

RULES AND REGULATIONS
OF THE MEDICAL STAFFS
OF NORTH BROWARD HOSPITAL DISTRICT

April 2006

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OF THE
NORTH BROWARD HOSPITAL DISTRICT

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RULES AND REGULATIONS FOR THE MEDICAL STAFFS OF THE NORTH BROWARD HOSPITAL DISTRICT

I. RULES FOR ADMISSION

A. Types of Patients

The hospital shall admit patients suffering from all types of diseases except those diseases which cannot be adequately treated because the hospital lacks appropriate equipment and facilities.

B. Admitting Privileges of Physicians

Patients may be admitted to the hospital only by practitioners with appropriate clinical privileges who have been duly appointed to the Medical Staff by the Board of Commissioners of the North Broward Hospital District ("Board of Commissioners").

C. Admitting Diagnosis, Provisional

A provisional diagnosis shall be stated at the time of admission.

D. Medical Screening for Obstetrical Patients

Medically qualified persons may perform medical screenings. These would include physician members of the medical staff and labor and delivery registered nurses or midwives who, under the supervision of a physician, are utilizing medical staff approved protocols for obstetric patients.

II. RULES FOR CARE IN THE HOSPITAL

A. Physicians' Responsibilities

1. Each patient admitted to the hospital will be under the care of a member of the Medical Staff who shall be responsible for the patient's medical care and treatment. Whenever the care for any patient is transferred to another staff member, a note shall be entered on the order sheet of the medical record indicating such transfer and acceptance of responsibility by the receiving physician.
2. The attending physician or physician designee shall see each patient within twenty-four (24) hours of admission and once daily during the patient's

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hospitalization, except when the patient is admitted to hospice, or is awaiting discharge placement and is not under active medical care.

3. Each member of the Medical Staff must provide for another Medical Staff member to assume his/her responsibilities during his/her absence. Appropriate "coverage" of a physician's responsibilities during his/her absence means equivalent competency by specialty or as approved by the applicable Department Chief.

B. Consultations

1. General Consultation Requirements

- a. The attending practitioner is responsible for requesting consultation when indicated. The attending physician will provide authorization to permit another practitioner to examine or provide consultation to the patient.
- b. Any qualified practitioner with clinical privileges in this Hospital may be called by the practitioner responsible for the patient to provide consultation within the consultant's area of expertise.

2. Required Consultations

It is the duty of each Medical Staff member to assure that consultations be obtained as needed.

The attending practitioner should consult with an appropriate specialist when necessary. Consultations will be required when a disease entity is not in the scope of the attending physician's expertise.

3. Documentation of Consultations

- a. Consultations must be ordered in writing by the attending practitioner.
- b. Consultants may write orders unless otherwise indicated by the attending physician. In the event of conflict of management, the attending physician must be notified immediately.
- c. Consultation reports should contain evidence that the consultant has examined both the patient and his medical record and shall include the consultant's findings and recommendations.

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- d. Except in emergency situations, so verified in the medical record, a consultation relative to an operative or potentially hazardous procedure shall be recorded prior to the surgical or other procedure being performed, and this consultation reported to the attending physician.
- e. Forms requesting consultations or radiology and pathology services shall be filled out adequately, indicating the reason for the request and relevant clinical information, based on physician orders.

III. RESTRAINTS AND SECLUSION

The use of restraints or seclusion in the hospital shall be in accordance with the written *Policies and Procedures on Restraints and Seclusion*.

IV. MEDICAL RECORDS

A. Content

Medical records contain sufficient information to:

- 1. Identify the patient;
- 2. Support the diagnosis;
- 3. Justify the treatment;
- 4. Document the course and results, and
- 5. Facilitate continuity of care.

B. Admission Note

Upon admission to the hospital, a patient's medical record should include either an admission note or a complete History and Physical. Information obtained prior to admission must be included in the medical record if the information is to be relied upon to document the medical necessity and appropriateness of the admission, surgery, or other services provided.

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C. History and Physical Exam

1. The physician on whose service the patient is admitted shall be responsible to provide, write or dictate the history and physical. Reports shall be completed and entered in the medical record within twenty-four (24) hours of admission, including weekends and holidays. If surgery is to be performed in less than twenty-four (24) hours, the history and physical shall be recorded and included in the medical record prior to surgery.

