THE

RULES AND REGULATIONS

OF

THE MIRIAM HOSPITAL MEDICAL STAFF

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TABLE OF CONTENTS

SECTION		PAGE
Preamble		3
I.	Admission of Patients	3
II.	Transfer of Patients	5
III.	Discharge of Patients	5
IV.	Criteria for Autopsy	6
V.	Medical Records	7
VI.	General Conduct of Care	12
VII.	General Rules Regarding Surgical Care	14
VIII.	General Rules Regarding Emergency Services	17
IX.	Miscellaneous	18
X.	Committees	19

PREAMBLE

The following Rules and Regulations for The Miriam 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 Miriam 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 Where conflicts in requirements arise, these Rules and Regulations are superseded by external regulatory requirements.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.

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 practitioners shall be governed by the admitting policies of the Hospital. The attending practitioner 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 practitioner from the applicable specialty department or section as an attending. Where no such request is made, or the requested practitioner 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 for the selected specialty service will be contacted regarding the recommended admission. The contacted attending always has the opportunity to directly evaluate

the patient and actively participate in the disposition decision. If that admitting attending 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 his/her 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.

7. Each practitioner 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 practitioner 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 and examined by the attending physician as promptly as necessary to ensure that appropriate evaluation and treatment are initiated such that preventable morbidity is avoided. 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 his/her designee, must evaluate a newly admitted patient within twenty-four (24) hours of the 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.

    b. 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.

    c. Pre-Operative/Procedural Inpatient Admissions, including patients already scheduled for surgery or other procedures. 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.

    d. Direct Admissions From Office Settings. These patients may need to be routed through the Emergency Department if medical stabilization is necessary.

II. TRANSFER OF PATIENTS

1. No patient shall be transferred without consultation with and approval by the practitioner responsible for that patient.

2. Patient transfers from another facility will adhere to the following guidelines:

    a. The 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 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 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 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 will contact the admitting attending (and accepting attending if different) 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 physician 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 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 practitioner or Licensed Independent Practitioner (LIP) designee. Should a patient leave the Hospital against the advice of the attending practitioner, LIP designee, or without proper discharge, 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/or psychosocial status;
      3. a summary of care, treatment, and services provided;
      4. medication reconciliation of the admitting medications with those to be given 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 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 shall conform to state and federal law.

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. The Medical Staff has determined the following situations as ones in which it is advisable to recommend the performance of an autopsy:

   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 ante mortem 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, will 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 when creating medical record entries to ensure 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 authorship 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, his/her resident designee or LIP 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 plan of treatment. 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 practitioner. An interim note is a statement entered into

the medical record, prior to the procedure, by the practitioner performing the procedure, to indicate that an H&P has been reviewed and stating:

"***I have seen and examined the patient and"*** either: "There are no changes to the findings contained in the H&P since the time the H&P was performed," or "There are changes and such changes are subsequently documented in the medical record."

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 practitioner 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-Procedures 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 of surgery;

   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 anesthesia and surgery;

   d. provisional diagnosis;

   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: A detailed operative report shall be written or dictated immediately after surgery or other high risk procedure and shall contain the following elements:

a. name and, if dictated, hospital identification number of the patient;

b. date and times of the surgery (start and end times);

c. name(s) of the surgeon(s)/proceduralist(s), anesthesia provider(s) and assistants or other practitioners who performed surgical tasks (even when performing those tasks under supervision);

d. preoperative and postoperative diagnosis(es);

e. name of the specific surgical procedure(s) performed;

f. type of anesthesia administered;

g. any unusual events or complications, if any;

h. a description of 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 practitioners name(s) and a description of the specific significant surgical tasks that were conducted by practitioners other than the primary surgeon/practitioner (significant surgical procedures include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices, 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, and date and time of the operation/procedure.

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 practitioner according to discharge criteria, and shall record the name of the practitioner 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 responsible practitioner.

8. Countersignature Requirements: Other providers whose clinical privileges require countersignature 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.

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 practitioners 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 practitioner 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 authorized quality assessments and 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 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, diskette, CD, 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 The Miriam 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 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 practitioner will enter all orders via

computerized order entry.

b. The practitioner'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.

3. Verbal Patient Orders:

a. Except in urgent/emergent situations, verbal orders should not be utilized if the practitioner 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 practitioner. The order shall be written or electronically entered upon receipt and shall include the date and the names of the individuals who gave and received the order. The qualified personnel taking the verbal order shall read it back aloud to the ordering practitioner 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 practitioner 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 practitioner, attending, or covering practitioner.

d. Authentication of special verbal orders, such as those for withholding resuscitative services (Do Not Resuscitate orders), for the use of restraints, and/or seclusion, shall follow applicable Hospital policy.

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. That 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 bona fide clinical investigations may be exceptions. These shall be used in full accordance with the Statement of Principles involved in the Use of Investigational Drugs in Hospitals, 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 practitioner with clinical privileges in the Hospital can be called for consultation within his/her area of expertise.

b. Consistent with Hospital policy, the attending practitioner is primarily responsible for requesting a consultation when indicated and for calling in a qualified consultant through the entry of a valid order and a record of the practitioner to consultant communication. The practitioner to consultant communication and the medical record shall indicate the reason(s) for the request and its urgency.

