# UF HEALTH SHANDS HOSPITAL

# MEDICAL STAFF BYLAWS

**Re-Adopted by**

**Board of Directors, Effective**

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disagreement with the conclusion of the author, the co-signer should record his/her differing conclusions or expand on the entry as appropriate.

## SECTION 2. MEDICAL RECORD CONTENT

A. The Attending is responsible for the accurate, timely, and legible completion of a medical record for each patient he/she admits or for whom he/she provides care.

B. Each medical record must contain at least the following information, as appropriate:

1. the patient's name, address, date of birth, and the name of any legally authorized representative;
2. for patient's receiving mental health services the patient's legal status;
3. emergency care provided to the patient prior to arrival;
4. the record and findings of the patient's assessment;
5. a medical history and physical examination including a statement of conclusions or impressions;
6. the diagnosis or diagnostic impression;
7. the reason(s) for admission or treatment; the goals of treatment and the treatment plan with episodic review;
8. evidence of known advance directives;
9. evidence of informed consent;
10. reports of operative and other procedures, tests and their results;
11. records of donation and receipt of transplants or implants;
12. diagnostic and therapeutic orders;
13. all diagnostic and therapeutic procedures and tests performed and the results;
14. progress notes that include clinical observations and the patient's response to medications and care provided;
15. all reassessments;
16. consultation reports;
17. medications ordered or prescribed during treatment or upon discharge;
18. all diagnoses established during the course of care;
19. conclusions at the termination of hospitalization;
20. discharge summary, or a final progress note or transfer summary;
21. discharge instructions to the patient or family;
22. referrals and communications made to external or internal care providers and to community agencies; and

23. autopsy results.

C. In all instances the content of the medical record shall be sufficient to justify the diagnosis and warrant the treatment and end result.

## SECTION 3. HISTORY AND PHYSICAL

A. General requirements:

1. A history and physical examination must in all cases, except normal obstetrical and newborn cases, be dictated or electronically created, signed, and available in the Electronic Health Record prior to the performance of any invasive procedure (whether inpatient or outpatient) or within twenty-four (24) hours after admission of the patient, whichever occurs earliest, or for emergency admissions, as soon as conditions permit. In addition, a history and physical examination is required for observation patients within 24 hours or before discharge. If the H&P has been performed by a Resident Physician, ARNP or PA, the Attending should review the H&P and enter a note of concurrence. For inpatients, an H & P performed at admission may be used for all subsequent inpatient procedures. If an H&P is performed and dictated within 24 hours after admission, the Practitioner performing the H&P must make an entry in the record stating the H&P has been performed and dictated.

2. If a history and physical examination has been performed by a Medical Staff member, Resident Physician, ARNP, or PA within thirty (30) days prior to the admission/procedure. The Attending should review the H&P and enter a letter of concurrence. A legible copy of the H&P may be used in the patient's medical record; provided that, at the time of admission/the procedure, an appropriate assessment is performed and documented, including a physical examination of the patient, to update any components of the patient's current medical status that may have changed since the prior H & P or to address any areas where more current data is needed. The update note must also confirm that the necessity for the care/procedure is still present and the H&P is still current. The update note must be on or attached to the full H & P, or when the H & P is accessed on-line by the Practitioner, must refer specifically to the date of the H & P being updated. Updates may be done by the Attending or his/her Resident or appropriately privileged ARNP or PA.

3. A history and physical that was performed within thirty (30) days prior to admission/procedure by a non-credentialed (non-resident) Practitioner must be reviewed by a Medical Staff member and a note of concurrence entered into the medical record.

4. Dentists are responsible for the part of their patients' history and physical examinations that relate to dentistry. Podiatrists are responsible for the part of their patients' history and physical examinations that relate to podiatry. A credentialed M.D. or D.O. must confirm the findings and conclusions of the H&P and assessment of risk(s) of any proposed operative or other procedure requiring written informed consent pursuant to hospital policy, done by a Dentist (except an Oral and Maxillofacial Surgeon) or Podiatrist, when the patient involved has a severe systemic disease that is considered a constant threat to the life of the patient.

B. H&P Required Elements

1. For inpatients, the history and physical must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; social history; family history; review of systems, and a relevant physical examination. A comprehensive assessment

2. should integrate the elements from the history and physical examination that support the reason for admission or need for intervention followed by the treatment plan.

3. For outpatient procedures, a history and physical must include, at a minimum: chief complaint; history of present illness; medications; allergies; adverse drug reactions; past medical history; review of relevant systems, including pain assessment and relevant physical examination that supports the need for intervention followed by the treatment plan.