2. A history and physical performed by any member of the Medical Staff within thirty (30) days prior to admission may be accepted in the patient's medical record, provided:

It is updated within twenty-four (24) hours after admission or prior to relevant procedures regardless of whether there were changes in the patient's status (an appropriate assessment includes a physician examination of the patient to update 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, confirming that the necessity for the procedure or care is still present and the H & P is still current).

Exceptions:

An interval history and physical report, reflecting changes from previous examination, may be used in the case of a patient's readmission within seven (7) days from the date of original history and physical for the same or related problem.

3. The history shall include the chief complaint, details of present illness, relevant past medical history, family and social histories appropriate to the patient's age, a summary of the patient's psychosocial needs, as appropriate to the patient's age, and an inventory by body system.
4. The physical examination shall include a relevant current physical examination covering each of the body systems with particular attention to the system involved with the chief complaint. Pertinent normal and abnormal findings and impressions should be included.
5. A statement of the conclusions or impressions drawn from the admission history and physical examination shall be noted.
6. A statement of the course of action planned for the patient for this episode of care and of its periodic review, as appropriate, shall be noted.

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D. Progress Notes

Progress notes shall include: 1) initial admission notes 2) reassessment at regular intervals in the course of care 3) medical and surgical treatment rendered, including a post-op note immediately after surgery 4) pre-op anesthesia evaluation, if applicable 5) post-op anesthesia evaluation, if applicable.

E. Discharge Summary

1. The physician on whose service the patient is at the time of discharge shall be responsible for the discharge summary.
2. The discharge summary shall include the following: the reason for hospitalization; significant findings; procedures performed and treatment rendered; the patient's condition at discharge; final diagnosis(es); and any specific instructions given to the patient and/or family, including physical activity, diet, medications and dosage.
3. For normal newborns with uncomplicated deliveries, or for patients hospitalized for less than 48 hours with only minor problems, a final progress note may substitute for the Discharge Summary. The progress note should include the patient's condition at discharge, discharge instructions and follow-up care required. The progress note may be handwritten.
4. A transfer summary may be substituted for the discharge summary in the case of transfer of the patient to another level of care within the organization, for example, a transitional care unit.
5. Discharge summaries on patients who have been hospitalized over forty-eight (48) hours must be typewritten, not handwritten.

F. Consultations

The medical record shall include consultations, if any, together with the reason for request and report of consultation (see General Consultation Requirements, Section II, B.1).

G. Hospital Service Reports

The medical record shall include reports from hospital service departments - Pathology; Clinical Laboratory; Radiology, Anesthesiology; Surgery, and other departmental and special service reports, as pertinent.

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H. Symbols and Abbreviations

Symbols and abbreviations may be used only when they have been approved by the Medical Staff. An official record of approved abbreviations should be kept on file in the Medical Records Department. No abbreviations are permitted on the face sheet.

I. Medical Records - General

1. A medical record, compliant with the rules and regulations herein provided, shall be developed for each patient admitted to the hospital and, as applicable, for patients receiving ambulatory services.
2. The medical record shall be confidential.
3. The medical record is the property of the hospital and a copy thereof may be released by the hospital only upon patient consent, court order, subpoena or pursuant to applicable law.
4. On readmission of the patient, previous records shall be available for the use of the attending physician.
5. Written consent or authorization of the patient or the patient's legal representative is required for the release of medical information to persons not otherwise authorized to receive this information.
6. All entries in the medical records shall be dated and authenticated. The medical practitioner authenticates the parts of the medical record that are his/her responsibility. Authentication may be by written signatures or initials, or computer key. Rubber stamp or computer key signatures are acceptable only when used by the authorized individual; otherwise, they are prohibited. When a rubber stamp or a computer key signature is authorized, the individual whose signature the stamp or computer key authorizes shall sign a statement that he/she alone will use the stamp or code for the computer key. This statement shall be filed with the hospital's Medical Staff Department. A copy will be retained in the corresponding department in the Medical Record Department of each hospital.
7. Medical record entries must be legible.
8. Corrections to medical record entries should be made by drawing a single thin line through each line of the inaccurate material, entering the correct information, dating and initialing the change.

