 4. Assess bleeding
 - a) CALL THE PHYSICIAN/CNM if abnormal due to:
 - 1) abnormal, color, odor, or amount
 - 2) suspected bleeding (greater than normal “bloody show”)
 - b) if normal, include this information with report to physician when total assessment is completed.
- D. Assessment of fetal well-being
 - 1. Identify fetal heart rate pattern with application of a doppler or an electronic fetal monitor.
 - 2. Abnormal patterns (non-reassuring) may include but are not limited to:
 - a) baseline outside normal range with recurrent late or variable decelerations
 - b) prolonged decelerations
 - c) absence of variability
 - d) sinusoidal pattern
 - e) severe bradycardia
 - f) if abnormal, CALL THE PHYSICIAN/CNM

3. Normal patterns (reassuring)
 - a) consistent baseline rate of 100-160 beats per minute
 - b) average variability
 - c) periodic accelerations
 - d) early decelerations
 - e) include this information with report to physician/CNM when total assessment is completed.

III. Qualified To Perform

1. A physician/CNM of the Hospital's medical staff with appropriate clinical privileges who is physically present in the Labor and Delivery Department.
- F. A qualified Registered Nurse who has demonstrated competencies to perform a medical screening exam in order to determine the presence or absence of labor.
- A. Qualifications for Registered Nurses
 1. Completes competency for Medical Screening Exam, validated by a member of the hospital's obstetrical medical staff.
 2. Annual Labor and Delivery competency skills review.
 3. Current Registered Nurse (RN) license.
 4. Completion of EFM program every two (2) years.
 - B. Evaluations
 1. Initial evaluation at completion of orientation and then annually.
 2. Annual employee evaluation will include intra-partum core competencies.
 - C. Records

A list of persons authorized to perform the medical screening exam will be kept in the Labor and Delivery Department and will be updated, as needed.

IV. Supervision

Following MSE, RN will report to physician by phone the Obstetric Medical Screening points, and any other pertinent information before any further procedures are performed or to receive authorization to discharge patient home with instructions.

DEPARTMENT OF PEDIATRICS

ARTICLE I

ENUMERATED POLICIES AND PROCEDURES

A. Physician Examination

The attending physician will be notified upon admission of the infant to nursery. All normal healthy newborns are to be seen by the physician within twenty-four (24) hours after notification and on a daily basis. The nurse has the responsibility to contact the physician at any time if she feels that the infant's care requires immediate attention. The infant must be examined before discharge or transfer from the nursery. The attending physician will examine and complete a history and physical on each infant which will become part of the infant's permanent records.

DEPARTMENT OF SURGERY

ARTICLE I

RETROSPECTIVE REVIEW

A retrospective review of the first five (5) operative cases performed will be done on initially being granted surgical or anesthesiology privileges at St. Petersburg General Hospital. However, the Chairman of the Department of Surgery or his/her designee does retain the right to recommend sponsorship if deemed appropriate.

ARTICLE II

EMERGENCY ROOM CALL

In order to ensure that the hospital's Emergency Room coverage needs are met, emergency room call is mandatory for all general surgeons who have less than 25 years of community service and urologists with Active and Courtesy privileges. Provisional members upon completion of their five (5) case retrospective review requirements will be required to provide emergency room coverage.

Surgical Admissions/Referrals:

Patients without a Primary Care Practitioner (PCP) on SPGH Staff:

Any patient presenting to SPGH needing surgical admission, consultation, or referral who has not designated their PCP or who has a PCP who is not on SPGH staff, will be admitted, consulted, or referred to the On-Call Surgeon.

Patients with a PCP on SPGH Staff:

Any patient presenting to SPGH needing surgical admission, consultation, or referral with a PCP on SPGH Staff will be admitted, consulted, or referred to the SPGH On-Call Surgeon with the following guidelines:

- A call will be placed to the SPGH PCP if the patient was told by the PCP to go to the ED and the appropriate referring surgeon discussed.
- If the PCP cannot be reached, the Surgeon On-Call will be contacted to address the patient's surgical needs.
- If the patient needs imminent surgical intervention, then the ED physician's direction takes precedence.

* If patient presenting is incoherent, efforts will be made to elicit PCP verification from family, Meditech history, ambulance run sheet, or skilled nursing facility documentation accompanying the patient/by phone.