4. If anesthesia or sedation is planned, the anesthesia assessment shall include, at a minimum: medication history, including drug allergies; previous experience with sedation and analgesia; results of relevant diagnostic studies; physical status assessment; airway assessment; and NPO status.

## SECTION 4. PRE-PROCEDURE DOCUMENTATION

A. Pre-procedure verification (including site marking and time out) must be performed and documented in accordance with Core Policy CP2.56, *Pre-Procedure Verification Process (Universal Protocol)*.

B. No anesthesia shall be given, nor invasive/significant risk procedure started, until the history and physical examination, pre-procedure diagnosis, indicated laboratory/diagnostic tests and informed consent are on the chart, unless the Attending documents in the Medical Record that delay would be detrimental to the patient's health. 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 procedure, including at a minimum, heart rate, respiratory rate, and blood pressure.

## SECTION 5. ADMISSION NOTES

In addition to the dictated history and physical, an admission note must be written for all inpatients and admitted observation patients. The admission note must include the reason for admission, pertinent findings, conclusions and plan of care. A handwritten update to a history and physical dictated within the past 30 days may be considered the admission note.

## SECTION 6. PRE-ANESTHESIA ASSESSMENT

Within 48 hours prior to the procedure a pre-anesthesia assessment of each patient for whom anesthesia is contemplated shall be performed and a determination made and documented by the Anesthesiologist that the patient is an appropriate candidate to undergo the planned anesthesia. Immediately prior to induction, an evaluation of the patient must be completed and documented.

## SECTION 7. POST OPERATIVE DOCUMENTATION AND DISCHARGE FROM RECOVERY AREA

A. The patient's postoperative status is to be assessed on admission to and discharge from the post-anesthesia recovery area.

B. If discharge criteria are to be used for patient discharge from post anesthesia care, they must be approved by the Medical Staff.

C. Postoperative documentation includes at least: a record of vital signs and level of consciousness; medications (including intravenous fluids); blood and blood components; any unusual events or postoperative complications, including drug and transfusion reactions, and the management of those events; identification of all care providers; the patient's discharge from the post-anesthesia care area including documentation of the responsible discharging Physician or, if discharge was by criteria, documentation of criteria used to determine patient readiness.

D. In addition, for inpatients, a post-anesthesia evaluation must be completed and documented by a qualified anesthesia provider within 48 hours following anesthesia.

## SECTION 8. OPERATIVE REPORTS

A. Operative reports shall include:

1. Name and medical record number of the patient;
2. Date and time of surgery;
3. Pre and post-operative diagnosis(es);
4. Name of the surgical procedure(s) performed;
5. Type of anesthesia administered;
6. Complications, if any;
7. Identification of participating surgeons and other practitioners;
8. Findings;
9. A description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/Practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices or altering tissues);
10. Prosthetic devices, grafts, tissues, transplants or devices implanted, if any;
11. Specimens removed;
12. Estimated blood loss.

B. Operative reports must be dictated; except that, with the exclusion of tracheostomies, procedures done at bedside may be handwritten or dictated. All tracheostomies, regardless of where performed, must be dictated.

C. Operative reports shall be dictated, or when permitted, written as soon as possible after surgery.

D. When the operative report is not placed in the medical record immediately after surgery, a progress note is entered in the patient's medical record immediately (before the patient moves to the next level of care). The immediate post-operative progress note must include at a minimum: date of procedure, pre-op diagnosis, post-op diagnosis, procedure(s) performed, surgeon(s) and assistant(s) names, findings, complications, estimated blood loss, specimens removed, surgeon's signature and provider ID number.

## SECTION 9. PROGRESS NOTES

Pertinent progress notes shall be recorded at the time of observation, sufficient to permit continuity of care and transferability. An Attending or his/her Resident, PA or ARNP shall enter a progress note in the medical record at least daily. 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.

## SECTION 10. CONSULTATIONS

A. The name of the requesting Practitioner, and the date and time of the request, must appear on all consultation requests.

B. All consultation requests are to be responded to by Practitioners or other appropriate healthcare professionals within 24 hours, unless a shorter time frame is important for a positive patient outcome, either through the completion of a consultation report form, or documentation in the progress note labeled "Consultation".

C. Consultations shall be provided upon request without regard to the patient's insurance or payment status.

D. See Article III, Section 10 of this chapter for a delineation of circumstances under which consultations are required. The consultation report/note must include:

1. The name of the requesting Physician;
2. The name of the responding service;
3. Reason for the consultation;
4. Evidence of a review of the patient's record;
5. Pertinent findings on examination;
6. Consultant's opinion and recommendations;
7. Signature, date and time by the consultant.