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J. Ambulatory Procedures

History and Physical Exam

A current history and physical (“H&P”) performed within thirty (30) days prior to a procedure must be recorded on any patient upon whom an ambulatory procedure or outpatient procedure is to be performed. The H&P may be performed by the physician performing the procedure or referring member of the Medical Staff. If the H&P was performed within the previous thirty (30) days, an appropriate assessment must be completed within seven (7) days prior to the ambulatory or outpatient surgery, which shall include a physical examination of the patient to update any component of the patient’s medical status that may have changed or address any areas where more current data is needed, and further confirming the continued necessity for the procedure, documented by an update note. In addition, if a significant change has occurred in the interim period from the original H & P or the “7-day” update note, as applicable, a note on the day of the procedure is necessary to reflect the patient’s interim and current status. The following guidelines will assist in making this determination:

1. No anesthesia or topical, local, regional block.
 - (a) Assessment of mental status, vital signs;
 - (b) An examination specific to the procedure proposed to be performed and any comorbid conditions.
2. Moderate/Deep Sedation
 - (a) Assessment of mental status, vital signs;
 - (b) An examination specific to the procedure proposed to be performed and any comorbid conditions;
 - (c) Examination of heart and lungs by auscultation.
3. General, spinal or epidural anesthesia

A complete examination, including but not limited to assessment of mental status, vital signs, examination of heart and lungs by auscultation and an examination specific to the procedure proposed to be performed and any comorbid conditions.

In addition to the above-noted documentation requirements, a preoperative assessment should include:

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- Indications/symptoms to justify procedures;
- Evidence of informed consent for procedures;
- List of current medications and dosage of each;
- Known allergies/medication reactions;
- Consultation when indicated — clearing patient for surgery.

K. Incomplete Medical Record

1. The medical record is to be completed by the thirtieth (30th) day following discharge. Completion means history, physical, consultations, progress notes, discharge summary, operative reports, face sheet and all signatures wherever needed to complete the chart.
2. If the total medical record is not finished at the end of the thirty (30) days following discharge, a notice shall be sent to the physician notifying him/her that he/she has a fourteen (14) day grace period in which to complete the chart.
3. Upon expiration of the grace period, the physician's name will be included on the next delinquent record list if incomplete records over twenty-nine (29) days post discharge have not been completed. A physician may not admit elective patients, provide consultation or schedule elective surgery/procedures when his name is on the delinquent record list.
4. A grace period will be granted for an extended physician illness or a vacation consisting of TWO (2) or MORE CONSECUTIVE WEEKS. There will not be a grace period for vacations of less than two (2) weeks. If a physician's name is on the currently effective delinquent record list and he/she does not complete the records prior to beginning the vacation, his/her name will remain on the delinquent record list, and a grace period will not be applicable.
5. The Chief of Staff, in the exercise of his reasonable discretion, may make exceptions upon proper showing by a physician of justification for not being able to comply with the rules enunciated herein.
6. By applying for and accepting membership to the Medical Staff, each physician agrees that if he/she does not complete his/her medical records within ninety (90) days after a patient's date of discharge, his or her name will be submitted to Medical Council for action, which may include dismissal from the Medical Staff membership. The admitting office shall be notified of this fact. Reinstatement to the Medical Staff shall be as a new applicant with all attendant costs and process.

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V. RULES FOR SURGICAL TREATMENT

A. Consent for Surgery - Informed Consent

All patients undergoing operative or other invasive procedures will have informed consent documented in the medical record. Before obtaining informed consent, the physician shall provide the patient, and family, if applicable, with a general understanding of the procedures or treatment, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures. Discussions with the patient and family are to be held about the need for, risks of, and alternatives to blood transfusion when blood or blood components may be needed.

B. Surgical Assistants

1. The use of a surgical assistant in a surgical procedure shall be at the discretion of the Department of Surgery.
2. The rules of the Department of Surgery shall require that surgical assistants meet one of the following criteria:
 - (a) Physicians with appropriate surgical privileges; or
 - (b) Members of an approved residency program; or
 - (c) A physician granted temporary privileges; or
 - (d) An Allied Health Professional approved for surgical assistance by the hospital.
3. Questions concerning (1) the appropriate use of a surgical assistant; or, (2), the selection of a surgical assistant, shall be referred to the Chairman of the Department of Surgery or his designee for disposition.

