

THE  
RULES AND REGULATIONS  
OF  
THE RHODE ISLAND HOSPITAL MEDICAL STAFF

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# MEDICAL STAFF RULES AND REGULATIONS

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## MEDICAL STAFF RULES AND REGULATIONS

### PREAMBLE

The following Rules and Regulations for the Rhode Island Hospital Medical Staff (the “Medical Staff”) describe specific policies and procedures of the Medical Staff and define in greater specificity, provisions of the Medical Staff Bylaws. All members of the Medical Staff are expected to comply with the provisions contained in these Rules and Regulations and to follow the Rhode Island Hospital (the “Hospital”) values of respect for every individual and a commitment to quality services.

These Rules and Regulations of the Medical Staff are designed to augment and/or clarify requirements related to clinical practice at the Hospital. Care is also governed by federal and state statutes and regulations; standards and conditions of accreditation organizations; the Conditions of Participation of the Centers for Medicare and Medicaid Services (CMS); and Hospital policies and procedures. Where conflicts in requirements arise, these Rules and Regulations are superseded by external regulatory requirements. When conflicts exist between regulatory agency requirements, the more stringent requirement is followed. The Rules and Regulations of the Medical Staff must conform to federal and state requirements, but they may also have additional requirements as set forth by the Medical Staff and the Hospital’s Board.

Throughout these Rules and Regulations, the term “Designee” refers to a resident, fellow, physician’s assistant, nurse practitioner, or CRNA, designated by an attending physician to perform duties as appropriate.

Whenever a patient is admitted or transferred to another service, direct verbal communication must occur between the attending physician or his/her Designee in the Emergency Department or on the transferring service and the attending physician or his/her Designee on the accepting service, to ensure appropriate and safe transition of care.

### I. ADMISSION OF PATIENTS

1. A patient meeting admission criteria may be admitted to the Hospital by any member of the Medical Staff who has been granted admitting privileges. All physicians shall be governed by the admitting policies of the Hospital. The attending physician must abide by the tenets of the Utilization Management Plan.
2. A member of the Medical Staff shall be responsible for the medical care and treatment of each patient in the Hospital. Whenever these responsibilities are transferred to another specialty service, a note covering the transfer of responsibility shall be entered in the patient's medical record. A corresponding order shall also be entered at the time of the transfer.
3. Except in an emergency, no patient shall be admitted to the Hospital until a provisional diagnosis or valid reason for admission has been stated. In the case of any emergency, such statement shall be recorded as soon as possible.
4. The history and physical examination must clearly justify the reason(s) for the patient to be admitted to the Hospital. These findings must be recorded within twenty-four (24) hours of admission.
5. A patient admitted to the Hospital may request any appropriately privileged physician from the applicable specialty department or section as an attending. Where no such request is made, or the

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requested physician is unavailable, a member of the Active Staff on-call for the specialty department, division, or Division of Hospitalist Medicine will be assigned to the patient. The Chief, or his/her Designee, of each department or division shall provide a schedule for such call coverage assignments.

6. For patients admitted through the Emergency Department, the Emergency Department attending physician will make an initial determination of the most appropriate specialty service for the patient. The attending on-call or his/her Designee for the selected specialty service will be contacted regarding the recommended admission. The contacted attending/Designee always has the opportunity to directly evaluate the patient and actively participate in the disposition decision. If that admitting attending/Designee feels that a different specialty service should admit the patient, it is that attending's responsibility to contact the other specialty's admitting attending to discuss the admission or the need for close consultation. The second attending also has the opportunity to directly evaluate the patient and actively participate in the disposition decision. If the admitting attendings disagree about which service is the more appropriate admitting service for the patient, and the attendings cannot reach a mutually acceptable agreement within sixty (60) minutes of the initial contact from the Emergency Department attending, the Emergency Department attending will have the authority to direct the admission to the service that he/she deems to be more appropriate. That selected attending (or Designee) will admit the patient, directly evaluate the patient, or arrange for the transfer of the patient to an appropriate accepting attending without further delay. While the patient remains in the Emergency Department after an admitting order is written, the Emergency Department staff should work collaboratively with the admitting physician/Designee to ensure that appropriate care is administered while the patient is in the Emergency Department.
7. Each physician must assure timely, adequate professional care for his/her patients in the Hospital by being available or having pre-arranged coverage available with equivalent clinical privileges. Failure of an attending physician to meet these requirements could result in loss of clinical privileges through the Medical Staff investigation and intervention process.
8. Patients admitted to the Hospital should be seen by the attending physician or his/her Designee as promptly as necessary to ensure that appropriate evaluation and treatment are initiated. The length of time which can safely elapse between the patient's admission and the initial exam is dependent on the patient's diagnosis and condition. It is the attending physician's responsibility to judge how urgently the patient must be seen or arrange surrogate care, if necessary, in order to meet care requirements. The attending physician or another attending physician from the same service must evaluate the patient within twenty-four (24) hours of admission.
9. Admissions to a Specialty Care Unit: Admissions to a Specialty Care Unit are governed by policies developed by the designated Department Chief in conjunction with Hospital Administration and subsequently approved by the Medical Executive Committee. If any questions as to the validity of the admission to or the discharge from a Specialty Care Unit should arise, that discussion and any subsequent determination is to be made through consultation with the Medical Director of the Specialty Care Unit and/or the Chief of the appropriate Department(s), or a duly authorized Designee.
10. Patient entry into the Hospital will occur according to the following priorities:
  - a. Emergency Department Inpatient Admissions.

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- b. Pre-operative Inpatient Admissions, including patients already scheduled for surgery. If it is not possible to handle all such admissions, the Chief of the respective surgical department/division may consult with Nursing Administration to decide the urgency of any specific admission.
- c. Direct Admissions From Office Settings. These patients may need to be routed through the Emergency Department if beds are not immediately available or if medical stabilization is necessary.
- d. Conversion From Observation Status. Patients who have been placed on observation status and are determined to require a higher level of care may be admitted to the Hospital for further evaluation and treatment.