E. A limited statement such as "I concur" does not constitute an acceptable report of consultation.

F. When operative procedures are involved, the consultation note shall, except in emergency situations so verified on the record, be recorded prior to the operation.

G. Follow-up consultations must be designated as such and again signed by the consultant.

## SECTION 11. OBSTETRICAL RECORD

The obstetrical record shall include a complete prenatal record. The prenatal record may be a legible copy of the referring Practitioner's office record transferred to the hospital before admission, but an admission note must be written that includes pertinent additions to the history and any subsequent changes in the physical findings.

## SECTION 12. DISCHARGE PROGRESS NOTE

A Discharge progress note must be written prior to discharge of the patient that includes: principal and secondary diagnoses, major procedures, list of current medications (after reconciliation in compliance with Hospital Policy PM02-49, *Medication Reconciliation*) and instructions to the patient, including medication instructions and prescriptions given. The note must be signed, dated and timed by the Attending or his/her resident.

## SECTION 13. DISCHARGE SUMMARY

A. Immediately prior to or within forty-eight (48) hours of discharge, a discharge/death summary shall be dictated for all observation patients and inpatients, except that for normal newborns, observation obstetrical patients, and obstetric patients with uncomplicated deliveries a final progress note including the final diagnosis(es), procedures, patient's condition at discharge, discharge instructions, and follow-up care may be substituted for the summary. The summary should concisely recapitulate: a complete listing of final diagnoses; the reason for hospitalization; the significant findings; the procedures performed and treatment rendered; the condition of the patient on discharge and any specific instructions given to the patient and/or family, *e.g.*, instructions relating to physical activity; complete current medication list(after reconciliation in compliance with Hospital Policy PM02-49, *Medication Reconciliation*); diet and follow-up care. All summaries must be signed by the Attending.

B. The discharging Attending is responsible for appropriate communication regarding treatment of the patient to the referring and/or next treating practitioner.

## SECTION 14. SYMBOLS AND ABBREVIATIONS

Only symbols and abbreviations recognized by an approved reference source designated by the Patient Record Committee may be used. A list of prohibited abbreviations can be found in Core Policy and Hospital Guideline CP2.53, *Abbreviations*. Abbreviations on the prohibited abbreviations' list must not be used in any handwritten medical order, medication related documents or on pre-printed forms.

## SECTION 15. REMOVAL OF MEDICAL RECORDS

Original records may not be removed from the hospital except as required by court order, subpoena or statute. All records are the property of the hospital and shall not otherwise be removed without permission of the Director of the Health Information & Record Management Department.
Unauthorized removal of a record from the hospital is grounds for disciplinary action in accordance with the Medical Staff Bylaws.

## SECTION 16. RELEASE OF MEDICAL RECORDS

Written consent of the patient or surrogate is required for release of medical information to persons not otherwise authorized by law to receive this information. Refer to Core Hospital Policies (CP3 series, CP1.35, CP1.18, and CP1.11).

## SECTION 17. COMPLETION OF MEDICAL RECORDS

A. Medical records of discharged patients are to be completed promptly. Physicians are expected to electronically complete all medical records including dictations, Physician queries, and electronic signatures in all systems at least once every seven days. Failure to do so may be cause for disciplinary action including suspension of clinical privileges according to these Bylaws and the procedures established by the Department of Health Information Management.

B. Medical Staff members shall not complete a medical record for a patient who has not been under his/her care. If the Attending is unavailable for completion of the record and no other Physician is adequately familiar with the care to allow completion of the record, it will be closed in accordance with the policy established by the Health Record Shared Governance Committee.

# ARTICLE III - GENERAL CONDUCT OF CARE

The management and care of each patient's care, treatment, and services is the responsibility of a Medical Staff member with appropriate clinical privileges.

## SECTION 1. RESIDENTS AND NON-FACULTY PATIENTS

A. UF fellows, residents, and students will not be involved the in evaluation or treatment of non-faculty Medical Staff member patients, except that in an emergency, UF fellows and resident physicians will assist in providing the necessary care until the patient's physician's arrival.

B. Non-faculty Attendings desiring assistance from UF faculty Attendings shall request consults in accordance with Section 10 of this Article.