C. Tissue Examination

An authenticated report shall be made by the hospital pathologist on all tissue sent for examination for tissue diagnosis.

D. Reports of Operations and Anesthesia

Surgery is performed only after a history, physical examination and the preoperative diagnoses have been completed and recorded in the patient's medical record. In emergency situations, when there is inadequate time to record the history and physical examination before surgery, a brief note, including the preoperative diagnoses is recorded before surgery.

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1. The operating surgeon shall write or dictate operative reports immediately after surgery that include a detailed account of the findings at surgery, specimens removed, the postoperative diagnosis, the name of the primary surgeon and any assistants, estimated blood loss, type of anesthesia and complications. This requirement applies to outpatients as well as inpatients, including donors and recipients of organs and tissues. The completed operative report shall be authenticated by the surgeon and filed in the medical record as soon as possible after surgery. A written operative note should be entered in the medical record immediately after surgery to provide pertinent information for any individual required to attend to the patient.
2. A pre-anesthesia evaluation is performed by an anesthesiologist. The evaluation will include, but is not limited to the following: anesthesia risk, anesthesia, drug and allergy history, any potential anesthesia problems and the condition of the patient prior to the induction of the anesthesia. The initial evaluation may be done as soon as surgery is planned to allow time for additional testing or medical clearance as deemed appropriate by the physician.

If the initial evaluation was performed more than 48 hours prior to induction of anesthesia, a re-evaluation is performed within 48 hours by an anesthesiologist prior to surgery to include the elements listed above to assure the patient may safely undergo surgery. The patient will also be re-evaluated immediately prior to induction of anesthesia in the operating room. The results are documented on the anesthesia record.

The post-anesthesia follow-up report for inpatients is written within forty eight (48) hours after surgery by the individual who administers the anesthesia, or the physician's designee. Ambulatory patients are discharged after fulfilling outpatient discharge criteria. Each post anesthesia note shall specify date and time.

VI. ORDERS FOR TREATMENT

A. Verbal Orders

All orders for treatment shall be in writing. A verbal order shall be considered to be in writing if dictated to a duly authorized person functioning within his or her sphere of competence, recorded, dated and signed by the appropriately authorized person to whom dictated. The individual receiving and recording the dictated order shall identify the practitioner that has dictated the order. Orders should be signed in accordance with state and federal laws.

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1. The individual receiving the order shall document it immediately in the medical record and read it back as written to the person dictating the order for verification.

The following personnel are authorized to receive dictated orders:

Registered Nurses
Registered or Certified Respiratory Therapists
Dietitians
Physicians' Assistants
Pharmacists
Licensed Physical Therapists
Licensed Occupational Therapists
Licensed Speech and Language Pathologists and
Social Workers
Registered Radiology Technologists
Registered Polysonographic Technicians
Licensed Laboratory Technologists
Advanced Registered Nurse Practitioners
Ultrasonographers
Nuclear Medicine Technologists

Certified Medical Assistants may receive verbal orders under the direct supervision and responsibility of a licensed physician limited to NBHD physician practice settings where there is an absence of other authorized personnel in that setting.

Verbal orders are discouraged.

B. Cancellation of Orders

Patients undergoing surgery or when transferred to special care units must have their orders rewritten or updated, as appropriate.

VII. PRONOUNCING DEATH

In the event of a hospital death, with the exception of "brain death," which circumstance is governed by the provisions of Section 382.009, Florida Statutes, the deceased shall be pronounced dead within one (1) hour by the attending practitioner, any available member of the Medical Staff, or the Registered Charge/Senior Resource Nurse, and said person shall make and sign an entry in the medical record of the deceased before the body is released.

A. Autopsies

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All staff members are encouraged to secure meaningful autopsies whenever possible. An autopsy may be performed at the hospital only with a written consent.

The physician or designee is to offer an autopsy to the patient's personal representative in deaths that meet autopsy criteria defined in organizational policies and procedures.

The autopsy reports, both provisional and final, will become part of the patient's permanent medical record. Provisional anatomic diagnoses should be recorded in the medical record within two (2) working days. Final anatomic diagnosis should be included in the record within thirty (30) days if the case is uncomplicated or sixty (60) days if the case is complicated.