### II. TRANSFER OF PATIENTS

- 1. No patient shall be transferred without consultation with and approval by the attending physician responsible for that patient.
- 2. Patient transfers from another facility will adhere to the following guidelines:
  - a. The attending physician who accepts a patient in transfer from another institution is responsible for the disposition of the patient upon arrival at the Hospital. Prior to accepting the patient, the attending physician or his/her Designee must determine that a bed is available. If, after evaluation, the accepting physician finds that the patient would be better served on another service, that physician is responsible to arrange for the transfer of care to that service.
  - b. If the attending physician who accepts a patient in transfer from another institution determines that the patient should be accepted through the Emergency Department for additional evaluation or stabilization, the accepting attending physician must communicate with the Emergency Department attending physician and must receive his/her agreement to accept the patient in the Emergency Department. After the Emergency Department evaluation, the Emergency Department attending or his/her Designee will contact the admitting attending or his/her Designee prior to admission or transfer from the Emergency Department to an inpatient care unit.
- 3. Patient transfers to another facility will adhere to the following guidelines:
  - a. Patients shall be admitted for the treatment of any and all conditions and diseases for which the Hospital has facilities and personnel. When it is determined, based on the patient's assessed need and the Hospital's capabilities, that the transfer of a patient to another facility is in the patient's clinical best interest, or when a request for a transfer arises from a patient or family member's request, the Hospital and/or the attending physician shall assist the patient in making arrangements for care at another facility as long as the patient is sufficiently stable for transfer.
  - b. If the patient is to be transferred to another health care facility, the transferring attending physician or his/her Designee shall enter all pertinent information into the patient's medical record prior to the transfer. A patient shall not be transferred to another medical care facility until the receiving facility has agreed to accept the patient and the patient is

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considered sufficiently stable for transport. Clinical records of sufficient content to ensure a successful transition of care shall accompany the patient on transfer.

### III. DISCHARGE OF PATIENTS

1. Patients shall be discharged only by order of the attending physician or his/her Designee. Should a patient leave the Hospital against the advice of the attending physician or his/her Designee, a notation of the incident shall be made in the patient's medical record. The patient shall be requested to sign a Leave Against Medical Advice (AMA) form.
2. The Medical Staff will actively participate in the discharge planning process.
  - a. Discharge planning shall be an integral part of the hospitalization of each patient and shall commence as soon as possible after admission. The discharge plan, which includes an assessment of the availability of appropriate services to meet the patient's needs after hospitalization, shall be documented in the patient's medical record. The discharge of a patient to another level of care, to different professionals, or to a different setting is based on the patient's assessed needs and the Hospital's capabilities. The discharge planning process shall address the reason(s) for admission; the conditions under which discharge can occur; shifting responsibility for a patient's care from one clinician, organization, or service to another; mechanisms for internal and external transfer; and the accountability and responsibility for the patient's safety during transfer of both the organization initiating the transfer and the organization receiving the patient.
  - b. Discharge planning shall include, but not be limited to, the following:
    - i. appropriate referral and transfer plans;
    - ii. methods to facilitate the provision of follow up care including communication of the following to the new organization or provider:
      1. the reason for hospitalization;
      2. the patient's physical and psychosocial status;
      3. a summary of diagnostic studies, care, treatment, and services provided;
      4. medication reconciliation of the patient's home medications with those to be continued at discharge; and,
      5. community resources or referrals provided to the patient; and,
    - iii. information to be given to the patient or the patient's family or other persons involved in the patient's care on matters such as the patient's condition; the reason for transfer or discharge; alternatives to transfer, if any; the anticipated need for continued care, treatment, and services after discharge; arrangements for services to meet the patient's needs after discharge; and written discharge instructions in a form the patient and/or caregiver can understand.

### IV. CRITERIA FOR AUTOPSY

1. In the event of a patient's death while in the Hospital, the deceased shall be pronounced dead by the attending physician or his/her Designee, within a reasonable time. The body shall not be released until an entry has been made and signed in the medical record by a member of the Medical Staff or his/her Designee. Policies regarding the release of the body from the Hospital

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shall conform to state and federal law. The directions in the Death Packet should be followed regarding notifying the New England Organ Bank (NEOB) and/or the Medical Examiner and completion of the death certificate. The attending physician or his/her Designee should document all discussions with the patient's family, the NEOB and the Medical Examiner, if appropriate.

2. Medical Staff Members should secure an autopsy whenever possible. An autopsy may be performed only with a written consent, signed in accordance with state law. All autopsies shall be performed in accordance with Hospital policies and procedures.
3. An autopsy should be requested under the following conditions:
  - a. an unanticipated death for which there is no known medical or surgical condition which can account for or explain the death;
  - b. a death in which there is an unexplained medical or surgical finding(s) for which an autopsy might potentially yield useful information; and,
  - c. a death in which there is significant medical information to be gained for the family, community, or as part of a medical education program (e.g., confirmation of suspected pathologic process(es), evaluation of new or experimental therapeutic regimens, investigation of antemortem diagnostic maneuvers, etc.).
4. Criteria for reporting Hospital deaths to the Rhode Island Medical Examiner are determined by state laws, statutes and regulations. These criteria, outlined in Hospital policy and mentioned below, shall be followed by all staff members. An autopsy may be performed on a reportable death only upon completion of the Medical Examiner's investigation or release of jurisdiction and only if it fulfills one of the above indications.

### V. MEDICAL RECORDS

1. The attending physician shall be responsible for the preparation of a timely, accurate, complete and legible medical record for each of his/her patients within thirty (30) days of a patient's discharge. Each health care record shall be pertinent and current, and shall include all items required by state and federal regulations, accreditation organizations, CMS Conditions of Participation, and other applicable standards as outlined in administrative policies.

Individuals completing patient care summaries and similar record entries will utilize the original source electronic and hard copy documents and laboratory/radiology results when creating medical record entries to ensure that an accurate account of the patient's care is conveyed.