## SECTION 2. INFORMED CONSENT

Informed consent must be obtained prior to any non-routine treatment or procedure, except in emergency situations when the patient is incapacitated and a surrogate/proxy, or parent if the patient is a minor, cannot be immediately reached. Written informed consent shall be obtained in conformance with Core Policy CP2.10 and Hospital Guideline CP2.10g, *Consent for Treatment* prior to any diagnostic or therapeutic procedure or treatment (1) that entails significant risk to the patient or (2) for which it is otherwise required by law, regulation or Hospital policy. The Attending scheduled to perform the procedure or another Physician designated by the Attending is required to obtain such consents.

## SECTION 3. DISCLOSURE OF UNANTICIPATED EVENTS

In accordance with Core Policy, CP1.43, *Disclosure of Unanticipated outcome of Care or Adverse Incident,* in order to be designated an "appropriately trained physician", all Attendings must complete the Self Insurance Program training concerning disclosure.

## SECTION 4. ORDERS

A. Orders for treatment may only be given by Attendings, residents and fellows, and by ARNPs /PAs

within the authority of their clinical privileges to practice, and in accordance with Core Policy CP2.58 and Hospital Guideline CP2.58g, *Medical Orders*. Orders that are illegible or improperly written shall not be carried out until rewritten and understood by the healthcare professional responsible for implementing the order.

B. Orders for Restraint or Seclusion must be given in accordance with Core Policy CP2.21 and Hospital Guideline CP2.21g, *Restraints and Seclusion*.

C. Verbal orders must be given in accordance with Core Policy CP2.58 and Hospital Guideline 2.58g, *Medical Orders*.

D. For DNR order procedures, refer to Core Policy CP2.12, *Do Not Resuscitate Orders*, or Core Policy CP2.13, *Withholding or Withdrawing Life Prolonging Treatment or Measures*.

E. Orders written by medical Students cannot be executed without the co-signature of a Practitioner with authority to give that order, in which case the order is deemed to be that of the co-signing Practitioner.

## SECTION 5. ADVANCE DIRECTIVES

Advance directives should be reviewed by the Attending or another Physician designated by the Attending with the patient or his/her proxy/surrogate at the time of each admission, when there is a significant change in the patient's condition, or at the patient's request. This discussion should be documented in the progress notes and, if appropriate, a new advance directive should be executed. Unless otherwise provided for by law, advance directives or a proxy/surrogate's decision on behalf of a patient shall be honored. See also Core Policy, CP 2.29, *Advance Directives*.

## SECTION 6. PERMITTED MEDICATIONS

A. All drugs, diagnostic agents, and commercially available dietary supplements administered to patients shall be listed in the latest edition of the USP-NF (United States Pharmacopoeia/National Formulary) or American Hospital Formulary Service. Medications listed in these compendia that have been deemed unavailable for safety or cost reasons by the Pharmacy and Therapeutics Committee will not be administered to patients.

B. Drugs for IRB approved 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 Federal Drug Administration. All drugs used for patient care will be issued or verified by the hospital Pharmacy Department. All compounded injectable medication and narcotics will be supplied by the Pharmacy.

C. A patient may bring in his or her own formulary or non-formulary medications for use during his/her hospitalization only in accordance with the provisions of Hospital Policy, PM02-37, *Patient Medication Brought into UF Health Shands*.

## SECTION 7. SEDATION BY NON-ANESTHESIA PROVIDERS

Sedation and analgesia for procedures shall be ordered and supervised only by Medical Staff privileged to do so, and only in accordance with Core Policy CP2.22, *Sedation by Non-Anesthesiologists/Non-CRNAs for Procedures* and Hospital Guideline CP2.22g, *Sedation of Patient for Procedure*.

## SECTION 8. STUDENTS

All students must work directly under the supervision of a licensed or registered professional.

## SECTION 9. TISSUE REMOVAL

All tissues removed at the operation, except those approved by the Perioperative Governance Committee and Quality and Operations Committee shall be sent to the hospital pathologist who shall make such examination as he/she may consider necessary to arrive at the tissue diagnosis. His/her authenticated report shall be made a part of the patient's medical record.

## SECTION 10. CONSULTS

A. High quality 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 Attending. Each clinical service should exercise its judgment regarding the specific conditions for which consultations are to be obtained.

B. Any qualified Practitioner with clinical privileges/scope of practice in this hospital must respond to a request for a consultation within his/her area of expertise within 24 hours, unless a shorter timeframe is important for a positive patient outcome.