VIII. RULES FOR DENTAL CARE (INCLUDING MAXILLOFACIAL AND ORAL SURGERY)

A patient admitted for dental care or for maxillofacial or oral surgery is generally a dual responsibility involving the dentist or the oral or maxillofacial surgeon and a physician member of the Medical Staff. However, a maxillofacial or oral surgeon who can document through his/her credentials appropriate capability, by education, training and experience, may be granted privileges to admit patients, perform the history and physical on the patient and otherwise perform the responsibilities hereinafter set forth for both the dental and general healthcare of the patient.

A. Responsibilities of Dentist/Oral Surgeon/Maxillofacial Surgeon

1. A detailed dental history justifying hospital admission.
2. A detailed description of the examination of the oral cavity and a preoperative diagnosis.
3. A complete operative report describing the findings and technique. In cases of extraction of teeth, the dentist or surgeon shall clearly state the number of teeth and fragments removed. All tissue, including teeth and fragments shall be sent to the hospital pathologist for examination.
4. Progress notes as are pertinent to the oral conditions.
5. Discharge summary

B. Responsibilities of Physician

1. Medical history pertinent to the patient's general health.
2. A physical examination to determine the patient's condition prior to anesthesia and surgery.
3. Supervision of the patient's general health status while hospitalized if a medical condition exists or influences the dental procedures planned.

C. Discharge

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The discharge of the patient shall be by written order of the dentist member of the Medical Staff.

IX. RULES FOR PODIATRIC CARE

- A. The scope and extent of surgical procedures that a podiatrist may perform in this hospital shall be delineated and recommended to the Board of Commissioners in the same manner as clinical privileges for physicians and dentists. Surgical procedures performed by podiatrists shall be under the overall supervision of the Chairman of the Department of Surgery.
- B. Podiatrists may arrange for the admission of a patient by a physician member of the Medical Staff and prescribe within the scope of their privileges. A physician member of the Medical Staff shall be responsible for the general history and physical and the care of any medical problems which arise during hospitalization or surgical procedure and for the total health status of the patient.
- C. The podiatrist shall be responsible for the podiatric care of the patient, including the podiatric history and extremity physical examination, as well as, all appropriate elements of the patient's record. The podiatrist may write orders within the scope of his privileges and consistent with the Medical Staff Rules and Regulations and in compliance with the Medical Staff Bylaws.
- D. Podiatric privileges shall be determined on the basis of submitted documentation of qualifications.

X. RULES FOR EMERGENCY COVERAGE

A. Emergency Service Coverage

A physician shall have a duty to provide Emergency Service Coverage only at his/her primary hospital facility (i.e., the hospital facility at which the physician performs the greater part of his/her work). A physician may provide Emergency Service Coverage at a non-primary hospital facility only upon the mutual consent of the physician and the appropriate clinical department at the affected non-primary hospital facility.

B. Exemptions From Emergency Service

Any physician who has served fifteen (15) calendar years of Emergency Service Coverage at any of the hospitals operated by the North Broward Hospital District shall, at his/her request, be exempt from Emergency Service Coverage responsibility. Such exemption shall be effective after giving sixty (60) days' written notice to the Medical Staff Department at his/her primary hospital.

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XI. RULES FOR NON-PHYSICIAN HEALTHCARE PROVIDERS

A. General Allied Health Professional Requirements

1. An Allied Health Professional ("AHP") is an individual other than a physician, oral surgeon, dentist, podiatrist or psychologist who is qualified by academic and clinical training and by prior and continuing experience and current competence in a discipline which the Board of Commissioners has determined to allow to practice in the hospital and who:

(a) is a professional of high moral character and one who adheres to generally recognized standards of professional ethics; one who has the ability to work cooperatively with others in a hospital environment.

and

(b) is licensed by the state and permitted by the state practice acts and the hospital to provide patient services in the hospital without the direction of or contractual agreement with a physician (i.e., "Independent AHP").

or

(c) is licensed by the state to perform patient care services ordinarily performed by a physician under the direction of a physician and with mutually agreed upon guidelines (i.e., "physician-directed AHP")

B. Current Categories of Allied Health Professionals Credentialed by the Medical Staff

The Board of Commissioners permits the following Categories of Physician directed Allied Health Professionals (AHP's) as credentialed by the Medical Staff to provide services in the hospital:

- Certified Nurse Midwife (CNM)
- Certified Registered Nurse Anesthetist (CRNA)
- Advanced Registered Nurse Practitioner (ARNP)
- Licensed Physician Assistant (PA)
- Registered Nurse First Assistants (RNFA)

C. Credentialing of Allied Health Professionals

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1. Privileges to serve as an Allied Health Professional, including AHPs sponsored by a physician member of the Medical Staff, at any of the NBHD hospitals will be granted by the Board of Commissioners only after the following procedures have been completed and the qualifications, current competence, training, experience, licensure, etc. of the applicant have been reviewed and found to be acceptable by the Credentials & Qualifications Committee and the Medical Council.
2. The Allied Health Professional applicant must complete and submit to the Medical Staff Department the appropriate forms, including:
 - (a) Application for Allied Health Professional (including supporting documentation, e.g., licensure, certification, case documentation)
 - (b) Completed privilege form or job summary (when applicable) of duties to be performed within hospital setting.
 - (c) Application fee
3. Upon completion of verified application and supporting documentation, the following procedure will be followed:
 - (a) After review by the appropriate clinical department member and/or nurse executive, the application will be forwarded to the Credentials & Qualifications Committee for review and recommendation to the Medical Council.
 - (b) Recommendation by the Medical Council for approval or denial of membership and clinical privileges will be forwarded to the Board of Commissioners for consideration at their next regularly scheduled meeting.
 - (c) The Administrator and/or his designee will advise the applicant of the Board of Commissioner's decision. If the applicant is approved, a copy of the delineation of privileges will be included in this letter.
4. Reevaluation of each Allied Health Professional will be accomplished as follows:
 - (a) Upon the anniversary date of the original appointment, a reappointment application will be completed and submitted to update fully any pertinent information including continuing education, licensure, certifications, etc. A reappointment application shall be completed and submitted every other year thereafter. If the Allied

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Health Professional is physician sponsored, a completed recommendation by the sponsor is required for each evaluation.

- (b) The Credentials & Qualifications Committee shall review said reappointment applications and make such adjustments in privileges and scope of duty as may be deemed appropriate based upon the re-evaluation.

D. Responsibilities and Limitations

Responsibilities and limitations are placed on all Allied Health Professionals and shall include the following

1. The Allied Health Professional may not admit or discharge patients.
2. When authorized by the delineation of privileges, the Allied Health Professional may make appropriate entries on the patient's chart and complete all necessary clinical records as defined by state licensure, statute and by the Medical Staff Bylaws and these Rules & Regulations.
3. The services of all Allied Health Professionals shall be controlled by the specific privileges granted at the time of appointment and at the time of reappointment by the Board of Commissioners.
4. Entries made in the patient's medical record by a physician directed Allied Health professional shall be reviewed by the responsible physician and a statement recorded in the chart that such entries have been reviewed during his/her daily visit.
5. Granting of privileges to a physician-directed Allied Health Professional does not constitute permission to treat any illness or pathologic finding except under the treatment plan established by the attending sponsoring Medical Staff member, who remains responsible at all times for the total care of his/her patient. Pursuit of professional activities shall always be in accord with existing laws defining the scope of such practices.
6. Physician-directed Allied Health Professionals approved for service shall be individually assigned to the Medical Staff department of the sponsoring Medical Staff member. Such individuals shall carry out their professional activities subject to departmental policies and procedures. Allied Health Professionals are not eligible to vote upon departmental matters, nor hold office or attend meetings unless by special invitation.

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7. Violation by either the attending sponsoring Medical Staff member or his/her sponsored Allied Health Professional of any of these regulations may result in loss of privileges granted to each of them. Allied Health Professionals are responsible to adhere to hospital policy and standards of practice as well as Medical Staff Rules and Regulations. Due to the specialized nature of some Medical Staff departments, minor exceptions to the foregoing may be established in departmental guidelines, subject to approval of the Medical Council.