All clinical entries in the health care record shall be accurately dated, timed and authenticated. "Authenticated" shall mean to confirm the accuracy of the content by written signature or electronic identification.

2. History and Physical (H&P): A complete history and physical by an attending physician member of the Medical Staff, or his/her Designee, shall be recorded within twenty-four (24) hours of inpatient admission. The history and physical should include the chief complaint, details of the present illness, including, allergies and medications, and when appropriate, assessment of the patient's emotional, behavioral, and social status. Relevant social and family history, as well as a review of body systems, shall be fully documented. Included shall be impressions drawn from the history and physical examination, and a statement of the impression and plan of treatment.

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When the history and physical is dictated but is not immediately available, a brief summary of the impression and treatment plan shall be placed in the progress notes.

- a. When a patient is admitted for a procedure, the H&P must be complete prior to the procedure.
    - i. Ambulatory Surgery patients shall have a history and physical pertinent to the patient's level of complexity and proposed anesthesia as outlined in Section VII, General Rules Regarding Surgical Care.
    - ii. A pre-operative H&P shall be valid for thirty (30) days.
    - iii. An interim note is required if the H&P was completed more than twenty-four (24) hours prior to the procedure. The interim note must delineate the patient's course since the history and physical was originally completed and must be signed and dated by the physician. An interim note is a statement entered into the medical record, prior to the procedure, by the physician performing the procedure, to indicate that the H&P has been reviewed; any pertinent changes in the history and physical are noted.
  - b. When the history and physical examinations are not recorded and entered into the patient record before an operation, the procedure shall be canceled unless the attending physician states, and subsequently documents in writing, that such a delay would be imminently detrimental to the patient's safety and welfare.
  - c. Further clarification of the H&P requirements is managed by the Medical Record Committee and Hospital policy.
3. Progress Notes: Pertinent progress notes shall be recorded at the time of evaluation, sufficient to permit continuity of care and transferability. Whenever possible, each of the patient's clinical problems should be clearly identified in the progress notes and correlated with specific orders as well as results of tests and treatments. Progress notes shall be written by the attending physician or his/her Designee at least daily. Progress notes should reflect a continuous documentation of the necessity of hospitalization and continuation of care.
4. Pre-Procedure Documentation: Except in emergencies, the following data shall be recorded in the patient's medical record prior to surgery or other invasive procedure, or the procedure shall be canceled:
- a. verification of, the patient's identity, the procedure to be performed, and the site and side of the planned procedure, if applicable;
  - b. medical history and supplemental information regarding drug allergies and other pertinent facts;
  - c. general physical examination, details of significant abnormalities, and evaluation of the capacity of the patient to withstand sedation/anesthesia and the planned procedure/surgery;
  - d. provisional diagnosis;

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- e. laboratory test results, if applicable, including those obtained from sources outside of the Hospital;
  - f. consultation reports if applicable;
  - g. an appropriately completed and signed consent form;
  - h. diagnostic imaging reports, if applicable, including those obtained from sources outside of the Hospital; and,
  - i. other ancillary reports, if applicable.
5. Operative Report/Procedure Note: A detailed operative report or procedure note shall be written or dictated immediately after surgery or other invasive procedure and shall contain the following elements:
- a. name, and, if dictated, medical record number of the patient;
  - b. date and times of the surgery or procedure (start and end times);
  - c. name(s) of the surgeon(s)/proceduralist(s), anesthesia provider(s) and assistants or other physicians who performed procedural tasks (even when performing those tasks under supervision);
  - d. preoperative and postoperative diagnosis(es);
  - e. name of the specific procedure(s) performed;
  - f. type of anesthesia administered;
  - g. any unexpected events or complications, if any;
  - h. a description of the procedure/surgery, surgical techniques, findings, tissues removed or altered, and specimens sent (include estimated blood loss, fluid replacement, use of bloods products, and use of drains);
  - i. surgeons or proceduralists name(s) and a description of the specific significant surgical tasks that were conducted by physicians other than the primary surgeon/physician (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, altering tissues); and,
  - j. prosthetic devices, grafts, tissues, transplants, or devices implanted, if any.

When the operative report is dictated, a brief postoperative note shall be entered in the patient's medical record immediately following the procedure to permit ongoing care until the dictated report is available. The note will contain the following limited information: the name(s) of the primary surgeon(s) and his or her assistant(s), procedure performed and a description of each procedure finding, estimated blood loss, specimens removed, postoperative diagnosis, date, and time of the operation/procedure.

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6. Peri-Operative Anesthesia Documentation:
  - a. Pre-Anesthesia Evaluation: A pre-anesthesia or pre-sedation evaluation (for use of moderate or deep sedation) shall be documented in the medical record of all patients undergoing surgery and shall include, at a minimum, information relative to the choice of anesthesia or sedative for the procedure anticipated and, where relevant, pertinent drug history and other anesthetic experiences.
  - b. Post-Anesthesia Documentation: Post-Anesthesia documentation shall also record the patient's discharge from the post-sedation or post-anesthesia care area by the responsible physician according to discharge criteria, and shall record the name of the physician responsible for discharge. The use of approved criteria to determine the patient's readiness for discharge shall be documented in the medical record. Post-anesthesia documentation shall also include the patient's vital signs, level of consciousness, and all medications (including intravenous fluids).
  - c. Post-Anesthesia Evaluation: A post-anesthesia evaluation shall be documented in the medical record of all patients who have undergone surgery. At least one post-anesthesia note shall describe the presence or absence of anesthesia related complications.
7. Discharge Summary: A discharge summary shall be dictated or written for all hospitalized patients within thirty (30) days of the patient's discharge from the Hospital. The discharge summary shall include the reason(s) for admission, the significant findings, the procedures performed, final diagnosis(es), the condition and disposition of the patient on discharge, the discharge instructions given to the patient and/or family including discharge medications (following medication reconciliation), and provisions for follow-up care, including specific pending tests, studies, or results that require further action. All discharge summaries shall be authenticated by the attending physician.
8. Countersignature Requirements: Other providers whose clinical privileges or status (e.g., medical students) require that notes and/or orders be countersigned will have those designated entries countersigned according to the mechanisms outlined by the applicable policy.
9. Medical Record Deficiencies: Failure to record any of the following within the specified time shall be considered a major deficiency and subject to the suspension policy for delinquent records:
  - a. history and physical examination, within twenty-four (24) hours of patient admission.
  - b. operative report, immediately after surgery.
  - c. consultation report, within forty-eight (48) hours of notification of request.
  - d. discharge summary, within thirty (30) days of patient discharge.
  - e. required record countersignatures within thirty (30) days of patient discharge.