C. Except in an emergency situation, consultation must be obtained at a minimum in the following situations:

1. To confirm the appropriateness of proceeding with a planned operation or treatment, despite the fact that the patient may not be a good risk for said operation/treatment;
2. Where the diagnosis is unclear after diagnostic procedures have been completed;
3. Where there are questions regarding the choice of therapeutic measures;
4. In cases where skills beyond the scope of the Attending may be needed, or where a second Attending's presence is advisable, e.g., complex, high risk surgery;
5. Prior to medical or surgical intervention when the patient exhibits severe psychiatric symptoms;
6. When requested by the patient or his/her proxy or surrogate;
7. When an ethics consult appears to be indicated such as disagreements between or amongst the healthcare team and the patient and/or patient's proxy or surrogate on treatment issues. See also Core Policy, CP2.28 and Hospital Guideline CP2.28g, *Ethics Consultation*;
8. In all instances of attempted suicide and drug overdose, psychiatric consultation shall be obtained.

## SECTION 11. PRACTITIONER SELF CARE OR CARE OF IMMEDIATE FAMILY MEMBER

A. Physicians generally should not treat themselves or immediate family members (parents, sibling,

children, or spouses); however there may be occasions where this is acceptable and appropriate.

B. Any Physician, who desires to provide treatment to him/herself or a family member must first contact the Chair of his/her, assigned department or the Chair of the Quality and Operations Committee. The Physician shall provide a memo to the Chair describing the nature of the problem and/or the intended treatment and advise the Chair of the reason that a non-related Physician is not providing the care. The Chair must provide the requesting Physician with the American Medical Association's Code of Ethics statement on this issue, which is appended (Appendix A) to these Rules and Regulations.

C. If, after reviewing the AMA Code of Ethics, the Physician informs the Chair of his/her intent to proceed with the delivery of care to self or family members, the Chair shall notify Quality Management and initiate a concurrent chart review of the care.

## ARTICLE IV - GENERAL RULES REGARDING DENTAL CARE

A patient admitted for dental care is the responsibility of both the dentist and a Physician or oral and maxillofacial surgeon.

### SECTION 1. DENTIST'S RESPONSIBILITIES

A. A detailed dental history justifying hospital admission;

B. A detailed description of the examination of the oral cavity and pre-operative diagnosis;

C. A complete operative report, describing the findings and techniques. For tooth extractions, the dentist shall clearly state the number of teeth and fragments removed. All tissue and teeth fragments shall be sent to pathology in accordance with Article III, Section 9 of this chapter;

D. A discharge of the patient, including Discharge Order and Summary, in accordance with requirements of Article II of this chapter, *Medical Records*.

### SECTION 2. PHYSICIAN'S OR ORAL AND MAXILLOFACIAL SURGEON'S RESPONSIBILITIES

A. A medical history and physical in accordance with Article II of this chapter, *Medical Records*;

B. Supervision of the patient's general health status while hospitalized.

## APPENDIX A

### American Medical Association's Code of Ethics Self-Treatment or Treatment of Immediate Family Members

Physicians generally should not treat themselves or members of their immediate families. Professional objectivity may be compromised when an immediate family member or the Physician is the patient; the Physician's personal feelings may unduly influence his or her professional medical judgment, thereby

interfering with the care being delivered. Physicians may fail to probe sensitive areas when taking the medical history or may fail to perform intimate parts of the physical examination. Similarly, patients may feel uncomfortable disclosing sensitive information or undergoing an intimate examination when the Physician is an immediate family member. This discomfort is particularly the case when the patient is a minor child, and sensitive or intimate care should especially be avoided for such patients. When treating themselves or immediate family members, Physicians may be inclined to treat problems that are beyond their expertise or training. If tensions develop in a Physician's professional relationship with a family member, perhaps as a result of a negative medical outcome, such difficulties may be carried over into the family member's personal relationship with the Physician.

Concerns regarding patient autonomy and informed consent are also relevant when Physicians attempt to treat members of their immediate family. Family members may be reluctant to state their preference for another Physician or decline a recommendation for fear of offending the Physician. In particular, minor children will generally not feel free to refuse care from their parents. Likewise, Physicians may feel obligated to provide care to immediate family members even if they feel uncomfortable providing care.

It would not always be inappropriate to undertake self-treatment or treatment of immediate family members. In emergency settings or isolated settings where there is no other qualified Physician available, Physicians should not hesitate to treat themselves or family members until another Physician becomes available. In addition, while Physicians should not serve as a primary or regular care provider for immediate family members, there are situations in which routine care is acceptable for short-term, minor problems.

Except in emergencies, it is not appropriate for Physicians to write prescriptions for controlled substances for themselves or immediate family members. (I, II, IV) Issued June 1993.