E. Duties and Privileges of Sponsoring Physician and Allied Health Professionals

1. It shall be the duty of the physician or physicians who employ or otherwise utilize an Allied Health Professional at the hospital to supervise such employee or AHP.
 - a. Supervision means reasonable supervision and control. Except in cases of emergency, supervision shall require the easy availability or physical presence of the licensed physician for consultation or direction of the Allied Health Professional.
 - b. The supervising physician shall, in all cases, designate another physician, who is a member of the Medical Staff, to assume responsibility for the Allied Health Professional when he is not immediately available.
 - c. It shall be the duty of the supervising physician to inform his/her patient that a portion of his or her treatment may be given by an Allied Health Professional. This information shall be communicated to the patient prior to the institution of any treatment by an Allied Health Professional.
 - d. Disciplinary Proceedings
 1. Any unidentified problem with an Allied Health Professional ("AHL") shall be in writing and shall be reviewed by the appropriate Department. If the Department's review so warrants, the AHP and supervising physician shall be afforded the opportunity to provide additional input and to respond to the issues raised.
 2. If action must be taken immediately in the interest of patient care, the Department Chair, in consultation with the Chief of Staff and/or Administrator, may suspend any or all privileges granted to the AHP.

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3. Upon the completion of its review, the Department shall issue a recommendation, in writing, regarding resolution of the issue(s) raised. If the Department's recommendation would adversely affect the AHP's privileges, the AHP may request a hearing before an Ad Hoc Committee comprised of three (3) members of the Department. The members of the Ad Hoc Committee, which shall not include the AHP's supervising physician, shall be appointed by the Department Chair.
4. The Departmental Ad Hoc Committee shall conduct a hearing within forty-five (45) days of receipt of the AHP's request for hearing. At least ten (10) days before the date of the hearing, the AHP shall be given written notice, via registered mail, of the date, time and place of the hearing. At the hearing before the Departmental Ad Hoc Committee, the AHP, or his or her representative, will be permitted to present evidence, to call and cross-examine witnesses, and to address the Committee. The Departmental Ad Hoc Committee shall operate under such rules and procedures for hearings as are reasonably necessary to ensure an orderly, fair and impartial proceeding in which all facts relevant to the AHP privileges may be heard.
5. The Departmental Ad Hoc Committee shall render a written decision, including a statement of the basis for its decision, within thirty (30) days of the conclusion of the hearing, and shall provide written notice of its decision to the AHP via registered mail.
6. If the AHP disagrees with the decision of the Departmental Ad Hoc Committee, he or she may appeal that decision to the Medical Council within fifteen (15) days of receipt of the Departmental Ad Hoc Committee's decision. The Medical Council shall meet to consider the Allied Health Professional's appeal within thirty (30) days of receipt of the AHP's request for appeal. Written notice of such hearing shall be sent to the AHP by registered mail not less than ten (10) days before the hearing date. The notice shall provide the date, time and place of the hearing, and shall inform the AHP that he or she may be represented by counsel at the hearing and will be afforded the opportunity to present such evidence as might demonstrate to the Medical Council that the AHP is entitled to the privileges previously conferred.

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7. The Medical Council shall operate under such rules and procedures for hearings as are reasonably necessary to ensure an orderly, fair and impartial proceeding in which all facts relevant to the AHP privileges may be heard.
8. The Medical Council shall, within thirty (30) days after the conclusion of the hearing, render a written decision and shall notify the AHP of its decision by registered mail. The decision of the Medical Council shall be final and binding on all parties, and shall be reported to the Board of Commissioners.
9. If the AHP is providing services to a contract or employment with the District, or pursuant to physician sponsorship, the termination of such contract, employment or sponsorship shall result in the automatic termination of the AHP's privileges, and the AHP shall have no right to a hearing, review or appeal of such action.

XII. RULES FOR HOUSE STAFF - INTERNS AND RESIDENTS

- A. The House Staff (interns and residents) shall consist of physicians who have received an appointment at the North Broward Hospital District ("District") for training purposes at either the intern or resident level.
- B. Applications for appointment to House Staff at the District shall be made to the specific residency program of the District.
- C. House Staff members will admit patients only under the name of the attending physician.
- D. House Staff, as part of their training, may participate in direct patient care under the direction and supervision of the patient's attending physician.
- E. House Staff are postdoctoral and are permitted to practice medicine only to the extent of their licenses issued by appropriate Florida Medical Licensure Boards or within the context of their respective training program. They are legally permitted to function within the training institution, bound only by the restraints of either the program or the attending physician. Their activities are supervised.

Medical Records: The House Staff may complete any portion of the medical record. History and Physical, Operative Reports, and Discharge Summaries must be countersigned by the attending physician. The supervising Medical Staff member

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may change a statement made in the record by the resident and shall initial the change.