The attending physician is responsible for medical record deficiencies regardless of whether a Designee was assigned to complete them.

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### 10. Medical Record Completion Process:

- a. All procedures shall be followed to ensure that health care records are fully documented within the above defined parameters and in all cases within thirty (30) days following patient discharge in accordance with the Rules and Regulations, the accreditation organizations, the CMS Conditions of Participation, and policies of the Medical Staff and Health Information Services (HIS).
- b. The practice for completion of Medical Records is outlined in the relevant Hospital Information Services (HIS) or Medical Staff policies. These policies specify the actions to be taken if physicians are delinquent in completing the medical record. In addition, these policies allow for serious action to be taken against health care providers who are delinquent in completing the medical records, up to and including suspension and/or termination.
- c. When an entry in a patient's medical record is amended or corrected in any way, the editing physician shall sign, date and time their entry at the point of amendment.

### 11. Confidentiality and Security of Patient and Organizational Information:

- a. Password, E-Signature or Other User Identification: No member of the Medical Staff shall provide or allow another individual to use his/her password, E-Signature or other user identification (hereinafter "password") whether or not such other individual is an authorized user of the Hospital's information systems or patient databases (collectively "information systems"). Each member of the Medical Staff acknowledges that his/her password shall constitute his/her legal signature and shall be accountable for all entries of patient information, orders, and data entered into the Hospital's information systems and all other actions taken as a result of the use of such password. In the event that a member of the Medical Staff reasonably suspects or becomes aware of any unauthorized use or disclosure of his/her password, he/she shall immediately change the password and report such unauthorized use or disclosure to the Hospital's Information Services Department.
- b. Patient Information and Records: Members of the Medical Staff shall access patient information or records through the Hospital's information systems either on-site or remotely only for the following purposes in accordance with state and federal laws and regulations:
  - i. providing health care to the patient or coordinating such care with other health care providers;
  - ii. billing activities and filing claims for reimbursement for patient care;
  - iii. conducting scientific or statistical research, management or financial audits;
  - iv. conducting quality assessments and authorized peer reviews; or,
  - v. performing other administrative duties in accordance with these Bylaws.

All such access and use shall be in accordance with state and federal law and regulations and with applicable Hospital and/or Lifespan policies governing patient data use. Each member of the Medical Staff shall be solely responsible for maintaining the

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confidentiality, security and integrity of all patient information and records acquired by or disclosed to a Medical Staff Member through access to the Hospital's information systems, including without limitation any patient information printed, photocopied, or downloaded to any hard drive, CD/DVD, tape, thumb drive, or other storage device or any portable or wireless devices (smart-phones, electronic notebooks or other electronic devices not yet foreseen).

- c. Peer Review Information: Medical Staff Members shall exercise appropriate confidentiality and security in the preparation, maintenance and control of credentialing, quality assurance and peer review information and documents to ensure that such information and documents are not distributed to individuals or entities other than those specifically authorized by these Bylaws, Rules and Regulations, Hospital policies, or as may be otherwise indicated by the Hospital or Medical Executive Committee.
- d. Proprietary Information: Medical Staff Members shall maintain the confidentiality and security of all of the Hospital's proprietary data, trade secrets, financial information or other confidential information acquired by or disclosed to a staff member in the course of performing his/her obligations pursuant to these Bylaws, Rules and Regulations, or Hospital policies.
- e. E-mail and Internet Usage: Medical Staff Members and their Designees who have authorized access to the Hospital's e-mail system and/or internet service provider shall abide by the Hospital's e-mail and internet usage policies.

### 12. Organized Health Care Arrangement:

- a. Medical Staff Members acknowledge that Rhode Island Hospital is a "Covered Entity" as that term is defined by the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d-1329d-8; 42 U.S.C. 1320d-2) ("HIPAA"), regulations promulgated thereunder ("HIPAA Regulations" or the "Privacy Rule" and the "Security Rule"), and Subsection D of the American Recovery and Reinvestment Act (ARRA) of 2009, more commonly referred to as the Health Information Technology for Economic and Clinical Health (HITECH) Act (Public Law 111-5) and that the Medical Staff is an integral component of the Hospital.
- b. The members of the Medical Staff agree, as may be permitted by HIPAA, HIPAA Regulations, and HITECH, to:
  - i. use reasonable efforts to preserve the security and confidentiality of Protected Health Information that each receives from the other;
  - ii. use and disclose such information to the extent necessary to conduct the activities of the Hospital and to the extent required by these Bylaws, Rules and Regulations, applicable state law; and,
  - iii. comply with the terms of the Hospital's Joint Notice of Privacy Practices, as may be amended from time to time, with respect to Protected Health Information created or received by each other in the course of participating in Hospital activities.

### 13. Official references defining approved abbreviations shall be kept on file in Health Information

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Services (“Medical Records”).

An official list of abbreviations, acronyms, and symbols that will not be used in the Hospital has been developed by the Medical Staff and is also available in the appropriate policy.