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. Except in emergency situations, when operative procedures are involved, the consultation report shall be recorded prior to the operation or procedure.

d. 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 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 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 practitioner 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 dentist's responsibility 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 physician's responsibility 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 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 applies to a patient undergoing a procedure for which the podiatrist does not have clinical privileges to perform the required H&P.

a. It is the podiatrist's responsibility 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 physician's responsibility 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 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 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.

d. Should a second operation 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 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 practitioner(s) who provided the patient care.

3. The Emergency Department physician shall decide when the services of a specialist are required for the patient.

4. Consistent with local, state and federal requirement the following suspected abuses must be reported immediately:

a. If a physician suspects that a child brought to the Emergency Department has been abused or neglected an immediate verbal report must be made 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.

d. Any suspect of Intimate Partner Violence shall be reported to the local police.

5. Responsibility of on-call physicians to respond to consultation requests from the Emergency Department:

   a. Physicians are expected to respond by telephone to pages from the Emergency Department as soon as possible and no later than thirty (30) minutes. Physicians who for legitimate reasons cannot respond at that time must designate a proxy individual to respond.

   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. Physicians who request other physicians to assume all or part of their scheduled on-call responsibilities must be certain that the physician has comparable privileges at the Hospital.

   d. Physicians are expected to respond regardless of a patient's financial class 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 as delineated in said 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. Recognition of Jewish Holidays: No formal Medical Staff meeting shall be scheduled or held on Yom Kippur, Rosh Hashanah, or the first two evenings of Passover. Medical education conferences are discouraged from being scheduled on the above dates.

4. Rhode Island Hospital Meetings: A physician who fulfills the meeting attendance requirements for staff membership at Rhode Island Hospital will be considered to have fulfilled the requirements for meeting attendance at The Miriam 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.

    The Committee shall meet as required. The Committee shall meet at least once a year during the month of September; it shall carefully review the Bylaws, and Rules and Regulations and submit a report in writing to the Medical Executive Committee through the President of the Medical Staff of any needed changes.

2. Cancer Care Committee: The Cancer Care Committee shall consist of a Chair and Vice Chair appointed by the President of the Medical Staff. Membership shall be multidisciplinary and include at least representatives from surgery, oncology, diagnostic imaging, radiation oncology, pathology and laboratory medicine, nursing, quality assurance, social services, the tumor registry and the cancer liaison physician. A subcommittee of the Cancer Committee, the Breast Program Leadership (BPL), shall be responsible for monitoring adherence to the applicable National Accreditation Program for Breast Centers (NAPBC) standards. The President of the Medical Staff shall appoint physician members and employees of the Hospital in consultation with Hospital Administration.

    The Committee shall:

    a. initiate, stimulate, and assess the results of cancer activities in the Hospital;

    b. ensure that patients have access to consultative services and disciplines;

c. strive to ensure that educational programs, conferences and other clinical activities relate to all aspects of cancer care;

d. actively monitor the cancer database for quality control of abstracting, staging, and reporting;

e. assure that the program is meeting the standards of the Commission on Cancer, National Accreditation Program for Breast Centers, and the College of Pathology; and,

f. on an annual basis, perform an audit function regarding patient care at the Hospital.

The Committee shall meet at least quarterly and shall maintain a permanent record of its proceedings and actions.

3. Clinical Quality Council (CQC): This Committee shall provide oversight to the Hospital's quality programs including review of indicators, and quality improvement teams. The CQC helps ensure 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.

4. Infection Control Committee:

   a. The Committee shall work to ensure an acceptably low level of infectious hazard for patients and Hospital personnel through the design, administration, and regular review of a program of infection control.

   b. The Committee shall include representative members from, but not limited to, the following departments: Medicine, Surgery, Nursing, and Hospital Administration. The Committee shall also include the Director of Infectious Diseases or his/her designee, 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 Medical Executive Committee.

5. Medical Records Committee**:** This Committee shall establish policy and manage the accountability of the Medical Staff for the medical records of Hospital patients and works with Health Information Services to ensure the integrity of the medical record and compliance with policy. The Committee shall meet at least quarterly and more frequently as necessary. The Committee shall report to the Medical Executive Committee.

6. Mortality Review Committee: This Committee shall be responsible for reviewing mortality cases to identify system as well as standard of care deficiencies contributing to unexpected patient deaths and provides constructive feedback to appropriate Medical Staff Members. The Committee will meet monthly or as determined by the Chair of the Medical Executive Committee. The membership will represent the Divisional specialties at the Hospital.

7. Patient Care Committee (PCC): This Committee shall provide oversight to the Hospital's operations in the areas of policy, order sets, work-flow, inter-disciplinary collaboration, and implementation of new programs and other assigned responsibilities.

8. Patient Safety Committee (PSC): This Committee shall provide oversight for the Hospital's safety programs and issues pertaining to the culture of safety, as well as for the Hospital indicators that relate to the safety agenda and their monitoring.

9. 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 Patient Safety Committee.

10. 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 Department 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 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, the Executive Director, the President of the Medical Staff, the SVPMA/CMO, and the Chief of the Department as necessary.

11. Radiation Safety Committee**:** This Committee shall develop and maintains 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 Patient Safety Committee.

12. 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, Resident Staff, Hospital Administration and other departments as it deems necessary.

    c. The Committee shall meet as required. The Committee shall report to the Medical Executive Committee or designated committee.

13. Utilization Review Committee**:** The Committee facilitates 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.

14. General Applicability to All Committees:

    a. The committees will 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 a 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 Chair of the Medical Executive Committee.

    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, and CMS Conditions of Participation).