Orders: The House Staff may write orders. These orders may be followed immediately and need not be countersigned.

- F. Teaching physicians, whether acting pursuant to affiliation agreements with the University of Florida, Nova Southeastern University, or similar education institutions, or as designated agents of the District, shall have the duty and obligation to teach, train and supervise House Staff of the District assigned to their respective Departments and Clinical Sections in accordance with the policies, procedures and requirements of the District, the American Council on Graduate Medical Education and the American Osteopathic Association.

XIII. MEDICAL STUDENTS

Medical students are predoctoral and as such, are not licensed. Therefore, all of their activities must be under the direct supervision of the teaching physician. Medical students have no legal status as healthcare providers. Medical students' examinations and assessments must be duplicated by the attending or teaching physician and the medical student's examinations and assessments may be entered by the medical student only in a separate section of the medical chart entitled, "Medical Student Notations--Not a Part of the Permanent Medical Record." Medical students may not initiate orders. The attending or teaching physician must write his or her own notes concerning the medical student's examination and assessment in the appropriate permanent section of the medical chart, and shall not countersign any of the notations by the medical student which appear in the "Medical Student Notations" section.

XIV. PSYCHOLOGY INTERNS

Psychology interns are predoctoral and as such are not licensed; therefore, all of their activities must be under direct supervision of the teaching psychologist. They may write on the chart in any capacity; however, all of the notations must be countersigned by the attending psychologist. They act as "scribes" ; but may not initiate orders. Consequently, no order that is written by a psychology intern will be followed until it is countersigned by the supervising psychologist.

XV. RULES FOR CONTINUING EDUCATION

Continuing education rules are as follows:

1. The Medical Staff is encouraged to attend continuing medical education programs held at the District hospitals, including those presented at departmental meetings.

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2. Non-District hospital educational efforts consistent with American Medical Association (AMA) or American Osteopathic Association (AOA) standards and with CME licensure requirements which are relevant to the facilities of the District, i.e., which shall relate, at least in part, to the type and nature of care offered by hospitals of the District, or to the findings of performance-improvement activities, may be substituted, at the discretion of the medical staff.
3. The degree of participation of each staff member shall be documented for both in-house and outside the hospital continuing education programs.
4. Information on attendance and the program shall be incorporated into each staff member's credentials file for evaluation at the time of reappointment/reappraisal.

XVI. GRADUATE MEDICAL EDUCATION COMMITTEE

A. Committee Role

The Graduate Medical Education Committee (GMEC) oversees matters concerning residency programs, including the coordination and development of District teaching faculty and the educational processes.

B. Committee Composition

The GME Committee reports to the Medical Council of Broward General Medical Center on a quarterly basis via the Director of Medical Education and the Associate Medical Education Program Director. The Committee is composed of the Director of Medical Education, the Associate Medical Education Program Directors, the Residency Program Directors and the Rotation Coordinators from the Departments of Medicine, Obstetrics and Gynecology, Pediatrics, Surgery and Emergency Medicine, who will be appointed for a four year term by the Chief of Staff of Broward General Medical Center, the DME and the Chief of the respective department. In addition, there will be one (1) representative on the Committee from each Medical Center participating in the medical education program. The Chief of Staff of Broward General Medical Center will appoint two additional members from the Medical Staff at BGMC to sit on the Committee.

The GME Committee will receive a budget. The GME Committee members are compensated for their activity monitoring the residency programs by the North Broward Hospital District. The GME Committee will oversee the compensation for the medical teaching service.

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A summary of the results of the activities of the residents, the evaluations of the rotations and attending physicians will be reported to the GME Committee on a quarterly basis by the Program Directors.

The Medical Center representatives are responsible for communicating the activities of the residency programs to their respective Medical Councils. A summary from the Medical Councils is presented to the Board of Commissioners.

XVII. AMENDMENT OF RULES

Neither the Medical Staff nor the Board of Commissioners may unilaterally amend these Rules and Regulations. Amendments to the Rules and Regulations shall follow the procedure outlined in the Bylaws of the Medical Staffs of the North Broward Hospital District.

When significant changes are made in the Rules and Regulations, those individuals with clinical privileges are provided with a copy of the approved document.