### VI. GENERAL CONDUCT OF CARE

1. Consent for Treatment: The Hospital’s Consent for Treatment form shall be signed by or on behalf of every patient admitted to the Hospital at the time of admission. In addition to obtaining the patient's general consent for treatment, a specific consent that informs the patient of the nature of and risks inherent in any special treatment or surgical procedure shall be separately obtained. Appropriate forms for such consent will be adopted with the advice of legal counsel, risk management, and standardized in the facility for both inpatient and outpatient services.
2. Written Patient Orders:
  - a. All orders for treatment shall be in writing or entered in the computerized physician order management system in accordance with approved Medical Staff Rules and Regulations. The expectation is that where and when available, the physician will enter all orders via computerized order entry.
  - b. The physician's orders must be written clearly, legibly, and completely. Orders that are illegible or improperly written will not be carried out until rewritten. Where applicable, this shall include a recognizable signature. All orders must be dated and timed, and countersigned where clinical privileges and/or status (e.g., medical students) dictate.
3. Verbal Patient Orders:
  - a. Except in urgent/emergent situations, verbal orders should not be utilized if the physician is physically present in the Hospital and/or accessible to a computer or like device capable of transmitting an electronic order entry. A verbal order, regardless of the mode of transmission of the order, shall be considered to be in writing if dictated to a duly authorized person functioning within his or her scope of competence and countersigned by the responsible covering physician. The order shall be electronically entered upon receipt and shall include the name of the individuals who gave and received the order. The qualified personnel taking the verbal order shall read it back aloud to the ordering physician in order to verify the verbal order as transcribed in the patient’s record.
  - b. Only appropriately licensed personnel authorized by state agencies and the Hospital administrative policies may accept verbal orders related to their respective scopes of practice.
  - c. All verbal orders must be appropriately authenticated by a physician involved in the care of the patient no later than the end of the next calendar day. The verbal order may be countersigned by the ordering physician, attending, or covering physician, or his/her Designee.
  - d. Authentication of special verbal orders such as Orders for Resuscitative Management (e.g., Do Not Resuscitate orders), for the use of restraints, and/or seclusion, shall follow applicable Hospital policy.

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4. Suspension of Do Not Resuscitate Orders: Any patient who is taken to the Operating Room or a Procedural area will have a suspension of a Do Not Resuscitate Order. The suspension is reviewed after the procedure and reinstated as appropriate.
5. Medication Orders:
  - a. All drugs and medications administered to patients shall be those listed in the latest edition of the United States Pharmacopoeia, of the National Formulary or of the American Hospital Formulary Service. Drugs for 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, the Institutional Board, and all regulations of the Federal Drug Administration.
  - b. A method to control the use of dangerous and toxic drugs shall be developed by the Medical Staff through its Pharmacy and Therapeutics Committee.
  - c. A method for control of drugs brought into the Hospital by patients shall be established by the Pharmacy and Therapeutics Committee.
6. Consultations:
  - a. Any qualified attending physician with clinical privileges in the Hospital can be called for consultation within his/her area of expertise.
  - b. Consistent with Hospital policy, the attending physician or his/her Designee is primarily responsible for requesting a consultation when indicated and for calling in a qualified consultant and making a record of the practitioner to consultant communication. The physician to physician consultant communication shall be documented in the medical record and shall indicate the reason(s) for the consultation request and its urgency. Consultations for hospital services such as physical therapy and nutrition services may be entered as orders in the electronic medical record.
  - c. Each consultation report shall contain a written or dictated opinion by the consultant that reflects an actual examination of the patient and review of the patient's medical record(s). The report shall be made a part of the current medical record within forty-eight (48) hours of request. All consultation reports shall be authenticated by the attending consultant physician.
  - d. Except in emergency situations, when operative procedures are involved, the consultation report shall be recorded prior to the operation or procedure.
  - e. When the consultation report is dictated, a brief summary of the consultant's impression and recommendations shall be entered in the patient's medical record to permit ongoing care until the dictated consultation report is available.

## VII. GENERAL RULES REGARDING SURGICAL CARE

1. Surgery: Except in significant emergencies, the pre-operative diagnosis, valid history and physical, signed surgical consent, anesthesia pre-operative assessment, and required laboratory and other pre-operative testing must be recorded in the patient's medical record prior to any surgical procedure. If these are not recorded, the operation shall be canceled unless failure to

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operate would result in serious harm to the patient and this imminent risk is documented in the medical record. For elective cases, all of these items except consents must be available in the pre-operative chart at least forty-eight (48) hours prior to the scheduled procedure. If circumstances require, the consent can be completed the day of the procedure.

- a. A full H&P by the attending physician or his/her Designee is required for all in-patients regardless of ASA classification or type of anticipated anesthesia.
  - b. An abbreviated H&P can be performed for Ambulatory Surgery patients based on the patient's level of complexity and proposed anesthesia.
  - c. The clinical evaluation required for moderate sedation cases is delineated in the Hospital's Sedation and Analgesia Policy.
  - d. An abbreviated evaluation can be performed for minor procedures conducted in Surgical Services under local anesthesia. The evaluation must document the patient's history pertinent to the planned procedure, the medical necessity of the procedure, pertinent other medical history including allergies and medications, and a physical exam of the area in question.
  - e. In any emergency, the physician shall make at least an explanatory note regarding the patient's condition prior to the start of the procedure, or when delay would place the patient at risk, the explanatory note will be documented as soon as safely possible.
2. Dental Care: A patient admitted for dental care is the dual responsibility of the dentist and a physician member of the Medical Staff if the dentist does not have admitting privileges. This caveat similarly applies to a patient undergoing an ambulatory procedure for which the dentist does not have clinical privileges to perform the required history and physical.
- a. It is the responsibility of the dentist (or his/her dental resident Designee) to provide:
    - i. a detailed dental history justifying the hospital admission or surgical procedure;
    - ii. a detailed description of the examination of the oral cavity and a pre-operative diagnosis;
    - iii. a complete operative report, describing the findings and technique. In cases of extraction of teeth, the dentist shall clearly state the number of teeth and fragments removed;
    - iv. progress notes as are pertinent to the oral condition; and,
    - v. a clinical summary at discharge.
  - b. It is the responsibility of the physician (or his/her Designee) to provide:
    - i. a medical history pertinent to the patient's general health;
    - ii. a physical examination to determine the patient's condition prior to anesthesia and surgery and medical clearance to proceed; and,

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- iii. if admitted, supervision of the patient's general health status while hospitalized.
  - c. Exception: If the procedure is to be performed under local anesthesia, the dentist may provide the abbreviated, general medical history and physical pertinent for the procedure.
3. Podiatric Care: A patient admitted for podiatric care is a dual responsibility involving the podiatrist and a physician member of the Medical Staff. The dual responsibility similarly applies to a patient undergoing an ambulatory procedure for which the podiatrist does not have clinical privileges to perform the required H&P.
- a. It is the responsibility of the podiatrist (or his/her Designee) to provide:
    - i. a detailed podiatric history justifying the hospital admission or surgical procedure;
    - ii. a detailed description of the examination of the feet and a pre-operative diagnosis;
    - iii. a complete operative report, describing finding(s) and technique(s). (All tissue shall be sent to the Hospital Pathologist for examination);
    - iv. progress notes as are pertinent to the condition of the feet; and,
    - v. a clinical summary at discharge.
  - b. It is the responsibility of the physician (or his/her Designee) to provide:
    - i. a medical history pertinent to the patient's general health;
    - ii. a physical examination to determine the patient's condition prior to anesthesia and surgery and medical clearance to proceed; and,
    - iii. if admitted, supervision of the patient's general health status while hospitalized.
  - c. Exception: If the procedure is to be performed under local anesthesia, the podiatrist may provide the abbreviated, general medical history and physical pertinent for the procedure.
4. Informed Consent to Care:
- a. A written and signed informed consent shall be obtained prior to an operative or other invasive procedure except in those situations wherein the patient's life is in jeopardy and suitable signatures cannot be obtained due to the condition of the patient.
  - b. In emergencies involving a minor or unconscious patient from whom consent for surgery or the procedure cannot be immediately obtained from parents, guardian or next of kin, these circumstances shall be fully explained on the patient's medical record. A confirmatory consultation in such instances may be desirable before the emergency operative procedure is undertaken if time permits.
  - c. Specific procedures related to obtaining informed consent are delineated in Hospital policy.

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- d. Should a second operation or invasive procedure be required during the patient's stay in the Hospital, a second consent shall be obtained. If two or more specific procedures are to be carried out at the same time and this is known in advance, they may all be described and consented to on the same form.
5. Anesthesia Record: The anesthesia provider shall maintain a complete anesthesia record to include evidence of pre-anesthesia evaluation and post-anesthesia follow-up of the patient's condition.
6. Administrative processing of all body fluids and tissue that are to be tested, whether at the Hospital or at some other testing site, shall occur through the Lifespan Laboratory.
7. All tissues removed during a surgical procedure shall be sent to the Hospital Pathologist who shall make such examination as he/she may consider necessary to arrive at a tissue diagnosis. His/her authenticated report shall be made a part of the patient's health care record.
8. At the discretion of the surgeon, the following specimens may be exempt from pathologic examination:
  - a. arthroscopic joint debridement specimens and articular fragments from arthrodeses;
  - b. bunions;
  - c. cataracts;
  - d. cosmetic/plastic surgery specimens, other than those from the breast;
  - e. debridement of necrotic tissues;
  - f. fingernails or toenails;
  - g. portions of bone and ligament removed to enhance exposure;
  - h. scars;
  - i. teeth; and,
  - j. varicose veins.
9. At the discretion of the surgeon, the following specimens may be submitted for gross examination only: foreign objects; orthopedic hardware and calculi (unless chemical analysis is requested).

### VIII. GENERAL RULES REGARDING EMERGENCY SERVICES

1. Record of Emergency Care: An appropriate medical record shall be kept for every patient receiving emergency service. The record shall include:
  - a. identifying patient information;
  - b. information concerning the time of the patient's arrival, means of arrival and who

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- provided transport;
- c. pertinent history of the injury or illness including details relative to first aid or emergency care given to the patient prior to arrival at the Hospital;
  - d. prescription of significant clinical, laboratory and diagnostic imaging findings;
  - e. diagnosis(es);
  - f. treatment provided in the Hospital;
  - g. condition(s) of patient on discharge or transfer and whether the patient left against medical advice; and,
  - h. final disposition, including instruction(s) given to the patient, and/or family member as well as designated care giver.
2. Each patient's medical record shall be signed (or electronically authenticated) by the physician(s) who provided the patient care.
  3. The Emergency Department attending physician or his/her Designee shall decide when the services of a specialist are required for the patient.
  4. Consistent with local, state and federal requirements, the following suspected abuses must be reported immediately:
    - a. suspected abuse or neglect of a child must be reported immediately to the Department of Children, Youth and Families;
    - b. suspected abuse of anyone sixty (60) or older must be reported to the Department of Elderly Affairs;
    - c. suspected abuse of any resident of a long term residential care facility, regardless of age, must be reported to the Department of Health; and,
    - d. any suspicion of domestic violence must be reported to the local police.
  5. When the Emergency Department requests a consultation from an attending physician or clinical service:
    - a. The attending physician or his/her Designee is expected to respond by telephone to pages from the Emergency Department within thirty (30) minutes.
    - b. Physicians who are on-call are expected to stay within a reasonable proximity to the Hospital such that they can be physically present within thirty (30) minutes after responding to a page. See Hospital policies for on-call details for the Emergency Department.
    - c. Attending physicians who request other attending physicians to assume all or part of their scheduled on-call responsibilities must be certain that the physician has comparable privileges at the Hospital and notify the Hospital paging operator of the schedule change.

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- d. Physicians are expected to respond regardless of a patient's financial status or insurance coverage.
  - e. It is the expectation that those who are on-call to cover the Emergency Department will make themselves available to see patients in follow-up when, in the judgment of the Emergency Department physician, it is an important component of Emergency Department care. Emergency Department patients should have easy access for necessary follow-up care that is not subject to unreasonable financial or scheduling barriers.
6. The Medical Staff will support and fully participate in the Hospital's Emergency Preparedness Plan.

### IX. MISCELLANEOUS

1. Expanding Staffing Obligations: If a Department Chief needs to invoke one or more of the Active Staff obligations delineated in Section 2.2.4 for members of the Courtesy Staff in accordance with Section 2.3.4, he/she shall forward his/her plan to the Medical Executive Committee for approval. In the event immediate action is necessary, the officers of the Medical Executive Committee shall review and act upon the Department Chief's plan until the next meeting of the full Medical Executive Committee.
2. Medical Staff Dues and Application Fees: The Medical Executive Committee will determine the annual dues and fees as required during the routine course of Medical Executive Committee business and these will be delineated in the associated Credentials Manual.
3. The Miriam Hospital Meetings: A physician who fulfills the meeting attendance requirements for staff membership at The Miriam Hospital will be considered to have fulfilled the requirements for meeting attendance at Rhode Island Hospital.

### X. COMMITTEES

1. Bylaws, Rules and Regulations Committee:
  - a. The Bylaws, Rules and Regulations Committee shall receive from the Medical Executive Committee all proposed new bylaws, rules, regulations and amendments to existing rules for the purpose of considering, developing and revising the existing Bylaws, Rules and Regulations. It shall maintain an up-to-date copy of all Bylaws, Rules and Regulations currently in effect.
  - b. All proposals for new or amended rules and regulations or amendments presented to the Medical Executive Committee shall be transmitted to the Chairman of the Bylaws, Rules and Regulations Committee for the implementation of its duty as set forth in the preceding paragraph.
  - c. The Committee shall consist of no less than four (4) physicians appointed from departments identified under the Medical Staff Bylaws' Article V, Section 5.6. In addition, the Committee shall include one Hospital administrator.
  - d. The Committee shall meet as required. The Committee shall meet at least once a year; it shall carefully review the Bylaws, and Rules and Regulations, and submit a report in

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writing to the Medical Executive Committee through the President of the Medical Staff of any needed changes.

### 2. Cancer Committee

- a. The Cancer Committee shall be charged with the responsibility for monitoring the entire spectrum of care given to cancer patients at the Hospital. The Committee shall be responsible for issuing an annual report.
- b. The Committee's membership shall include representatives from Medical Oncology, Radiation Therapy, Diagnostic Imaging, Hematology, Pediatric Oncology, Pharmacy, Pathology, Surgery, Oncology Nursing, Nursing Service, Social Work, Cancer Registry, and other departments or divisions as may be deemed necessary. Meetings shall be held monthly. The Committee shall report to the QMIC.
- c. The activities and composition of the Committee shall be consistent with the philosophy and standards established by the American College of Surgeons' Commission on Cancer for an accredited Cancer Program.

### 3. Cardiac Arrest Committee:

- a. The Cardiac Arrest Committee shall plan for the management of cardiac arrests in the Hospital, and assess the results of resuscitation efforts and make recommendations as necessary. The Committee shall report to the QMIC.
- b. The Committee shall meet at least quarterly and consist of representatives from Medicine, Nursing, Surgery, Respiratory Therapy, and Emergency Medicine.

### 4. Committee on Protection of Human Subjects:

- a. The Committee on Protection of Human Subjects shall be responsible for the protection of the rights of the human subjects of research and the assurance of informed consent of such human subjects to participation in research by reviewing and approving all individual research projects involving human subjects proposed for performance within the Hospital.
- b. This Committee shall meet the requirements and perform the functions of an Institutional Review Board as required by federal law. Membership shall consist of representatives of the various medical and medically related Hospital departments, and shall also include representation of the public-at-large as required by law. The Committee shall meet as required. The Committee shall report to the QMIC.

### 5. Continuing Medical Education Committee:

- a. The Continuing Medical Education Committee shall be responsible for coordinating the continuing medical education effort at the Hospital to ensure compliance with applicable standards of the Rhode Island Medical Society and the Accreditation Council for Continuing Medical Education.
- b. The Continuing Medical Education Committee chair shall be appointed by and report to the Medical Executive Committee.

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### 6. Ethics Committee:

- a. The Committee shall assist health care providers, administrators, patients, and families in resolving problems with ethical dimensions. The Committee's activities shall include education, development of policy and guidelines, and case review and consultation.
- b. The Committee shall include representatives from the Medical Staff, Nursing, Clinical Social Work, Hospital Administration, Risk Management, the clergy, the legal profession, ethicists/philosophers, and the Board.
- c. The Ethics Committee shall meet at least quarterly, or more often as needed for case consultation. The Committee shall report to the Medical Executive Committee at least annually on their work.

### 7. Graduate Medical Education Committee:

- a. The Graduate Medical Education Committee shall oversee all graduate medical education at Rhode Island Hospital and at all sites to which residents/fellows of Rhode Island Hospital rotate.
- b. The Committee shall monitor and ensure compliance of individual residency and fellowship programs and the Hospital with regards to the rules and regulations of the Accreditation Council for Graduate Medical Education (ACGME) and other accreditation bodies. The membership shall be governed by the policies and procedures of the Graduate Medical Education Committee, the ACGME, and the Office of Graduate Medical Education.
- c. The Committee shall report to the Medical Executive Committee on a quarterly basis.

### 8. Infection Control Committee:

- a. The Committee shall work to ensure an acceptably low level of infectious hazard for patients Hospital personnel, and visitors through the design, administration, and regular review of a program of infection prevention and control.
- b. The Committee shall include representative members from, but not limited to, the following departments: Medicine, Surgery, Pediatrics, Pharmacy, Nursing, and Hospital Administration. The Committee shall also include the Director of Microbiology or his/her Designee, and Nursing representatives from their Department of Epidemiology and Infection Control.
- c. The Committee shall meet at least quarterly. The Committee shall report to the QMIC.

### 9. Medical Records Committee: This Committee shall set policy and manage the accountability of the Medical Staff for the medical records of Hospital patients, and works with the Health Information Services to ensure the integrity of the medical record and compliance with policy. The Committee shall report to the QMIC.

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### 10. Pharmacy & Therapeutics Committee:

- a. The Committee shall be responsible for development and implementation of standards and policies for the medication management process, including but not limited to, prescribing, dispensing, administering, monitoring, and information exchange.
- b. The Committee shall recommend the adoption or assist in the formulation of professional policies regarding evaluation, selection, procurement, distribution, use, safe practices, and other matters pertinent to medications.
- c. The Committee shall review and recommend or assist in the formulation of new programs and services proposed by the Director of Pharmacy Services, other Hospital personnel or physicians. The Committee shall govern the admission of new drugs to the Hospital Formulary.
- d. The Committee shall consist of the representatives of both RIH and TMH as determined by the Committee charter.
- e. The Committee shall meet monthly. The Committee shall report to the QMIC.

### 11. Physician's Health Committee:

- a. The Committee shall identify and assist staff members suffering from any illness that may impair a physician's ability to practice medicine; accept referrals from the Department Chief in those cases where impaired performance is suspected to be related to a health problem (this in no way will supersede the Chief's authority and responsibility to suspend privileges in the best interest of patient care); refer physicians who are identified to have an impairment to the Rhode Island Medical Society's Physician's Health Committee for intervention; and/or monitor the impaired physician's progress.
- b. The Committee shall consist of three (3) physicians appointed by the President of the Hospital Medical Staff. No member of the Committee shall be a member of the Medical Executive Committee or Division Director. If possible, at least one member of the Committee shall also be a member of the Rhode Island Medical Society's Physician's Health Committee.
- c. The Committee shall meet on an as needed basis. The Committee shall report to the Hospital President, President of the Medical Staff, SVPMA/CMO and Chief of the Department as necessary.

### 12. Procedure Review Committee:

- a. The duties of the Procedure Review Committee shall be to study and to report to the QMIC on the agreement or disagreement of the operative, post-operative, and pathological diagnoses, and on whether the surgical procedures undertaken in the Hospital are acceptable. This study will include those procedures in which normal tissue is removed.
- b. The Procedure Review Committee shall include representatives of the Departments of Surgery, Gynecology and Obstetrics, Medicine, one (i) member who will be chosen from among the various surgical subspecialties, and Hospital Administration. The Chief of the

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Department of Pathology, or a delegate or representative from his/her department, shall serve as an ex-officio member of this Committee.

- c. The meetings of this Committee shall occur on a monthly basis. The Committee shall report to the QMIC.
13. **Quality Management and Improvement Committee (QMIC):** This Committee provides oversight to the Hospital's quality programs including review of indicators, and quality improvement teams. The QMIC assures accountability for the quality programs, monitors departmental and divisional quality programs and indicators, and sets the goals to ensure that the Hospital strives to be in the top decile in all measures.
  14. **Radiation Safety Committee:** This Committee shall develop and maintain a radiation safety program of governance, enforcement, and surveillance to ensure regulatory compliance for routine use and research with radioactivity. This is a joint Rhode Island Hospital and The Miriam Hospital Committee with appropriate representation of the services that use radioactive material or laser. The Committee shall report to the QMIC.
  15. **Transfusion Committee:**
    - a. The Committee shall define the overall scope, program, and policy of blood bank operations; educate House Officers and visiting physicians as required; assist in carrying out new blood bank programs; and review blood utilization to ensure conservation and proper transfusion therapy.
    - b. The Committee shall include the Director of the Blood Bank and representative members from the following departments: Medicine, Surgery, Hospital Administration and other departments as it deems necessary.
    - c. The Committee shall meet as required. The Committee shall report to the QMIC.
  16. **Trauma Committee:**
    - a. The function of the Trauma Committee shall be to establish standards and policies under which injured patients receive care at Rhode Island Hospital. These standards and policies shall be recommended to the QMIC and the Medical Executive Committee for approval. The Committee shall institute and monitor a distinct, interdisciplinary quality assurance program for trauma patients and also shall identify system problems relating to trauma care and recommend solutions to the QMIC.
    - b. The Trauma Committee shall consist of the following members: physician representatives from the Departments and Divisions of Anesthesiology, Emergency Medicine, General Surgery, Neurosurgery, Orthopedic Surgery, Pediatric Surgery, Plastic Surgery, Radiology and Rehabilitation Medicine; the Medical Director of the Trauma Service, the Hospital's Vice President of Patient Services, the State Medical Examiner's Office Representative, an Emergency Medical Services Representative, the Emergency Department Nurse Manager, and the Trauma Care Coordinator.
    - c. The Committee shall meet on a monthly basis. The Committee shall report to the QMIC.

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17. **Utilization Review Committee:** This Committee shall facilitate effective utilization of hospital resources, while providing the highest quality patient care, placing the patient in the appropriate level of care, reducing overall length of stay, and maximizing the efficiency and value of the Hospital stay to any patient or third party payer. The Committee shall report to the Medical Executive Committee at least annually.
18. **General Applicability to All Committees:**
  - a. The committees shall submit minutes to the Medical Executive Committee after each meeting. Each committee Chair or a designated person will provide a written and verbal report to the Medical Executive Committee at least annually on their goals, outcomes, decisions and progress toward their goals.
  - b. The committee Chairmanship and membership shall be reviewed by the Chair of the Medical Executive Committee with final recommendations to the Medical Executive Committee at least on an annual basis.
  - c. The charters, agendas, and membership will be reviewed annually by the committee chairperson and designated membership, and reported to the President of the Medical Staff.
  - d. Additional Medical Executive Committee committees may be developed during the regular course of business of the Medical Executive Committee as required by the needs of the Medical Executive Committee, Medical Staff, or regulatory requirement (TJC, state or federal regulations, CMS Conditions of Participation).